Provider Manual - Combined

The information provided is the most up-to-date as of the date of this publication. For the most up-to-date information, visit providerlibrary.healthnetcalifornia.com

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Provider Manual

The Medi-Cal Operations Manual offers Health Net Community Solutions, Inc. (Health Net), CalViva Health, and Community Health Plan of Imperial Valley providers access to important information about plan benefits, limitations and administration processes to make sure members enrolled in the Medi-Cal managed care plan receive covered services when needed.

Health Net, CalViva Health, and Community Health Plan of Imperial Valley are regulated by the California Department of Health Care Services (DHCS) and the California Department of Managed Health Care (DMHC). The Health Net, CalViva Health, and Community Health Plan of Imperial Valley Medi-Cal plans are offered by Health Net, CalViva Health, and Community Health Plan of Imperial Valley under a contract with the DHCS.

CalViva Health contracts with DHCS to provide services to Medi-Cal managed care members under the Two-Plan model in all ZIP Codes in Fresno, Kings and Madera counties. The Operations Manual for CalViva Medi-Cal providers in Fresno, Kings and Madera counties is developed and maintained for CalViva Health by Health Net.

Community Health Plan of Imperial Valley contracts with DHCS to provide services to Medi-Cal managed care members under the Single-Plan model in Imperial County. The Operations Manual for Community Health Plan of Imperial Valley Medi-Cal providers in Imperial County is developed and maintained for Community Health Plan of Imperial Valley by Health Net.

In Los Angeles County, Health Net is a primary contractor with DHCS as the commercial plan under the Medi-Cal Managed Care Two-Plan Model. However, Health Net entered into a contract with Molina Healthcare as a subcontracting health plan to arrange for the provision of Medi-Cal services through Molina's provider network. Some Medi-Cal members in Los Angeles County are Health Net members, even if assigned to Molina. Except as noted, the policies, procedures and programs described in the Medi-Cal Operations Manual are applicable to all contracting providers, including those contracting through Molina.

The four provider types, Physicians and Practitioners, Participating Physician Groups (PPGs), Hospitals, and Ancillary, are listed at the top of each page. Unless specified within the body of the document, refer to the Provider Type listed at the top of the page to see if the content applies to you.

As a Health Net participating provider, you are required to comply with applicable DHCS laws and regulations and Health Net policies and procedures.

The contents of Health Net's Medi-Cal Operations Manual are in addition to your Provider Participation Agreement (PPA) and its addenda. When the contents of Health Net's Medi-Cal Operations Manual conflicts with the PPA, the PPA takes precedence.

Adverse Childhood Experiences (ACEs)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information is intended to provide a general guide to help you implement screening for adverse childhood experiences (ACEs) and better determine the likelihood that a patient may be at increased health risk due to a toxic stress response. Screening for ACEs helps inform patient treatment and encourages the use of trauma-informed care. For more information, visit ACEs Aware.

Prevent

Trauma Informed Care

ACEs are stressful or traumatic experiences people have by age 18, such as abuse, neglect and household dysfunction. By screening for ACEs, providers can better determine the likelihood that a patient may be at increased health risk due to a toxic stress response. This is a critical step in advancing trauma-informed care.

Follow the principles of trauma-informed care. Use these key principles as a guideline:

- Establish the physical and emotional safety of patients and staff.
- Build trust between providers and patients.
- Recognize the signs and symptoms of trauma exposure on physical, psychological and behavioral health.
- Promote patient-centered, evidence-based care.
- Train leadership, providers and staff on trauma-informed care.
- Ensure provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed-upon goals for treatment.
- Provide care that is sensitive to the racial, ethnic, cultural and gender identity of patients.

References

For more information, refer to ACEs Aware.

Toxic Stress

Everyone experiences stress. Stress can show up in our bodies, emotions and behavior in many different ways. Too much of the wrong kind of stress can be unhealthy and, over time, become “toxic” stress and harm physical and mental health. An adult who has experienced significant adversity in the past, especially during the critical years of childhood, may be at higher risk of experiencing health and behavioral problems during times of stress.

References

For more information, refer to:

- ACEs Aware
- California All
- CFAP
- Healthy Children

ACEs Training and Self-Attestation Requirement for Billing

Effective July 1, 2020, Medi-Cal providers who have completed the two-hour online ACEs training and submitted their self-attestation to DHCS can continue or begin billing for ACEs screenings. Providers who missed the July 1 deadline can still complete the training, self-attest and begin billing the month of completing the attestation.

- **To get started,** register for the online training.
- **To self-attest,** complete the DHCS Trauma Screening Training Attestation in the ACEs Aware Learning Center.

You must attest with a valid NPI number, or you will not be eligible to receive payment. DHCS maintains a roster of providers who have attested to completing the Becoming ACEs Aware in California training, which is shared with the Managed Care Plans for reimbursement validation. Our support teams at Provider Services and the Provider Relations Department will have the latest attestation list and be able to look up the customer/provider to see if DHCS has received their ACEs training attestation online form.

Screen for ACEs

Screening for ACEs can help determine if a patient is at increased health risk due to a toxic stress response and help a clinician provide trauma-informed care. Identifying and treating cases of trauma in children and adults can lower long-term health costs and support the well-being of individuals and families.

The California Department of Health Care Services (DHCS) has identified and approved specific screening tools for children and adults for the 10 categories of ACEs grouped under three sub-categories: abuse, neglect and household dysfunction.

For children and adolescents, use PEARLS.

PEARLS is designed and licensed by the Center for Youth Wellness and is available in additional languages. There are three versions of the tool based on age:

- PEARLS for children ages 0–11, to be completed by a parent/caregiver
- PEARLS for ages 12–19, to be completed by a parent/caregiver
- PEARLS for teenagers ages 12–19, self-reported

Note: PEARLS includes Part 1 (ACEs) and Part 2 (additional adversities/related life events). Only part 1 is used to calculate the ACE score and for Medi-Cal billing purposes.

For adults, use the ACEs assessment tool.

The ACEs assessment tool is adapted from the work of Kaiser Permanente and the Centers for Disease Control and Prevention (CDC). Other versions of the ACEs questionnaires can be used, but to qualify, questions must contain the 10 categories mentioned above.

Use of tools

AGES	USE THIS TOOL	TO RECEIVE DIRECTED PAYMENT
0-17	PEARLS	Permitted for periodic ACEs rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children and adolescents should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1]
18 or 19	ACEs or PEARLS	Permitted for periodic ACEs rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1]
20-64	ACEs screening portion of the PEARLS tool (Part 1) can also be used.	· **Age 20:** Permitted for periodic ACEs rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology. · **Adults ages 21 through age 64:** Permitted once in their adult lifetime (through age 64), per clinician (per managed care plan). Screenings

AGES	USE THIS TOOL	TO RECEIVE DIRECTED PAYMENT
		completed while the person is under age 21 do not count toward the one screening allowed in their adult lifetime. Adults should be screened at least once in adulthood. Although ACEs occur in childhood (by definition) and therefore do not change, patient comfort with disclosure may change over time, so re-screening for adults may be considered, but repeat adult screenings are not billable.[1]

[1]https://www.acesaware.org/learn-about-screening/billing-payment. Copyright © 2023 by the State of California Department of Health Care Services.

The approved tools are available in two formats:

- **De-identified screening tool:** Patients have the option to choose a de-identified screening, which counts the numbers of experiences from a list without specifying which adverse experience happened.
- **Identified screening tool:** Patients can opt in for an identified screening in which respondents specify the experience(s) that happened to their child or themselves.

Providers are encouraged to use the de-identified format to reduce the fear and anxiety patients may have.

Administering the screening

There are several ways to administer the screening. Providers are encouraged to use the tools appropriate for their patient population and clinical workflow. Before administering, providers should consider the following:

- Identify which screening tools and format to use for adults, caregivers of children and adolescents, and adolescents.
- Determine who should administer the tool, and how.
- Determine which patients should be screened.

It is recommended that the screening be conducted at the beginning of an appointment. Providers or office staff will provide an overview of the questionnaire and encourage the patients (adolescent, adults or caregivers) to complete the form themselves in a private space to allow members to disclose their ACEs without having to explain their answers. Patients may take up to five minutes to complete the screening tool.

References

For more information, refer to:

- ACEs Aware screening tools
- ACE Screening Clinical Workflows and Assessment Algorithm

Treatment

The ACEs score determines the total reported exposure to the 10 ACEs categories indicated in the adult ACEs assessment tool or the top box of the pediatric PEARLS tool. ACEs scores range from 0 to 10 based on the number of adversities, protective factors and the level of negative experience(s) that have impacted the patient. Providers will obtain a sum total of the number of ACEs reported on the screening tool.

For children and adults, two toxic stress risk assessment algorithms based on the score were developed to determine the level of risk and referral needs. According to the algorithm, risk and scores are determined as follows:

Risk	Score	Action
Low	0	If a patient is at low risk, providers should offer education on the impact of ACEs, anticipatory guidance on ACEs, toxic stress and buffering factors.
Intermediate	1 – 3	A patient who scores 1–3 has disclosed at least one ACEs-associated condition and should be offered educational and appropriate resources.
High	1 – 3 with associated health conditions, or a score of 4 higher	The higher the score, the more likely the patient has experienced toxic stress during the first 18 years of life and may be at increased risk for mental health conditions, such as depression, post-traumatic disorder, anxiety and engaging in risky behaviors. Assess for toxic stress and provide interventions and referrals services.

References

For more information, refer to:

- ACEs Aware treatment
- ACEs Screening Clinical Workflows and Assessment Algorithm
- ACEs Aware resources

Heal: Referral and Resources

As part of the clinical workflow, providers should be prepared with a treatment plan and referral process so patients who have identified behavioral, social or trauma can be connected to trained professionals and resources. Building a strong referral network and conducting warm hand-offs to partners and services are vital to the treatment plan. In addition, it is critical to build a follow-up plan to effectively track the patient's process to ensure they get connected to the support needed.

ACEs resources

Free ACEs resources for providers on screening and clinical response.

The Live Beyond Campaign: Raising Awareness to Help Californians Heal from ACEs

The Office of the California Surgeon General has launched the Live Beyond campaign to raise awareness about ACEs and toxic stress, particularly targeting youth and young adults in California. The Live Beyond campaign focuses on increasing knowledge about ACEs, influencing attitudes toward seeking help, building skills for managing stress, and inspiring action to break the cycle of trauma. To learn more, visit the Live Beyond Campaign here.

Behavioral Health Services

Health Net Medi-Cal members enrollees can obtain individual and group mental health evaluation and treatment. Providers can call Behavioral Health Provider Services.

CalViva Health Medi-Cal members can obtain individual and group mental health evaluation and treatment. Providers should call Health Net if a member needs emergent or routine treatment services. Members should call CalViva Health Member Services if they need these services.

For Community Health Plan of Imperial Valley (CHPIV) Medi-Cal members:

CHPIV Medi-Cal members can obtain individual and group mental health evaluation and treatment. Providers should call Health Net if a member needs emergent or routine treatment services. Members should call CHPIV Member Service if they need these services.

Case Management

If your patient is uncertain about next steps or would like to learn more, please refer them to the health plan's behavioral health Case Management Department.

Health Net, Community Health Plan of Imperial Valley & CalViva Community Connect

Community Connect are powered by Findhelp formerly known as Aunt Bertha, which is the largest online search and referral platform that provides results customized for the communities you and your health care staff serve or where members live. To use the tool:

- **Health Net and CHPIV** members should go to Findhelp, enter a ZIP code and click *Search* .
- **CalViva Health Medi-Cal** members should go to CalViva Findhelp, enter a ZIP code and click *Search* .

Appeals, Grievances and Disputes

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes initial organization determinations, member and provider appeals, dispute resolution processes, and peer-to-peer review requests.

Select any subject below:

- Member Appeals
- Provider Appeals and Dispute Resolution
- Grievances

Member Appeals

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes information on the member appeals process, including procedures and requirements.

Select any subject below:

- Member Appeals Overview
- State Hearing Division

Member Appeals Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A member appeal is a request for reconsideration of an adverse benefit determination that involves the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit. An adverse benefit determination notice is also known as Notice of Action (NOA). Member appeals may be submitted by the member, or the provider on the member's behalf, verbally or in writing, within 60 calendar days of receipt of a denial for prior authorization or receipt of an NOA to the Health Net Medi-Cal Member Appeals and Grievances Department.

Appeals filed by the provider on behalf of the member require written consent from the member. Appeals received after the 60-day time frame are not considered. Upon request, Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) representatives are available to assist members in writing an appeal. An appeal must include any additional or supporting information the member would like Health Net to consider.

Medi-Cal Pharmacy Benefit Carve Out - Medi-Cal Rx

Medi-Cal pharmacy benefits are administered through the Department of Health Care Services (DHCS) fee-for-service delivery system called Medi-Cal Rx. Appeals and grievances for outpatient pharmacy benefits and services are not Health Net's responsibility and must be directed to Medi-Cal Rx.

Notice of Action

Members may receive a written notice of adverse benefit determination as a notice of action (NOA) regarding a denial, delay, modification, or termination. If a member received a NOA, the following options are available:

- The member has 60 calendar days from the date on the NOA to file an appeal of the NOA with Health Net.
- The member may request an independent medical review (IMR) from the Department of Managed Health Care (DMHC) after first filing an appeal with Health Net, or right away if the member's health is in immediate danger or if the request was denied because treatment is considered experimental or investigational.
- Aid Paid Pending (Medi-Cal only).
- Members have 60 days from the date of the NOA letter to file an appeal. If Health Net decided to reduce, suspend or terminate a service the member is currently getting, the member may be able to continue the service until an appeal decision is made. This is called Aid Paid Pending. To qualify for Aid Paid Pending, the member must file an appeal within 10 days from the NOA letter.

Availability of Member Assistance in Filing an Appeal

The member can ask for an appeal. Or, they can have someone like a relative, friend, advocate, doctor, or attorney ask for one for them. This person is called an Authorized Representative. The member's health plan can provide a form for them to identify their Authorized representative. The member, or their Authorized Representative, can send in anything they want their health plan to look at to make a decision on their appeal. A doctor who is different from the doctor who made the first decision will look at the member's appeal.

A provider may also submit an appeal on behalf of the member or an authorized representative, when the member is challenging a denial of a prior authorization request or a service. Appeals filed by the provider or authorized representative, on behalf of the member, require written consent from the member or authorized representative. Members have a right to access their medical records. Written authorization from the member or the member's authorized legal representative must be obtained before medical records are released to

anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the Health Plan.

These appeals are considered member appeals, not provider appeals. They are processed in the same manner as an appeal submitted by a member:

- Health Net, not the participating physician group (PPG) or subcontractor, processes the appeal.
- There is no second-level appeal between Health Net and the PPG. Additional appeal rights are provided in their appeal resolution letter.

Health Net, its PPGs and participating providers will not discriminate against members who have filed an appeal in accordance with Title 28, CCR 1300.68(b)(8). Health Net does not take any punitive action against a provider who requests an expedited appeal or supports a member's appeal. Further, Health Net does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is his or her patient for:

1. The member's health status, care, or treatment options, including any alternative treatment that may be self-administered.
2. Any information the member needs, in order to decide among all relevant treatment options.
3. The risks, benefits and consequences of treatment or non-treatment.
4. The member's right to participate in decisions regarding his or her care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Appeal Resolution Process

When the Health Net Medi-Cal Member Appeals and Grievances Department receives the appeal, it is assigned a case number, is researched and resolved. A written acknowledgment is mailed to the member within five calendar days of receipt of the written standard appeal. Within 30 calendar days of receipt of a standard appeal and within 72 hours of receipt of an expedited appeal, members are sent a written Notice of Appeal Resolution (NAR), stating the decision made and the rationale for that decision. An NAR is a formal letter informing a beneficiary that an adverse benefit determination has been overturned or upheld.

If Health Net upholds the initial denial of coverage, the member has the following options:

- The member may apply to the DMHC for an Independent Medical Review (IMR) within 180 days from the date of the NAR letter or after exhausting the plan’s grievance and appeals process. However, the member may request an Independent Medical Review (IMR) from the DMHC right away if the member’s health is in immediate danger or if the request was denied because treatment is considered experimental or investigational; otherwise, the member must first file an appeal with the plan.
- The member may request a state hearing by phone or in writing from the California Department of Social Services (DSS) only after receiving an NAR and within 120 calendar days from the date of the NAR letter. However, if Health Net continued to provide the member with the disputed service(s) (Aid Paid Pending) during the appeal process, and the member wants to continue to receive the service until there is a State Hearing decision, the member must request a State Hearing within 10 days of the NAR. Members also have the right to representation by legal counsel, a friend or other spokesperson during the process.
- Members may ask for both an IMR and State Hearing at the same time. However, if the member asked for a State Hearing first and the hearing already took place, then the member cannot ask for an IMR. This means the State Hearing’s outcome is the final decision.

Expedited Appeals

Members can request an expedited appeal if his or her health or ability to regain maximum function could seriously be harmed by waiting for a standard service appeal. A member or provider, acting on behalf of a member and with written consent from the member, may file an expedited appeal either orally or in writing to resolve the expedited appeal within 72 hours of receipt.

State Hearing

Members may request a state hearing by phone or in writing from the California Department of Social Services (DSS) after receiving a NAR from Health Net stating that their member's appeal is denied the member has exhausted the appeals process. Members may request a state hearing up to 120 calendar days from the date on Health Net's NAR. Members may continue to receive benefits during the hearing process, and have the right to representation by legal counsel, a friend or other spokesperson during the process.

Within two business days of being notified by the Department of Health Care Services (DHCS) or DSS that a member has filed a request for a state hearing, which meets the criteria for expedited resolution, Health Net delivers directly to the designated or appropriate DSS administrative law judge all information and documents which either support, or which Health Net considered in connection with, the action which is the subject of the expedited state hearing. If the NOA or NAR notices are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and NAR.

If the member is currently getting treatment and he or she wants to continue getting treatment, the member may ask for a state hearing within 10 days from the date that the NAR was postmarked or delivered or before the date Health Net benefits will end or stop. The member must state that he or she wants to continue treatment when he or she requests the state hearing.

The state must reach a decision for a standard state hearing and notify the member within 90 days of the date of the request. For an expedited state hearing, the state must reach its decision within three business days of receipt of the expedited state hearing request.

Medi-Cal members must first undergo Health Net's appeal process before they may submit a hearing request unless Health Net did not issue the NOA within the required timeframe, Health Net exhausted the appeal process time or Health Net did not send the NOA in the member's preferred language. Members may receive continued benefits during the hearing process. Members have the right to be represented by legal counsel, a friend or other spokesperson. Filing a grievance does not waive a member's right to a hearing.

Representation and Assistance Rules at A State Fair Hearing

The member can speak for themselves at the State Hearing. Or, they can have someone like a relative, friend, advocate, doctor, or attorney speak for them. If a member wants someone else to speak for them, they must add their name, address, and telephone number to the form or letter and sign the form telling the State Hearings Division that the person can speak for them. This person is called an Authorized Representative.

The member will not have to pay for an interpreter if one is needed. The State Hearings Division will get them one. If the member has a disability, the State Hearings Division can get them special accommodations free of charge to help them participate in the hearing.

Expedited Hearing

It could take up to 90 days to decide on a case. If waiting 90 days will hurt the member's health, they can request an expedited hearing. If the State Hearings Division approves their request for an Expedited Hearing, they may be able to get a hearing decision within 3 days from the date it receives the member's case file from their health plan.

The member can ask for an Expedited Hearing by calling or sending the State Hearing form or a letter to the State Hearings Division. The member must explain how waiting for up to 90 days for a decision will harm their life, health or ability to get or keep maximum function. The member can also get a letter from their doctor to help show why they need an Expedited Hearing.

Provider Appeals and Dispute Resolution

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes general information on provider dispute resolution and appeals processes.

Select any subject below:

- Overview
- Acknowledgement and Resolution
- Dispute and Appeal Status
- Dispute Submission
- Inquiry Submission

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's provider dispute resolution process ensures correct routing and timely consideration of provider disputes (or appeals). Participating providers use this process to:

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net.
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim.
- Challenge a request by Health Net for reimbursement for an overpayment of a claim.
- Seek resolution of a billing determination or other contractual dispute with Health Net.
- Appeal a participating physician group's (PPG's) written determination following its dispute resolution process when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the PPG's written determination.

- Challenge capitated PPG or hospital liability for medical services and payments that are the result of Health Net decisions arising from member grievances, appeals and other member services actions.
- Challenge capitation deductions that are the result of Health Net decisions arising from member billings, claims or member eligibility determinations.

Health Net does not charge providers of service who submit disputes to the Health Net Provider Appeals Unit or the Health Net Medi-Cal Appeals Unit for processing provider disputes and does not discriminate or retaliate against a participating provider who uses the provider dispute process. Further, providers participating through a Health Net PPG cannot be charged a processing fee when utilizing the PPG's provider dispute process.

Disputes regarding the denial of a referral or a prior authorization request are considered member appeals. Although participating providers may appeal such a denial on a member's behalf, the member appeal process must be followed. Refer to the Dispute Resolution and Appeals topic for additional information.

In addition to the provider dispute resolution process (PDF), a provider inquiry process is available for routine claim follow-up when a participating provider wants to:

- Inquire regarding the status of a claim or obtain payment calculation clarification.
- Resubmit contested claims with the missing information requested by Health Net.
- Submit a corrected claim (additional charges previously not submitted).
- Clarify member responsibility.

To check the status of an appeal or dispute, contact the applicable Health Net Provider Services Center for members:

- Health Net Provider Services Center - Commercial (HMO, HSP, EPO, PPO)
- Health Net Medi-Cal Provider Services Center
- Community Health Plan of Imperial Valley Provider Services Center
- CalViva Health Provider Services Center

Overview for Physicians

Health Net's provider dispute resolution process ensures correct routing and timely consideration of provider disputes (or appeals). Participating providers use this process to:

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net.
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim.
- Challenge a request by Health Net for reimbursement for an overpayment of a claim.
- Seek resolution of a billing determination or other contractual dispute with Health Net.
- Appeal a written determination when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the written determination.

Health Net does not charge providers of service who submit disputes to the Health Net Provider Dispute - Commercial Appeals Unit, the Health Net Provider Appeals Unit - IFP or the Health Net Medi-Cal Appeals Unit

for processing provider disputes and does not discriminate or retaliate against a participating provider who uses the provider dispute process.

Disputes regarding the denial of a referral or a prior authorization request are considered member appeals. Although participating providers may appeal such a denial on a member's behalf, the member appeal process must be followed. Refer to the Dispute Resolution and Appeals topic for additional information.

In addition to the provider dispute process, a provider inquiry process is available for routine claim follow-up when a participating provider wants to:

- Inquire about the status of a claim or obtain payment calculation clarification.
- Resubmit contested claims with the missing information requested by Health Net.
- Submit a corrected claim (additional charges previously not submitted).
- Clarify member responsibility.

To check the status of an appeal or dispute, contact the applicable Health Net Provider Services Center for members:

- Health Net Provider Services Center - Commercial (HMO, PPO)
- Health Net Medi-Cal Provider Services Center
- Community Health Plan of Imperial Valley Provider Services Center
- CalViva Health Provider Services Center

For additional information refer to Definition of Contracted Provider Dispute..

Acknowledgement and Resolution

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net acknowledges receipt of each provider dispute, in writing and within 15 business days of receipt. If the provider dispute submission does not include all pertinent details of the dispute, it is returned to the provider with a request detailing the additional information required to resolve the issue. The amended dispute must be submitted with the missing information within 30 business days from the date of receipt of the request for additional information.

Providers are not asked to resubmit claim information or supporting documentation that was previously submitted to Health Net as part of the claims adjudication process, unless Health Net returned the information to the provider.

Health Net resolves each provider dispute within 45 business days following receipt and sends the provider a written determination stating the reasons for the determination.

If the provider dispute involving a claim for a provider's services is resolved in favor of the provider, Health Net pays any outstanding money due, including any required interest or penalties, within five business days of the decision. Accrual of the interest and penalties, if any, commences on the day following the date by which the claim or dispute should have been processed.

Participating providers who contract directly with Health Net and disagree with Health Net's determination may refer to their Provider Participation Agreement (PPA) for other available resolution mechanisms.

Dispute and Appeal Status

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers can contact the Health Net Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) or Molina Healthcare to check the status of a dispute or appeal.

Dispute Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net accepts disputes, including appeals, from participating providers if they are submitted within 365 days of receipt of Health Net's decision (for example, denial or adjustment), except as described below. If the participating provider does not receive a decision from Health Net, the dispute must be submitted within 365 days after the deadline for contesting or denying the claim has expired. If the participating provider's Provider Participation Agreement (PPA) provides for a dispute-filing deadline that is greater than 365 calendar days, this longer time frame continues to apply until the contract is amended.

When submitting a provider dispute, a provider should use the Provider Dispute Resolution Request form - Provider Dispute Resolution Request form - Health Net (PDF), Provider Dispute Resolution Request form – Community Health Plan of Imperial Valley (PDF) or Provider Dispute Resolution Request form - CalViva Health (PDF). If the dispute is for multiple, substantially similar claims, the Provider Dispute Resolution Request spreadsheet (page two of the request form above and up to 12 claims) or the Claims Project Submission Universal Template spreadsheet (used for more than 12 claims) should be submitted with the Provider Dispute Resolution Request form. The Claims Project Submission Universal Template spreadsheet should be requested from your Provider Network Management contact. Provider Network Management will email you a copy of the spreadsheet template to complete and submit along with the Provider Dispute Resolution Form.

The provider dispute must include:

- The provider's name; identification (ID) number; contact information, including phone number; and the original claim number.
- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include: a clear identification of the disputed item; the date of service; and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is not about a claim, the provider must include a clear explanation of the reason for the dispute, including, if applicable, relevant references to the PPA.

Providers who participate under a capitated agreement with a participating physician group (PPG) must submit disputes to the PPG that processed the claim.

Inquiry Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For routine claim follow-up, providers may contact the Health Net Provider Services Department. Providers may also use any of the following claims and appeals address information:

- Submission of a new claim.
- Resubmission of contested claims with missing information (requested individual claim documents), including submission of a corrected billing (additional charges previously not submitted).
- Submission of provider appeals.

Providers may use their own spreadsheet or form when submitting provider inquiry requests to the Health Net Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center. Providers must include the following information to ensure appropriate research:

- Provider's full name
- Provider tax ID or NPI number
- Member's name
- Member's date of birth (DOB)
- Health Net identification (ID) card number
- Date of service
- Billed amount
- Claim number

Providers who participate in Health Net's Medi-Cal plan under a capitated agreement with a participating physician group (PPG) must submit inquiries to the PPG or affiliated health plan (Molina Healthcare in Los Angeles County) that processed the claim.

For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. For Molina Healthcare Provider Services Department please contact Molina directly.

Grievances

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Member Grievance Process

A member, or his or her physician or other representative, may file a grievance on behalf of the member anytime according to the current federal regulations, Title 42, CFR, Section 438.402(c)(i). Grievances filed by the member's physician or other representative, on behalf of the member, require written consent from the

member or authorized representative. Members may submit grievances verbally or in writing by contacting the Health Net Medi-Cal Member Appeals and Grievances Department.

Members may obtain a member grievance/complaint form from their providers' office, or they may contact the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department for assistance. The Member Grievance/Complaint forms are available online for Health Net Medi-Cal members.

A member grievance is an oral or written expression of dissatisfaction or concern that does not involve a prior determination. Member grievances include quality of care concerns, access to care concerns, complaints regarding delays of referrals or authorizations, and provider refusals to submit medical records. There are two types of member grievances:

- administrative - concerns of a non-clinical nature
- clinical - concerns of a clinical nature

Member grievances may be submitted orally or in writing any time. The first step in registering a grievance is to call the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

The second step is to submit it in writing with the following information:

- a description of the problem, including all relevant facts
- names of involved people
- date of occurrence
- supporting documentation

Health Net members are notified in writing of receipt of a grievance within five calendar days.

Members are informed in writing of resolution of the grievance within 30 calendar days. If resolution of the case exceeds 30 calendar days, Health Net will send the member a letter of explanation by the 30th calendar day, documenting the reason for the delay and an estimated completion date for the resolution.

Resolution Process

A Health Net Appeals & Grievances Case Coordinator handles the grievance and corresponds with the provider, including requesting any additional information necessary. Upon receipt, the Case Coordinator forwards the case to a Health Net Clinician for review of all clinical grievances. For Non-Clinical grievances, the Case Coordinator will handle to resolve. In both instances the member will receive a written resolution.

Information gathered by Health Net, and as a result of the review of quality-related grievances that involve a provider, is considered confidential and protected from disclosure as quality of care-related peer review activities under California law. Member grievances related to a request for reassignment or disenrollment of a Medi-Cal member are referred to the Health Net Medi-Cal Member Services Department.

Member Grievance Procedures

A member, or his or her physician or other representative, may file a grievance on behalf of the member anytime according to the current federal regulations, Title 42, CFR, Section 438.402(c)(i). Grievances filed by the member's physician or other representative, on behalf of the member, require written consent from the member or authorized representative. Members may submit grievances verbally or in writing by contacting the Health Net Medi-Cal Member Appeals and Grievances Department.

Members have a right to access their medical records. Written authorization from the member or the member's authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the Health Plan.

DSS And DMHC Telephone Lines

Members who have a grievance against Health Net should contact Health Net and use its grievance process. However, members may also contact the California Department of Social Services (DDS) or the Department of Managed Health Care (DMHC) for assistance with an emergency grievance or with a grievance that has not been satisfactorily resolved by Health Net.

Benefits

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information.

Benefits in Alphabetical Order

Select any subject below:

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

- Access to Sensitive Services
- Acupuncture
- AIDS
- Alcohol and Drug Abuse
- Ambulance
- Autism Spectrum Disorders

B

Behavioral Health

C

- Chiropractic
- Clinical Trials
- Cosmetic and Reconstructive Surgery

D

- Dental Services
- Dialysis
- Durable Medical Equipment
- Doula Services
- Dyadic Services

E

Enteral Nutrition

F

Family Planning

G

H

- Hearing/Hearing AID
- HIV Testing and Counseling
- Hospice Care

I

- Immunizations
- Incontinence
- Initial Health Appointment
- Injectables

J

K

L

Long-Term Care

M

Maternity

N

Nurse Midwife

O

Obesity

P

- Podiatry
- Preventive Services
- Primary Care
- Principle Exclusions and Limitations

Q

R

S

- Second Opinion by a Physician
- Subacute Care Facilities
- Street Medicine Services
- Support for Disabled Members

T

- Transgender Services
- Transitional Rent
- Transplants
- Transportation

U

V

Vision

W

X

X-Ray and Laboratory Services

Y

Z

Cognitive Health Assessment

Provider Type: Physicians | Participating Physician Groups (PPG)

Medi-Cal providers must take required training, self-attest to having completed training and use approved screening tools to receive payment for conducting an annual cognitive health assessment for eligible members age 65 or older and who are not eligible for a similar assessment as part of an annual wellness visit under the Medicare program.

For more information on billing and payments for annual cognitive assessments, see the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025.

Training

You are eligible to receive the payment if you comply with both of the following:[1]

- Finish and attest to completing the cognitive health assessment training, as specified and approved by the DHCS. Training is available at the Dementia Care Aware website.
- Conduct the cognitive health assessment using a tool suggested by the DHCS.

Assessment tools

At least one 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**
    - General Practitioner assessment of Cognition (GPCOG)
    - Mini-Cog
- **Informant tools** (family members and close friends)
    - Eight-item Informant Interview to Differentiate Aging and Dementia
    - GPCOG
    - Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Based on the scores from these assessments, additional assessment or a specialist referral may be appropriate.

[1] Information taken or derived from DHCS APL 22-025, *Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older* (PDF).

Street Medicine Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net covers street medicine for Medi-Cal members experiencing unsheltered homelessness. The street medicine benefit covers up to the full array of services necessary to meet immediate needs, including but not limited to, preventive services, and the treatment of acute and chronic conditions.

Member eligibility verification

Providers are responsible for verifying benefits and member eligibility each time a member is scheduled to receive services.

Check eligibility through either of the following:

- The provider portal (preferred method) .
- The Automated Eligibility Verification System (AEVS).

Coordinating services

Street medicine providers are responsible for coordinating member care with the member's primary care physician (PCP) and/or participating physician group (PPG) and initiating specialist referrals, including behavioral health, Community Supports and social services, when needed.

Claims billing

Claims are paid based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Providers may bill Place of Service (POS) codes to Fee-for-Service Medi-Cal or the Plan when rendering medical services for street medicine. For more information on billing for street medicine refer to the Department of Health Care Services (DHCS) billing guidelines.

Subacute Care Facilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members in need of adult or pediatric subacute care services must be placed in a health care facility that is licensed for subacute care with the California Department of Public Health and providing the level of care commensurate with their medical needs.

Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

Subacute patients require special medical equipment, supplies and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.

Coordination of Care

The primary care physician (PCP) continues to provide care during the transition to subacute care, and coordinates with the Subacute attending physician to ensure continuity of care. This includes forwarding all pertinent records to the new PCP (attending in subacute facility) when identified and available to consult.

Long-Term Care for Permanently Institutionalized

Medi-Cal members residing in a Subacute Care Facility with institutional status, as indicated by long-term aid codes, are considered permanently institutionalized if their inpatient stay continues beyond the initial month of admission and the expected subsequent month. PPGs remain responsible for Subacute members until those members are removed from their monthly eligibility reports.

Health Net must authorize subacute long-term care services when a member has a medical condition that requires subacute level of care. Subacute care includes both skilled nursing care and non-skilled care.

Members in need of Subacute care services are placed in facilities providing the level of care commensurate with their medical needs.

Criteria for Adult Subacute Care Program

Adult subacute level of care refers refers to the level of care required by a patient who does not require hospital acute care, but who requires a more intensive level of licensed skilled nursing care than is typically provided to the majority of patients in a skilled nursing facility. To qualify for Subacute level of Care, the member must require twenty four (24) hour access to nursing care by registered nurse for services available in a general acute care hospital including but not limited to the following:

Adult subacute care qualification

Topic	Description
Tracheostomy/Mechanical Ventilation	Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day; **OR** Tracheostomy care with suctioning and room air mist or oxygen as needed, **and** one of the six treatment procedures listed below.
Treatment Procedures (Administration of any three of the six treatment procedures listed)	Administration of any three of the following treatment procedures:

Topic	Description
	1. Total parenteral nutrition. 2. Inpatient physical, occupational or speech therapy at least two hours per day, five days per week. 3. Tube feeding (nasogastric or gastrostomy). 4. Inhalation therapy treatments every shift and a minimum of four times per 24-hour period. 5. Intravenous (IV) therapy involving one of the following: continuous administration of a therapeutic agent; hydration; or frequent intermittent IV medication administration via a peripheral or central line (heparin lock). 6. Wound debridement, packing and medicated irrigation with or without whirlpool treatment.

The criteria Health Net uses to determine medical necessity for Subacute services is Title 22 Chapter 7 of theDepartment of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF). California Code of Regulations (CCR), Title 22, Section 51124.5.

Criteria for Pediatric Subacute Care Program

To qualify for the pediatric subacute care program, the member must be under 21 years of age and require services consistent with the criteria outlined below. For complete criteria, refer to California Code of Regulations (CCR), Title 22, Section 51124.6.

Pediatric subacute care qualification

Topic	Description
Mechanical Ventilation	Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day.
Tracheostomy with Suctioning	Tracheostomy care requiring suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one of the treatment procedures listed in items 2 through 5 below.

Topic	Description
Total Parenteral Nutrition (TPN)	Total parenteral nutrition or other intravenous nutritional support and dependence on one of the treatment procedures listed in items 1 through 5 below.
Skilled Nursing with Multiple Treatments	Skilled nursing care in the administration of any three of the treatment procedures listed in items 1 through 5 below.
Treatment Procedures (Items 1–5)	Dependence on the following: 1. Intermittent suctioning at least every eight hours and room air mist or oxygen as needed. 2. Continuous intravenous therapy, including administration of therapeutic agents necessary for hydration or intravenous pharmaceuticals, or administration of more than one agent via a peripheral or central line. 3. Peritoneal dialysis treatment requiring at least four exchanges every 24 hours. 4. Tube feeding via nasogastric or gastrostomy tube. 5. Other medical technologies required continuously, which, in the opinion of the attending physician and Medi-Cal consultant, require the services of a professional nurse.

The criteria Health Net uses to determine medical necessity for Subacute services is Title 22 Chapter 7 of theDepartment of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF). California Code of Regulations (CCR), Title 22, Section 51124.6

Second Opinion by a Physician

Physicians | Participating Physician Groups (PPG)

All requests for a second opinion meeting the California Health and Safety Code Section 1383.1 and 1383.5 require health plans to allow members to obtain second opinions in any of the following situations:

- Member questions the reasonableness or necessity of recommended surgical procedures

- Member questions a diagnosis or plan of care for a condition that threatens loss of life, limb, bodily function, or substantial impairment, including a serious chronic condition
- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating physician is unable to diagnose the condition, and the member requests an additional diagnosis
- Treatment plan is in progress, but is not improving the member's medical condition within an appropriate period of time given the diagnosis and plan of care
- Member has attempted to follow the plan of care or has consulted with the initial provider with serious concerns about the diagnosis or plan of care

Second opinion consultations include a history, an examination and a medical decision of some complexity. They do not include additional tests, which have to be approved separately.

Office visits, consultations with a participating physician, or a referral to a physician or qualified professional provider necessary for obtaining a second opinion, are covered.

Out-of-Network Requests

Members who initiate a request for a second or third opinion are limited to in-network providers, except where appropriate in-network providers are not accessible.

If the member refuses to see an in-network provider and is requesting an out-of-network provider, all requests for a second opinion from a non-participating provider, should be directed to the Health Net Member Services Department or the CalViva Health Medi-Cal Member Services Department or Community Health Plan of Imperial Valley Member Services Department.

Second Opinion Referral Responsibilities

The health plan and delegated participating physician groups (PPGs) provide timely referral for a second opinion consultation by an appropriately qualified health care professional when the second opinion is requested by a member or the member's physician. An appropriately qualified health care professional is a primary care physician (PCP) or specialist acting within the PCP's or specialist's scope of practice and possessing clinical background, training and expertise related to the particular illness, disease or other condition associated with the request for a second opinion. Second opinion referrals are approved for a one-time-only consultation. All tests, lab and X-ray services must be directed back to the member's PPG or PCP for coordination. All care must be performed or authorized by the PPG or PCP in order to be covered. There are few, if any, circumstances under which second opinion requests should be denied.

PPGs delegated for utilization management (UM):

- Provide second opinions by an appropriately qualified health care professional (of the same or equivalent specialty) of the member's choice, from the PPG's network
- Make every effort to accommodate the member within the PPG network
- Must consider all participating specialists for second opinion referrals
- Should instruct members who request an out-of-network second opinion and refuse to accept redirection in-network, to contact the Health Net Member Services Department the CalViva Health Medi-Cal Member Services Department or Community Health Plan of Imperial Valley Provider Services Center for further assistance

Health plan:

- Authorizes second opinions from appropriately qualified health care professional (of the same or equivalent specialty) of the member's choice from the plan's network when appropriate
- May limit referrals to its network providers if criteria for appropriately qualified health care professionals are met within the network. The health plan authorizes a second opinion by an appropriately qualified out-of-network health care professional when no participating health plan provider is available

Access to Sensitive Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on access to sensitive and minor consent services, as well as confidentiality requirements.

Select any subject below:

- Confidentiality
- Coverage and Services
- Freedom of Choice
- Minor's Consent for Services
- Sensitive Services

Confidentiality

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

All Health Net employees and participating providers must maintain the confidentiality of member information pertaining to the member's access to sensitive services.

Freedom of Choice

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members have the freedom of choice to receive timely, confidential services for family planning, diagnosis and treatment for sexually transmitted infections (STIs) and HIV counseling and testing services from any family planning provider without prior authorization. Further, members may receive timely and confidential referral for drug and alcohol treatment services, refer to the Public Programs section for additional information.

Medi-Cal-only members under age 18 may obtain sensitive services without parental consent.

Minor's Consent for Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For Minor's Consent for Services, refer to Provider Oversight > Services and Quality Requirement > Access to Care and Availability Standards (Medi-Cal, CalViva Health, Community Health Plan of Imperial County).

Sensitive Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Sensitive services include those services related to treatment for injuries resulting from sexual assault, drug or alcohol abuse treatment, pregnancy, family planning, HIV counseling and testing, pregnancy termination, outpatient mental health treatment and diagnosis, residential shelter services, intimate partner violence, and treatment of sexually transmitted infections (STIs) for children under age 18.

Reproductive rights, privacy and the exchange of information

The Reproductive Privacy Act guarantees individuals a fundamental right to privacy regarding their reproductive choices, preventing the state from denying or interfering with a person's right to choose or obtain an abortion before the fetus is viable or when the abortion is necessary to protect the person's life or health.[1]

Certain businesses handling medical information on sensitive services must develop security policies for data related to gender-affirming care, abortion, abortion-related services, and contraception. California law also prohibits health care providers, plans, contractors, or employers from sharing medical information for investigations or inquiries from other states or federal agencies regarding lawful abortions unless authorized by existing law.

Data for gender-affirming and abortion-related services must be omitted from data exchanged via health information exchanges (HIEs) and not be transmitted to California HIEs.

State law specifically states:[1]

- **A business that electronically stores or maintains medical information on the provision of sensitive services**, including, but not limited to, on an electronic health record system or electronic medical record system, on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer, must have capabilities, policies, and procedures that enable all of the following:

- **Limit user access privileges** to information systems that contain medical information related to gender affirming care, abortion and abortion-related services, and contraception only to those persons who are authorized to access specified medical information.
- **Prevent the disclosure, access, transfer, transmission, or processing of medical information** related to gender affirming care, abortion and abortion-related services, and contraception to persons and entities outside of the state of California.
- **Segregate medical information** related to gender affirming care, abortion and abortion-related services, and contraception from the rest of the patient's record.
- **Provide the ability to automatically disable access** to segregated medical information related to gender affirming care, abortion and abortion-related services, and contraception by individuals and entities in another state.

Additionally, state law prohibits the collection or disclosure of information outside California for operational claims payment purposes. State law includes requirements for provider licensing, enhanced protections for individuals and providers in sensitive services and "legally protected health care activity," including preventing the disclosure of medical information related to sensitive services outside the state, segregating such information from the patient's record, and enabling automatic disabling of access by entities outside the state.

Legally protected health care activity includes, but is not limited to:

- Reproductive health care services,
- Gender-affirming health care services, and
- Gender-affirming mental health care services.

Sensitive services include, but are not limited to:

- Services related to mental/behavioral health,
- Sexual and reproductive health,
- Sexually transmitted infections,
- Substance use disorder,
- Gender affirming care, and
- Intimate partner violence.

Requirements for providers

Physicians and other health care providers must incorporate and/or adhere to the following:

- Specified businesses that store or maintain medical information regarding sensitive services must develop specific policies, procedures and capabilities that protects sensitive information.
- Health care service plans, providers and others may not cooperate with any inquiry or investigation from any individual, outside state, or federal agency that would identify an individual that is seeking, obtaining, or has obtained an abortion or related services that are lawful in California. Exceptions may be authorized if the individual has provided authorization for the disclosure.
- The exchange of health information related to abortion and abortion-related services is excluded from automatically being shared on the California Health and Human Services Data Exchange Framework.

[1]Information taken or derived from Assembly Bill 352, Senate Bill 345, or information at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB352 or https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB345.

Impacts of regulations on business, business partners, or members

- **Regulations prohibit healing arts boards** from denying an application for a license, or from imposing discipline on a licensee, on the basis of a civil judgment, criminal conviction or disciplinary action in another state if that judgment is based solely on the application of another state's law that interferes with a person's right to receive sensitive services.
- **The practice of nurse-midwifery** includes care for common gynecologic conditions and (when certified by a physician or surgeon) to furnish or order Schedule II and III controlled substances as specified.
- **Regulations prohibit a person or business** from collecting, using, disclosing, or retaining the personal information of a person who is physically located at or within a precise geolocation of a family planning center.
- **Regulations repeal current state provisions that:**
  - Prohibit an abortion from being performed upon an unemancipated minor unless they have first given written consent to the abortion and also has obtained the written consent of one parent or legal guardian.
  - Provide specified judicial procedures when consent of a parent or guardian cannot be obtained by the pregnant unemancipated minor.

Rape and sexual assault

Rape and sexual assault could also be inferred as "intimate partner violence" and would also be identified as a sensitive service.

SECTION 1. Section 56.05 of the Civil Code is amended to read:

56.05. For purposes of this part:

(n) "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Coverage

Health Net covers emergency room care and follow-up medical treatment without any member cost share for members who have suffered rape or sexual assault.

Members may obtain any of the following services for rape or sexual assault without any member cost share from the start of treatment:

- Emergency room care.
- Follow-up treatments, including any medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault.
- Mental health treatments.

- Out-of-network services if medically necessary care is not available within the member's network.

Medi-Cal only: No prior authorization needed for services from non-participating providers

As a part of the Medi-Cal covered benefit, Medi-Cal members may access care from non-participating providers for sensitive services without prior authorization.

How to bill for services

Providers may use standard diagnosis codes recognized by Health Net that pertain to rape or sexual assault following Billing and Submission requirements. Health Net requires that the ICD-10 Dx code is visible on the face of the paper-based prescription when pharmacist is filling the prescription. For electronic scripts, providers are responsible for determining where to place this information, based on their Electronic Medical Record (EMR) system.

If you have questions on how or where to place the Dx code, please contact your EMR vendor for information. Please note that any prescriptions given for member care will need to include the relevant diagnosis code(s).

HIV test result disclosure

- Providers may disclose HIV test results that identify Medi-Cal beneficiaries to:
  - The member's assigned Medi-Cal Managed Care Plan (MCP).
  - External quality review organizations contracted by the California Department of Health Care Services (DHCS).

These disclosures are permitted for quality improvement activities, including value-based payment and healthy behavior incentive programs. Written patient authorization is not required for these disclosures.

Disclosure of non-identifying HIV test results

- MCPs may share HIV test results that do not identify Medi-Cal patients with the DHCS staff for quality improvement purposes. Written patient authorization is not required for these disclosures.

Restrictions on disclosure

- Disclosure of identifying HIV test results to other health care service plans (not the assigned Medi-Cal MCP) requires written authorization from the patient or their representative.
- Disclosure to federal agencies or authorities in other states is only permitted when required by federal law.

Coverage and Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members may access sensitive services in a timely manner and without barriers. Prior authorization is not required for access to certain services. Members may access most sensitive services from any qualified provider, in- or out-of-network, except obstetrical care for pregnancy.

The primary care physician (PCP) should encourage members to access in-network providers for services whenever possible. This process improves coordination of care and has a positive impact on health outcomes. Out-of-network providers must demonstrate reasonable efforts to coordinate services with a member's PCP or obtain the member's written refusal to do so. Health Net only covers out-of-network provider services that are within the definition of sensitive services.

Members should receive medical care according to the nature of the medical problem. The member or PCP should make the determination of timely access. Members can receive family planning services, including pregnancy testing, sexually transmitted infection (STI) diagnosis and treatment and HIV counseling and testing from participating or non-participating providers. Refer to the Family Planning and HIV Testing and Counseling discussions under the Benefits topic and the Sexually Transmitted Infections discussion under the Public Programs topic for additional information.

Although pregnancy testing is considered to be a family planning service and may be obtained from any qualified provider, in- or out-of-network, obstetrical care for pregnancy must be arranged through in-network providers. Refer to the Maternity discussion under the Benefits topic for additional information.

Refer to the Alcohol and Drug Treatment Services and Mental Health under Public Programs topic for additional information.

AIDS

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on AIDS/HIV injectable medications. Refer to AIDS Definition for additional information.

Select any subject below:

- AIDS Waiver Program
- AIDS/HIV Injectable Medications

Medi-Cal Waiver Program (formerly AIDS Waiver Program)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Refer to the Medi-Cal Waiver Program description under Public Programs for additional information.

AIDS/HIV Injectable Medications

AIDS/HIV injectable medications are injectable medications that have been approved by the Food and Drug Administration (FDA) and Health Net for the treatment of AIDS/HIV. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF)for covered AIDS/HIV injectable medications.

For Medi-Cal members, certain medications for HIV and AIDS are excluded from Health Net's coverage responsibilities but may be covered under Medi-Cal Rx. For more information refer to the Excluded Medications for HIV and AIDS discussion in the AIDS Waiver Program section under the Public Program topic.

Alcohol and Drug Abuse

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information and provider referral information on alcohol and drug abuse services.

Select any subject below:

- Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
- Medication Assisted Treatment

Medication Assisted Treatment

Medications for addiction treatment also known as medication-assisted treatment (MAT) are covered when delivered in primary care offices, emergency departments, inpatient hospitals, and other contracted medical settings.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment

Provider Type: Physicians | Participating Physician Groups (PPG)

Alcohol and drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. These services are administered by Counties and overseen by the state of California.

Health Net, its affiliated health plans and subcontracting providers are available to coordinate referrals for members requiring substance use treatment and services. Members receiving services under this program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member. Additionally, participating providers must maintain documentation of Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services provided to members. 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. Member medical records must include the following:

- The service provided (e.g., screen and brief intervention).
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- 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
- If and where a referral to an alcohol use disorder (or substance use disorders program was made.

Alcohol Misuse Screening and Behavioral Counseling

Consistent with U.S. Preventive Services Task Force (USPSTF) Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, Managed Care Plans (MCPs) must provide alcohol and drug SABIRT services for members 11 years of age and older, including pregnant women. These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists.

Screening

Alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

- Alcohol use disorders identification test (AUDIT).

- Alcohol use disorders identification test (Audit-C).
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents.
- Cut down-annoyed-guilty-eye-opener adapted to include drugs (CAGE-AID).
- Drug abuse screening test (DAST-10).
- Drug abuse screening test (DAST-20).
- Michigan alcoholism screening test geriatric (MAST-G) alcohol screening for geriatric population.
- National institute on drug abuse (NIDA) quick screen for adults.
- The single NIDA quick screen alcohol-related questions can be used for alcohol use screening.
- NIDA-modified alcohol, smoking and substance involvement screening test (NM-ASSIST).
- Parents, partners, past and present (4Ps) for pregnant women and adolescents.
- Tobacco alcohol, prescription medication, and other substances (TAPS).

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if

alcohol use disorder (AUD) or substance use disorder (SUD) is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST)-20
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to members whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:

- Provide feedback to the patient regarding screening and assessment results;
- Discuss negative consequences that have occurred and the overall severity of
- the problem;
- Support the patient in making behavioral changes; and
- Discuss and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

The USPSTF recommends that clinicians screen adults ages 18 or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

The following HCPCS codes may be used to bill for these services:

- G0442 - annual alcohol misuse screening, 15 minutes
- G0443 - brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Code G0442 is limited to one screening per year, any provider, unless otherwise medically necessary. Code G0443 may be billed on the same day as code G0442. Code G0443 is limited to three sessions per recipient per year, any provider, unless otherwise medically necessary.

Treatment Referral

Providers are responsible for referring members who meet criteria for alcohol and drug disorders to a county drug program for services. These services are not covered by Health Net. A list of county contacts for local substance use disorder treatment information and referrals is available on the DHCS website at DHCS website, under Referral to Treatment.

Documentation Requirements

Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument
- (unless the screening tool is embedded in the electronic health record);
- 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
- If and where a referral to an AUD or SUD program was made.

PCPs must maintain documentation of SABIRT services provided to members. 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.

Acupuncture

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on acupuncture services, including coverage exclusions and limitations.

Select any subject below:

- Acupuncture Services

Acupuncture Services

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net members may only access acupuncture services and treatments through American Specialty Health Plans, Inc. (ASH Plans).

Acupuncture outpatient services are limited to two services in a month, in combination with audiology, chiropractic, occupational therapy, and speech therapy services (limits do not apply to children under 21). Acupuncture services are limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Authorization is not required for acupuncture services for up to two visits per month. Prior authorization is required if additional visits are needed through ASH (see below for link) during the same month.

Medi-Cal members may self-refer for acupuncture (first two services per month) for certain conditions, illnesses or injuries only covered in conjunction with services from a medical doctor (for example, chronic pain or nausea related to chemotherapy). Additional appointments require referral.

Participating physician groups (PPGs) and direct network providers must only refer Medi-Cal members to ASH Plans for acupuncture services.

Los Angeles County members assigned to Molina

This is not applicable to Health Net members assigned to Molina. Contact Molina about acupuncture services.

Ambulance

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on ambulance services.

Select any subject below:

- Transportation

Transportation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal members are entitled to non-medical transportation (NMT) and non-emergency medical transportation (NEMT) benefits. Modivcare™ is Health Net's contracted provider for all covered non-emergency medical transportation (NEMT) and non-medical transportation (NMT) services for members assigned to a direct network provider or to shared-risk participating physician groups (PPGs). Shared-risk PPGs are PPGs that are delegated for utilization management but not financially at risk for transportation services. All referral sources (PPGs, hospitals, skilled nursing facilities, etc.) are required to contact Modivcare to arrange for transportation services. Failure to do so may result in the denial of the claim for which the PPG or hospital may be liable. For members assigned to Dual Risk PPGs, please refer to the section below. For all NEMT services, a Physician Certification Statement (PCS) form must be submitted to Health Net's Care Ride Unit to obtain Prior Authorization.

Health Net is responsible for NMT to Medi-Cal services, including services that are carved-out, including but not limited to dental services, specialty mental health services and pharmacy services. Members are instructed to contact the Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) to request NMT services.

Requirements per the Medi-Cal contract

The contractor must require members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider, as described in APL 22-008, before prior authorization can be granted for NEMT services, except as provided in 22 CCR section 51323(b)(2)(A).(C). For covered services requiring recurring appointments, the contractor must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months, and ensure the member has a standing order guaranteeing assigned rides for the duration of the recurring appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(a) and (d), and APL 22-008, contractor must also cover transportation-related travel expenses for members obtaining medically necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.

Dual-risk PPGs and hospitals

PPGs or hospitals that have risk for NEMT in the Division of Financial Responsibility (DOFR) must authorize and coordinate with their transportation provider for medically necessary services in a timely manner. Failure to do so will result in the plan approving and arranging the transportation and processing a capitation payment deduction. A Physician Certification Statement (PCS) form is required for all NEMT services. A PCS process must be followed to collect the PCS form and arrange NEMT services.

Participating physician groups and hospitals that have risk for NEMT in the Division of Financial Responsibility (DOFR) must authorize and coordinate with their transportation provider to ensure Medi-Cal members have 24-hour access to NEMT to a pharmacy or urgent care facility that is open 24 hours a day.

Health Net provides NMT through Modivcare for medically necessary covered services and all Medi-Cal covered services.

Coverage Requirements

NEMT services are covered when the member's condition is such that ordinary means of transportation are medically inadvisable. Such transportation is covered only for the purpose of obtaining needed Health Net-covered service. Coverage is limited to the least costly medical transportation available to adequately meet the member's medical needs.

All non-emergency medical transportation (NEMT) requires a Physician Certification Statement (PCS) form:

- Physician Certification Statement Form - Request for Transportation (PDF)
- Physician Certification Statement Form - Request for Transportation CalViva Health (PDF)
- Physician Certification Statement Form - Request for Transportation (CHPIV) (PDF)

Ground NEMT is authorized by the Care Ride Unit (ambulance, ambulatory door-to-door [needs assistance and/or using walker/cane/crutches], gurney/stretcher, wheelchair).

A PCS form is required before NEMT can be provided, therefore, it is very important for ordering providers to return the completed and signed form.

NMT services are covered for members to obtain medically necessary Medi-Cal services, including carve out services, including but not limited to, specialty mental health, substance use disorder, pharmacy, dental, and any other benefits covered by FFS Medi-Cal. Non-medical transportation (NMT) is available upon request by contacting Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

NEMT and NMT services include transportation for the member and one attendant, such as a parent, guardian or spouse, and must be requested at the time of the initial transportation arrangement.

With written consent of a parent or guardian, NEMT and NMT may be arranged for a minor under age 18 who is unaccompanied by a parent or guardian. Health Net provides transportation services for unaccompanied minors under age 18 when state or federal law does not require parental consent for the minor's services. All necessary written consent forms, such as Consent for Minors to Travel without an Escort Form (PDF), must be received prior to arranging transportation for an unaccompanied minor and must be provided to Health Net.

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT) includes ambulances, wheelchair vans and gurney vans and is provided when medically necessary and the patient is not ambulatory.

NEMT is a covered Medi-Cal benefit when the member needs to obtain medically necessary covered services and when prescribed in writing via the PCS form signed by a physician, physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), dentist, podiatrist, or mental health or substance use disorder provider. NEMT under Medi-Cal is covered only when the patient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated. Additionally, NEMT is covered for patients who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (ambulatory door to door). This includes door-to-door assistance for all members receiving NEMT services.

The physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or to be transported by public or private vehicles. NEMT may be authorized for visits up to 12 months in advance. A new PCS form is required every 12 months if NEMT is continued to be utilized.

NEMT necessary to obtain medical services is covered subject to the written authorization of a licensed practitioner consistent with their scope of practice. Additionally, if the non-physician medical practitioner is under the supervision of a physician, then the ability to authorize NEMT also must have been delegated by the supervising physician through a standard written agreement.

Physicians, dentists, podiatrists, PAs, NPs, and CNMs, mental health or substance use disorder providers may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the Welfare and Institutions Code (W I Code).

The NEMT modalities, in accordance with the Medi-Cal Provider Manual, are:

- NEMT ambulance services which include:
  - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
  - Transfers: 1) from an acute care facility to another acute care facility, immediately following an inpatient stay at the acute level of care, 2) to a skilled nursing facility or 3) to a licensed intermediate care facility.
- Litter van services, when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:
  - The member must be transported in a prone or supine position because the member is incapable of sitting for the period of time needed for transport.
  - Specialized safety equipment is required over and above that which is normally available in passenger cars, taxi cabs or other forms of public conveyance.
- Wheelchair van services, when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
  - The member is incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
  - Members who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (ambulatory door to door).
  - The member must be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
  - Specialized safety equipment is required over and above that which is normally available in passenger cars, taxicabs or other forms of public conveyance.
- NEMT by air (requires Health Net authorization and Letter of Agreement) only under the following conditions:
  - Transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible.

Physician Certification Statement Form - Request for Transportation

Use the Physician Certification Statement Form – Request for Transportation – Health Net (PDF), Physician Certification Statement Form – Request for Transportation – CalViva Health (PDF) or Physician Certification Statement Form – Request for Transportation – Community Health Plan of Imperial Valley (PDF) to document the specific transportation restrictions of a member due to a medical condition, and request non-emergency medical transportation (NEMT) for Medi-Cal members. A physician certification statement (PCS) form is not required for non-medical transportation (NMT).Providers who may complete and sign the PCS form include:

- Physician
- Dentist
- Podiatrist
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Certified nurse midwives (CNMs)
- Mental health or substance use disorder providers

Non-Medical Transportation

Modivcare can also arrange non-medical transportation (NMT), including rideshare, passenger car, taxi or other forms of public/private conveyances for ambulatory members when services are covered or for any Medi-Cal covered service, as follows:

NMT includes transportation for medically necessary appointments or for any Medi-Cal covered service, and may be provided by rideshare, passenger car/sedan, taxicab, paratransit, such as Access, or fixed route transportation, such as a bus, and mileage reimbursement.

- Passenger car/sedan, taxi (ambulatory curb-to-curb): Member is ambulatory and can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus or train (curb-to-curb).
- Rideshare. Member may use:
    - Wheelchair, able to transfer from a folding wheelchair without assistance. Note, if assistance is required, choose wheelchair van under NEMT.
    - Walker.
    - Cane.
    - Crutches.

- Paratransit services: Member is ambulatory and can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus (curb-to-curb).
- Mass transit: Member is ambulatory and is able to use public transportation and may be medically able to walk up to a half mile to a bus stop (curb-to-curb).
- Mileage reimbursement: Member is ambulatory and has access to other means of transportation such as a working vehicle in the home, family member or neighbor. Member may request mileage reimbursement at the time the trip is scheduled (curb-to-curb).

NMT services include: round-trip transportation for a member by rideshare, passenger car, taxicab, or any other form of public or private conveyance (private vehicle), as well as mileage reimbursement (at the time transportation is arranged), bus passes, taxi vouchers, or train tickets for medical purposes.

Round-trip NMT is available for the following:

- medically necessary covered services
- members picking up drug prescriptions
- members picking up medical supplies, prosthetics, orthotics, and other equipment
- dental services
- mental health services
- substance abuse services
- all Medi-Cal covered services

Ground Emergency Medical Transportation (GEMT)

Participating physician groups (PPGs) and hospitals must submit a list of their contracted ground emergency medical transportation (GEMT) providers annually. This applies to Medi-Cal providers contracted under a global and dual risk arrangement. The list is due annually no later than March 31.The list will help identify non-contracted GEMT providers for automated payments that meet the requirements under the Department of Health Care Services' Public Provider Ground Emergency Medical Transport (PP-GEMT) and GEMT quality assurance fee (QAF) programs. At a minimum, include the following information on the list:

- Provider name.
- Provider type (PPG or Hospital).
- Risk type (Dual or Global).
- GEMT provider name.
- GEMT National Provider Identifier (NPI) number.

PPGs and hospitals can send their list to their assigned Provider Relations & Contracting Specialist (PRCS).

Transportation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Physician Certification Statement Form - Request for Transportation

Refer to Ambulance for Transportation information.

Autism Spectrum Disorders

Provider Type: Physicians | Participating Physician Groups (PPG)

Autism Spectrum Disorders (ASDs) include the former diagnoses of Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS), Asperger's Syndrome and Autism. Autism is a developmental disorder that presents in the first few years of life and profoundly interferes with the individual's lifelong functioning.

Health Net has developed a medical policy, Applied Behavioral Analysis (ABA), which provides more detailed information about the screening, diagnosis and treatment of ASD. This medical policy is available on the Health Net website .

Members under age 21 are entitled under Medi-Cal for Kids & Teens (EPSDT) to all medically necessary services to correct or improve Autism Spectrum Disorder–related conditions, even when services exceed standard benefit limits or require services not otherwise covered for adults.

Screening

Autism is characterized by impairment in three core areas:

- Social interactions
- Verbal and nonverbal communication
- Restricted activities or interests and/or unusual, repetitive behaviors

The degree of impairment in these areas varies widely from child to child. The American Academy of Pediatrics (AAP) has added screening for autism at ages 18 and 24 months to its recommendations for preventive pediatric care. Additional follow up in six months for borderline development of autism screening results, such as a 30-month visit, are the providers' clinical decision. Moreover, parental concerns about their child's development should lead to a careful assessment of development at any pediatric visit.

Screenings may include:

- Assessing vision and hearing.
- Directly observing the child in structured and unstructured settings.
- Evaluating cognitive functioning (verbal and nonverbal).
- Assessing adaptive functioning.
- Discussing with parents any concerns they have and asking specific questions regarding the child's functioning.

AAP guidelines for Autism Spectrum Disorders are available online. Additional AAP autism resources are available at healthychildren.org

Diagnostic Evaluation

If a child exhibits the above behavioral impairments and has an abnormal developmental screening, the next step is referral to one or more medical and behavioral specialists who can include a developmental pediatrician, child psychiatrist, speech and language pathologist, and other ancillary clinical specialists, such as physical therapists and occupational therapists, as needed. These specialists provide input to the primary care physician (PCP) or psychologist for a diagnosis of ASD.

A thorough evaluation for ASD may include the following:

- Parents and/or caregiver interview, including interviews of siblings of the child with suspected autism.
- Comprehensive medical evaluation.
- Direct observation of the child.
- Evaluation by a speech-language pathologist.
- Formal hearing evaluation, including frequency-specific brainstem auditory evoked response.
- Evaluation of the child's cognitive and adaptive functioning.
- Evaluation of academic achievement for children ages six and older.

There are a number of assessment tools that are used by clinicians to assist in the diagnosis of autism, including:

- Pervasive Developmental Disorders Screening Test-II (PDDST-II) for children from birth to age three.
- Checklist of Autism in Toddlers (CHAT) for children age 18 months.
- Modified Checklist for Autism in Toddlers (M-CHAT™) for children starting at age 16 months. (Spanish, Turkish, Chinese, and Japanese versions are available.) A revised version, M-CHAT-R,™ is also available.
- Screening Test for Autism in Two-Year-Olds (STAT).
- Social Communication Questionnaire (SCQ) for children ages four and older.

Upon diagnosis, children often are referred to a provider of Applied Behavioral Analysis for a functional behavioral assessment. If the assessment reveals that the child can benefit from ABA treatment a request for authorization is submitted to Health Net. Upon authorization, children may receive ABA services for a period of time spanning from a few months to a few years, depending on the child's level of impairment and response to treatment. Additionally, referral to a local Regional Center may be appropriate. Children may also receive school-based services based on recommendations in an Individualized Education Plan (IEP).

Medical Services

Medical services for the treatment of ASD may include physical therapy (PT), occupational therapy (OT), speech therapy (ST), and/or specialty management for comorbid disorders, such as seizure disorders.

Health Net covers medical services for the treatment of ASD. Parents or legal guardians of the member with ASD can ask for one physician to lead the care plan and coordinate services with other physicians and specialists. PT and ST are limited benefits under the Medi-Cal program, based on Title 22, California Code of Regulations (CCR), Section 51309 (rehabilitation benefits) states that:

- Physical therapy services shall include physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications. Services do not include the use of Roentgen rays or radioactive materials or the use of electricity for surgical purposes including cauterization. Services are limited to treatment immediately necessary to prevent or to reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.
- Such services, except physical therapy, are subject to the limitations set forth in Section 51304(a): Program coverage of services is limited to a maximum of two services from among those services set forth in those sections in any one calendar month.
    - Members under age 21 have access to additional medically necessary therapy visits, subject to prior authorization.
- Provision of the services is with the expectation that the beneficiary will improve significantly in a reasonable and generally predictable period of time or to establish an effective maintenance program in connection with a specific disease state.
- The service is reasonable and medically necessary for the treatment of the beneficiary's condition.

The regional center assesses each referral, and if the member is eligible for regional center programs, outlines a case-specific plan of therapy and other services, taking into account the benefits and availability of services through the health plan and Local Education Authority (school district). The benefit for OT is limited to two visits

per month (this limit does not apply to children under age 21). PT and OT services must be coordinated with the regional center or school district for a coordinated approach to maximize benefits.

Behavioral Health Therapy Services

Behavioral health therapy (BHT) services may include ABA psychiatric services, such as medication management of specific symptoms related to ASD, as well as any comorbid psychiatric conditions; family therapy to help parents and siblings cope with the diagnosis and the member with ASD's behaviors; brief psychotherapy to teach behavior modification techniques to parents to assist them in managing their child; and individual psychotherapy for adolescents and young adults with an ASD. Inpatient hospitalization may also be necessary if the child with ASD becomes an acute danger to self or others, or is behaviorally disruptive, requiring intensive intervention to stabilize the individual.

For assistance with specific member referrals, contact the Health Net Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center for Fresno, Kings and Madera counties.

Educational Services

An important potential source of help for educational services for children with autism is the public school system. Under Federal Public Law 94-142 (the Individuals with Disabilities Education Acts of 1990 and 1997), each school is required to provide handicapped children with free, appropriate education through age 21. The school is required to evaluate each child and, with the parents, develop an IEP. The IEP determines the educational setting that is most appropriate for the child, establishing goals for each child that are academic and behavioral/social. The local public school system may provide for or refer the child for educational interventions, such as applied behavioral analysis (ABA), intensive behavioral intervention (BI), discrete trials training, early intensive behavioral intervention (EIBI), intensive intervention programs, Picture Exchange Communication Systems (PECS), facilitated communication, Treatment and Education of Autistic and Related Communication of Handicapped Children (TEACCH), or floortime.

The local school system is responsible for education services once the child reaches age three. California's Early Start Program (for children under age three) or the local regional center (for children ages three and up) provides other services, such as in-home services.

Health Net is not responsible for and does not provide coverage for educational services.

Case Management/Care Coordination

At the provider's request, Health Net or Health Net's delegated PPG provides a case manager who is knowledgeable about plan benefits to assist in the coordination of health care treatment services, including behavioral health services.

Coordination of Care

Health Net expects all providers involved in the treatment of a member with ASD to coordinate the care and treatment they are providing and maintain appropriate communication. The PCP has primary responsibility for providing and maintaining the medical home for these children. Communication with other providers and the member's caregivers helps prevent duplication of tests and contraindicated medications and treatment and allows providers the opportunity to modify the member's treatment plan based on more thorough information.

Coordination with the school system, Early Start Program, county mental health, and regional centers regarding educational, therapeutic and psychiatric services helps ensure the member with ASD receives the full range of benefits allowed under legislation and regulations in California.

Resources

The following online resources are available to assist providers in the screening, diagnosis and treatment of ASD and other services.

- Health Net website
- AAP recommendations for preventive care - https://brightfutures.aap.org
- Other AAP resources - www.healthychildren.org/English/health-issues/conditions/Autism/Pages/Autism-Spectrum-Disorder.aspx
- Regional centers contact information - www.dds.ca.gov/rc/listings/
- Early Start Program - www.dds.ca.gov/services/early-start/early-start-publications-resources-and-program-guidance/program-guidance-materials/
- Individual with Disabilities Education Act - https://sites.ed.gov/idea

ABA Forms

A licensed physician or licensed psychologist must complete the below form for behavioral analysis (ABA) services requiring a medical necessity recommendation.

- Applied Behavioral Analysis (ABA) Recommendation and Referral Form – Health Net (PDF)
- Applied Behavioral Analysis (ABA) Recommendation and Referral Form – CalViva Health (PDF)
- Applied Behavioral Analysis (ABA) Recommendation and Referral Form – Community Health of Imperial Valley (PDF)

ABA treating practitioners are required to submit the below prior authorization request form along with an updated treatment plan to Health Net prior to delivering ABA services.

- Applied Behavioral Analysis (ABA) Prior Authorization Request Form – Health Net (PDF)
- Applied Behavioral Analysis (ABA) Prior Authorization Request Form – CalViva Health (PDF)
- Applied Behavioral Analysis (ABA) Prior Authorization Request Form – Community Health of Imperial Valley (PDF)

Behavioral Health

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information and provider referral information on behavioral health and substance abuse care services.

Select any subject below:

- Overview
- 5150 Holds
- Management of Outpatient Services
- Minors and/or Adults Unable to Give Consent

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net Medi-Cal members obtain the following mental health services through Health Net

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include laboratory work, medications and supplies
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultations

Members do not need to contact their primary care physician (PCP), participating physician group (PPG) or attending physician to request a referral for mental health care services. Health Net members may obtain these services directly through our extensive behavioral health network by calling the member services phone number listed on their identification card (ID). Participating providers may also contact Behavioral Health Provider Services for assistance with mental health services referrals.

Prior authorization is not required for initial assessment for outpatient behavioral health services.

PCPs may refer members to marriage and family therapists, social workers, professional counselors, psychologists, and psychiatrists for services, as follows:

- Marriage and family therapists, social workers, professional counselors, and psychologists can:
  - Diagnose, treat and consult for the management of mild to moderate emotional problems for which the PCP or member feels the need for consultation.
  - Evaluate cases for which a member would benefit from psychotherapy in addition to psychotherapeutic medication.
  - Conduct psychological testing for clarification of diagnosis to establish a treatment plan (psychologists).
- Psychiatrists can:
  - Diagnose, treat and recommend a medication regimen in difficult or complex cases, including cases of depression that do not respond to a 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants.
  - Evaluate cases in which members report feeling suicidal or homicidal, severe anxiety states, clear somatoform disorders, schizophrenic disorders where Clozaril® or risperidone is being considered, and bipolar disorder where lithium, carbamazepine or valproic acid may be needed.

PCPs are responsible for coordinating referrals for members requiring specialty or inpatient mental health services to county mental health plans (CMHPs). PCPs retain responsibility for coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications.

The Mental Health Services Division (MHSD) oversees CMHPs and each county is required to provide access to specialty mental health services for Medi-Cal members. Refer to the MHSD Medical Necessity Criteria document for additional information about criteria for specialty mental health services.

Refer to the following Behavioral Health definition in the glossary for more information.

- Mental health application information
- Mental Health Digital Services

5150 Holds

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Under Section 5150 of the California Welfare and Institutions Code, a person who may be dangerous to self or others can be taken into custody and placed in an approved facility for a 72-hour treatment and evaluation. This is commonly referred to as a "5150 hold." 5150 holds are considered emergencies and should be handled like any other emergency inpatient hospitalization where the member cannot be immediately transferred.

For Medi-Cal members, all facility-based care for behavioral health and substance use disorders is administered by their respective county behavioral health department(s). Emergency services in which the member is not admitted to an inpatient psychiatric facility are covered by Health Net.

Management of Outpatient Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net uses analytics to identify providers who may have practice patterns that are at significant variance to Health Net expected treatment norms.

“Exception” reports are regularly generated for Health Net management review. If the manager identifies practice patterns that suggest variance from clinically accepted guidelines, these practitioner/member combinations are assigned to a licensed Utilization Manager for clinical review. The Utilization Manager does a full review of case notes and member history to better understand the clinical situation and history of treatment. If, based on the clinical aspects of the case, the Utilization Manager decides that no further intervention is required, they will consider the review complete. If further discussion is indicated, they will contact the practitioner for a discussion of the member’s clinical status, current signs and symptoms, the practitioner’s goals and milestones of treatment, and how the current treatment plan is designed to meet these goals.

Health Net has found that in most cases, practitioners are very open to a collegial, collaborative discussion and often will accept the Utilization Manager's offer of assistance; for instance, to arrange for a medication evaluation, or an adjustment in the treatment plan with an agreement to review again at a later, mutually established time.

In those infrequent cases in which there are ongoing concerns after contacting the provider, the Utilization Manager will consult with a Health Net medical director to determine the next steps. Health Net has found that due to this collaborative process with practitioners, a need for further corrective action is rarely required. Overall, this process has been very well received by the provider community.

Minors and/or Adults Unable to Give Consent for Treatment; Consent For Release of Information

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net and its contracted practitioners have a responsibility to recognize and help protect the rights of minors and adults unable to give consent. When consent for "Release of Information" or treatment is necessary for members who are minors or adults unable to give consent, the practitioner should obtain written consent from a parent, legal guardian, or other appropriate individual or agency.

The completed consent for treatment or "Release of Information" form should be in the practitioner's treatment record. When practitioner treatment records are audited against treatment record standards, consents should be present when records pertain to members who are minors or adults unable to give consent. For additional information refer to:

- Access to Care and Availability Standards (HMO)
- Access to Care and Availability Standards(PPO)
- Access to Care and Availability Standards (Medi-Cal, CalViva Health, CHPIV)
- Access to Care and Availability Standards (Medicare)

Chiropractic

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on chiropractic services.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

With the exception of members who are under age 21, pregnant, or residents in a skilled nursing facility or long-term care, chiropractic benefits of manual manipulation of the spine to correct sprain, strain or dislocation of the spine or neck are covered for Medi-Cal members only when provided by a contracted county hospital outpatient department and hospital outpatient clinic, contracted Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) provider and other contracted chiropractic providers. Referrals may be needed for out-of-network FQHC, RHCs and IHCPs. Chiropractic services are:

- Limited to a maximum of two services per month, in combination with audiology, acupuncture, occupational therapy, and speech therapy services. Limits do not apply to members who are children under age 21, pregnant or residents in skilled nursing facility or long-term care.
- Limited to treatment of the spine by means of manual manipulation (only one chiropractic manipulative treatment is reimbursable when billed by the same provider, for the same recipient and date of service)

Maintenance care is not considered to be medically reasonable and necessary, and is not covered.

Health Net and its delegated participating physician groups (PPGs) apply Medi-Cal coverage criteria when determining whether a referral to an FQHC or RHC chiropractor or other contracted chiropractic providers is warranted.

A chiropractor may use an X-ray or other diagnostic test, performed for diagnostic purposes, to demonstrate medical necessity before commencing treatment; however, these diagnostic tests or X-rays are not covered when ordered, taken or interpreted by a chiropractor. Therefore, if the existence of subluxation is not known, an evaluation to determine subluxation should be considered prior to issuing a denial of chiropractic treatment.

Coverage for chiropractic services is limited to those services performed by a doctor of chiropractic, osteopathy or medicine licensed by the state of California.

The following information is required for appropriate billing of chiropractic services.

- Primary diagnosis must indicate chiropractic-related care. Primary diagnosis must be indicated by an approved chiropractic diagnosis code from the ICD-10-CM table below. If the relevant diagnosis code is not in the primary diagnosis code position, the claim will be denied.
- CPT code must be one of the codes shown in the CPT code table below. Evaluation and management (E M) codes are not reimbursable.

CPT Codes and Rates for Chiropractic Services

Chiropractic services are reimbursed as follows:

CPT code	Type of visit	Maximum allowance
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	$16.72
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions	$16.72
98942	Chiropractic manipulative treatment (CMT); spinal, five regions	$16.72

ICD-10-CM Diagnosis Codes Required for Chiropractic Services

Providers may be reimbursed for chiropractic services when billed in conjunction with one of the following ICD-10-CM diagnosis codes.

Chiropractic Services

ICD-10-CM Code	Description
M50.11-M50.13	Cervical disc disorder with radiculopathy
M51.14-M51.17	Intervertebral disc disorders with radiculopathy
M54.17	Radiculopathy, lumbosacral region
M54.31, M54.32	Sciatica
M54.41, M54.42	Lumbago with sciatica
M99.00-M99.05	Segmental and somatic dysfunction
S13.4	Sprain of ligaments of cervical spine

Chiropractic Services

ICD-10-CM Code	Description
S16.1	Strain of muscle, fascia and tendon at neck level
S23.3	Sprain of ligaments of thoracic spine
S29.012	Strain of muscles and tendon of back wall of thorax
S33.5	Sprain of ligaments of lumbar spine
S33.6	Sprain of sacroiliac joint
S33.8	Sprain of other parts of lumbar spine and pelvis
S39.012	Strain of muscle, fascia and tendon of lower back

Clinical Trials

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information for clinical trials services.

Select any subject below:

- Clinical Cancer Trial
- Routine Care Costs for Qualifying Clinical Trials

Clinical Cancer Trial

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal members are eligible for participation in cancer clinical trials. These trials are for treatment with a drug that is exempt from federal regulation in relation to a new drug application, or are approved by one of the following:

- National Institutes of Health (NIH)
- Food and Drug Administration (FDA) as an investigational new drug application
- Department of Defense (DOD)
- Veterans' Administration (VA)

Health plans or delegated participating physician groups (PPGs) must cover all medically necessary routine patient care costs related to a clinical trial for a member diagnosed with cancer whose physician has recommended participation in the clinical trial, and who has been accepted for participation in a nationally recognized phase I, II, III, or IV clinical trial for cancer.

Routine patient care costs refer to the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

The California Department of Health Care Services (DHCS) has not contracted with Health Net to provide managed health care services or treatment for a member with a California Children's Services (CCS)-eligible condition; such coverage is carved out from Health Net coverage responsibilities and must be authorized by and provided through the CCS Program.

Medi-Cal members under age 21 are eligible for participation in cancer clinical trials when authorized by the CCS program. Members under age 21 who are candidates for cancer clinical trials can be referred to the county CCS office for authorization to participate in the cancer clinical trial. Health Net's care managers assist primary care physicians (PCPs) , specialists and members in ensuring timely referral to the CCS program.

CCS coverage is dependent on the timeliness of referral to CCS. Refer to the CCS Program Description for information on participating provider responsibilities for referring potential eligible members to CCS and for identifying CCS-eligible conditions.

The Health Net prior authorization letter for a cancer clinical trial identifies items and services, which are considered part of the cancer clinical trial to the extent they are known at the time of the initial review. These items and services are covered by the study entity.

Services rendered as part of a cancer clinical trial may be provided by a Health Net-participating provider or by a non-participating provider when the protocol for the trial is not available through a participating provider. The provider's recommendation for participation must be based on a determination that participation in the clinical trial has a "meaningful potential to benefit the member." Members participating in cancer clinical trials must continue to obtain primary and specialty health care services from or through their PCPs. Authorization requirements that would apply to services were they are not performed in relation to a clinical trial continue to apply to routine services provided in relation to a clinical trial. PPGs and PCPs should authorize the services of, and refer members to, in-network providers whenever it is medically appropriate.

Refer to definition of clinical trials for more information.

Phase I, II, III, IV Clinical Trials

Trial Phase	Description
Phase I	Determine toxicity through a continuum of modest dosing to determine safe levels for humans (classically considered the "first in human" studies)
Phase II	Begin to evaluate the effectiveness of the treatment
Phase III	Compare the new regimen to standard care to evaluate relative efficacy and therapeutic value
Phase IV	Post-marketing studies to delineate additional information, including the medication's risk, benefits and optimal use

Exclusions and Limitations

Coverage for cancer clinical trials does not include health care services that would not normally be covered and are provided only as a result of a member's participation in the clinical trial. Coverage for clinical trials does not include:

- Medications or devices not approved by the FDA
- Travel, housing, companion expenses, and other non-clinical expenses
- Items or services used solely for data collection and analysis. Health Net does not cover imaging or lab tests beyond those reasonably necessary for routine care
- Health care services customarily provided free of charge by the research sponsors of the clinical trial
- Any medication, item, device, or service that is specifically excluded from coverage under the medical plan

When a referral to a non-participating provider is necessary because a cancer clinical trial is not available through a participating provider, Health Net or the PPG may condition the referral to the non-participating provider on its acceptance of a negotiated rate that Health Net or the PPG would otherwise pay to a participating provider for the same services, less any applicable copayments and deductibles or for the clinical trial to work with the PPG to have the routine services done within the network.

Utilization Management Process

The following information applies only to participating physician groups (PPGs) and physicians.

Participating physician groups (PPGs) or directly contracting physicians should use the following process when requesting that Health Net provide prior authorization for a Health Net member to participate in a cancer clinical trial:

- Request a copy of the clinical protocol summary sheet and other pertinent documents
- Identify the sponsor of the clinical trial
- Confirm that the medications or service being evaluated meet the criteria established in the applicable legislation. Welfare and Institutions Code WIC § 14132.98 and 42 U.S. Code § 1396d(gg)(2)
- Require documentation by the treating physician that the trial may have therapeutic benefit for the member
- Obtain a copy of the member's informed consent
- Submit the completed prior authorization request to Health Net as an urgent review request

All prior authorization requests for cancer clinical trials including items and services furnished in connection with participation by members in a qualifying clinical trial are considered urgent/expedited and are completed within 72 hours.

Health Net requires the submission of the "Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for approval of the clinical trial. The attestation form must include the following information:

1. The member's name and client identification number;
2. The national clinical trial number;
3. A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
4. A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

When Health Net receives a direct communication from a provider requesting authorization to allow a member to participate in a cancer clinical trial, Health Net alerts the PPG of such a request in order to better ensure that the member is appropriately case managed.

Qualified Individual

A member in a group health plan who meets the following criteria is considered a qualified individual for a clinical trial:

- Diagnosis of cancer
- Eligible to participate in an approved clinical trial according to the trial protocol
- Member's provider supplies medical and scientific documentation establishing that the member's participation in such a trial would be appropriate based upon them meeting the guidelines and eligibility criteria

For information on Medi-Cal members under 21 years of age, refer to Coverage Explanation - Cancer Clinical Trial in this section.

Routine Care Costs for Qualifying Clinical Trials

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

When a prior authorization request is required for routine care costs, for items and services that are furnished as part of a qualifying clinical trial, requests are considered urgent and processed within 72 hours after the necessary clinical information is received.

To obtain urgent status when submitting the request for authorization to the Prior Authorization Department for Medi-Cal, either:

- Attach the downloaded Medicaid Attestation Form (PDF) **or**
- Indicate 'Routine Care Cost Services Associated with the Clinical Trial" on the appropriate Prior Authorization Request Form.

Refer to the Medi-Cal Prior Authorization Requirements for a complete list of services that require prior authorization.

Cosmetic and Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on cosmetic and reconstructive surgery.

Select any subject below:

- Overview
- Breast Cancer Reconstructive Surgery
- Cleft Palate Diagnoses

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

Reconstructive surgery is covered by Health Net. Reconstructive surgery is defined as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, to do either of the following:

- Improve function

- Create a normal appearance to the extent possible

In the case of transgender members, gender dysphoria is treated as a “developmental abnormality” for purposes of the reconstructive statute and “normal” appearance is to be determined by referencing the gender with which the member identifies.

Cosmetic surgery is defined as surgery that is performed to alter or reshape normal structures of the body to improve appearance. Health Net does not cover cosmetic surgery. For Medicare Advantage (MA) members, Medicare generally does not cover cosmetic surgery unless it is needed due to accidental injury or to improve the function of a malformed part of the body. Medicare covers breast reconstruction if the member has had a mastectomy due to breast cancer.

Prior authorization for reconstructive surgery procedures, services and evaluations may be required. Providers should refer to the applicable prior authorization requirements under the Prior Authorization section for more information. Upon review, requests may be denied in any of the following situations:

- Denial of the proposed surgery if there is another more appropriate surgical procedure that is approved for the member
- Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only minimal improvement in the member's appearance
    - The determination of whether a surgery will produce only minimal improvement should be based upon the standard of care, as practiced by physicians specializing in reconstructive surgery or other licensed physicians competent to evaluate the specific clinical issues involved in the care rendered
- Denial of payment for procedures performed without prior authorization
- For services provided by the Medi-Cal program (Chapter 7 (commencing with Section 14000), Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the member, as may be defined in any regulations that may be promulgated by the California Department of Health Care Services (DHCS)

Participating physician groups (PPGs) or attending physicians can refer to the Reconstructive Surgery Decision Tree (PDF) for guidance in making decisions about reconstructive surgery cases.

Breast Cancer Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG)

Mastectomy is defined as the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins. Complications from a mastectomy are covered, including lymphedema. Lymphedema sleeves and gloves are covered as prosthetic devices.

Treatment for breast cancer includes coverage of prosthetic devices or reconstructive surgery to restore and achieve symmetry for the member incident to a mastectomy.

In addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for the healthy breast are also covered when necessary to achieve normal symmetrical appearance.

A subsequent request for additional surgery to change the previously achieved symmetry is considered cosmetic unless the subsequent surgery is medically necessary or is being performed again to achieve symmetry after subsequent surgery has been performed on the diseased breast. Such cosmetic surgery is not a covered benefit.

Cleft Palate Diagnoses

Provider Type: Physicians | Hospitals| Participating Physician Groups (PPG)

Treatment for cleft lip/palate as covered under California Children's Services (CCS). Cleft palate may also include, cleft lip or other craniofacial anomalies associated with cleft palate. Health Net covers medically necessary services that are an integral part of cleft palate reconstruction and are not approved by CCS. To the extent that Medi-Cal members who require medically necessary dental or orthodontic services are determined eligible for the California Children's Services (CCS) program, these services are provided by CCS.

Cleft palate reconstruction services require prior authorization.

Dental Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on dental screening and services.

Select any subject below:

- Dental Screening and Services

Dental Screening and Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal members are entitled to dental screenings/oral health assessments, as described in the periodic health exam schedule.

Dental services other than dental screenings are not covered under Health Net's Medi-Cal plans. Health Net is not financially responsible for covering dental services under any circumstances, including when they are provided as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens

service. Health Net's participating primary care physicians (PCPs) refer members for dental services to Medi-Cal dental providers if the member is eligible for Medi-Cal Dental.

Medical services

Health Net covers the following medical services related to non-covered dental services:

- Contractually covered prescription medications.
- Medically necessary laboratory services.
- Pre-admission physical examinations required for admission to an outpatient surgical center or an inpatient hospitalization required for a dental procedure.
- Facility fees for inpatient and outpatient services (such as ambulatory surgery center) that are prior authorized.
- Physician administered anesthesia services such as intravenous (IV) sedation and general anesthesia for inpatient and outpatient services.
- Covered medical services related to dental services that are not provided by dentists or dental anesthetists.
- Fluoride varnish, up to three times in a 12-month period, for Medi-Cal members under age 6 years.

Dental services

Each dental plan, and full-service plan offering coverage for dental services, must ensure that contracting dental provider networks have adequate capacity and availability of licensed health care providers to offer members appointments for covered dental services in accordance with the following requirements, based on California Department of Managed Health Care (DMHC) regulations (Section 1300.67.2.2, et. Seq. of Title 28 of the California Code of Regulations) concerning timely access standards:

- Urgent appointments within the dental plan network are offered within 24 hours of the time of request for appointment, when consistent with the member's individual needs and as required by professionally recognized standards of dental practice.
- Non-urgent appointments are offered within four weeks of the request for appointment, except as provided in subsection (c)(6)(C).
- Preventive dental care appointments are offered within four weeks of the request for appointment.

IV MODERATE SEDATION AND DEEP SEDATION/GENERAL ANESTHESIA COVERAGE

Health Net does not cover any charges for the dental procedure itself, including the professional fee of the dentist or any other dental provider.

However, medically necessary physician administered general anesthesia and IV sedation and associated facility charges for non-covered dental services rendered in a hospital (inpatient or outpatient) or ambulatory surgery center setting are covered if under one or more of the following circumstances:

1. member is under age 7 years,
2. member is developmentally disabled, regardless of age,

3. member's health is compromised and physician administered anesthesia is medically necessary for dental services, regardless of member's age, or
4. dental services are medically necessary and behavior modification and local anesthesia have failed or are not possible.

Coverage Criteria

Behavior modification and local anesthesia must generally be attempted first, but may not be required in certain situations, depending on the medical needs of the member. Thereafter, minimal sedation must then be considered or determined not feasible based on the medical needs of the member, and is not always required depending on the medical needs of the member. If the provider provides clear medical record documentation of both number 1 and number 2 below, then the member must be considered for IV moderate sedation or deep sedation/general anesthesia.

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the member.
2. Use of minimal sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the member.

If the provider documents any one of the bullets below, then the member must be considered for IV moderate sedation or deep sedation/general anesthesia.

- Use of effective communicative techniques and the inability for immobilization (member may be dangerous to self or staff) failed or was not feasible based on the medical needs of the member.
- Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation.
- Member has acute situational anxiety due to immature cognitive functioning.
- Member is uncooperative due to certain physical or mental compromising conditions.

The procedures are ranked from low to high profundity as follows:

1. minimal sedation via inhalation or oral anesthetics
2. non-intravenous conscious sedation
3. IV moderate sedation
4. deep sedation/general anesthesia

Members with certain medical conditions such as, but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrythmias and significant bleeding disorders, uncontrolled seizures and sleep disordered breathing, should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis, as determined most appropriate by the provider.

In compliance with 42 CFR 455.410, all ordering or referring physicians or other professionals providing Medi-Cal services must be enrolled as an original fee-for-service (FFS) Medi-Cal provider. All providers, such as the selected anesthesiologist must also meet standards for participation in the FFS Medi-Cal program at the time services are prescribed, ordered or rendered.

Prior Authorization Requirements

Requests for authorization (RA)/prior authorization (PA)/Treatment Authorization Requests (TAR) are required for physician-administered anesthesia services or IV sedation. Member selection for dental procedures under physician-administered deep sedation/general anesthesia or IV moderate sedation considers medical history, physical status, and indications for anesthesia management.

The dental provider in consultation with the anesthesiologist is responsible for determining whether a member meets the minimum criteria necessary for receiving deep sedation/general anesthesia and/or IV moderate sedation. In addition:

- The dental provider submits the RA/PA/TAR to the dental carrier for the dental procedure and works in collaboration with the anesthesiologist to determine whether the patient meets the minimum criteria for receiving IV moderate sedation, deep sedation/general anesthesia.
- The physician who renders the IV moderate sedation, deep sedation/general anesthesia is responsible to submit the RA for deep sedation/general anesthesia or IV moderate sedation to Health Net or to the member's delegated participating physician group (PPG). The RA must:
    - State the criteria indications, such as failed attempts of conscious sedation, local anesthesia and other mechanisms, or why prior attempts could not be attempted and include the planned location of the service.
    - The provider performing the IV moderate sedation, deep sedation/general anesthesia, must provide documentation and a copy of the approved RA/PA/TAR to request PA prior to delivering deep sedation/general anesthesia or IV moderate sedation.

- Prior to anesthesia services being rendered, the provider must have a copy of a complete history and physical examination and the indication for IV moderate sedation or deep sedation/general anesthesia. Additionally, and not as a prerequisite to authorization, the provider and primary care physician must fulfill the requirements for chart documentation which, in addition to the above, includes diagnosis, treatment plan and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure.

[1]Information taken or derived from APL 23-028 Attachment A, Policy for Intravenous Moderate Sedation and Deep Sedation/General Anesthesia.

Delegated PPG Response to Prior Authorization Requests

Delegated participating physician groups (PPGs) must respond to PA requests submitted for general anesthesia or IV sedation as outlined above and render a utilization management decision in a timely manner in accordance with the PPG's Provider Participation Agreement (PPA).

If additional clinical information is required, the member and providers must be notified in writing within the applicable regulatory time frame. The PPG is also responsible for communicating the decision to the member and providers within the applicable regulatory time frame from the date of the original receipt of the request.

The member's PCP provides any necessary pre-operative history and physical examination and necessary laboratory or other medically necessary ancillary services. Both the dentist and anesthesiologist must have privileges at the selected place of service (such as the hospital (outpatient, inpatient or ambulatory surgery center), or a Letter of Agreement (LOA) needs to be initiated by the PPG in order to authorize and provide services at the designated facility site.

PCP Responsibilities

The primary care physician (PCP) must conduct a dental assessment for members under age 21 to check for normal growth and development and the absence of tooth and gum disease at the time of the initial health appointment (IHA) and at each preventive, well-child screening examination visit according to the periodic health examination schedules.

A dental screening for children under age 3 includes, but is not limited to, an examination of the mouth and gums; and anticipatory guidance on proper feeding practices and on cleaning the mouth to remove bacteria. For children over age 3 years, the screening includes, but is not limited to, an examination of the mouth, teeth and gums; prescription for fluoride supplementation if drinking water is not adequately fluoridated; and anticipatory guidance in the prevention of dental caries, orofacial injury and disease, proper oral hygiene practices, and consideration of dental sealants.

PCPs are also responsible for performing a dental screening exam on adult members as part of the initial health appointment and at scheduled periodic health assessments, and to encourage them to receive an annual dental exam. All screenings, referrals and the reason for the referral must be documented in the member's medical record.

Mandatory Referral

The PCP must make a mandatory dental referral following the member's initial dental health screening starting at age 3 years, or earlier, if dental problems are identified and continue to refer the member on subsequent, annual dental health screenings if warranted at the time by any new or ongoing dental issues identified. The PCP must provide a topical fluoride varnish to the member's teeth during their exam. A referral to a dentist or orthodontist should be made if the member has severe malocclusion within six months of the first tooth erupting or no later than the member's 1st birthday. All screenings, referrals and the reason for the referral must be documented in the member's medical record.

Providers or members may call Denti-Cal for a list of three Denti-Cal providers in their ZIP Code (Los Angeles and Sacramento County members may also obtain services from a Health Net Dental provider, if applicable). Members who need interpreter assistance to locate a dentist may call Health Net's Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

Dialysis

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on dialysis.

Select any subject below:

- Out-of-State Dialysis

Out-of-State Dialysis

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

If an end-stage renal disease (ESRD) member receiving dialysis informs the participating physician group (PPG) of an intention to travel within the United States, making it impossible for the member to use the customary in-area services or facilities, the PPG must:

- Authorize dialysis services by other providers
- Arrange for the services to be performed by providers in the member's temporary location
- Inform the member that it may be necessary to change the type of setting in which dialysis is performed, because local circumstances may not allow the same type of setting to be used.
- Authorize the services for the length of the planned trip
- Inform the member in writing about the details of what has been authorized and state that, if travel plans change and additional time is needed, the member must inform the PPG. If the member extends the duration of the trip and informs the PPG, a one-time modification of the authorization is made to cover the additional time period

Costs are borne in the same manner as if the member received the services within the PPG service area. Dialysis services are not covered if received outside the United States, except emergency services requiring hospitalization are covered outside the United States in Canada or Mexico.

Medi-Cal members diagnosed with ESRD are eligible for Medicare coverage after a four-month waiting period. If a Medi-Cal member requires dialysis and is under age 21 years, the member must be referred to the California Children's Services (CCS) program. Health Net's care managers assist primary care physicians (PCPs) in ensuring timely referral to the CCS program. Refer to the CCS Program Overview for information on participating providers' responsibilities for referring potential eligible members to CCS and for identifying CCS-eligible conditions.

If the Medi-Cal member is over age 21 for chronic hemodialysis or chronic peritoneal dialysis, the member becomes eligibile for Medicare and the PPG, Health Net or the dialysis center should initiate the Medicare application. Health Net only provides dialysis until Medicare eligibility becomes effective. Given that Medicare is the primary payer before Medi-Cal, PPGs should verify Medicare eligibility and enrollment for any Medi-Cal member diagnosed with ESRD prior to authorizing and billing for dialysis services.

Doula Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Per State Plan Amendment (SPA) 22-0002, doula services are provided as preventive services pursuant to Title 42 Code of Federal Regulations (CFR) Section 440.130(c).

The Department of Health Care Services (DHCS) issued a statewide standing recommendation that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from receiving doula services from a Medi-Cal enrolled doula provider. The recommendation fulfills the federal requirement for a physician or other licensed practitioner of the health arts acting within their scope of practice to provide a written recommendation for preventive services. Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of members while adhering to evidence-based best practices.

Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

This section contains general information on doula services. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

- Doulas are 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 also offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.
- Doulas are not licensed, and they do not require supervision. Doulas do not diagnose medical conditions, provide medical advice, or clinical assessment, exam, or procedure.

Eligibility requirements

The member must be active and enrolled in the Medi-Cal Plan.

- Doulas must verify eligibility for the month of service by contacting the Plan or looking the member up in the provider portal.
- The member must be pregnant or have been pregnant within the past year and would benefit from doula services.

Documentation requirements

Additional visits during the postpartum period require a recommendation from a licensed practitioner of the healing arts. Up to nine postpartum visits can be added.

Initial Set of Services:

Members can receive doula services virtually or in-person in any setting, such as home, office, hospital, or an alternative birthing center. All visits are limited to one per day, per member.

The initial recommendation authorizes the following:

- One initial visit.
- Additional visits – up to eight given in any combination of prenatal and postpartum visits.
- Labor and delivery support – including labor and delivery resulting in miscarriage, stillbirth and abortion.
- Postpartum – up to two extended three-hour visits. These visits do not require the member to meet any criteria or receive a separate recommendation.

Assistive services during visits

Doulas can also give assistive or supportive services during an in-home prenatal or postpartum visit. This support provides face-to-face interaction while helping with emotional or educational support, such as folding laundry or drying dishes with the pregnant member. An assistive or supportive activity with the member cannot be billed to the member.

Note: If a doula teaches classes, the classes can be offered at no cost to a member receiving services from the doula.

Coordinating services

Doulas should work with the member's primary care physician (PCP) or contact the Plan if the member needs additional support.

Non-covered doula services

The following are not covered under doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Durable Medical Equipment

Physicians | Hospitals | Ancillary | Participating Physician Groups (PPG)

This section contains general member benefit information on durable medical equipment.

Select any subject below:

- Coverage
- Coverage Criteria for Wheelchairs and Seating and Positioning Components
- Service Providers

Coverage

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Durable medical equipment (DME) is a covered benefit and subject to prior authorization and coordination. DME is subject to coordination with California Children's Services (CCS), as appropriate for applicable diagnosis. Apria Healthcare is the preferred provider for DME services.

Orthotics

Health Net covers orthotic and prosthetic devices and services that are medically necessary and prescribed by physician, podiatrist, dentist, or non-physician medical provider. They include implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments, and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part.

Orthotic services are not available through Health Net's preferred DME provider (Apria). They may be obtained through prosthetic and orthotic providers, such as Linkia, LLC.

Exclusions and Limitations

The following information applies only to participating physician groups (PPGs), physicians and ancillary providers.

Durable medical equipment (DME) is a covered benefit on most health plans. Additional non-covered items are:

- Comfort, convenience, or luxury equipment, features, and supplies, except retail-grade breast pumps as described in this chapter under “Breast pumps and supplies” in “Maternity and newborn care”
- Items not intended to maintain normal activities of daily living, such as exercise equipment including devices intended to provide more support for recreational or sports activities
- Hygiene equipment, except when medically necessary for a member under age 21
- Nonmedical items such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (diabetes blood glucose monitors, continuous glucose monitors, test strips, and lancets are covered by Medi-Cal Rx)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse, except when medically necessary for a member under age 21
- Other items not generally used mainly for health care

Coverage Criteria for Wheelchairs and Seating and Positioning Components

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net ensures that medically necessary wheelchairs and seating and positioning components (SPCs) are provided to Medi-Cal members in a timely manner and in accordance with applicable laws and policies. Specifically, for wheelchairs and SPCs, criteria for medical necessity must include a medical evaluation of the member and review of the equipment to ensure that the member has appropriate mobility in or out of the home.

Health Net covers medically necessary equipment, regardless of whether the needed equipment will be used inside or outside the member's home. A prescription for a wheelchair or SPC is not to be denied solely on the grounds that it is for use outside the home, when determined to be medically necessary for the member's medical condition.

Face-to-Face Examination

The member must have a face-to-face examination by a licensed clinician and an evaluation performed by a qualified provider who has specific training or experience in wheelchair evaluation and ordering, as applicable, and as defined in Welfare and Institutions Code Section 14105.485. PPGs are to perform prior authorization in accordance with Title 22, California Code of Regulations (CCR), Section 51321. Refer to the criteria in All Plan Letter (APL) 15-081 (PDF) to confirm medical necessity of wheelchairs and SPCs.

Service Providers

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Durable medical equipment (DME) is paid for in accordance with the Provider Participation Agreement (PPA). Fee-for-service (FFS) providers may be directed to any participating Health Net DME provider, including Apria Healthcare, Inc. Custom rehabilitation equipment services are obtained through the following organizations:

- Custom Rehab Network
- National Seating & Mobility
- Hoveround, Inc.
- Numotion.

For insulin pumps and supplies, contact Advanced Diabetes Supply, MiniMed, Inc.,CCS Medical, or Tandem Diabetes.

For blood pressure monitors and cuffs, use the Blood Pressure Monitor Request Form (Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley) and fax it to our preferred DME vendor, Western Drug.

Orthotics and prosthetics can be obtained from any Health Net participating provider, such as Linkia, LLC. Refer to the PPA to determine financial responsibility.

For delegated providers, please contact the PPGs for more information.

Dyadic Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Dyadic Services denote a family and caregiver-focused Model of Care intended to address developmental and Behavioral Health conditions of Children as soon as they are identified. Dyadic services include dyadic behavioral health (DBH) well-child visits, dyadic comprehensive community support services, dyadic psychoeducational services, and dyadic family training and counseling for child development. The DBH well-child visit is provided for both child (members under age 21) and parent(s)/caregiver(s) together, preferably within the pediatric primary care setting the same day as the medical well-child visit. Dyadic services screen for

behavioral health problems, interpersonal safety, tobacco and substance misuse and social drivers of health (SDOH), such as food insecurity and housing instability, and include referrals for appropriate follow-up care.

Facilities or clinics that offer integrated physical health and behavioral health services, such as Community Health Centers and Federally Qualified Health Centers (FQHCs), are able to conduct the medical well-child visit, the DBH well-child visit and some or all of the ongoing dyadic services. Physicians who do not offer integrated behavioral health services are able to initiate dyadic services by conducting the medical well-child visit and making referrals to behavioral health providers for the DBH well-child visit and ongoing dyadic services.

ELIGIBILITY REQUIREMENTS

Members under age 21 and their parent(s)/caregiver(s) are eligible for DBH well-child visits when:

- Delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment.
- Medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.
- The child must be enrolled in Medi-Cal. The parent(s) or caregiver(s) does/do not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.

REFERRAL TO BEHAVIORAL HEALTH SERVICES

Primary care physicians (PCPs) or sites that do not offer behavioral health services can initiate dyadic services by conducting the medical well-child visit and referring members to Health Net to connect with a dyadic services provider who will conduct the DBH well-child visit and determine needs for ongoing dyadic services.

CLAIMS SUBMISSION

Provider sites with integrated physical health and behavioral health services, such as Community Health Centers, FQHCs, and some primary care sites, will be able to administer the medical well-child visit, the DBH well-child visit and some or all of the additional dyadic services (depending on scope of practice). In such cases, integrated provider sites will bill the Plan for the medical well-child visit and dyadic service(s).

Enteral Nutrition

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Enteral nutrition products are a conditional benefit under the Health Net Medi-Cal program. Prior authorization is required. Enteral nutrition products are used as a treatment plan for conditions that do not accept the full use of regular food. This is subject to Medi-Cal's list of enteral nutrition products and utilization controls.

Coverage for enteral nutrition products, including therapeutic infant formula, must meet medical necessity criteria. It cannot be a convenience item or used in place of food for social and economic reasons. If regular foods are available to provide needed nutrients and calories, then enteral nutrition becomes a convenience item, which is not covered.

Enteral Nutrition products may also be covered under Medi-Cal Rx program when billed under the Pharmacy benefit. Visit Medi-Cal Rx for more information.

Benefits for Members Ages 21 and Over

The Department of Health Care Services (DHCS) and Health Net may deem a nutrition product taken by mouth a medically necessary benefit for patients ages 21 and over. This applies to certain diagnoses, such as intestinal malabsorption and inborn errors of metabolism among others. It can also apply to medical conditions where enough nutrition is not achieved with dietary changes or from soft or pureed foods.

Benefits for Members Under Age 21

Members under age 21 are covered by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Enteral nutrition is a covered benefit for California Children's Services (CCS) eligible diagnoses, such as malabsorption, genetic disorders and inborn errors of metabolism. If the member qualifies for coverage under the CCS program, then CCS-approval should be obtained for medically necessary enteral nutrition. Information on Lactation Education and Support Services is located in the Maternity section.

Prior Authorization Process

Prior authorization is required for enteral nutrition products and supplies. Providers participating through a participating physician group (PPG) should follow the PPG's guidelines for prior authorization.

Fee-for-service (FFS) providers must complete the Pharmacy Prior Authorization Form for members.

The CCS program also requires a Service Authorization Request (SAR) for enteral products for CCS-eligible conditions.

Products billed must be identical to products authorized.

Authorization Time Frames

Decisions regarding enteral nutrition products are performed timely. They are based on the member's medical condition within the following time frames:

Type of Request	Time Frame
Emergency requests	Emergency requests occur when prescribing providers determine the product is required immediately to prevent serious disability or

Type of Request	Time Frame
	death. Prior authorization is not required when there is truly an emergency requiring immediate treatment.
Urgent requests	72 hours of receipt of all the information reasonably necessary to make a decision. Urgent requests occur when the requesting provider or Health Net determines that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum functions.
Non-emergent/routine requests	Seven calendar days of receipt of all the information reasonably necessary to make a decision. Routine requests are for treatment plans already in place.

If a decision about enteral nutrition products is delayed past these time periods, the request is considered approved.

Family Planning

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on family planning services.

Select any subject below:

- Overview

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members have the right to access family planning services without prior authorization from any qualified Medi-Cal enrolled participating or non-participating family planning provider in or out of Health Net's service area. A qualified Medi-Cal enrolled family planning provider includes a member's primary care physician (PCP) and other participating or non-participating providers, including obstetricians/gynecologists (OB/GYNs), nurse midwives, nurse practitioners (NPs), physician assistants (PAs), federally qualified health centers (FQHCs), Indian Health Clinics (IHCs), Rural Health Centers (RHCs), and county family planning providers.

Capitated participating physician groups (PPGs) are responsible for payment of claims to all qualified family planning providers for appropriate billable services covered by the Department of Health Care Services (DHCS) Medi-Cal fee-for-service (FFS) program, including office visits, laboratory tests, and Medi-Cal approved contraceptive medications, devices and supplies. Refer any problems involving claims payment responsibility to a Health Net provider network management representative.

Problem Resolution

Any conflicts concerning provision of family planning services, excluding member or provider grievances or appeals, should be referred to Health Net's public programs administrators for resolution. During any problem periods, a Health Net care manager and the PCP or specialty provider continues to coordinate the member's care.

Provider Responsibilities

Providers may not restrict a member's access to family planning services or subject a member to any prior authorization process for them. Providers who do not comply are subject to administrative review or disciplinary action.

The family planning provider must obtain informed consent for sterilization. A signed Consent Form (PM-330 (PDF)) must be included with all claims for payment for sterilization.

Coverage

The following information applies only to Exclusively Aligned Enrollment Dual Special Needs Plan (EAE D-SNP) participating physician groups (PPGs) and Medi-Cal PPGs and physicians.

The following family planning services are covered for all members of childbearing age:

- Health education and counseling necessary to make informed choices and understand contraceptive methods.
- Limited history and physical examination.
- Laboratory tests, if medically indicated, to assist with decision-making for contraceptive methods (except cervical cancer screening, such as Pap test, provided by a nonparticipating provider where Health Net has previously covered a cervical cancer screening performed by a participating provider in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines).
- Diagnosis and treatment of sexually transmitted infections (STIs).
- Screening, testing and counseling of individuals at risk for HIV infection.
- Most methods of sterilization (the member must be at least age 21 at the time consent is obtained), including:
  - Tubal ligation.
  - Vasectomy.
- Same methods of birth control as covered by the Department of Health Care Services (DHCS) for the Medi-Cal fee-for-service (FFS) program, devices and supplies (including Depo-Provera® and Lunelle™). Members may receive up to a 12-month supply dispensed at one time for U.S. Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives, such as 13 vaginal rings, 52 patches and 18 cycles of oral contraceptives.

- Oral contraceptives are covered when dispensed from an onsite clinic and billed by any qualified provider. A qualified provider is 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 Medi-Cal enrollee as specified in Title 22, California Code of Regulations, Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, nurse practitioner, and pharmacist are authorized to dispense medications. When furnished by a pharmacist self-administered hormonal contraceptives must be dispensed in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Pursuant to the California Business and Professions Code (B&P Code), Section 2725.2, if contraceptives are dispensed by a registered nurse (RN), the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with evaluation and management (E&M) procedure codes 99201, 99211 or 99212 with modifier TD (used for behavioral health RN) as directed in the DHCS Medi-Cal Provider Manual.

- Office-administered follow-up treatment of complications associated with contraceptive methods issued by a family planning provider.
- Outpatient office visits to manage minor issues associated with hormonal methods of birth control, not limited to two visits; prior authorization is not required.
- Pregnancy testing and full-options counseling when performed by trained staff under the supervision of a licensed physician.

Coordination With Non-Participating Providers

Health Net encourages the primary care physician (PCP) to coordinate care with non-participating providers to avoid duplication of services. If the PCP previously provided the service the non-participating provider is now providing, the non-participating provider is not paid (unless they have documented attempts to contact the member's PCP for medical information).

When a member requests that medical records be forwarded to a non-participating provider, it is the PCP's responsibility to comply. The PCP must obtain a completed signed consent form from the member for records to be transferred to the non-participating provider.

If the member needs medically necessary follow-up care, the non-participating provider must obtain a signed consent from the member to notify the member's PCP. Health Net's Health Services staff are available to assist non-participating providers if any concerns about timely provision of services and referrals arise.

Member Education

Health Net provides new members the following information on family planning services through the Evidence of Coverage (EOC) :

- The member's option to receive family planning services from any qualified participating provider (in- or out-of-network), without referral or prior authorization of coverage
- A complete list of the services offered and descriptions of limitations on the family planning services members may seek from non-participating providers
- The member's right to timely services
- Notification that members must provide informed consent for sterilization

- That confidentiality of medical information and personal data of all members is maintained through strict adherence to applicable state and federal requirements
- The member's right to confidentiality when receiving socially sensitive services, including the availability of services for minors without parental consent
- The positive effect of coordinated care on health outcomes

Hearing/Hearing Aids

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Health Net plans cover hearing tests provided by a member's physician, audiologist or other qualified provider in accordance with Hearing Aid CAP FAQ and Medi-Cal guidelines (DOC). Hearing aids, including molds, supplies, inserts, and an initial set of batteries, are also covered.

Replacement of a hearing aid is covered if:

- Hearing loss is such that the member’s current hearing aid is not able to correct it
- Hearing aid is lost, stolen, or broken and cannot be fixed (and was not the member’s fault).

State law requires children under 21 years old who need hearing aids to be referred to the California Children’s Services (CCS) program to decide if the child qualifies for CCS. If the child qualifies for CCS, CCS will cover the costs for medically necessary hearing aids if it is to treat the medical condition. If the child does not qualify for CCS, Health Net will cover medically necessary hearing aids as part of Medi-Cal coverage.

For adults ages 21 and older, Medi-Cal does not include:

- Replacement hearing aid batteries

Health Net contracts with Connect Hearing, Inc., Sonus and Hearing Healthcare Providers (HHP) to provide hearing aid services. Providers should refer members with a prescription, to one of these contracting providers. Once the contracting provider receives a prescription from the treating provider, the contracting provider verifies the member's eligibility and administers benefits in accordance with Medi-Cal guidelines (DOC). For additional information on hearing aid services, refer to the Department of Health Care Services (DHCS) Medi-Cal Provider Manual.

HIV Testing and Counseling

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers and non-participating providers may provide confidential HIV testing, counseling and follow-up services for Medi-Cal members, without authorization. Providers must provide information about HIV testing, treatment options and additional testing needed, and advise members of their right to decline testing. If a member declines HIV testing, the provider must document this information in their medical records.

When a member requests confidential HIV testing, counseling or follow-up services, the provider or staff person with authority and license to do so, must administer pre-test counseling services, obtain a complete history and physical (if indicated), and order the requisite lab work. The provider must follow the Centers for Disease Control and Prevention (CDC) guidelines for pre- and post-testing counseling.

Medi-Cal members may also obtain confidential or anonymous HIV testing and counseling services from a local health department (LHD), community-based organization testing site, or a non-participating family planning provider. The member's primary care physician must perform follow-up services. Members who are age 12 years and older may get HIV/AIDs preventive, testing and treatment services without parent’s or guardian’s permission.

Reimbursement Policy

Providers rendering confidential HIV testing and counseling services are reimbursed at the allowable Medi-Cal fee-for-service (FFS) rate established by the Department of Health Care Services (DHCS), unless a specific rate is included in the provider's contract.

Participating providers are required to coordinate all follow-up services with the member's primary care physician (PCP). Referrals must be obtained from the PCP and authorization for services requiring prior authorization must be obtained. If a participating provider treats a member for follow-up HIV services without the PPGs approval, payment of claims for the services may be denied.

Claims for reimbursement are processed within 45 business days of receipt. Providers are notified in writing of any contested claim in suspense longer than 45 business days.

Release of Confidential Information

The custodian of records is responsible for controlling the release of records related to HIV testing to any third party not involved in the member's care.

If a copy of the member's medical record is requested, the custodian of records must review the record and remove the confidential consent form or the HIV test results, along with any other portion of the record that contains documentation of the HIV test being ordered or the HIV test results (for example, history, physical, consultations, and progress notes). If the HIV test or HIV test results are mentioned anywhere in the medical record, the information is protected. If necessary, the custodian must explain that the protected portion of the record requires special written authorization from the member. The custodian of records must not identify in any way that the record is confidential because of the HIV or AIDS test. It must state that disclosure of it is protected under state law and requires special authorization from the member. After removing all confidential material, the record may be released to the requestor.

Requests by a member for access to medical records containing HIV test result information should be processed according to established guidelines. Prior to providing a member access to the medical record, verify with the provider that the member has been previously informed of the test results. The provider must disclose the results of an HIV test to the subject of the test in a confidential manner. Disclosure must be in person only and not by telephone.

Hospice Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal members who qualify for and elect hospice care services remain enrolled with Health Net while receiving these services. To avoid problems caused by late referrals, participating physician groups' (PPGs') written policies and procedures must clarify how members may access hospice care services in a timely manner, preferably within 24 hours of the request. Medi-Cal members ages 21 and above may not have palliative care at the same time as hospice care.

Certification and documentation

Health Net follows state of California regulations on certification that states a member whose prognosis indicates a life expectancy of six months or less is considered terminally ill.

Documentation to be submitted within five (5) calendar days of hospice election

When Health Net is at financial risk and a member begins outpatient hospice care, participating physician groups (PPGs) and providers must submit required forms and documents to Health Net **within five (5) calendar days** of hospice certification and election to initiate and recertify care. Failure to submit the Medi-Cal Hospice Program Election Notice within this timeframe will result in non-coverage of services from the hospice admission date until the completed form is received.

To initiate hospice services, the following documentation must be submitted to Health Net. (Note: Not all documents are required for each submission. Refer to **Hospice Services Documentation Guide** (Medi-Cal, CalViva Health, CHPIV).

1. **Certificate of terminal illness (CTI)**
2. Medi-Cal **Hospice Program Election Notice**
3. **Initial care plan**
4. **Transfer summary, discharge summary** and/or prior revocation(s) of hospice election
5. **Written prescription (required for inpatient)**

Documentation submission:

- For detailed instructions and submission guidelines to initiate or recertify hospice, refer to the **Hospice Services Documentation Guide** (Medi-Cal, CalViva Health, CHPIV) in the *Forms and References* section of the provider library.
- Non-Compliance– If the Medi-Cal Hospice Program Election Notice (PDF) form, CTI and face-to-face (for recertification periods 3 and beyond) are not completed and submitted within 5 calendar days of hospice certification and election, Health Net is not required to pay for services before receipt of completed information The hospice provider is financially responsible, and members cannot be billed.

Hospice benefit periods and eligibility requirements

Hospice care is divided into benefit periods as follows:

- First benefit period: 90 days
- Second benefit period: 90 days
- Subsequent periods: Unlimited 60-day periods
- Each benefit period begins on the first day hospice care is provided and continues for the full duration of that period.
- A physician CTI is required for each benefit period to confirm the member's terminal condition.

Starting with the third benefit period, a face-to-face encounter with a hospice physician or nurse practitioner is required within 30 days prior to the new period to verify continued eligibility.

California Children's Services Eligible Services for Life-Limiting Conditions

Hospice care options for children do not fit the traditional adult hospice model. Pediatric palliative care is authorized and managed by the health plan through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This applies to members who meet the eligibility criteria.

Policy guidelines and directions for authorization of medically necessary services (PDF) related to a CCS life-limiting condition for children who have elected hospice is available on the DHCS website.

Health Net and its delegated PPGs work with CCS to help with continuity of medical care. This includes keeping the current relationship between patient and provider. If elected, hospice care for children with terminal diseases requires working closely with Health Net, the PPG, the local CCS program, and other caregivers. Hospice counseling, including grief, bereavement and spiritual services, may be needed during this transition.

Concurrent Hospice, Palliative and Curative Care for Children

A member under age 21 may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302 as detailed in CMS Letter #10-018.

Information regarding the concurrent care policy is available in Policy Letter (PL) 11-004, The Implementation of Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," APL 25-008; and the appropriate California Children's Services (CCS) Numbered Letter (NL), including any future iterations of the-se letters.

Palliative care CCS NL 16-1218 (PDF) provides additional palliative care information on the DHCS website.

Note: Palliative care services may be authorized by CCS if they are part of a plan of care for a CCS special care center (SCC). CCS is financially responsible for the palliative care services and not the medical plan.

Description of Hospice Care Services

Upon the Medi-Cal member's election of hospice care services, Health Net and its delegated participating physician groups (PPGs) must ensure provision of, and payment for, hospice care services (listed below) provided by a hospice provider.

Hospice care services include, but are not limited to, the following:

- Nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy or speech therapy
- Medical social services under the direction of a physician
- Home health aide and homemaker services
- Medical and surgical supplies, and durable medical equipment (DME)
- Prescribed medications (some drugs may be available through Medi-Cal Rx).
- Family counseling related to the member's terminal condition
- Bereavement services
- Educational services
- Pastoral services
- Dietician services
- Continuous nursing services may be provided for 24 hours to achieve palliation or management of acute medical symptoms. The care must be required due to periods of crisis and only as necessary to maintain the terminally ill member at home. Care provided requires a minimum of eight hours of nursing care within a 24-hour period commencing at midnight a minimum of 51 percent of which time must be provided by a licensed nurse. Nursing services include either homemaker or home health aide services. The eight hours of care do not need to be continuous within the 24-hour period.
- Inpatient hospice respite care, short-term care provided to the member only when necessary to relieve the family or other caregivers. Respite care may be on an intermittent, non-routine or occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility. Prior authorization is required for inpatient admission.
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility. Prior authorization is required for inpatient admission.

Physician Services

Physician services include general supervisory services of the hospice medical director and participation in establishing the member's plan of care, supervision of care and services, periodic review and updating plan of care, and establishing governing policies by the physician of the hospice interdisciplinary team. Other physician services not related to hospice services are covered separately.

Provision of Hospice Care Services by Interdisciplinary Group

Interdisciplinary hospice services may be provided to patients with serious illnesses, as determined by the physician and surgeon in charge of their care, and patients who continue to receive curative treatment from other licensed health care professionals.

Due to the highly specialized services provided by hospice providers, federal law mandates the hospice provider designate an interdisciplinary group to plan, provide and supervise the care and services offered by the hospice provider. A written plan of care must be established by the attending physician, the medical director or designated physician, and the interdisciplinary hospice group prior to providing care. The plan of care is then reviewed and updated as specified in the plan of care by the attending physician, medical director or designated physician and interdisciplinary hospice group.

Health Net and its delegated PPG or primary care physician (PCP) coordinate the care between Health Net, the member's PPG and hospice care providers, and allow for the interdisciplinary hospice group to manage the Medi-Cal member's care.

Election Statement

Providers must submit the DHCS Medi-Cal Hospice Program Election Notice (PDF) form, which must include the following:

- Identification of the hospice agency that will provide the care
- A statement describing the hospice care program and requirements
- Member's acknowledgment of full understanding that hospice care given as it relates to the member's terminal illness is palliative, and certain specified Medi-Cal benefits are waived by the election. Members under age 21 who voluntarily elect hospice care do not constitute a waiver
- Effective date
- Signature of member or guardian
- A statement explaining the member's right to revoke hospice services at any time

The member is required to elect hospice care and the attending physician is required to establish a plan of care before services are provided.

As of May 5, 2025, the DHCS Medi-Cal Hospice Program Election Notice (PDF) form must be used and submitted to Health Net within **five calendar days** of election and certification. The form confirms a Medi-Cal member’s choice to receive hospice care. The form Must include:

- Be completed by the hospice provider and submitted to Health Net within **five calendar days** of the member’s election and certification of terminal illness. Must include:
    - The **name of the hospice provider**.
    - An **acknowledgment** from the member or authorized representative that hospice care is **palliative, not curative**, and that certain Medi-Cal benefits are waived.
    - The **effective date** of the election.
    - The **signature** of the member or their representative.
    - A **statement of the member’s right to revoke** hospice services at any time.
- Be submitted on time to avoid non-payment for services rendered before submission. If submissions is received late, the hospice provider is financially responsible and **cannot bill the member**.
- The Medi-Cal Hospice Program Election Notice form can be accessed through the DHCS Hospice Care website.

Face-to-Face Encounters for Continued Hospice Eligibility

The following information applies to participating physician groups (PPGs) and ancillary providers only.

Hospice physicians or hospice nurse practitioners (NPs) must have a face-to-face encounter with every hospice patient to determine continued hospice eligibility. To satisfy this requirement, the following criteria must be met:

1. The face-to-face encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter
2. The hospice physician or NP who conducts the face-to-face encounter **must attest in writing** to it. The attestation:
    - Must be on a separate and distinct section of, or addendum to, the recertification form.
    - Be clearly titled and include the rendering physician's or NP's signature and
    - Date of face-to-face encounter.
3. When an NP conducts a face-to-face encounter, the attestation must:
    - State the clinical findings were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, if the illness runs its normal course.

In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period (as described in criteria 1). For example, if the patient is an emergency admission on a weekend, it may be impossible for a hospice physician or NP to see the patient until the following Monday, or the hospice may be unaware that the member is in the third benefit period. In such documented cases, a face-to-face encounter within two days after admission is considered timely. If the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as completed.

The hospice must retain the certification statements and have them available for Health Net's audit purposes.

Prior Authorization

California Code of Regulations (CCR), Title 22, Section 51349 describes four levels of hospice care, which are routine home care, continuous home care, respite care, and inpatient care. Only general inpatient care is subject to prior authorization (PDF). Providers must submit the following to request prior authorization:

- Certification of physician orders for general inpatient care
- Justification for this level of care
- Written prescription
- Certification of terminal illness
- Initial plan of care

- Signed election form

Health Net does not require prior authorization for:

- Routine home care.
- Continuous home care requiring a minimum of eight hours of care per 24-hour period.
- Respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time.

  Physician services. Health Net and its delegated participating physician groups (PPGs) reimburse this code as limited to one visit per day, per patient

- Consulting/special physician services may be billed only for physician services to manage symptoms that cannot be remedied by the patient's attending physician because of one of the following:
  - Immediate need.
  - The attending physician does not have the required special skills.

Hospice providers must notify the Health Net Hospital Notification Unit and the member's participating physician group (PPG) or primary care physician (PCP) on the next business day when a member is admitted for inpatient care after normal business hours.

Hospice Care Rates

Health Net will reimburse hospice services at **rates equal to or greater than Medicare's**, based on the level of care provided. These include routine home care, continuous home care, inpatient respite care, general inpatient care and physician services, each with specific revenue codes.

- **Routine home care** – Is paid at a higher rate for the first 60 days and a lower rate thereafter.
- **Room and board** – For members in skilled nursing or intermediate care facilities, the hospice provider is responsible for reimbursing the facility for room and board. Reimbursement must be no less than 95% of what Medi-Cal or Health Net would have paid the facility if the member were not enrolled in hospice.
- **Dual eligibles** – Medicare is the primary payer; Health Net shall cover the cost-sharing and room and board without requiring prior authorization or Medicare denial documentation.
- **Physician services** – Physician services related to a member's terminal condition must be billed under revenue code 0657 and limited to one visit per member per day.
- **Timeliness** – If inpatient care starts after hours, Health Net must be notified the next business day.
- **Oversight** – Health Net may review documentation to verify medical necessity and prevent fraud.
- Refer to the Department of Health Care Services (DHCS) website for information on hospice care rates.

Long-Term Care Residents

Hospice services are covered and are not categorized as long-term care (LTC) services regardless of the member's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care. Section 1905(o)(1)(A) of the Social Security Act (SSA) allows for the provision of hospice care while an individual is a resident of a skilled nursing facility (SNF) or intermediate care facility (ICF).

Health Net and its PPGs should not require authorization for room and board as described in Code of Federal Regulations (CFR), Title 42, Section 418.112 and Section 1902(a)(13)(B) of the SSA.

In accordance with the Centers for Medicare and Medicaid Services (CMS), the hospice provider reimburses the NF for the room and board at the rate negotiated between the hospice and SNF. Payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by fee-for-service (FFS) Medi-Cal or Health Net less the member's share of cost, if applicable. Payments by a hospice provider to a nursing home for room and board are not to exceed what would have been received directly from FFS Medi-Cal or Health Net if the member had not been enrolled in a hospice.

Revocation of Hospice Election

Members who elect hospice or their authorized representatives may revoke or modify their decision at any time during an election period. To revoke the election of hospice care, the member or the member's authorized representative must file a signed statement with the hospice revoking the individual election for the remainder of the election period. The effective date may not be retroactive. At any time after revocation, the member may execute a new election, which starts the 90-day/90-day/unlimited 60-day certification periods of care. A member or their representative may change the designation of a hospice provider once per benefit period. The member's change from one designated hospice to another is not considered a revocation of the hospice election.

Non-Participating Hospice

Health Net restricts coverage of hospice services to in-network providers unless medically necessary services are not available in the network. OON coverage will not be available to members who are newly entering hospice care. The only exception to allow OON coverage for hospice services is when medically necessary services are not available from in-network providers.

To find available hospice providers in the service area, use the Health Net Find a Provider tool, select "Hospice" as the provider type.

If no in-network hospice provider is available, providers may submit a request for a Single Case Agreement (SCA) including the initial assessment and all required documentation.

If a Medi-Cal member wishes to elect a hospice provider that is not contracting with Health Net or the delegated participating physician group (PPG), the PPG must consider each member's case individually. The PPG has the option to immediately initiate a contract (one-time or ongoing) with the chosen hospice provider or refer the patient to a participating hospice for hospice care. In some cases, members receiving hospice at the time they become Health Net Medi-Cal members may not be able to change their hospice provider due to limitations on the number of times the member can change a hospice provider during an election period. Health Net or the PPG may also determine that such a change is disruptive to the member's care or is not in their best interest. PPGs must consider a one-time or ongoing contract with the established hospice provider until the new benefit period, or until the end of hospice services.

Home Setting

Hospice care services may be initiated or continued in a home or clinical setting. Health Net and its delegated PPGs remain responsible for the provision of, and payment for, all fee-for-service (FFS) Medi-Cal-covered services not related to the terminal illness, including those of the member's primary care physician (PCP).

Period of Crisis

A period of crisis is time during which the member requires continuous primary nursing care to achieve palliation or to manage acute medical symptoms. Nursing care may be covered for up to 24 hours a day during periods of crisis if necessary to allow the member to remain at home. Care during such a period must be predominantly nursing care.

Transitioning to Hospice Services

Health Net emphasizes the importance of timely recognition of a member's eligibility for hospice care services and their election of these services. Health Net and delegated participating physician groups (PPGs) must ensure timely identification and coordination when a member elects hospice care, support a smooth transition from curative to palliative care and maintain services for unrelated conditions.

Once a member has elected hospice care services, participating providers and case management staff work closely with hospice providers to facilitate the transfer of member services from those directed towards cure and/or prolongation of life to those directed towards palliation. Ongoing care coordination ensures that services necessary to diagnose, treat and follow-up on conditions not related to the terminal illness continue or are initiated as necessary (Code of Federal Regulations (CFR), Title 42, CFR, Section 438.208).

Utilization Review

Neither Health Net nor delegated participating physician groups (PPGs) may restrict access to hospice care services (Code of Federal Regulations (CFR), Title 42, Section 438.210(a)). The Medi-Cal fee-for-service (FFS) program does not require prior authorization of hospice services except for inpatient admissions; therefore, Health Net and PPGs only require prior authorization for inpatient admission.

Fraud, Waste, and Abuse Monitoring

Health Net must take steps to prevent fraud, waste, and abuse in hospice care by reviewing hospice claims and documentation, **flag members who elect hospice using the DHCS "900" code**, and notify the member's primary care provider. Health Net must also verify hospice eligibility, request additional documentation when needed, and submit accurate encounter data—including referring and rendering providers and service start dates. DHCS may audit Health Net records at any time to ensure compliance with these requirements.

Immunizations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on immunizations, including immunization schedules.

Select any subject below:

- Administration of Immunizations
- Immunization Schedule
- Local Health Department
- Reimbursement for Ages 19 and Older

Administration of Immunizations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Primary care physicians (PCPs) are responsible for immunizing members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize Health Net Medi-Cal members.

The Department of Health Care Services (DHCS) and The California Department of Public Health (CDPH) require the timely provision of recommended immunizations for both children and adults. The official vaccine policy for the State of California is established by the California Department of Public Heath (CDPH). Providers should follow CDPH guidance for pediatric and adult immunizations.

The CDPH develops its immunization recommendations using evidence from medical researchers and frontline clinicians. This process includes input from leading professional organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists, in collaboration with the Western Healthcare Alliance.

Participating providers are required to document each member's need for recommended immunizations as part of all regular health visits and to report the administration of immunizations within 14 days.

PCPs must be available to administer immunizations during office hours. The PCP is responsible for updating the state-supplied "yellow card" (PM 298) immunization record or other immunization record and giving a copy to the patient or parent/guardian. Providers who administer vaccines must submit patient vaccination records to local health departments and appropriate immunization registries within the specified timelines. Providers must enroll in and use California Immunization Registry (CAIR) to report and track patient immunization records online. At each visit, the PCP should inquire whether the patient has received immunizations from another provider. The PCP should also educate members regarding their responsibility to inform the PCP if they receive immunizations elsewhere (such as from an LHD or non-participating provider). This information is necessary for documentation and the member's safety.

Vaccines for Children Program

Refer to the Centers for Disease Control and Prevention (CDC) website for Vaccines for Children (VFC) program and other forms for Medi-Cal-eligible members. Providers are required to enroll in the program in order to participate. This federally funded program furnishes free vaccines in bulk to enrolled providers. All Medi-Cal-eligible children under age 19 may receive VFC vaccines.

To participate in the VFC program, providers must complete these forms:

- Provider Enrollment Form
- Provider Profile Form
- VFC Program Vaccine Order Form

Promoting Immunization and Access to Care

The Health Net Medi-Cal Facility Site Review (FSR) Compliance Department provides educational materials that physicians can use to promote immunization services and access to care. Materials available include pediatric and adult immunization checklists, a basic screening questionnaire for contraindications to child and teem immunizations, a health screening schedule, a member immunization chart, and reproducible member educational materials.

In alignment with CDPH, Health Net utilizes the AAP immunization schedule for children and the AAFP immunization schedule for adults ages 19 and older. This remains the clinical and operational standard for all pediatric and adult vaccine requirements.

- AAP-2026 Immunization-Schedule (PDF).
- AAFP-2025 Adult Immunization-Schedule (PDF).

The Health Net FSR Compliance nurses also promote the use of the CDC Vaccine Information Statements (VIS). Distribution of VIS is required when a member receives an immunization. Distribution of VIS and the VIS publication date must be documented in the member's medical record. Refer to the CDC website for VIS and other immunization resources.

Member Outreach Education

Health Net's member outreach and health education efforts concentrate on informing members about the importance of immunizations, immunization schedules, and the need to preserve immunization records. Members receive information in their new member packet, annual immunization reminder postcards, and brochures that are available through the Health Net member website and Health Education Department toll-free information line.

Immunization Schedule

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Following are immunization schedule recommendations.

Childhood Immunization Schedule Recommendation

The official vaccine policy for the State of California is established by the California Department of Public Heath (CDPH). In alignment with CDPH, Health Net utilizes the American Academy of Pediatrics (AAP) immunization schedule for children, and the American Academy of Family Physicians (AAFP) immunization schedule for adults ages 19 and older.

- AAP-2026 Immunization-Schedule.pdf (PDF).
- AAFP-2025 Adult Immunization-Schedule (PDF).

Documentation Requirements

At each non-emergency primary care visit with members less than 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, must be advised of the vaccinations due and available immediately, if the member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the member's medical record which must indicate the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the member's medical record which must indicate the vaccinations were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the medical record must demonstrate that the member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

Medi-Cal Routine Vaccinations for Adults

In alignment with CDPH, Health Net utilizes the American Academy of Family Physicians (AAFP) immunization schedule for adults ages 19 and older, AAFP-2025 Adult Immunization-Schedule (PDF) - (AAFP-Adult-Immunization-Schedule.pdf).

The following information applies only to participating physician groups (PPGs) and physicians.

Medi-Cal adult members may obtain routine vaccinations that are not subject to prior authorization (PA) from their participating provider or participating pharmacy. The Medi-Cal Rx Contract Drug List for applicable utilization restrictions about age or quantity. The Contract Drug List can be found on the Medi-Cal Rx website.

The financial responsibility for adult immunizations is the same for in-network or self-referral to out-of-network providers. When the Medi-Cal member of a capitated participating physician group (PPG) obtains a vaccine from a participating pharmacy, the cost of the immunization is deducted from the PPG's monthly capitation amount in the same manner as other injectable medications that are the PPG's responsibility. PPGs remain responsible for adult immunizations.

Documentation requirements

At each non-emergency primary care encounter the member must be advised of the vaccinations due and available, if the member has not received vaccinations in accordance with CDPH recommendations. Documentation must be entered in the member's medical record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with CDPH recommendations. If vaccinations that could be given at the time of the visit are refused, documentation must be entered into the member's medical record which must indicate the vaccinations were advised, and the member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the medical record must demonstrate that the member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations,

Local Health Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

In accordance with the Department of Health Care Services (DHCS) guidelines, Health Net reimburses local health departments (LHDs) for certain immunizations given without prior authorization. The LHD is responsible for verifying the member's immunization status, as it is not reimbursed for immunizations provided when the member's immunizations are current. LHDs must submit a copy of the member's immunization record with their claim form. On request, Health Net assists LHDs with obtaining the member's immunization history and forwards a copy of the member's immunization record to the member's PCP for inclusion in the member's medical record.

If the member receives an immunization from the LHD and complications occur, the member must contact their PCP for care as with any other medical problem.

Public Health Coordination

Health Net's Public Programs specialists and County Liaisons work with local health departments (LHDs) to facilitate the exchange of data and information.

Reimbursement for Ages 19 and Older

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For immunizations of members ages 19 and older, Health Net reimburses contracting fee-for-service (FFS) providers at the Medi-Cal FFS rate, which includes an allowance for the vaccine and its administration.

Incontinence Medical Supplies

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Incontinence medical supplies are covered when prescribed by licensed, in-network providers within their scope of practice for the treatment of members who are incontinent. Health Net contracts with J&B Medical Supply Company, Inc. and Byram to provide these supplies. Incontinence medical supplies include disposable diapers, protective underwear (pull-on products), underpads, belted undergarments, shields, liners, pants and pad systems, pads, and reusable underwear.

Incontinence medical supplies are covered for use only when the member's incontinence is caused by chronic pathologic conditions. When incontinence is a short-term problem or when there is no underlying pathologic condition causing it, incontinence supplies are not covered.

Providers must document the following in the member's medical record to support the need for prescribed incontinence medical supplies:

- Diagnosis for the medical condition and diagnosis causing incontinence.
- Diagnosis for the type of incontinence for which supplies are required.
- Product name and description.
- Anticipated frequency of replacing the supplies.
- Quantity.

Incontinence supplies are limited to the items listed above up to $165 per month. Incontinence creams and washes are not subject to the $165 per month limit and are available for members ages 21 and older.

For more information about incontinence medical supply coverage, refer to the Department of Health Care Services (DHCS) Medi-Cal Provider Manual.

Health Net does not provide benefits for incontinence supplies for Medi-Cal members younger than age five. Benefits are provided only if the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, at an age when the child would normally be expected to achieve continence. Incontinence creams and wash products are covered under Medi-Cal.

Initial Health Appointment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on the requirements for initial health appointment.

- Requirements
- PCP coordination

Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

All Medi-Cal members ages 18 months and older must have an initial health appointment (IHA), which includes an age-appropriate history and physical examination, within 120 calendar days after their date of enrollment. For Medi-Cal Members less than 18 months of age, the IHA must be completed within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages 2 years and younger, whichever is sooner.

The member may be seen initially during a visit for episodic care. Regardless of the reason for the initial visit, the provider should conduct the IHA at the first health care contact and document the assessment in the medical record. The IHA must be completed by a provider in the primary health setting.

An IHA at a minimum must include: a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the member's primary care physician (PCP) determines that the member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.

The IHA must be conducted in a culturally and linguistically appropriate manner for all members, including those with disabilities, and it must be documented in the member's medical record.

IHA Guidelines

For members under age 21, the IHA and ongoing assessments must follow the current AAP Recommendations for Preventive Pediatric Health Care (PDF). The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the member is up to date with the Recommended Childhood Immunization Schedule (PDF) based on joint recommendations of the Advisory Committee on Immunization Practices (ACIP), Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings. Providers must also ensure that members receive all screening, preventive and Medically Necessary diagnostic and treatment services required under the EPSDT benefit, as described by DHCS in the EPSDT Provider Information.

For members ages 21 and older, the initial appointment includes, but is not limited to, an evaluation and timely provision of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

IHA Documentation and Reporting

For all providers, a member eligibility report is available through Health Net Membership Accounting at the primary care physician's (PCP's) request to allow providers to reach out to their new members and ensure completion of all appropriate preventive care services and the IHA within 120 calendar days. Providers may log on to Health Net's provider portal to access the online IHA reports located under Provider Reports.

Health Net reviews monthly claims and encounter data of initial health appointments rendered by participating providers. These encounters are cross-checked against member enrollment data. A member eligibility report is available at the PCP's or participating physician group's (PPG's) request on a monthly basis to provide an aid for IHA compliance.

In all cases, the PCP must document all member contacts, including scheduling of the appointment or the member's refusal to schedule an appointment, in the member's medical record.

Childhood Blood Lead Screening

Providers must follow guidelines issued by the Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB) Health and the California Childhood Lead Poisoning Prevention Branch (CLPPB)-issued guidelines on childhood blood lead screening, which includes CDC Recommendations for Post-Arrival Lead Screening of Refugees, of the Department of Public Health and also:

- Provide oral or written anticipatory guidance to the parents or guardians of a child that includes information that children can be harmed by exposure to lead. The guidance must be provided at each periodic health assessment for ages 6-72 months.
- Perform blood lead level (BLL) testing on all children as follows:

- At ages 12 months and 24 months.
- When the provider performing the periodic health assessment becomes aware that a child age 12-24 months has no documented evidence of a BLL test taken at age 12 months or thereafter.
- When the provider becomes aware that a child age 24-72 months has no documented evidence of BLL test results taken at age 24 months or thereafter.
- Whenever the provider becomes aware that a child age 12-72 months has had a change in circumstances that places the child at increased risk of lead poisoning, in the provider's professional judgement.
- When requested by the parent or guardian.

- The health care provider is not required to perform BLL testing in the following cases. The reasons for not screening must be documented in the child's medical record.
  - The parent or guardian refuses consent for the screening. Providers must obtain a signed statement of voluntary refusal by the parent or guardian, or document reasons for not obtaining the signed statement (i.e. parent refused or is unable to sign, assessment done via telehealth, etc.).
  - If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.

Blood lead level screening must be reported.

- Encounter or claims data is used to track the administration of blood level screenings. Providers must ensure that encounters are identified using the appropriate CPT codes for blood level screenings.
- Laboratories and health care providers performing blood lead analysis on specimens are to electronically report all results to CLPPB, with specified patient demographics, ordering physician and analysis data on each test performed. Information on how to report results to CLPPB can be found at CLPPB website.

Coordination by Health Net

Health Net sends new members a welcome packet that includes an initial health appointment (IHA) notification, provider directory, Evidence of Coverage (EOC), preventive care services, and other important plan information. Instructions are included for new members to schedule appointments with their primary care physicians (PCPs).

Health Net contacts new Medi-Cal members by telephone after mailing the new member packet to communicate the importance of scheduling an IHA and to share other relevant information about members using their benefits. Health Net makes three outbound call attempts to newly enrolled members to remind member to schedule their IHA. If a member, or the parent or guardian of a child member, refuses to have the IHA performed, it must be documented in the member's medical record.

Providers may contact the Health Net Education Department for more information.

PCP Coordination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net sends new members a welcome packet that includes an initial health appointment (IHA) notification and information on how to schedule appointments with their primary care physicians (PCPs). The IHA notification instructs new members to schedule appointments with their PCP for their IHA.

PCPs must document all member contacts, including the scheduling of the IHA appointment or the member's refusal of an appointment in their medical record.

During the initial and subsequent health assessments, PCPs must inform members, parents or guardians of the need for and importance of periodic health assessments and reinforce the member's understanding of the need for routine preventive, well-child screening services at each medical encounter. PCPs are encouraged to schedule the next visit at the conclusion of the member visit. PCPs are also encouraged to use an appointment reminder system. If PCPs identify a medical condition during the IHA, diagnosis and treatment must begin with 60 calendar days. Justification for any delays beyond 60 calendar days must be documented in the member's medical record. If an appointment is scheduled, but missed or broken, PCPs must follow the procedure for missed or broken appointments.

Injectables

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information and protocols for injectables, including prior authorization requirements.

Select any subject below:

- Overview
- Chemotherapy
- Chemotherapy Off-Label Use
- Home Infusion
- Prior Authorization
- Self-Injectable Medications
- Therapeutic Injections and Other Injectable Substances

Overview

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Standard definitions determine the Division of Financial Responsibility (DOFR) categories into which injectable medications are placed and include brand names, generic names and associated HCPCS codes. The categories mirror the DOFR matrix categories located in the Health Net Provider Participation Agreement (PPA) DOFR agreement.

For Medi-Cal members under age 21 with California Children's Services (CCS)-eligible conditions, injectable medications used in the treatment of CCS-related conditions are not included in Health Net's coverage responsibilities under its Medi-Cal managed care contract with the Department of Health Care Services (DHCS).

Injectable medications are separated into two primary categories - therapeutic injections and self-injectables. These categories are sub-divided into secondary categories as follows:

- Therapeutic injections
  - Allergy serum
  - Blood and blood products for hemophilia (carved out for Medi-Cal)
  - Chemotherapy
  - Chemo adjunct
  - Home health/infusion
  - Immunizations
  - Immunosuppressants for transplants
- Self-injectables
  - Chemotherapy
  - Chemo adjunct
  - Growth hormones
  - HIV/AIDS
  - Infertility medications

If an injectable medication does not have a secondary category, it defaults to the DOFR primary category. There are five secondary categories that are contingent on meeting specific criteria - chemotherapy, chemo adjunct injectable medications, HIV/AIDS, immunosuppressants for transplants and home health/infusion:

- Chemotherapy and chemo adjunct injectable medications must be associated with a cancer diagnosis using ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9. If the appropriate codes are not used, these injectables default to the primary category
- HIV/AIDS must be associated with a HIV or AIDS diagnosis. If the diagnosis is not HIV or AIDS, these injectable medications default to the DOFR therapeutic category
- Home health infusion must be administered in the home by a nurse or physician. If it is not, this injectable medication defaults to the DOFR primary category
- Immunosuppressants for transplants must be associated with an organ transplant. If they are not, these injectable medications default to the DOFR primary category

Injectable medications are categorized using a standardized methodology to ensure clear and proper benefit administration and reimbursement. Chemotherapy, chemo adjunct, HIV/AIDS, home health/infusion, and immunosuppressants for transplants are the only injectable medications that may change categories depending on whether contingent criteria are met.

For additional current information regarding injectable medications, refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table.

Allergy testing agents and immune globulins given intramuscularly and subcutaneously that produce passive immunizations are classified as therapeutic injectable medications. Certain vaccines (for example, BCG) are categorized as chemotherapy or a therapeutic injection based on the appropriate indication.

Growth hormones and injectables considered safe for self-administration at home and packaged for this purpose are classified in the primary category of self-injectable medications.

Additional information regarding clinical guidelines and coverage criteria for injectable medications can be found in the Health Net Prior Authorization guidelines on the provider portal.

Hemophilia

Antihemophilic agents include hemophilic factors VIII and IX and factors used in the treatment of bleeding episodes in hemophilia A or B members with inhibitors to factor VIII or IX (for example, coagulation factor VIIa and anti-inhibitor coagulant complex). These agents must be used for Food and Drug Administration (FDA)-approved indications. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk table for more information.

Hemophilic factors are covered under the blood and blood products for hemophilia category. Refer to the Schedule of Benefits to determine coverage for these services. If services are covered under the member's plan, the services must be pre-approved and obtained from a participating provider.

For Medi-Cal members, blood and blood products for hemophilia are carved out and billed to Medi-Cal. For Medi-Cal members under age 21, hemophilia is a CCS-eligible condition and treatment is not included in Health Net's coverage responsibilities under its Medi-Cal managed care contract with the DHCS.

Chemotherapy

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The terms of compensation for chemotherapy medications are stated in the participating physician group's (PPG's) Provider Participation Agreement (PPA).

Chemotherapy and chemo adjunct medications are composed of antineoplastic and adjunctive medications. An antineoplastic medication is a compound used to destroy malignant cancer cells or shrink or kill malignant tumor cells circulating in the blood and lymphatic systems. Antineoplastics must be approved by the Food and Drug Administration (FDA) for a specific cancer indication or listed in the most recent bulletin by the Association of Community Cancer Centers to be eligible for coverage under a Health Net benefit plan.

Adjunctive medications are additional pharmaceutical agents added for the purposes of palliative symptomatic treatment of side effects directly related to the chemotherapy treatment regimen. The specific purpose of the adjunctive therapy is for a defined duration of therapy, for only as long as the chemotherapy is continued, and may not be used for chronic maintenance use. Adjunctive therapy may not include products that are already part of the outpatient pharmacy benefit program.

Refer to the Health Net Injectable HCPCS/DOFR Crosswalk (PDF) table for chemotherapy and chemo adjunct medications.

Chemotherapy medications may be administered by a participating provider in a hospital inpatient setting, at the PPG, at other patient settings, or in the member's home. Some chemotherapy agents may require prior authorization. Refer to the Health Net Injectable Prior Authorization Guidelines on the Health Net provider portal (Commercial, Medi-Cal).

Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

There are three options for submitting a prior authorization form:

1. Complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (Health Net, CalViva Health, Community Health Plan of Imperial Valley) and submit to Pharmacy Services.
2. Contact Pharmacy Services directly via telephone.

When certain designated injectables are requested by a participating provider or physician group (PPG) that participates in a shared-risk arrangement, or when the financial risk belongs to Health Net, prior authorization must be obtained through Pharmacy Services. This requirement also applies to PPGs with delegated utilization management (UM). The only injectable medications that require prior authorization are self-injectable medications and a few specific injectable medications.

Some injectables (i.e., self-injectables) are excluded from Health Net's coverage responsibilities when used in the treatment of Medi-Cal members enrolled in carve-out programs, such as Medi-Cal Rx, California Children's Services (CCS) or the HIV/AIDS waiver program. Other injectables are excluded when a Medi-Cal member has a waiver program-eligible condition for which the member is disenrolled from Health Net (for example, most major organ transplants for adult members). For additional information regarding injectable medications, refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table.

When using the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (Health Net, CalViva Health, Community Health Plan of Imperial Valley) the participating provider or PPG must complete a Prior Authorization Request form detailing the medical necessity and the duration of the requested medication. The completed form must be faxed to Pharmacy Services. The participating provider or PPG may call Pharmacy Services directly for urgent requests.

The approval or request for additional information is faxed back to the original requester. Upon approval, Pharmacy Services forwards the approved authorization to one of Health Net's participating specialty pharmacy providers. The specialty provider contacts the Health Net member to arrange for delivery.

Chemotherapy Off-Label Use

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Food and Drug Administration (FDA)-approved chemotherapy medications used for off-label malignancies or indications are covered if they are listed in the Health Net Injectable Protocol Guidelines, or if evidence is

presented that the medication is used in treatment for a particular neoplasm under a professionally recognized standard of care, such as an official medication compendium (for example, AHFS Drug Information), or in the bulletin published by the Association of Community Cancer Centers.

Home Infusion

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Home infusion services involve the administration of prescribed intravenous substances and solutions administered in the member's home by qualified staff. Members who receive home infusion services do not need to be homebound, but must meet other criteria for home health care, which includes the member's willingness to learn the administration of therapy at home or the presence of another willing and able caregiver to administer the therapy. Injectable medications that require admixing by a home health provider or pharmacy are also included. Infusion medications given in the home setting and approved by Health Net include, but are not limited to:

- Total parenteral nutrition (TPN)
- Intravenous antibiotic and antiviral therapies
- Aerosolized therapy
- Pain management
- Chelation therapy
- Inotropic therapy
- IVIG/IGIV immunoglobins
- Hydration therapy
- Steroid therapy
- Remicade
- Chemotherapy

Home infusion services provided to members affiliated with a shared-risk participating physician group (PPG) must be obtained through a Health Net contracted home infusion provider.

Shared risk PPGs should utilize a Health Net contracted home infusion provider or they will be liable for claims payments.

Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table for home health infusion medications.

For Medi-Cal members under age 21, medications used in the treatment of California Children's Services (CCS) eligible conditions are not included in Health Net's coverage responsibilities under its Medi-Cal managed care contract with the Department of Health Care Services (DHCS).

Self-Injectable Medications

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Self-administered medications, as determined by Health Net, include, but are not limited to, medications cited by the Food and Drug Administration (FDA) as a self-injectable, orally, or topically administered medications and specifically packaged by the manufacturer to be administered by the member in an outpatient environment or at home. Self-injectable medications can be administered subcutaneously or intramuscularly with a syringe and needle. The administration routes must be proven safe and effective when self-injected by the member.

Prior Authorization for these self-administered medications can be obtained by faxing a request to Medi-Cal Rx at 800-869-4325 or by using CoverMyMeds®.

There are three options for submitting a prior authorization form:

1. Submit the prior authorization electronically through CoverMyMeds which is Health Net's preferred way to receive prior authorization requests.
2. Complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (Health Net, CalViva Health, Community Health Plan of Imperial Valley) and submit to Pharmacy Services.
3. Contact Pharmacy Services directly via telephone.

Therapeutic Injections and Other Injectable Substances

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

HMO

Therapeutic injections and other injectable substances are covered, subject to scheduled copayments, when their use is indicated by standard medical practices. These injections are usually administered in the participating provider's office or professional outpatient facility. Refer to the Health Net Injectable Medications HCPCS/DOFR Crosswalk (PDF) table for therapeutic injectables information.

The following contraceptives are covered when determined to be medically necessary for the member and prescribed by a participating provider:

- Depo-Provera® Contraceptive Injections - One injection administered every three months to prevent pregnancy
- Depo-Sub Q Provera® 104 - One injection administered subcutaneously every three months to prevent pregnancy
- Lunelle™ Contraceptive Injections - One injection administered monthly to prevent pregnancy

Except for insulin, injectable medications defined as self-injectables continue to be processed as self-injectable medications when provided in an office setting.

Medi-Cal

Therapeutic and physician-administered injections are usually administered in the participating provider's office or professional outpatient facility. Refer to the Health Net Injectable Medications HCPCS/DOFR Crosswalk (PDF) table for therapeutic injectables information.

These injections may be covered by either Medi-Cal Rx under the pharmacy benefit or by Health Net. If submitted on a medical claim, the above crosswalk applies and financial responsibility for the claim is the plan's risk. If the claim is submitted by a pharmacy, visit the Medi-Cal Rx website site and view the contract drug list to determine coverage.

The following contraceptives are covered when determined to be medically necessary for the member and prescribed by a participating provider:

- Depo-Provera® Contraceptive Injections - One injection administered every three months to prevent pregnancy
- Depo-Sub Q Provera® 104 - One injection administered subcutaneously every three months to prevent pregnancy
- Lunelle™ Contraceptive Injections - One injection administered monthly to prevent pregnancy

Long-Term Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on long-term care services and problem resolution. Unless specified in title, information provided applies to all Health Net participating counties.

Identification

The two primary methods of identifying hospitalized Medi-Cal members who may require long-term care (LTC) are:

- Physician identification - The member's primary care physician (PCP) or specialist makes a diagnosis that requires services in an LTC facility. The physician or the physician's representative then contacts Health Net's Utilization Management (UM) Department (or participating physician group (PPG), if UM responsibilities have been delegated to the PPG) to request prior authorization for admission
- Concurrent Review - Health Net or the subcontractor's concurrent review nurses review daily census reports that identify members who may need LTC services following discharge

Other means of identifying a member for LTC services are reviewing retroactive claims for LTC services or through social workers, discharge planners and other health care providers involved in the member's care.

Additional communication requirements for appropriate and timely concurrent review, claims submission and claims adjudication include:

- Hand-off communications - Upon authorizing LTC services, Health Net and the PPG communicate about the member's LTC admission

- Level of care communications - Health Net and the PPG communicate regarding changes in the member's level of care or transition from Medicare-based skilled nursing services to Medi-Cal-based LTC benefits

Long-Term Care

Medi-Cal members in need of long-term care (LTC) facility services should be placed in facilities providing the level of care commensurate with their medical needs.

- Skilled nursing facility (SNF) for short and long-term care
- Intermediate care facility (ICF)
- Adult subacute care facility
- Pediatric subacute care facility

Turnaround times are as follows:

- Authorization 72 hours
- Placement requirements five business days for Los Angeles and Sacramento Counties, seven business days for San Joaquin, Stanislaus, 14 business days for all other counties.

Hospice services are not considered LTC services. When hospice services are provided in an LTC facility, the member's eligibility under the Medi-Cal managed care is not affected regardless of the member's expected or actual length of stay in the nursing facility.

Special Treatment Program Services

Special treatment program services in nursing facilities are covered under Medi-Cal and rendered to members who:

- Have chronic psychiatric impairment and whose adaptive functioning is moderately impaired
- Have conditions that are responsive to special treatment program services and prohibitive to placement in a skilled nursing facility
- Require a therapeutic program of services designed, staffed and implemented by a special treatment program unit for the purpose of meeting the special needs of this identified population group
- Are disabled mentally or physically and such disability is expected to be prolonged

Coordination of Care

The primary care physician (PCP) continues to provide care during the transition to long-term chronic care, and coordinates with the LTC attending physician to ensure the Member’s care continues without delay. This includes forwarding all pertinent records to the new PCP when identified and available to consult.

Long-Term Care for Permanently Institutionalized

Medi-Cal members who reside in a long-term care (LTC) facility beyond the month of admission plus one month, are deemed permanently institutionalized. These members are reassigned from their participating physician groups (PPGs) to Health Net for utilization management upon Health Net's evaluation that the

member is deemed permanently institutionalized and qualifies for reassignment. PPGs are responsible for LTC members until they are no longer listed on their monthly eligibility reports.

Health Net must authorize long-term care (LTC) services when a member has a medical condition that requires LTC. LTC includes both skilled nursing care and non-skilled custodial care, specific to out-of-home protective living arrangements with 24-hour supervised or observation care on an ongoing intermittent basis to abate deterioration.

LTC is care provided in a skilled nursing facility (SNF), intermediate care facility or subacute care facility. Additionally, it is an inpatient care level for members who meet medical necessity at the following care levels as defined in the Manual of Criteria for Medi-Cal Authorization:

1. A skilled nursing facility admission for members accessing Medi-Cal nursing facility Level A or B benefit level.
2. An intermediate care facility admission for members accessing Medi-Cal nursing facility Level A benefits.
3. A subacute care facility admission for members accessing Medi-Cal covered subacute care services.

Members in need of LTC services are placed in facilities providing the level of care commensurate with their medical needs.

Criteria for Long-Term Care

To qualify for long-term care (LTC), which includes nursing facility and custodial care, a member must have a medical condition that requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate deterioration. LTC services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encourage each member's independence to the extent of the member's ability. The following factors are considered in determining appropriate placement for LTC:

- The complexity of the member's medical problem is such that the member requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet the member's health needs.
- Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Members on daily, injectable medications or frequent doses of pro re nata (PRN) narcotics may not qualify.
- Diet may be special, but the member needs little or no feeding assistance.
- The member may require minor assistance or supervision in personal care, such as in bathing or dressing.
- The member may need encouragement in restorative measures for increasing and strengthening functional capacity to work toward greater independence.
- The member may have some degree of vision, hearing or sensory loss.
- The member may have some limitation in movement but must be ambulatory with or without an assistive device, such as a cane, walker, crutches, prosthesis or wheelchair.
- The member may need some supervision or assistance in transferring to a wheelchair but must be able to ambulate the chair independently.
- The member may have occasional urine incontinence; however, a member who has bowel incontinence or complete urine incontinence may qualify for intermediate care service when the member has been taught and is capable of self-care.
- The member may exhibit some mild confusion or depression; however, the member's behavior must be stabilized to such an extent that it poses no threat to self or others.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Coordination of Care

The PCP continues to provide care during the transition to LTC, and coordinates with the LTC attending physician to ensure the member's care continues without delay. This includes forwarding all pertinent records to the new PCP when identified and available to consult. For coordination of benefit questions, providers may contact the Health Net Public Programs Department.

Additional communication requirements for appropriate and timely concurrent review, claims submission and claims adjudication include:

- Hand-off communications - Upon authorizing LTC services, Health Net and the participating physician group (PPG) communicate about the member's LTC admission.
- Level of care communications - Health Net and the PPG communicate regarding the member's level of care or transition from Medicare-based skilled nursing services to Medi-Cal-based LTC benefits.

Referrals and Authorizations

Providers must supply both the completed Health Net Long-Term Care Authorization Notification Form Medi-Cal (PDF), Long-Term Care Authorization Notification Form - Community Health Plan of Imperial Valley (PDF), Long-Term Care Authorization Notification Form - CalViva Health (PDF), as well as any supporting clinical information, such as the Pre-Admission Screening and Resident Review (PASRR), Minimum Data Set (MDS) or approved Treatment Authorization Request (TAR), as applicable, to the Health Net Long-Term Care Intake Line by fax. Health Net continues to honor any currently active TAR approved authorizations.

For new admission authorization/notification requests, once a decision is made, Health Net notifies the provider by phone or fax. Other ancillary services may require prior authorization and are not included in the nursing facility room rate. Providers must obtain prior authorization prior to providing such services.

Providers may contact the Health Net Long-Term Care Intake Line with all questions regarding LTC referrals and authorizations, or to check the status of a request.

Claims and Payment

Most non-dual and dual LTC members in all counties (including those with a Share of Cost) are required to enroll in a Medi-Cal Managed Care Plan, including Imperial, Fresno, Kings and Madera counties. Providers may refer to the Integrated Care for Dual Eligible Beneficiaries website for enrollment information, Policy Resources, Workgroups and other materials.

Additionally, providers must verify eligibility to ensure claims are appropriately directed and may submit claims directly to the Health Net Medi-Cal Claims Department, as outlined in the Division of Financial Responsibility (DOFR).

Member Selection Criteria - Los Angeles County Only

Long-term care (LTC) coverage eligibility is based on intensity of medical services required and severity of illness. Each member is evaluated based on primary care physician (PCP) diagnosis and treatment recommendations, facility heath care team assessments, Medi-Cal regulations, including the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization, and the Minimum Data Set (MDS). The MDS is a standardized, primary health status screening and assessment tool that forms the foundation of the comprehensive assessment of all nursing facility residents in LTC facilities.

If the provider's Medi-Cal contract is through Molina Healthcare, providers should contact Molina for a copy of its LTC member selection criteria. Specific policies can be accessed by contacting the participating physician group (PPG) administrator. Where there are conflicts between established Health Net medical policy and DHCS policies and guidelines, Health Net defers to DHCS requirements.

Member Selection Criteria - All other counties

Long-term care (LTC) coverage eligibility is based on intensity of member services required and severity of illness. Each member is evaluated based on primary care physician (PCP) diagnosis and treatment recommendations, facility health care team assessments, Medi-Cal regulations, including the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization, and the Minimum Data Set (MDS).

The MDS is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment of all nursing facility residents in long term care facilities.

Criteria for Adult Subacute Care Program

Adult subacute level of care refers to very intensive, licensed, skilled nursing care provided to members who have fragile medical condition. To qualify for the adult subacute program, the member must require at least four hours of direct skilled nursing care per day and at least one of the following:

- Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day
- Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six treatment procedures listed below; or
- Administration of any three of the six following treatment procedures:
    - total parenteral nutrition
    - inpatient physical, occupational or speech therapy at least two hours per day, five days per week
    - tube feeding (nasogastric or gastrostomy)
    - inhalation therapy treatments every shift and a minimum of four times per 24-hour period
    - intravenous (IV) therapy involving one of the following:
        - continuous administration of a therapeutic agent
        - hydration
        - frequent intermittent IV medication administration via a peripheral or central line (heparin lock)
    - wound debridement, packing and medicated irrigation with or without whirlpool treatment

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Criteria for Coverage of Skilled Nursing Facility Care

To qualify for coverage of skilled nursing facility (SNF) care, the member must no longer need acute hospital care, but requires skilled nursing or skilled rehabilitation services daily. The member's overall condition must be evaluated for purposes of admission to a SNF.

Criteria for coverage of skilled nursing services are as follows:

- Intravenous, intramuscular or subcutaneous injections and intravenous feeding.
- Administration of new medications requiring initial observations by skilled staff.
- Levin tube and gastrostomy feedings.
- Nasopharyngeal and tracheostomy aspiration.
- Insertion, sterile irrigation and replacement of catheters.
- Application of dressings involving prescription medications and aseptic techniques.
- Treatment of extensive decubitus ulcers or other widespread skin disorder.
- Heat treatments that have been specifically ordered by a physician as part of active treatment and require observation by skilled staff to evaluate the member's response.
- Initial phases of a regimen involving administration of medical gases.
- Rehabilitation nursing procedures, including related teaching and adaptive aspects of nursing, that are part of active treatment (for example, institution and supervision of bowel and bladder training programs).
- Colostomy and ileostomy care for new colostomies and ileostomies or for debilitated members.

Criteria for coverage of skilled rehabilitation services are as follows:

- Services concurrent with management of a member care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language, or hearing disorders.
- Therapeutic exercises or activities that, because of the type of exercises employed or the condition of the member, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the member and the effectiveness of the treatment.
- Gait evaluation and training furnished to restore function to a member whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.
- Range of motion exercises that are part of active treatment of a disease that has resulted in a loss of, or restriction of, mobility.
- Maintenance therapy, when the specialized knowledge and judgment of a physical therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the member's needs.
- Ultrasound, short-wave and microwave therapy treatment by a physical therapist.
- Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool in cases where the member's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications and the skills, knowledge and judgment of a physical therapist are required.
- Services of a speech pathologist or audiologist when necessary for the restoration of speech or hearing.

Additional requirements for skilled nursing services and/or skilled rehabilitation services:

- The service must be so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical staff.
- A condition that does not ordinarily require skilled services may require them because of special medical complications.
- The restoration potential of a member is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a member may need skilled services to prevent further deterioration or preserve current capabilities.
- Criteria for "daily" means with the following frequency:
    - Skilled nursing services or skilled rehabilitation services must be needed and provided seven days a week.
    - As an exception, if skilled rehabilitation services are not available seven days a week, those services must be needed and provided at least five days a week.
    - A break of one or two days in the furnishing of rehabilitation services does not preclude coverage if discharge would not be practical for the one or two days during which therapy is suspended (for example, the physician has postponed therapy sessions because the member exhibited extreme fatigue).
- The primary care physician (PCP) and hospital discharge planner determine that the member requires short-term nursing facility care for post-surgical, rehabilitative, or therapy services designed to cure the member's condition rather than just relieve the condition. In making a practical matter determination, consideration must be given to the member's condition and to the availability of more economical, alternative facilities and services:
    - Member's condition - Inpatient care would be required as a practical matter if transporting the member to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.
    - Economy and efficiency - Even if the member's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Criteria for Pediatric Subacute Care Program

To qualify for the pediatric subacute care program, the member must be under age 21 and need one of the following:

- Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day
- Tracheostomy care requiring suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one of the four (2-5) treatment procedures listed below
- Total parenteral nutrition or other intravenous nutritional support and one of the five treatment procedures listed below
- Skilled nursing care in the administration of any three of the five treatment procedures listed below

Treatment Criteria for Pediatric Subacute Care

1. Intermittent suctioning at least every eight hours and room air mist or oxygen as need.

2. Continuous intravenous therapy, including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals, or intravenous pharmaceutical administration of more than one agent via a peripheral or central line without continuous infusion.
3. Peritoneal dialysis treatment requiring at least four exchanges every 24 hours.
4. Tube feeding via nasogastric or gastrostomy tube.
5. Other medical technologies required continuously, which, in the opinion of the attending physician and Medi-Cal consultant, require the services of a professional nurse.

Additional Criteria

- The intensity of medical/skilled nursing care required by the member is such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the member's health care needs and not be any less than the nursing staff ratios required.
- The member's medical condition must have stabilized so that the immediate services of an acute care hospital, including daily physician visits, are not medically necessary.
- The intensity of medical/skilled nursing care required by the member is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the member's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Maternity

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information about maternity care services.

Select any subject below:

- Coverage Explanation
- At-Risk Pregnancy Conditions
- CPSP
- Lactation Education and Support Services
- Maternal Mental Health Screening Requirements
- Pregnancy Termination
- Birth Centers

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members may see any qualified participating Health Net provider within their participating physician group (PPG), including their primary care physician (PCP), obstetrician or gynecologist (OB/GYN), or certified nurse midwife (CNM) and certified nurse practitioner (CNP) for prenatal care. PPGs or PCPs and specialists are prohibited from requiring a referral or prior authorization for basic prenatal care. If there are no CNMs or CNPs in the PPG network, access to non-contracting CNMs or CNPs is a benefit.

All pregnant members must have access to Comprehensive Perinatal Services Program (CPSP) services, which integrate health education, nutrition and psychosocial services with obstetrical care. CPSP support services providers are required to use the Department of Health Care Services (DHCS)-approved assessment tools. Health Net has developed assessment tools approved by DHCS that are included in this manual. The multidisciplinary approach to delivering perinatal care in the CPSP framework is based on the recognition that providing these services from conception through 60 days following delivery improves pregnancy outcomes.

The provision of CPSP services to pregnant members is the responsibility of all California Department of Public Health (CDPH)-certified CPSP providers who contract with Health Net, a subcontracting health plan or PPG.

Health Net-participating PPGs must maintain and reimburse a network of obstetric and community providers who are CPSP-certified in order to promote access to CPSP and improve birth outcomes for their patients. PPGs may not redirect CPSP services away from participating CPSP-certified providers who are in good standing with the state and local county CPSP program. CPSP-certified providers must be allowed to provide services to Health Net Medi-Cal members. Health Net and CDPH attempt to have all obstetricians providing care to Medi-Cal members become CPSP-certified to allow CPSP services to be provided during routine obstetric prenatal and postpartum visits.

Refer to Doula section of the provider operations manual for additional information.

Billing

Individual participating providers who are not certified by the California Department of Public Health (CDPH) for the Comprehensive Perinatal Services Program (CPSP) are reimbursed for maternity services with a global professional fee, which includes all professional services normally provided for routine perinatal care. CPSP providers should bill each service separately, using the DHCS designated "Z" codes.

Compliance and Quality Improvement

Compliance with Health Net's perinatal standards of care is monitored by the Health Net State Health Programs Quality Improvement Department.

Comprehensive Risk Assessment and Individualized Care Plan

All perinatal care providers should complete a comprehensive risk assessment and individualized care plan (ICP), even if the obstetric care provider is not providing the full scope of CPSP support services.

The comprehensive risk assessment tool must be comparable to ACOG and the CPSP standards. Individualized care plans must be developed to include obstetrical, nutrition, psychosocial and health education interventions when indicated by identified risk factors. The assessment is designed to evaluate the member's

health behaviors, knowledge base, medical conditions, and psychosocial situation. The ICP is developed by the provider in consultation with the member.

The provider is responsible for making referrals to alleviate identified risks, with priority given to the most severe. This assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.

Identified risks, interventions and referrals comprise the ICP. The ICP includes a statement of the risks identified and the interventions taken to address the risks in priority order, the identification of the persons responsible for carrying out the proposed interventions, the evaluation or outcome of the actions taken by the provider or member, and any updates. The provider must retain a copy of the ICP in the member's medical record.

For all members, risk reassessment occurs during each trimester and the postpartum period. The ICP is revised as indicated.

Health Net makes available the following CPSP assessment tools and resources:

- Initial and Trimester Assessment (PDF)
- Postpartum Assessment and Individualized Care Plan (PDF)

Educating Providers on Perinatal Services

Information regarding perinatal services and community information sources is available from the Health Net Medi-Cal Facility Site Review (FSR) Compliance Department and the Health Net Health Education Department.

Member Rights

Prior to the administration of any assessment, medication, procedure, or treatment, the member must be informed of potential risks that may affect them or their unborn child during pregnancy, labor, birth, or postpartum, and the alternative therapies available to them. The member has a right to consent to or refuse administration of any assessment, medication, procedure, test, or treatment.

The member has the right to:

- Be treated with dignity and respect
- Have their privacy and confidentiality maintained
- Review their medical treatment record with their physician
- Be provided explanations about tests, and clinic and office procedures
- Have their questions answered about procedures and care
- Participate in planning and decisions about their management during pregnancy, labor and delivery, and the postpartum period

Notification and Early Entry into Care

Upon the discovery that a member is pregnant, all participating providers (including primary care physicians (PCPs), obstetric care providers, midwives, and family planning clinics) are required to notify the care manager of their affiliated participating physician group (PPG). Direct network providers must notify the Health Net Medi-Cal Health Services Department. Primary care physicians only should complete the Confirmation of Pregnancy Form (Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley) for the pregnant member and fax it to the number at the top of the form.

The Pregnancy Outcome Notification Report provides Health Net with the information needed to meet the Department of Health Care Services (DHCS) reporting requirements. Completed forms must be faxed to the Health Net Medi-Cal Health Services Department .

Pregnancy Care Management

The initial prenatal examination must occur within two weeks (for Medi-Cal facility site review purposes, within seven calendar days) of the initial referral or request for pregnancy-related services. The obstetric provider is expected to provide care for members using standards consistent with current American Congress of Obstetricians and Gynecologists (ACOG) recommendations and within accepted Health Net guidelines.

ACOG's guidelines for Perinatal Care and Post partum Care (PDF) recommends the following examination schedule for a woman with an uncomplicated pregnancy:

- Tailor visit frequency based on individual needs, traditionally every four weeks for the first 28 weeks.
- Tailor visit frequency based on individual needs, traditionally every two to three weeks until 36 weeks gestation.
- Tailor visit frequency based on individual needs, traditionally weekly from 36 weeks gestation until delivery.
- Postpartum, individualized and woman centered. All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.

Women with medical or obstetric problems may require closer surveillance. The interval between visits is determined by the obstetric provider according to the nature and severity of the problems.

Recommended intervals for routine tests for individual members during pregnancy based on ACOG prenatal care services guidelines:

- Initial visit (as early as possible):
  - Complete Blood Count (CBC).
  - Urinalysis and urine culture.
  - Blood type, Rh(D) Type, antibody screening.
  - Hemoglobinopathy testing as appropriate based on ACOG recommendations.
  - Rubella antibody titer measurement.
  - Syphilis screening (Venereal Disease Research Laboratory (VDRL) test and Rapid Plasma Reagin (RPR) test).
  - HBSAg, anti-HBs Ab, anti-HBc Ab, HepC Ab.
  - HIV education, counseling and voluntary testing according to the California Perinatal HIV Testing Project guidelines.
  - Tuberculosis testing (PPD/QuantiFERON).
  - Varicella immunity testing (VZV IgG antibodies).

- Chlamydia testing.
- Gonorrhea testing.
- Cervical cytology ± HPV testing.
- Early diabetes screen.
- Carrier counseling and screening as appropriate based on ACOG recommendations.
- Blood pressure.
- Complete medical and obstetrical history, including genetic risk assessment and review of systems.
- Complete physical examination components as indicated based on gestational age and individual risk-factors.
- Orientation to Comprehensive Perinatal Services Program (CPSP).
- Prescription and dispensing of 300-day supply of vitamin and mineral supplements as needed.
- Counseling (anticipatory guidance) related to:
  - Pregnancy options
  - Expected prenatal care
  - Weight gain
  - Nutrition, dietary precautions
  - Exercise
  - Exposures ((e.g., Toxoplasmosis, Zika/COVID, heat, work)
  - Use of medications
  - Sexual activity
  - Dental care/referral
  - Seat belt use
  - Preparation for birth
  - Breastfeeding
  - Teratogens
  - Smoking, alcohol and substance use
- Breastfeeding promotion.
- Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program.
- Referral to Department of Health Care Services (DHCS)-certified genetic services (if needed).
- Comprehensive nutrition, psychosocial (mental health conditions, substance use/abuse, intimate partner violence/ trauma, social drivers of health), and health education risk assessment (ideally at initial visit, but within four weeks of initial visit).
- Development of an individualized care plan (ICP).

- 8 to 12 weeks:
  - Ultrasound (if indicated).
- 10 to 21 weeks (15 weeks 0 days to 21 weeks 0 days):
  - Aneuploidy screening, cell-free fetal DNA (cfDNA) screening (recommended from 10 weeks 0 days though 21 weeks 0 days, but can be ordered on or after 10 weeks 0 days through term), to screen for fetal autosomal trisomies (trisomy 21, trisomy 18, and trisomy 13) and sex chromosome aneuploidy (X, XXY, XYY, XXX).
- 15 to 21 weeks (15 weeks 0 days to 21 weeks 0 days):
  - Maternal serum alpha-fetoprotein (MSAFP).
- 18 to 21 weeks:
  - Ultrasound assessment.
- 14 to 27 weeks:

- Repeat psychosocial screening (mental health conditions, substance use/abuse, intimate partner violence).
- Repeat anticipatory guidance (Signs and symptoms of preterm labor, Selecting a newborn care clinician, reproductive life planning & contraception, postpartum care planning).
- Reassessment of nutrition.
- Revise ICP as needed.

- 24 to 28 weeks:
  - Diabetes screening (1-hour GTT).
  - Repeat CBC.
- 28 weeks:
  - Repeat antibody test for unsensitized Rh-negative members.
  - Prophylactic administration of Rho (D) immune globulin (if indicated).
- 28 to 26 weeks:
  - Tdap.
- 38 to 39 weeks:
  - Repeat testing for sexually transmitted infections (STIs, HIV, Syphilis, Gonorrhea/ Chlamydia), if indicated.
  - Repeat psychosocial screening (mental health conditions, substance use/abuse, intimate partner violence).
  - Repeat anticipatory guidance (fetal movement monitoring, signs and symptoms of preeclampsia, labor signs, reproductive life planning & contraception, infant feeding, newborn education, Family Medical Leave Act or disability forms, postpartum depression, post-term counseling, birth preferences [e.g., birth plan, pain management/coping, trial of labor after cesarean as indicated, induction of labor, labor support, infant medications, feeding, circumcision]).
- 32 to 36 weeks:
  - RSV (seasonal).
- 36 to 37 weeks:
  - GBS screen.
- 36 weeks
  - Physical exam should include assessment of fetal presentation if relevant to planned mode of birth.
- Every prenatal visit:
  - Urine check for glucose and protein.
  - After quickening, report of fetal movement.
  - Blood pressure, weight, uterine size, fetal heart rate, edema, Leopold's maneuvers.
  - Interval history.
  - Opportunity for questions.
  - Continual risk assessment, education and revision of the ICP and referral (if needed).
- Postpartum care visits 7 to 84 days after delivery, and additional postpartum care as needed until 365 days after delivery) based on ACOG recommendations:
  - Mood and emotional well-being:
    - Screen for postpartum depression and anxiety with a validated instrument.
    - Provide guidance regarding local resources for mentoring and support.
    - Screen for tobacco use; counsel regarding relapse risk in postpartum period.
    - Screen for substance use disorder and refer as indicated.
    - Follow-up on preexisting mental health disorders, refer for or confirm attendance at mental health-related appointments, and titrate medications as appropriate for the postpartum period.
  - Infant care and feeding

- Assess comfort and confidence with caring for newborn, including:
  - feeding method.
  - child care strategy if returning to work or school.
  - ensuring infant has a pediatric medical home.
  - ensuring that all caregivers are immunized with Tdap.
- Assess comfort and confidence with breastfeeding, including:
  - breastfeeding-associated pain.
  - guidance on logistics of and legal rights to milk expression if returning to work or school.
  - guidance regarding return to fertility while lactating; pregnancy is unlikely if menses have not returned, infant is less than 6 months old, and infant is fully or nearly fully breastfeeding with no interval of more than 4–6 hours between breastfeeding sessions.
  - review theoretical concerns regarding hormonal contraception and breastfeeding, within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy.
- Assess material needs, such as stable housing, utilities, food, and diapers, with referral to resources as needed.

◦ Sexuality, contraception, and birth spacing:
- Provide guidance regarding sexuality, management of dyspareunia, and resumption of intercourse.
- Assess desire for future pregnancies and reproductive life plan.
- Explain the rationale for avoiding an interpregnancy interval of less than 6 months and discuss the risks and benefits of repeat pregnancy sooner than 18 months.
- Review recommendations for prevention of recurrent pregnancy complications, such as 17-hydroxyprogesterone caproate to reduce risk of recurrent preterm birth, or aspirin to reduce risk of preeclampsia.
- Select a contraceptive method that reflects patient's stated needs and preferences, with same-day placement of LARC, if desired.

◦ Sleep and fatigue:
- Discuss coping options for fatigue and sleep disruption.
- Engage family and friends in assisting with care responsibilities.

◦ Physical recovery from birth:
- Assess presence of perineal or cesarean incision pain; provide guidance regarding normal versus prolonged recovery.
- Assess for presence of urinary and fecal continence, with referral to physical therapy or urogynecology as indicated.
- Provide actionable guidance regarding resumption of physical activity and attainment of healthy weight.

◦ Chronic disease management:
- Discuss pregnancy complications, if any, and their implications for future childbearing and long-term maternal health, including ASCVD.
- Perform glucose screening for women with GDM: a fasting plasma glucose test or 75 g, 2-hour oral glucose tolerance test.
- Review medication selection and dose outside of pregnancy, including consideration of whether the patient is breastfeeding, using a reliable resource such as LactMed.
- Refer for follow-up care with primary care or subspecialist health care providers, as indicated.

◦ Health maintenance:

        - Review vaccination history and provide indicated immunizations, including completing series initiated antepartum or postpartum.
        - Perform well-woman screening, including Pap test and pelvic examination, as indicated.
    - Laboratory data as indicated (for example, CBC if anemic on discharge from hospital).
    - Preventive and well-child screening exams and well-child care needs inquiry and referral.
    - Reassessment of nutrition, psychosocial and health education needs (revise or close ICP as needed).
    - Send copy of the ICP to the member's primary care physician (PCP).

For information on provider responsibility and pregnancy program, refer to Maternal Mental Health Screening Requirement.

At-Risk Pregnancy Conditions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Obstetric care providers are required to use a comprehensive risk assessment tool for all pregnant members that is comparable to the American College of Obstetricians and Gynecologists' (ACOGs') and Comprehensive Perinatal Services Program (CPSP) and maintain the results of the assessment in the member's medical record. This assessment tool must be administered at the initial prenatal visit, once each trimester, and at the postpartum visit. Providers are responsible to refer pregnant members to freestanding birthing centers, certified nurse midwives, licensed midwives and inform them of doula coverage as appropriate. For members with high-risk pregnancy indicators, providers must refer them to perinatal specialists, coordinating other medically necessary services, and making referrals to social services and community support agencies at any time during the pregnancy when high-risk indicators are identified.

The Medical Management Department is available to help coordinate services. The obstetric care provider supervises the member's individualized care plan (ICP) to ensure that risks are addressed by priority and that actions taken can be expected to ameliorate the conditions identified. This responsibility exists notwithstanding that the services may take place outside the provider's practice.

Social, Health Education, Health Behaviors, and Medical Risk Factors

The following is a list of some of the risk factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Sexually transmitted infections (STI) and HIV history and current risk
- Not following medical advice
- Failed appointments
- Occupational risk
- Teratogen exposure since pregnancy and ongoing exposure risk
- Diabetes
- Hypertension

- Cardiovascular problems
- Hepatitis
- Tuberculosis and other infectious diseases, past and ongoing risk
- Other chronic medical conditions
- Kidney problems
- Pulmonary disease
- Epilepsy
- Hematologic disorders
- Poor oral health
- Eating disorders
- Physical disabilities
- Inability to read or low reading level
- Language barriers
- Low educational level
- Low motivation
- Negative attitude about pregnancy
- Little or no prior experience with Western medicine/ health care
- Lack of social support structures
- Inability to reach decisions/comprehension difficulties
- Transportation challenges
- Family problems/abuse
- Economic/housing needs
- Informed consent needs
- Other children not linked to well-child care resources
- Lack of knowledge related to management of common pregnancy and postpartum-related conditions/discomforts

Nutritional Disorders and Nutritional Risk Factors

The following is a list of some of the nutritional risk factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Inadequate (less than two pounds per month after first trimester) or excessive (more than eight pounds per month) weight gain
- Eating disorders
- Tobacco, alcohol, drug, and caffeine use
- Hematocrit less than 27 percent
- Hemoglobin less than 9 percent
- MCV less than 83 or greater than 95 cu ml
- Abnormal three-hour glucose tolerance test
- Presence of glucose, ketones or protein in urine
- Pica
- No cold food storage or cooking facilities
- Less than three years since onset of menses
- High parity (five or more previous deliveries at greater than 20 weeks gestation)
- Excessive use of nutrient supplements
- Chronic use of laxatives, antacids or other over-the-counter medications known to affect nutritional status
- Use of herbal remedies known or suspected to cause toxic side effects

Obstetric or Gynecologic and Genetic Problems

The following is a list of some of the factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Age less than 17 or greater than 35
- Late initiation of prenatal care
- Primagravida or grand multipara
- Pregnancy complicated by detection of fetal anomaly
- Previous pregnancies with poor outcomes, previous pregnancy loss
- Preterm labor
- Previous congenital anomalies
- Multiple gestation
- Isoimmunization
- Intrauterine growth retardation
- Third-trimester bleeding
- Pregnancy-induced hypertension
- Uterine structural anomalies (for example, septum abnormality caused by in utero exposure to diethylstilbestrol)
- Abnormal amniotic fluid volume
- Fetal cardiac arrhythmias
- Prematurity
- Breech or transverse lie (intrapartum)
- Rupture of membranes for a period of time longer than 24 hours
- Chorioamnionitis
- Inadequate pregnancy interval
- Infertility and use of ART
- Family history of
    - Genetic or congenital defects or conditions in the genetic family of the fetus
    - Recurrent pregnancy loss or pregnancy complications
    - Chronic medical conditions or cancer

Psychosocial Problems, SDoH

The following is a list of some of the factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Demographic characteristics and identities associated with poor health outcomes and experience of marginalization.
    - Race, ethnicity
    - Gender identity sexual orientation
    - Religion
    - Nationality
    - Geographic location
    - Primary language
- Inadequate housing
- Domestic violence
- Absence of adequate social network and psychosocial support

- History of trauma or intimate partner violence
- Material needs: housing, food, transportation needs, financial resource strain, health care affordability
- Education and employment
- Excessive worries and fears
- Eating disorders
- Substance use and substance use disorder
- Mental health diagnoses
- Severe emotional problems
- Extreme anxiety or emotional problems
- History of depression, suicidality, psychosis, or hospitalization
- Cognitive deficits
- Mental disabilities
- Extreme difficulty or resistance to compliance with medical recommendations or restrictions
- Postpartum depression

Comprehensive Perinatal Services Program (CPSP)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers are required to refer members to California Department of Public Health (CDPH)-certified Comprehensive Perinatal Services Program (CPSP) providers to ensure that all pregnant women have access to care in accordance with DHCS requirements. The required services include:

- Client orientation
- Obstetrical services
- Nutrition, psychosocial and health education support services initial assessments
- Formal reassessments offered each subsequent trimester and in the postpartum period
- Development of individualized care plans (ICPs) that include planned actions as indicated by the assessments and objectives for each of the four categories, with revision at least each subsequent trimester and postpartum
- Case coordination
- Vitamin and mineral supplementation
- Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Provision of, or referral for, dental, genetic, family planning, and preventive, well-child screening care exams and services

California Department of Public Health (CDPH)-certified CPSP providers who contract to provide CPSP support services for non-certified providers are responsible for providing all support services and assessments, ICPs, reassessments, interventions, and case coordination information to pregnant members enrolled in CPSP upon referral from the identified obstetric provider.

The division of responsibilities between obstetric care providers and CDPH-certified CPSP providers for the rendering of CPSP support services is outlined below. Providers in a participating physician group (PPG) should contact their PPG administrator for sources of CPSP support services.

Obstetrical care provider responsibilities:

- Provide for all obstetrical care, including antepartum, intrapartum and postpartum care
- Prescribe prenatal vitamins and indicated medications
- Refer all pregnant Medi-Cal members to a CPSP support services provider
- Provide a copy of all antepartum exams, labor and delivery experience, and postpartum exam to a CPSP support services provider to be included in CPSP chart
- Include copies of all assessments, reassessments and interventions by CPSP support services provider in the medical chart

Responsibilities of the CPSP support services provider:

- Provide support services assessment, an ICP, reassessments, interventions, and case coordination information to pregnant members enrolled in CPSP pursuant to a referral
- Bill for all CPSP services, including case coordination bonus if called for by contract
- Provide copy of assessments, reassessments and intervention documentation to an obstetric provider for inclusion in the obstetric medical record each trimester and more frequently if needed
- Include copies of obstetric exams, labor and delivery experience, and postpartum exam in CPSP chart as received from the obstetric provider

The ICP must comply with the requirements described in the Comprehensive Risk Assessment and Individualized Care Plan discussion.

The Health Net Medi-Cal Health Services Department is available to coordinate care with other case management agencies to ensure that services are available to the member and to avoid duplication.

CDPH-Certified CPSP Providers

Contracting CDPH-certified CPSP providers are responsible for providing CPSP services to pregnant members and for complying with CPSP requirements. CDPH-certified CPSP providers are also responsible for complying with Health Net policies, procedures and standards, including:

- Use of assessment and documentation tools (CPSP assessment tools, individualized care plans (ICPs) and protocols are available at no cost to participating providers)
- Submission of encounter and outcomes data (PDF)

Health care workers who perform CPSP support services assessments and interventions must meet Medi-Cal standards for comprehensive perinatal providers. More information about these requirements may be found in the CPSP Provider Handbook.

Health plan-approved policies, procedures and standards are available from the Health Net Public Program Department.

CPSP Provider Requirements

The provision of Comprehensive Perinatal Services Program (CPSP) services to pregnant members is the responsibility of all California Department of Public Health (CDPH)-certified CPSP providers who participate with Health Net.

All CDPH-certified CPSP providers must have access to the CDPH's CPSP template protocols, the CPSP Provider Handbook and the CPSP Steps to Take Manual and Handouts. These materials contain information helpful to staff members in assessing and planning actions (for common pregnancy conditions and discomforts, not for high-risk situations) and referral of pregnant members.

Intrapartum Care

Pregnant members are assigned a facility for delivery. The obstetric provider forwards a copy of the member's prenatal care records in accordance with the facility's procedures.

Women with high-risk pregnancies must be directed to facilities with advanced obstetrics and California Children's Services (CCS)-designated neonatal care units. Care for CCS-eligible newborns is carved out of Health Net's coverage.

The following conditions require specialized care and may require member referral or transport:

- Intermediate, community or regional neonatal intensive care unit (NICU) designation recommended:
  - Premature rupture of membranes, 32 to 34 weeks gestation
  - Premature labor greater than 32 weeks and less than 36 weeks gestation
  - Twins or triplets at 34 to 38 weeks gestation
  - Hydrops fetalis
- Community or regional NICU designation recommended:
  - Intrauterine growth retardation
  - Premature rupture of membranes less than 32 weeks gestation, unknown dates with estimated fetal weight 2,000 grams
  - Premature labor less than 32 weeks gestation and unknown dates with estimated fetal weight 2,000 grams
  - Trauma requiring intensive care or surgical correction or requiring a procedure that may result in the onset of premature labor
  - Acute abdominal emergencies
  - Preeclampsia, eclampsia or other hypertensive complication
  - Third-trimester bleeding
  - Multiple gestation less than 34 weeks gestation and all pregnancies where there are more than three fetuses
- Medical complications:
  - Infections
  - Heart disease
  - Diabetes mellitus
  - Thyrotoxicosis
  - Renal disease with deteriorating function or increased hypertension
  - Hepatic disease
  - Drug overdose
- Fetal conditions:
  - Anomalies that may require surgery
  - Congenital anomalies requiring specialized newborn care
  - Erythroblastosis requiring intrauterine transfusion
- Neonatal conditions where transport may be indicated:
  - Gestation less than 32 weeks or weight less than 1,500 grams
  - Persistent respiratory stress

- Seizures refractory to usual treatment
- Congenital malformations requiring special diagnostic procedures or surgical care
- Sequelae of hypoxia persisting beyond two hours, with evidence of multisystem involvement
- Cardiac disorders that require special diagnostic procedures or surgery
- Sepsis

Monitoring and Oversight

Health Net assesses and tracks all participating providers' ability to deliver Comprehensive Perinatal Services Program (CPSP) services required by Medi-Cal. Health Net monitors compliance and provision of obstetrical services according to the American Congress of Obstetrics and Gynecology (ACOG) guidelines for Prenatal and Perinatal Health (PDF).

All compliance monitoring and oversight activities are undertaken with the goal of helping the obstetrical provider comply with the standards.

Non-CDPH-Certified Obstetric Care Providers

A non-California Department of Public Health (CDPH)-certified provider must comply with Health Net policies, procedures and standards, including:

- Use of assessment and documentation tools (Comprehensive Perinatal Services Program (CPSP) assessment tools, individualized care plans (ICPs) and protocols are available at no cost to participating providers)
- Submission of encounter and outcomes data (PDF)
- Establishment of a formal agreement with a CDPH-certified CPSP provider for provision of CPSP support services for Medi-Cal members

The Health Net public health program administrator is available to provide information about:

- Memorandum of understanding (MOU) or formal agreement language requirements
- Coordination activities requirements
- CPSP program information and technical assistance in collaboration with local public health departments' Perinatal Service Coordinators.

Lactation Education and Support Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Lactation education and support services are considered medically necessary for those members who would like to breastfeed, but for whom the standard education and support services have not proven sufficient to secure sustained, effective breastfeeding.

Lactation education and support services may be provided by the following:

- A lactation educator-counselor
- An International Board-Certified Lactation Consultant (IBCLC)

Providers participating through participating physician groups (PPGs) must follow the PPGs' processes.

Billing for Lactation Education and Support Services

Persons with lactation educator-counselor or IBCLC certifications are not recognized by the state of California as designated professionals who can be assigned a Medi-Cal provider number or bill Medi-Cal for services directly. A Medi-Cal provider, however, can bill for lactation support services under their Medi-Cal number if the services are rendered by a community perinatal health worker (CPHW), medical assistant (MA), registered nurse (RN), nurse practitioner (NP), or physician assistant (PA) who has one of these certifications. If the provider does not have a person on staff with a lactation certification, the provider may contract with a lactation consultant and reimburse that individual as a subcontracting employee.

Referral for Lactation Education and Support Services through CPSP Providers

Comprehensive Perinatal Services Program (CPSP)-certified providers can provide breastfeeding education, support and referrals in the antepartum and postpartum period to members.

Referral for Lactation Education and Support Services by Non-CPSP Providers

Health Net directly contracting (fee-for-service (FFS)) Medi-Cal participating providers who are not CPSP certified can provide lactation services if a staff member is a lactation educator-counselor or IBCLC and bill using appropriate ICD-10 or CPT codes. Providers may refer a member to lactation services for infants up to age one.

Without a formal arrangement with a participating physician or facility, the lactation consultant is considered a non-participating provider and must contact Health Net prior to rendering service to confirm authorization and receive billing instructions.

Lactation Durable Medical Equipment

Lactation durable medical equipment (DME) includes breast pumps, breast shells and nipple shields. These items help establish and sustain milk supply when nursing at the breast is difficult or not possible, and help eliminate breastfeeding difficulties.

A mother or baby may need lactation DME for one or more of the following reasons:

- Mother and infant are separated due to hospitalization
- Infant is unable to nurse (for example, latch or suck issues, post-operative, tube feedings)
- Mother has a physical condition requiring mechanical lactation assistance
- Mother is exclusively breastfeeding and is preparing to return to work or school
- Mother experiences nipple or breast pain
- Infant experiences latch-on difficulties
- Mother has flat or inverted nipples
- Mother has low milk supply
- Infant experiences slow weight gain
- Mother is breastfeeding a premature infant
- Mother is breastfeeding twins or triplets
- Mother is providing re-lactation or adoptive breastfeeding
- Infant has a neurological deficit or physical disability

Health Net Medi-Cal members may obtain the following types of breast pumps:

- Manual breast pump
- Personal-use electric breast pump and kit
- Hospital-grade electric breast pump and kit - rentals only (prior authorization required)

Prescriptions for lactation DME must be written by a licensed provider, including a physician, physician assistant, nurse practitioner, or certified nurse midwife.

Providers participating through participating physician groups (PPGs) must follow the PPGs' processes.

Maternal Mental Health Screening Requirement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Licensed health care practitioners who provide prenatal or postpartum care for a patient are required to screen for maternal mental health conditions once during pregnancy and once within the first six weeks postpartum. Additional screenings must be offered if determined to be medically necessary and clinically appropriate.

Maternal mental health condition means a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy and includes, but is not limited to, postpartum depression.

Providers serving Medi-Cal members can use one of the following screening tools, as appropriate to the member's plan:

- Patient Health Questionnaire-2 (PHQ-2)
- Patient Health Questionnaire-9 (PHQ-9)
- Edinburgh Postnatal Depression Scale

You can refer members with a positive screen to the Plan's Case Management Department for further assistance with the member's mental health needs.

Notice of Pregnancy

Let us know about a member's pregnancy so they can receive personalize care. Complete the Notification of Pregnancy form and fax it to the number on the form. This helps the member and their baby get the best care possible.

- Provider Notification of Pregnancy (PDF)
- Provider Notification of Pregnancy - CalViva Health (PDF)
- Provider Notification of Pregnancy - CHPIV (PDF)

Pregnancy Program

Health care service plans and health insurers must develop a maternal mental health program. The program must be consistent with sound clinical principles and processes.

A pregnancy program is available to pregnant commercial and Medi-Cal members. The program provides customized support and care needed for a healthy pregnancy and baby. It helps pregnant members access medical care, educates them about their health care needs and assists with social needs and concerns. The program uses the Edinburgh Postnatal Depression Scale to assess for mental health needs of pregnant members and facilitates referrals to a mental health specialist as needed.

Refer members to the pregnancy program by contacting the Case Management Department.

Pregnancy Termination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Certain different rules of confidential treatment, coverage and selection of providers apply to the sensitive services of family planning services, sexually transmitted disease (STD) treatment, abortion (pregnancy termination), and human immunodeficiency virus (HIV) testing as follows:

Abortion (pregnancy termination) services do not require prior authorization of coverage by the health plan. The primary care physician, their physician group, or the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) can help identify an appropriate provider.

PPG Financial Responsibility

Abortions performed by participating and non-participating providers are the financial responsibility of the capitated participating physician group (PPG). PPG financial responsibility for non-participating providers is limited to the Medi-Cal fee-for-service (FFS) rate.

Pregnancy Termination Services

An abortion is classified as a sensitive service. Medi-Cal members may obtain an abortion from any qualified provider, in or out of plan, without obtaining a referral or prior authorization (unless the abortion is performed during an inpatient hospitalization). Members may also receive mifepristone (RU-486) and misoprostol in accordance with the Food and Drug Administration (FDA)-approved treatment regimen and other mandated requirements.

A Medi-Cal member seeking an abortion may self-refer or request a referral from her primary care physician (PCP). If asked for a referral, PCPs may direct members to an abortion provider within their participating physician group (PPG) but may not indicate in any manner that the member cannot seek services elsewhere. A qualified provider of abortion services is the member's PCP, an OB/GYN, certified nurse midwife, nurse practitioner, physician assistant, family planning clinic, or a federally qualified health center (FQHC).

Birth Centers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Birth centers are required to provide a full range of pregnancy and postpartum services. These include psychosocial and nutritional assessments, childbirth education, and parenting support. All services must adhere to established midwifery and birth center care standards.

Hospital transfer policy

Birth centers must maintain a written hospital transfer policy. This policy must ensure:

- Immediate transfer of medical records to the receiving hospital.
- Direct verbal communication between the midwife and the hospital provider.
- Clear patient communication regarding estimated transfer time and emergency transport plans.

Licensing standards

Birth centers are not required to hold certification as Comprehensive Perinatal Services Program providers under Medi-Cal. However, birth centers must comply with midwifery and birth center care standards and maintain detailed written hospital transfer protocols that outline communication procedures.

Medi-Cal reimbursement

Facility-related delivery costs are reimbursed at a statewide all-inclusive rate, capped at 80 percent of the average hospital reimbursement. To qualify for reimbursement, birth centers must:

- Meet updated licensing standards.
- Use qualified providers, such as licensed midwives or certified nurse-midwives.
- Hold certification from the American Association of Birth Centers or an equivalent organization.

Nurse Midwife

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on nurse midwife services.

Select any subject below:

- Covered Services

Covered Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal members have the right to receive covered nurse midwife services from any Medi-Cal freestanding birth centers and to services provided by certified nurse midwives and licensed midwives without referral or prior authorization.

Services provided by Medi-Cal participating freestanding bith centers, certified nurse midwives and licensed modwives are a covered benefit. However, services or treatments that are specifically excluded from Medi-Cal coverage are not covered.

Certified Nurse Midwives and Licensed Midwives

The Department of Health Care Services (DHCS) authorizes certified nurse midwives and licensed midwives as providers of all services permitted within the scope of the practitioner's license. Both are authorized under state law to provide prenatal, intrapartum and postpartum care. This includes family planning care for the mother and immediate care for the newborn.

The table below outlines the differences between these two provider types and conditions under which they can provide care.

Midwife type	Licensing	Services
Certified nurse midwife	Licensed as a **registered nurse** and certified as a nurse midwife by the *California Board of Registered Nursing.*	Permitted to "attend cases of normal childbirth"

Midwife type	Licensing	Services
Licensed midwife	Licensed as a **midwife** by the Medical Board of California.	Permitted to “attend cases of normal pregnancy and childbirth, as defined” and must adhere to a detailed set of restrictions and requirements when a patient’s condition deviates from the legal definition of normal.

Freestanding Birth Centers

Federal law mandates coverage of services from freestanding birth centers, also referred to as alternative birthing centers, and requires separate payments to providers administering prenatal labor and delivery or postpartum care. Freestanding birth centers or alternative birth centers are specialty clinics authorized to bill Medi-Cal for Comprehensive Perinatal Services Program (CPSP), obstetrical and delivery services.

Primary care physicians (PCPs) may help members in obtaining freestanding birth centers, alternative birth centers, certified nurse midwife, and licensed midwife services by accessing the American College of Nurse Midwives' Find a Midwife website, and entering the member's geographic information. Members who do not have internet access, or need translation services or other assistance, may call the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

For additional information, please see Birth Centers.

PCP and Care Management Responsibilities

Participating providers are required to inform Medi-Cal members of their right to obtain covered services from an out-of-network, non-participating certified nurse midwife if one is not available in the network.

It is the PCP's responsibility to forward the member's medical records to the certified nurse midwife within 30 days after receiving the member's request.

Health Net's Health Services staff is available to assist certified nurse midwives or PCPs if they have any concerns about members' care, including provision of timely services and referrals.

Obesity

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Obesity is defined as an excess of body fat. Body mass index (BMI) is a measure of body weight relative to height. BMI can be used to determine if people are at a healthy weight, overweight or obese. An adult member whose BMI is 25 to 29.9 is considered overweight and a BMI of 30 or more is considered obese. Children of the same age and sex, with a BMI at or above the 85th percentile and lower than the 95th percentile is defined as overweight. Considerations for obesity is having a BMI at the 95th percentile or above.

Obesity is a treatable medical condition. Treatment of this condition varies depending on the severity of the members' condition.

Coverage

The primary care physician (PCP) or attending provider may recommend a diet plan for the member to follow and, if medically appropriate, the PCP may refer the member to a dietitian or a provider who specializes in weight-loss management. These services are covered as specialist consultation services. In cases of extreme morbid obesity, other treatments, such as pharmaceutical and surgical services, may be covered.

Health Net does not provide coverage for diet programs, such as Weight Watchers®. Gym memberships and exercise programs are also not covered under Medi-Cal.

The following information does not apply to Medi-Cal

All participating physician groups (PPGs) or attending providers offer patient education programs, including weight management. For more information regarding Health Net's weight loss interactive tools, discounts and online education programs, refer to the Eat Right Now by Sharecare program.

Eat Right Now by Sharecare program. Eat Right Now by Sharecare is an evidence-based app designed to help patients make better food choices and practice healthy habits that lead to sustainable weight-loss. The program includes daily guided lessons, mindfulness exercises, craving tools, community support, and live weekly calls with a behavior change expert.

For more information, select the subject below:

Bariatric Surgery Services (HMO and PPO only)

Podiatry

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

If determined to be medically necessary by the member's participating physician group (PPG) or Health Net, podiatry services are covered for Medi-Cal members. Podiatry services are:

- Limited to medical and surgical services necessary to treat disorders of the feet, ankles or tendons that insert into the foot; that are secondary to or complicated by chronic medical conditions; or that significantly impair the member's ability to walk
- Subject to prior authorization:
    - Surgical procedures for members under age 21

- Custom orthotics
- Office visit limitations do not apply.
- Limited to a maximum of two services in any one calendar month unless authorization for additional services is obtained

Routine nail trimming is not covered, and emergency services do not require prior authorization. Medically necessary podiatry services for Medi-Cal members who are hospitalized or in a nursing facility are covered Inpatient services require prior authorization. Refer to the Prior Authorization Requirements for additional information.

Preventive Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on preventive care services.

Select any subject below:

- Overview
- Preventive Services Guidelines

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Preventive care aims to prevent or reduce disease risk factors and promote early detection of disease or precursor states. Medical services and supplies required for preventive care are to be provided to all members as directed by the primary care physician (PCP) or designee.

Preventive care service guidelines include:

- Routine pediatric and adult examinations and health screenings, newborn hospital visits, counseling anticipatory guidance, developmental and behavioral assessment, and laboratory services
- Routine pediatric immunizations recommended jointly by the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians (AAFP)
- Routine adult immunizations recommended by ACIP

Health Net PCPs should consult the Guide to Clinical Preventive Services, a report of the U.S. Preventive Services Task Force (USPSTF), as the minimum acceptable standard for adult health services. Current USPSTF guidelines can be found on the Agency for Healthcare Research and Quality (AHRQ) website.

Covered CPT Codes

Most preventive services are covered by the following CPT codes:

- 99381-99384 (physical examination for new patients under age 18).
- 99203-99205 (physical examination for new patients ages 18 and over).
- 99391-99394 (physical examination for established patients under age 18).
- 99203-99205 (physical examination for established patients ages 18 and over).

PCP Responsibilities

The primary care physician (PCP) is responsible for:

- Providing an initial health appointment (IHA), which includes an age-appropriate history and physical examination within 120 calendar days after the member's date of enrollment.
- Completing ongoing health assessments as indicated in the periodicity table. Adult and senior assessments are completed every three to five years.
- Notifying members of periodic or clinically indicated appointments.
- Documenting assessment findings, treatment, recommendations, and follow-up in the member's medical record.
- Providing follow-up care, laboratory evaluation and specialty care if a medical condition warranting further care is found at the time of routine assessment.
- Coordinating care with specialists, including providing adequate clinical information to specialists to whom a member was referred for additional services.
- Making appointments for required assessments.
- Documenting missed or broken appointments in the member's medical record and following up with the member according to the procedure for missed or broken appointments.

Click To Edit

Preventive Services Guidelines

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The preventive services listed in the following tables are not necessary at every periodic visit (except in accordance with the American Academy of Pediatrics (AAP) guidelines). The services may be performed during visits for other reasons (for example, illness visits or chronic disease check-ups). This list does not include reviews of body systems and history relevant to lifestyle in a routine physical, as they are assumed to be covered during the physical.

- A & B Recommendations – U.S. Preventive Services Task Force
- Preventive health services – HealthCare.gov
- Women's Preventive Services Guidelines – Health Resources & Services Administration

Refer to the AAP website for:

- Recommendations for preventive pediatric health care (PDF).

Refer to the CDC website for:

- Healthcare Professionals: Adult Immunization Schedule by Age | Vaccines & Immunizations | CDC.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger; 2025 U.S (PDF).

Additional information on preventive service guidelines for pregnant members is provided under Benefits > Maternity > Pregnancy Care Management.

Preventive and Screening Services Under Age 21

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Some preventive and screening services previously provided by the Child Health and Disability Prevention (CHDP) program will continue to be provided by the Managed Care Plan (MCP). Health Net provides preventive, well-child screening services to children and youth under age 21.These services encompass the requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens program, and aim to prevent childhood disability by screening children during critical times of growth and development and making referrals necessary to improving their health.

Preventive and screening services must be provided in accordance with the most recent AAP Recommendations for Preventive Pediatric Health Care (PDF), and the Recommended Childhood Immunization Schedule (PDF) based on joint recommendations of the Advisory Committee on Immunization Practices (ACIP).

For more information, select any subject below:

- Certification for School entry
- Appointment and Referrals
- Coordination of Care
- Coordination of Services with School-Based Programs
- Examinations
- Follow-up for Missed Appointments
- Obtaining Consent
- Billing for Services
- Provider Certification Requirements

Certification for School Entry

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

California law requires that children entering first grade must provide their schools with a certificate documenting that they have had a preventive, well-child screening exam or a waiver of the exam signed by the parent or guardian. The exam may be done up to 18 months prior to, or within 90 days after, entrance into first

grade. Providers must give the parent or guardian of a child entering kindergarten or first grade a certificate documenting that the child has received the health exam. A child may be certified without a preventive, well-child screening exam if the child has received a physical exam and ongoing comprehensive medical care from that physician during the 18-month period prior to, or within 90 days following, entrance into the first grade. Health Net and local schools urge parents to get their child's health assessment on entry into kindergarten. If a health assessment is refused by the parent or guardian, the parent or guardian must submit a waiver to the school.

The Advisory Committee on Immunization Practices (ACIP) has formally adopted an exception to their recommendation for MMR vaccination, now allowing administration of the MMR to children up to four days prior to their first birthday. California state laws regarding school entry, however, preclude this exception for children in California. Children in California who receive the MMR immunization prior to their first birthday are required to be reimmunized prior to entrance into first grade.

Refer to the samples of the Report of Examination for School Entry PM 171A in English (PDF) and Spanish (PDF).

Appointments and Referrals

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal members requesting an appointment with their primary care physician (PCP) must be scheduled for an appointment within 10 business days if the child is behind schedule for a preventive, well-child screening exam. If the PCP cannot provide the needed services within 10 business days, the PCP may refer the member to another participating provider, out-of-network well-child screening services provider, local health department, or school-based well-child screening services program. A PCP referring a member to an out-of-network provider must furnish a complete referral.

If an external source (for example, school, member or out-of-network provider) contacts the Health Net Medi-Cal Member Services Department Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties), a representative makes contact with the member's PCP to determine whether the member is in need of current preventive, well-child screening services and to provide assistance with appointment scheduling as needed.

Coordination of Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The primary care physician (PCP) is responsible for supervision of physician extenders, providing ongoing care and coordination of all services the member receives. The provider must verify any suspected serious medical condition (for example, heart murmur, scoliosis and developmental problems). If needed services fall outside the PCP's scope of practice, referrals must be made and treatment initiated within 60 days after the health assessment appointment at which the condition was identified. The Health Net Medi-Cal Health Services

Department is available to provide coordination, if indicated by the member's condition and requested by the PCP.

Physician extenders may not be barriers to a request to see a physician. Any member being cared for by a physician extender must be given an appointment with the PCP without having to work through the physician extender.

If a member disenrolls, services are stopped.

If members in need of transportation assistance do not meet the criteria for non-emergency transportation, the PCP refers the member to Public Programs for assistance with transportation.

Coordination of Services with School-Based Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's policy on routine preventive, well-child screening services to children under age 21 is that they are provided principally by the member's primary care physician (PCP) for the following reasons:

- Services are the PCP's basic responsibility.
- All members have an assigned PCP who can provide these services.
- Provision of these services by the member's PCP provides for better continuity of care.

Recognizing the significance for improving both public and personal health outcomes and indicators, as well as health care access for school age Health Net members, Health Net has entered into contracts and agreements to provide and coordinate health care services where school-based clinics operate under the auspices of a Health Net participating physician group (PPG). Members who are identified at school sites as being in need of preventive and screening services receive these services from the participating school-based clinics within the required state and federal time frames. Health Net follows up and documents that preventive and screening services are provided to members. Health Net's participating school-based clinics and PCPs provide health assessments in accordance with the most recent American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care (PDF) for preventive health services.

All Health Net PPG-linked school-based clinics and PCPs must comply with the provisions of EPSTD/Medi-Cal for Kids & Teens. When a request is made for preventive and screening services by a member, the member's parent or guardian, an appointment must be made for the member to be examined within 14 days from the request if the child is deficient for EPSDT/Medi-Cal for Kids & Teens services. PCPs and PPG-linked school-based clinics must provide health assessments in accordance with the AAP Recommendations for Preventive Pediatric Health Care.

All members who are identified at school sites as being in need of preventive and screening services are to receive these services from their PCPs within the required state and federal time limits. If the member's PCP is unable to provide the needed exam within 14 days of the request when the exam is overdue, the PCP may refer the member to another Health Net provider, out-of-network provider, local health department, or PPG-linked school-based clinic.

Health Net's Public Programs Specialists may work with the PPG-linked school-based clinics to coordinate preventive and screening services to Medi-Cal members. School-based providers are required to:

- Coordinate with the child's PCP for identified follow-up care. The PCP's name and telephone number are listed on the child's Health Net member identification (ID) card.
- Notify the PCP of all needed services identified during the examination.

Examinations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Preventive, well-child screening exams must include:

- A complete health and development history, including mental health development (risk assessment)
- A head-to-toe unclothed physical examination, including assessment of physical growth
- A vision screening
- A hearing screening
- Identify dental health, screening of fluoride supplementation and applied varnish, as appropriate
- Nutritional assessment and counseling
- Laboratory tests appropriate to age and sex, including tests for anemia, diabetes and urinary tract infections
- Tuberculosis screening/testing, as indicated
- Testing for sickle cell trait, when appropriate
- Lead screening/testing, as appropriate
- Immunizations, if needed
- Additional tests or exams, if needed
- Health education and anticipatory guidance appropriate to the person's age and health status
- Weight assessment by BMI percentage and counseling intervention, as appropriate
- Counseling for physical activity

The primary care physician (PCP) must provide the member and the member's parent or guardian with a copy of the member's examination results and an explanation of results in terms of needed diagnosis and treatment.

All children with dental problems must be referred directly to a dentist for care. All members ages three and older must be referred annually for preventive dental care to a dentist that accepts Denti-Cal, regardless of whether a dental problem exists. Providers or members may contact Denti-Cal for a list of three Denti-Cal providers within the requester's ZIP code. Providers may also call their affiliated health plan's provider inquiry units for directions on dental referrals and dental networks.

Follow-Up for Missed Appointments

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

No-show appointments must be followed up with a telephone call/text/email or a letter from the provider's office to the member's parent or guardian to schedule another appointment (this includes the member's failure to follow-up on a referral to a specialist). Place a copy of the letter and documentation of any follow-up attempts in the member's medical record. After two no-shows, primary care physician (PCPs) should contact Health Net's public programs specialist, or their participating physician group (PPG) if contracting through a PPG, which then contacts Health Net's public program specialist or subcontractor.

Obtaining Consent

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers must obtain the voluntary written consent of the member or the member's parent or legal guardian before performing a preventive, well-child screening exam. Consent is also required for any release of medical information. The program has a standard consent form (PM 211 in English (PDF) and Spanish (PDF)) available to providers who do not have their own consent form for release of information.

If the member or member's parent or legal guardian refuses to have the exam or any portion of it performed, this information must be documented in the member's medical record.

Billing for CHDP Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Billing for Services

For fee-for-service (FFS) physicians, preventive and screening services for children and youth under age 21 years are billed on a CMS-1500 form using appropriate CPT/HCPCS codes. The XX indicator "3" must be also entered in the box 24H (EPSDT/family planning) of the CMS-1500 to indicate that the visit was for preventive and screening services.

For capitated providers, preventive and screening services for children and youth under age 21 must be submitted on an encounter to the participating physician group (PPG) for each visit.

Note that health assessment services are included in payment for the office visit and are not separately payable.

Provider Certification Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers of pediatric primary care services must be enrolled in the Medi-Cal program. Medi-Cal enrollment is offered at no charge to providers by the Department of Health Care Services (DHCS) Provider Enrollment Division (PED). Non- Medi-Cal-enrolled providers may obtain enrollment information by contacting DHCS or, go to the DHCS Provider Application and Validation for Enrollment.

Due to the CHDP transition, physicians and other providers enrolled and active in the Child Health and Disability Program (CHDP) Gateway on June 30, 2024, are automatically enrolled in the Children's Presumptive Eligibility (CPE). Additional information about the transition can be found on the CHDP Program Transition website.

Physicians and other providers not active in CHDP as of June 30, 2024, must complete steps to meet eligibility requirements to become enrolled as a Medi-Cal provider and then a CPE provider. After enrolling in Medi-Cal and receiving approval, providers can take the training on the Medi-Cal Learning Portal to participate in CPE as of July 1, 2024.

Primary Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following services, including ancillary services, are available to members for the prevention, diagnosis and treatment of illness or injury.

Visits for the following services are covered as medically necessary:

- Routine adult and pediatric examinations
- Specialist consultations
- Injections and allergy tests and treatments
- Physician services in or out of the hospital

American Indian Health Service

All eligible American Indians have the right to medical services from Indian Health Care Provider (IHCP) facilities. Members do not need a referral from their primary care physician (PCP) to obtain care at these facilities. AIHP providers can operate as PCPs for American Indian members and provide referrals directly to network providers. AIHP services are covered by Health Net Medi-Cal plans and only apply to American Indian members. Members have the right to disenroll from the plan at any time, without cause.

Emergency Services

The following information about coverage for emergency services is from the Member Handbook.

Emergency services are health services needed to evaluate or stabilize an emergency medical condition. An emergency medical condition can involve one or more of the following symptoms:

- Difficulty in breathing
- Seizures (convulsions)
- Unusual or excessive bleeding
- Unconsciousness
- Severe pain
- Possible ingestion of poison, or medicine overdose
- Suspected broken bones

If a medical emergency occurs, members should be directed to go to the nearest emergency room for care or call 911. Members are encouraged to use the 911 emergency response system as appropriate. Members are required to notify their primary care physician (PCP) as soon as they are able. Emergency services are available 24 hours a day, seven days a week.

Emergency services are covered under this health plan when they are provided in the United States. No services are covered outside of the United States, except for emergency services requiring hospitalization in Canada or Mexico.

Extended Care in Skilled Nursing Facility

Long-term care coverage is a managed health care benefit. Services provided when medically necessary include, but are not limited to, the following:

- Room and board
- Physician and nursing services
- Medication administration

Home Health Care

The following home health care services are covered when medically necessary, referred by the member's primary care physician (PCP), and not covered under a carve-out or waiver program:

- Part-time skilled nursing services
- Visits by a registered nurse (RN)
- Diagnostic and treatment services, which can reasonably be provided in the home, including nursing care
- Rehabilitation, physical, occupational, or other therapies (may require prior authorization)

Family Planning

Members do not need a referral or prior authorization to receive the family planning services listed below. Members may also see a provider who is not a Health Net participating physician without obtaining a referral or prior authorization from their primary care physician (PCP). Members may see licensed California providers who are practicing in another county from their county of residence.

A full range of family planning services is covered for members of child-bearing age that enable them to determine the number and spacing of their children. These services include all methods of birth control approved by the U.S. Food and Drug Administration (FDA), including:

- Contraceptive pills, including emergency contraceptives.
    - Members may receive up to a 12-month supply dispensed at one time for FDA-approved, self-administered hormonal contraceptives, such as 12 vaginal rings, 36 patches and 13 cycles of oral contraceptives, when dispensed from an onsite clinic and billed by any qualified provider. A qualified provider is 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 Medi-Cal enrollee as specified in Title 22, California Code of Regulations, Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, nurse practitioner, and pharmacist are authorized to dispense medications. Pursuant to the California Business and Professions Code (B P Code), Section 2725.2, if contraceptives are dispensed by a registered nurse (RN), the RN must have completed required training pursuant to B P Code Section 2725.2(b), and the contraceptives must be billed with evaluation and management (E M) procedure codes 99201, 99211 or 99212 with modifier TD (used for behavioral health RN) as directed in the DHCS Medi-Cal Provider Manual.
- Contraceptive devices (intrauterine device (IUD), Depo-Provera and diaphragm).
- Vasectomy and tubal ligation.
- Pregnancy testing and counseling.

Maternity Care

Members may choose any Health Net participating provider or certified nurse midwife within their participating physician group (PPG) for maternity care services. Members do not need to be referred by their PCPs, but may ask their PCPs to recommend a maternity care provider. Covered professional maternity care services include:

- Prenatal services.
- Postpartum services.
- Nutrition assessment and information.
- Health education assessment and information.
- Psychosocial assessment.

The following hospital services are covered:

- Semi-private accommodations, including all hospital services for mother and child.
- Hospital services for at least 48 hours following vaginal delivery, or at least 96 hours following a delivery by cesarean section. The coverage for the inpatient hospital stay may be less if the decision to discharge the mother and her newborn is made by the treating physician in consultation with the mother.
    - When a delivery occurs in the hospital, the stay begins at the time of delivery (in the case of multiple births, at the time of the last delivery).
    - When a delivery occurs outside a hospital, the stay begins at the time the mother is admitted.
- Newborn coverage is limited to the month of birth and the following month if the child does not enroll in the plan.

Federally Qualified Health Centers

Federally qualified health center (FQHC) services must be made available to all Medi-Cal beneficiaries, including those enrolled in managed care plans. A Medi-Cal member who seeks care from an FQHC must choose a primary care physician (PCP) at an FQHC that contracts with Health Net. This does not apply to services that do not require prior authorization from Health Net or the member's PCP, such as emergency services, family planning services, nurse midwife services, sexually transmitted infection (STI) treatment, and confidential HIV testing and counseling services.

Health Net does not cover FQHC services if:

- The member receives services in an FQHC that is a participating provider with Health Net, but is not the FQHC that was chosen by the member or was assigned to the member as the primary care location
- The member receives services in an FQHC that is not a participating provider with Health Net

Inpatient Hospital Services

The following are covered when medically necessary:

- Room and board in a semi-private room, or if medically necessary, in a private room
- Surgical procedures
- Anesthesia
- Laboratory and X-ray, including radiation therapy
- Use of operating room, special cardiac care units, intensive care, recovery room
- All other medically necessary hospital services, including medications and nursing services

Laboratory and Prescribed Services and Supplies

The following are covered for diagnosis and treatment and may be subject to prior authorization requirements. Direct network physicians can refer to the Prior Authorization list .

- Laboratory tests
- X-ray procedures
- Other medically necessary tests, such as electrocardiograms (EKGs) and electroencephalograms (EEGs)
- Prostheses (for example, artificial arms and legs)
- Prosthetics and orthotic devices (subject to utilization controls)
- Orthopedic and conventional shoes when provided by a prosthetic and orthotic supplier when at least one of the shoes is attached to a prosthesis or brace
- Eyeglasses (subject to utilization controls)
- Medical supplies when prescribed by a licensed practitioner
- Durable medical equipment (DME) (for example, wheelchairs and crutches)
- Blood and blood plasma
- Hospice services for terminally ill members
- Audiology services and hearing aids for hearing disorders
- Podiatry services
- Speech, physical and occupational therapy when the services meet the requirements of Title 22, California Code of Regulations

Medications (Medi-Cal Rx)

The Medi-Cal Rx Contract Drug List (CDL) is the list of covered drugs that the Medi-Cal Rx program covers. The Medi-Cal Rx CDL applies to drugs that members can receive at retail pharmacies. To learn about the Medi-Cal Rx program, visit the Medi-Cal Rx website

The following medications are covered by Health Net:

- Medications administered while the member is hospitalized or in an emergency room
- Medications administered in a provider's office or infusion center billed through the medical benefit
- Home infusion or other medication-related services billed through the medical benefit

The following medications are covered by the Medi-Cal Rx program:

- Self-administered and provider-administered medications listed on the Medi-Cal Rx Contract Drug List (CDL) and billed through a pharmacy claim
- Self-administered and provider-administered medications not listed on the Medi-Cal Rx CDL billed through a pharmacy claim (prior authorization may be required)
- Medications prescribed by a psychiatrist that are on the Medi-Cal Rx CDL and filled at a participating Medi-Cal Rx Pharmacy
- A 72-hour supply of a covered medication in a medical emergency.

Principal Exclusions and Limitations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

General Exclusions and Limitations

The following are the general exclusions and limitations for the Health Net or Medi-Cal fee-for-service(FFS) program:

- Covered services are limited to those services and supplies covered under the Medi-Cal FFS program that are described in Health Net's agreement with the Department of Health Care Services (DHCS) as being Health Net's coverage responsibility. In the event the California legislature passes a law to eliminate or reduce a service that was covered under the Medi-Cal FFS program, or the DHCS amends its Medi-Cal agreement with Health Net to eliminate or reduce a service that was covered under the agreement, benefits under this health plan are similarly eliminated or reduced upon the effective date of the change.
- Unless specified in the member's plan coverage, in order for services to be covered, they must be provided by a participating provider and coordinated by the member's primary care physician (PCP). The following services do not require a referral or pre-approval: emergency services, family planning services, nurse midwife services, sexually transmitted infection (STI) treatment, confidential HIV testing, and counseling services.
- Refer to the Prior Authorization Requirements for details on services that require authorization.

- Coverage is limited to services that are medically necessary.
- Coverage for hospice services is limited to terminally ill members with a life expectancy of six months or less. Coverage is provided in accordance with the hospice benefit and terms and conditions of eligibility and coverage under the Medi-Cal program and is subject to all exclusions and limitations of coverage under this plan.
- Newborn coverage is limited to the month of birth and the following month if the child is not enrolled. Members must contact the Health Care Options (HCO) office to enroll the child to ensure continuous coverage.
- Children may be entitled to additional services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Program under certain conditions.

A maximum of two visits per calendar month for any single combination of categories of services listed below (this limit does not apply to children under age 21):

- Speech therapy
- Occupational therapy
- Acupuncture
- Audiology services
- Chiropractic services
- Podiatry services

Exclusions

The following are not covered by Health Net or the Medi-Cal FFS program:

- Experimental procedures
- Cosmetic surgery (except when required to repair trauma, congenital defects or disease-related disfigurement)
- Personal comfort or convenience items
- Services to reverse surgically induced infertility
- Infertility treatment
- Fertility preservation
- Home modifications
- Vehicle modifications
- Private-duty nurses (except when medically necessary)
- Circumcision for members age 31 days and older (except when medically necessary)
- Custodial care while confined to a facility or home
- Chronic kidney dialysis when a member is eligible for coverage under Medicare
- Vaccines not recommend by the Advisory Committee on Immunization Practices (ACIP) or CDC
- The following vision services:
    - Eyeglasses used for protective, cosmetic, or job-related purposes
    - Eyeglasses prescribed for other than the correction of refractive errors or binocular vision problems
    - Progressive lenses
    - Multifocal contact lenses
    - Vision therapy or visual training

Exceptions Due to Extraordinary Circumstances

Health Net makes all reasonable attempts to provide coverage for services, but is not responsible for:

- Delay or failure to render service due to major disaster or epidemic affecting facilities or staff
- Interruption of services due to war, riot, labor disputes, or destruction of facilities

Failure to provide service when a member has refused a recommended service for personal reasons or when participating physicians believe no professionally acceptable alternative treatment exists.

Determinations of medical necessity of treatment are subject to review by a medical director, who is to consider all opinions and make a final decision about whether the services are covered.

FFS Program

The following are not covered by Health Net, but are covered by and coordinated with the Medi-Cal fee-for-service (FFS)or Medi-Cal Rx program:

- Self-administered oral, topical and injectable medications
- Some medications to treat behavioral health conditions, HIV and AIDS
- Alcohol and medication treatment services
- Outpatient heroin detoxification services
- Dental services and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental dental services for certain beneficiaries
- California Children's Services (CCS) program services
- Waiver program services (Home and Community Based Services (HCBS), AIDS, and Multipurpose Senior Services Program (MSSP))
- Direct observation treatment (DOT) for tuberculosis
- Alpha-fetoprotein (AFP) screening
- Blood coagulation factors
- Home and community-based services
- In-home support services

Support for Members with Disabilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information about support for disabled members.

Select any subject below:

- Auxiliary Aids and Services

Auxiliary Aids and Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Participating providers are required to take steps to ensure that no person with a disability is excluded, denied services, segregated, or otherwise treated differently. Health Net provides no-cost aids and services to people with disabilities to communicate effectively, such as qualified Sign Language interpreters, closed captioning interpreters, video remote interpreters, and written information in other formats (large print, audio, accessible electronic formats and additional formats), upon request and at no cost for members with disabilities.

Providers can request interpreter support for members, including auxiliary aids and services, by calling the Health Net Provider Services Department.

Transgender Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medically necessary transgender services for treatment of gender identity disorder (GID) are covered benefits for Medi-Cal beneficiaries, as defined in the Medi-Cal Provider Manual, Part 2, Department of Health Care Services, All Plan Letter (APL) 20-018, and any superseding letter. Medi-Cal's criteria for medical necessity of transgender services is based on the most current "Standards of Care for Health of Transsexual, Transgender, and Gender Nonconforming People" (SOC) published by the World Professional Association for Transgender Health (WPATH). Additional clinical information is located on the Health Net provider portal under Working with Health Net > Clinical > Medical Policies > Gender Affirming Procedures.

Gender Affirming Care and Gender Affirming Care Mental Health Care are classified as “Sensitive Services” under California law. Please see the Sensitive Services section for additional information.

Transgender services refer to the treatment of GID, which may include the following:

- consultation with transgender service providers
- transgender services work-up and preparation
- psychotherapy
- continuous hormonal therapy
- laboratory testing to monitor hormone therapy
- gender reassignment surgery that is not cosmetic in nature

Treatment for GID is a covered Medi-Cal benefit for members, who have the capacity for fully informed consent, and when medical necessity has been demonstrated. Covered benefits include mastectomy, orchiectomy, hysterectomy, salpingo-oophorectomy, ovariectomy, and genital surgery, including placement of testicular prostheses when indicated, as well as other medically necessary reconstructive surgery.

Medically Necessary/Reconstructive Surgery

No categorical exclusions or limitations apply to coverage for the treatment of GID. Each of the following procedures, when used specifically to improve the appearance of an individual undergoing gender reassignment surgery or actively participating in a documented gender reassignment surgery treatment plan, must be evaluated to determine if it is medically necessary reconstructive surgery to create a normal appearance for the gender with which the member identifies. Prior to making a clinical determination of coverage, it may be necessary to consult with a qualified and licensed mental health professional and the treating surgeon.

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Electrolysis
- Facial bone reduction
- Facial feminization
- Hair removal
- Hair transplantation
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Subcutaneous mastectomy
- Voice modification surgery

Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body... to create a normal appearance to the extent possible." (Health and Safety Code, Section 1367.63(c)(1)(B)). In the case of transgender patients, "normal appearance" is to be determined by referencing the gender with which the patient identifies. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance." (Health and Safety Code, Section 1367.63(d)).

This section clarifies how Health Net administers benefits in accordance with the WPATH, SOC, Version 8. Provided a patient has been properly diagnosed with gender dysphoria or GID by a mental health professional or other provider type with appropriate training in behavioral health and competencies to conduct an assessment of gender dysphoria or GID, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy, certain options for social support and changes in gender expression are considered to help alleviate gender dysphoria or GID.

For example, with respect to hair removal through electrolysis, laser treatment, or waxing, the WPATH "Statement of Medical Necessity for Electrolysis" (July 15, 2016) clarifies that patients with the same condition do not always respond to, or thrive, following the application of identical treatments. Treatment must be individualized, such as with electrolysis, and medical necessity should be determined according to the judgment of a qualified mental health professional and referring physician. The documentation to support the medical necessity for hair removal should include three essential elements:

1. A properly trained (in behavioral health) and competent (in assessment of gender dysphoria) professional has diagnosed the member with gender dysphoria or GID.
2. The individual is undergoing feminizing hormonal therapy.
3. The medical necessity for electrolysis has been determined according to the judgment of a qualified mental health professional and the referring physician.

If any element remains to be satisfied before medical necessity can be determined, the individual should be directed to an appropriate network participating provider for consultation or treatment.

Requesting Services

Prior authorization is required for gender reassignment services (transgender services). Providers must submit clinically relevant information for medical necessity review with the prior authorization request.

Members may select available specialists in the diagnosis and treatment of GID from Health Net's network. When network specialists are not available, arrangements must be made to refer members to appropriate out-of-network specialists. To find out which specialist providers contract with Health Net or accept Health Net members and who perform transgender services, contact the PPG or Health Net Provider Services Department.

Direct Network Providers

Direct Network providers must request prior authorization for gender reassignment services and can fax a completed Prior Authorization request form to Health Net's Prior Authorization Department. The current Prior Authorization Lists and Prior Authorization Request Forms can be found on the Prior Authorizations page.

Providers Participating through PPGs

Providers participating through PPGs must contact their PPGs, follow the PPGs' prior authorization process and use the PPGs' forms. PPGs are responsible for authorizing GID services.

Transitional Rent

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Plan covers Transitional Rent for eligible members. Members can access rental subsidies funded through Behavioral Health Services Agency Housing Interventions following their receipt of Transitional Rent. Transitional Rent is not a temporary reprieve from homelessness, but a pathway to long-term housing stability. **Transitional Rent cannot be used to pay for rental arrears** (back rent) or for prospective rental assistance to individuals who are already housed but at risk of homelessness.

Eligibility requirements

The Medi-Cal member must be enrolled with Health Net, CalViva Health or Community Health Plan of Imperial Valley, and meet all the following criteria:

- Have a qualifying behavioral health need AND;
- Be homeless or at risk of homelessness AND;
- Be part of a specified transitioning population, including those exiting institutional care, incarceration or the child welfare system.

Initial coverage for Transitional Rent

- Transitional Rent may be used to cover up to six months of rental assistance in allowable settings.

- A member may not receive more than a combined six months of Short-Term Post-Hospitalization, Recuperative Care and Transitional Rent within a rolling 12-month period.[1]

The Housing Deposits Community Support may be deployed for coverage of additional expenses not provided under Transitional Rent.

Allowable settings

Transitional Rent can provide for a member's housing in a permanent or interim setting, or some of the months in an interim setting and the remainder in a permanent setting.

Permanent settings

- Single-family and multi-family homes (e.g., duplexes)
- Apartments
- Housing in mobile home communities
- Accessory dwelling units (ADUs)
- Shared housing – where two or more people live in one rental unit
- Project-based or scattered-site permanent supportive housing
- Single-room occupancy units
- Tiny homes
- Recovery housing
- License-exempt room and board

Note: Member must have a Housing Support Plan that includes confirmation of long-term housing funding source (e.g., Behavioral Health Services Act Housing Voucher or other long-term subsidies).

Interim settings

- Single-room occupancy units
- Tiny homes
- Hotels/motels when serving as the member's primary residence
- Interim settings with a small number of individuals per room (not large dormitory sleeping halls)
- Transitional and recovery housing
- Medically appropriate Community Supports services

Note: Members must have a Housing Support Plan that includes documentation from the county behavioral health agency that they will be able to transition to BHSA Housing Interventions at the expiration of Transitional Rent.

The availability of each setting type will vary by county. Utilization will reflect this variation in local supply.

Automatic authorization for ECM and the Housing Trio when authorized for Transitional Rent services

When a member is approved for Transitional Rent, the Plan must also authorize for Enhanced Care Management (ECM) and the Community Supports Housing Trio:

- Housing Navigation or Tenancy Support
- Housing Deposits
- Housing Transition and Stabilization Services

ECM helps connect members to health and social services to support their housing stability, while Housing Trio services assist them in finding and maintaining long-term housing after Transitional Rent ends.

Requesting services

Prior authorization is required for Transitional Rent. To request authorization, submit a Transitional Rent Authorization Form (Health Net (PDF), CalViva (PDF), Community Health Plan of Imperial Valley (PDF)) along with the required supporting documentation online on the provider portal or via fax as noted on the form. The turnaround time for a routine request is seven calendar days. Examples of supporting documentation include, but are not limited to:

- Housing Support Plan
- Lease agreement
- Interim housing agreement
- Behavioral health eligibility confirmation
- Long-term subsidy

[1]For more information, refer to the Community Supports Policy Guide Volume 2, Date April 2025.

Transplants

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on transplant evaluations and services.

Select any subject below:

- Coverage Explanation
- Injectable Transplant Medication
- Health Net Transplant Performance Centers
- Responsibility for Inpatient Concurrent Review and Transfer for Transplant Evaluation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

All Transplants for Members Under Age 21

All transplant services for Medi-Cal members under age 21 are coordinated through California Children's Services (CCS). Health Net is not responsible for payments related to any transplant or post-transplant care, as these services are carved out to the CCS program.

A primary care physician (PCP) or specialist who identifies a member as a potential candidate for transplant services must submit a referral to the appropriate CCS program office and request prior authorization for a pre-transplant evaluation at a CCS-approved facility. If the CCS program office deems the member to be a potential candidate, the transplant physician must submit a Service Authorization Request (SAR) in a timely manner to the appropriate CCS program office and coordinate services with the CCS case manager. If the CCS program determines that the member is not eligible for the CCS program, but the transplant service is medically necessary, Health Net will be responsible for authorizing the transplant service, as appropriate.

Transplants for Members Ages 21 and Over

Subject to prior authorization, all transplants, as well as all pre- and post-operative transplant-related costs, not limited to evaluation, hospitalization, transportation, and drugs that are not covered by Medi-Cal Rx, are covered under the Health Net Medi-Cal contracts. There is *no* PPG delegation for Medi-Cal transplants.

Health Net covers the cost of medically necessary, non-experimental and non-investigative organ and stem cell transplants at a Medi-Cal approved, Center of Excellence (COE) transplant program which operates within a hospital setting.

Health Net must provide prior authorization for requests for transplant services on an expedited, 72-hour basis, or less if the member's condition requires it or if the organ or bone marrow the member will receive is at risk of being unusable due to any delay in obtaining prior authorization or delay in obtaining the organ or bone marrow.

Referral Process for Solid Organ Transplant and Bone Marrow Transplant (BMT) – Both Allogenic Stem Cell and Autologous Stem Cell

A PCP, specialist or participating physician group (PPG) who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Medi-Cal approved, Health Net Transplant Performance Center (Center) for transplant evaluation.

The Center must submit a prior authorization request for the evaluation to the Centene Centralized Transplant Unit (CTU) through the provider portal, or via fax directly to the CTU at 833-769-1141. On receipt of a request for an evaluation, the CTU contacts the Center to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number for the evaluation.

Once a member has completed an evaluation and is approved by the Center for transplant, the Center must submit a prior authorization request for listing to the Centene CTU through the provider portal, or via fax directly to the CTU at 833-769-1141. On receipt of a request for a listing, the CTU contacts the provider to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number.

CAR-T cell therapy, corneal transplant, tissue transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy requests must be submitted directly to Health Net. The CTU reviews all solid organ and stem cell transplants including human leukocyte antigen (HLA) typing for stem cell, donor search and stem cell harvest and collection.

Refer to the Prescription Drug Program topic for additional information about coverage for immunosuppressive medications following a Medi-Cal approved transplant.

Injectable Transplant Medication

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

An injectable transplant medication is an injectable immunosuppressive used specifically during the course of transplantation to prevent organ rejection. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table for a list of injectable transplant medications.

Health Net Transplant Performance Centers

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Refer to the Health Net Transplant Performance Center (PDF) matrix, which lists the Transplant Performance Centers and programs by region, when referring members for a transplant procedure.

Participation in Health Net's transplant network follows the Evaluation Process Standards to meet industry-accepted standards.

Responsibility for Inpatient Concurrent Review and Transfer for Transplant Evaluation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For members in need of an evaluation for transplant eligibility, responsibility for the transfer and continued concurrent review remain with the delegated entity until such time as a transplant event occurs or the member no longer requires an inpatient level of care and can be safely discharged. The financial risk upon transfer to a transplant facility will follow the standard Division of Financial Responsibility for inpatient admissions up to the day of transplant, when Health Net takes over risk for the transplant.

If, during the continued stay, the transplant occurs, the member's case is transitioned to Health Net's concurrent review team on the day of the transplant. Until that happens, the delegated entity maintains its concurrent review responsibilities even if the member is evaluated for transplant eligibility during that time.

Vision

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section provides general member benefit information for vision services.

Select any subject below:

- Overview

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following vision services are covered under Medi-Cal plans:

- Routine eye examination and refraction every two years (service date to service date).
- Annual diabetic retinal eye examinations by an ophthalmologist or optometrist for members who have been diagnosed with diabetes.
- Second eye examination with refraction within two years is covered only when the criteria for replacement lenses and the following criteria are met:
    - The member is unable to return to or obtain the prescription from the previous provider.
    - The examination is necessary to determine a change in vision.
- Medically necessary eye exams by ophthalmologists or optometrists for acute or urgent care.
- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus. Adults ages 21 and older are covered for bandage contacts only when medically necessary; other ophthalmological materials are not covered.

Frames and Lenses

- Optical lenses and frames are covered every two years (service date to service date).

Polycarbonate Lenses

- Polycarbonate lenses are covered for:

- Visual impairment in one or both eyes where the optimal correction is equal to or less than 0.30 decimal or 20/60 Snellen or equivalent at specified distances.
- Either visual field is limited to 10 degrees or less from the point of fixation in any direction.

Note: Optical lenses are made by California Prison Industry Authority (CALPIA) optical laboratories and provided without cost through the optometrist's or ophthalmologist's office participating with Centene Vision Services for those identified above.

Frame Replacement and Repair

- Replacement within two years of initial coverage is limited to the same model whenever feasible.
- Replacement frames within two years are not covered if an existing frame can be made suitable for continued use by the following:
  - Adjustment
  - Repair of broken frame
  - Replacement of broken frame part

Replacement Lenses*

Replacement is covered when:

- The power is changed at least 0.50 diopters in any corresponding meridian.
- The cylinder axis is changed 20 degrees or greater for cylinder power of 0.50 - 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 - 0.87 diopters, 10 degrees or greater for cylinder power of 1.00 - 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 - 0.37 diopters, as the sole reason for change, is not covered.
- The prismatic differential correction is changed at least 0.75 prism diopters in the vertical meridian or at least 1.5 prism diopters in the horizontal meridian.
- The previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety.
- A different frame size or shape is necessary due to patient growth, metal allergy or other justifiable medical reasons.
- *Replacement lenses should be ordered directly through the CALPIA optical laboratories.

Low Vision Examinations and Aids

- Low vision examinations and aids (including the fitting) are covered if:
- The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point.
- The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means.
- The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient.
- The aid prescribed or provided is the least costly type that will meet the needs of the recipient.

Contact Centene Vision Services to refer members or arrange visits. Centene Vision Services optometrists or ophthalmologists arrange orders and dispense lenses and frames, if indicated.

For River City Medical Group (RCMG) members, contact RCMG. For Molina Healthcare members, contact March Vision Care.

Routine Eye Examinations

The primary care physician (PCP) is the primary screener for ocular abnormalities requiring referral for a comprehensive eye examination. Comprehensive eye examinations performed by an optometrist or ophthalmologist are covered for all Medi-Cal members.

Providers should refer to the Health Net Provider Directory for a list of participating optometrists and ophthalmologists. Providers may contact the Health Net Medi-Cal Provider Services Center, CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) or Community Health Plan of Imperial Valley Provider Services Center to obtain the most current directory.

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at about age three. Children between ages four and six should have a comprehensive eye examination in addition to the screening performed by the PCP. Children with prescription eyewear or contact lenses should have an eye examination annually.

Referrals to ophthalmologists or optometrists for non-routine eye problems should be directed and coordinated by the PCP or PPG. Children with one or more of the following should have a comprehensive eye evaluation by an ophthalmologist:

- Abnormalities detected in the screening evaluation
- Signs or symptoms of eye problems
- History of eye problems
- Multiple health problems, systemic disease or use of medications that are known to be associated with eye disease and vision abnormalities
- Family history of conditions that cause, or are associated with, eye or vision problems
- Health and developmental problems that make screening by the PCP difficult or inaccurate

Obtaining an Eye Exam (Los Angeles County Only)

Health Net and Molina Healthcare each contract with a specific panel of optometric providers. These providers are listed in the provider directory. Providers may contact the Health Net Medi-Cal Member Services Department to obtain the most recent provider directory.

Non-routine visits, such as evaluation of apparent or potential ocular abnormalities are coordinated through the primary care physician (PCP).

In some cases, the participating physician group (PPG) may contract with a panel of vision providers. Members must direct questions about the vision network to their PPG for Medi-Cal member referral purposes.

Obtaining an Eye Exam (All Other Counties)

Members may self-refer to obtain annual routine vision services from a participating optical provider. Members should refer to the Health Net provider directory for participating optometrists. Members may contact the Health Net Medi-Cal Member Services Department, CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) or Community Health Plan of Imperial Valley Member Services Department to obtain the most recent provider directory.

Filling Lens Prescriptions and Fitting

Filling Lens Prescriptions

The participating optical provider sends the lens prescription and frame order to the California Prison Industry Authority (CALPIA) laboratory for production.

The PIA laboratory manufactures the lenses, inserts them into the frames, and returns them to the dispensing provider.

In instances when members require lenses that are not available through PIA, Health Net will cover the cost of fabrication and dispensing of lenses by another laboratory.

Fittings

Once the glasses are received in the optical provider's office, the participating optical provider ensures that each member receives an appointment for an eyeglass fitting and adjustment.

Contracting Optical Providers

Members of all ages have additional benefits for lenses and frames provided by the California Prison Industry Authority (CALPIA) every two years.

Additionally, medical eye exams (to monitor diabetes, hypertension and other medical conditions) are available as medically necessary, generally on an annual basis or as indicated by the primary care physician (PCP) or treating specialty ophthalmologist.

Health Net contracts with Centene Vision Services (to provide vision benefits to Health Net Medi-Cal members; however, River City Medical Group (RCMG) members must contact RCMG and Health Net members assigned to Molina Healthcare must contact March Vision Care.

Exclusions

The following are not covered:

- Eyeglasses used primarily for protective, cosmetic, occupational, or vocational purposes
- Eyeglasses prescribed for reasons other than the correction of refractive errors or binocularity anomalies
- Progressive lenses
- Orthoptic and/or pleoptic training
- Prescription eyeglasses for alternative use by a person who has and is able to wear contact lenses

- Upgraded frames or non-standard lenses, unless when meeting medical necessity.
- Prosthetics (may be covered by the health plan/medical group).
- Surgical professional services normally performed by an ophthalmologist (may be covered by the health plan/medical group).
- Multifocal contact lenses

X-Ray and Laboratory Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on x-ray and laboratory services.

Select any subject below:

- In-Office Laboratory Services
- Laboratory Services

In-Office Laboratory Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Coverage for laboratory and radiology services for Health Net's Medi-Cal plan mirrors that of the Department of Health Care Services (DHCS) fee-for-service (FFS) Medi-Cal program. Additionally, in accordance with the correct coding initiative and the Centers for Medicare and Medicaid Services (CMS), there are certain restrictions in place to ensure professional interpretation and billing are performed by specialists trained in the interpretation of radiology tests.

In-office laboratory services are only covered for certain STAT and sensitive services, when medically necessary and ordered by a Health Net provider. Supplies needed to stock the laboratory or perform the test, such as needles, syringes, slides, reagents, bandages, and labels, are included in the reimbursement for the laboratory test. Collection of venous blood by venipuncture and handling or conveyance of specimen for transfer to a laboratory are not benefits of the Medi-Cal program.

Surgical pathology is not within the scope of this policy. Laboratory tests for the evaluation and treatment of infertility are not covered under the Medi-Cal program. Tests required for the performance of family planning services or abortion are not subject to prior authorization requirements and can be provided at any facility, by any willing provider, whether in- or out-of-network.

Laboratory Services

Provider Type: Physicians

Quest Diagnostics® and LabCorp® are Health Net's preferred providers are Health Net's preferred provider for laboratory services for the following lines of business:

- Point of Service (POS)
- PPO
- Fee-for-service (FFS):
  - HMO
  - Medicare Advantage (MA)
  - Medi-Cal

  Quest Diagnostics is the world's leading provider of diagnostic testing, information and services, and offers:

- Convenient access to testing services with over 400 Quest Diagnostics Patient Service Center (PSC) locations in California, in addition to an online PSC locator and appointment scheduling function to minimize wait times.
- Access to more than 3,000 clinical, esoteric and anatomic pathology tests performed at one of Quest Diagnostics' testing facilities.
- Industry-leading standards of quality, integrity and clinical excellence, providing the greatest level of consistency and security for providers' practices.
- Consultation services with more than 800 physician and clinical specialists for rare or difficult test results.
- 24-hour-a-day, seven-day-a-week access to electronic laboratory orders and results, and other office solutions through Care360® Labs & Meds.
- Electronic prescription capability to order and renew prescriptions.
- Patient-friendly reports that help easily explain test results.

CalAIM

Please refer to the CalAIM Resources for Providers page for Plan information and materials related to CalAIM.

- Community Supports
- Enhanced Care Management
- Community Health Worker Services

Community Supports

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Community Supports (CS) services are part of the California Advancing and Innovating Medi-Cal (CalAIM) program, through the Department of Health Care Services (DHCS), to help improve the health of Medi-Cal members across the state. There are 14 CS services that are optional to members, as described in the table below.

Services to Address Homelessness and Housing

Description	Eligibility Criteria
Housing Transition Navigation Services: Assistance with obtaining housing. This may include assistance with searching for housing or completing housing applications, as well as developing an individual housing support plan.	• Experiencing homelessness and have a serious health condition; or • Determined eligible for Transitional Rent; or • Prioritized for housing through the local homeless Coordinated Entry System or similar system.
Housing Tenancy and Sustaining Services: Assistance with maintaining stable tenancy once housing is secured. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services, to develop financial literacy.	
Housing Deposit: Available for members in housing navigation and housing tenancy if there is a need and all county resources have been expended.	
Transitional Rent: Up to six months of rental assistance to support connection to long-term housing supports.	• Serious health condition; and • Experiencing or at risk of homelessness; and • Exiting a hospital, jail, foster care or unsheltered homelessness, or eligible for full-service partnership.

Recuperative Services

Description	Eligibility Criteria
Recuperative Care (Medical Respite): Short -term residential care for members who need to recover from an injury or illness.	• Individuals requiring recovery in order to heal from an injury or illness; and • Experiencing or at risk of homelessness.
Short-Term Post-Hospitalization Housing: Setting in which members can continue receiving care for medical psychiatric, or substance use disorder needs immediately after exiting an institution.	• Exiting recuperative care or other facility; and • Experiencing or at risk of homelessness; and • Serious health condition; and • At risk of hospitalization.
Respite Services: Short-term relief provided to caregivers of members who require intermittent temporary supervision.	• Live in the community and are compromised in their Activities of Daily Living and need non-medical care from a caregiver; and • Respite service is rest for the caregiver only, to avoid institutional placement of the member.
Sobering Centers: Alternative destinations for members who are found to be intoxicated and would otherwise be transported to an emergency department or jail.	• Individuals ages 18 and older who are intoxicated (appropriate for sobering centers); and • Conscious, cooperative, able to walk, nonviolent and free from any medical distress.

Services for Long-Term Well-Being in Home-Like Settings

Description	Eligibility Criteria
Asthma Remediation: Physical modifications to a member's home to mitigate environmental asthma triggers.	• Completed an in-home environmental trigger assessment within the last 12 months through the Asthma Preventive Services (APS) benefit that identifies medically appropriate asthma remediation and specifies how the intervention meets the needs of members.

Description	Eligibility Criteria
Day Habilitation: Programs provided to assist members with developing skills necessary to reside in home-like settings, often provided by peer mentor-type caregivers. These programs can include training on use of public transportation or preparing meals.	• Experiencing homelessness; or • Exited homelessness and entered housing in the last 24 months; or • At risk of homelessness or institutionalization whose housing stability could be improved.
Environmental Accessibility Adaptation (Home Modifications): Physical adaptations to a home to ensure the health and safety of the member. These may include ramps and grab bars.	• At-risk for institutionalization in a nursing facility.
Medically Tailored Meals/Medically Supportive Food: Meals delivered to the home that are tailored to meet members' nutrition-sensitive health condition(s) and unique dietary needs.	• Has nutrition-sensitive health condition(s) (e.g., cancer, diabetes, heart failure and more). • Must be assessed by a registered dietician or other appropriate clinician.
Assisted Living Facility (ALF) Transitions Services are designed to assist individuals with living in the community and avoiding institutionalization, whenever possible.	• Resided in a nursing facility for 60+ days. • Willing to live in an assisted living setting as an alternative to a nursing facility. • Able to reside safely in an ALF. **OR** • Interested in remaining in the community; and • Willing and able to reside safely in an ALF; and • Meets the minimum criteria to receive nursing facility level of care services[1] and, in lieu of going to a facility, chooses to remain in the community and continue to receive medically necessary nursing facility level of care services at an ALF. [1]Nursing facility level of care as defined in Section 51124 of Title 22 of the California Code of Regulations.

Description	Eligibility Criteria
Personal Care and Homemaker Services: Services can be provided for members who need assistance with Activities of Daily Living such as bathing, dressing, toileting, ambulation or feeding. Personal care services can also include assistance with Instrumental Activities of Daily Living such as meal preparation, grocery shopping and money management.	• At-risk for hospitalization or institutionalization in a nursing facility; or • Individuals with functional deficits and no other support system; or • Individuals approved for In-Home Supportive Services.

To check for CS services by county, refer to the below provider directory. However, please note that specific CS services by county may be subject to change depending on network availability and other factors.

- Health Net Provider Directory
- CalViva Health Provider Directory
- Community Health Plan of Imperial Valley Provider Directory

Referrals to Community Supports Services

Use one of the ways below to make a CS referral.

1. **Findhelp** (providers, members and community referrals)
    - Go to findhelp (Health Net and Community Health Plan of Imperial Valley) or findhelp (CalViva Health) to identify local resources
        - Log in/or create an account on findhelp.
        - Complete and submit the appropriate CalAIM Community Supports Assessment.
        - View available CS programs and make a referral.

2. **Member Services** (Anyone can make a referral)
    - Contact applicable member services, Monday-Friday, 8 a.m. to 5 p.m.
        - Health Net: 800-675-6110
        - CalViva Health: 888-893-1569
        - Community Health Plan of Imperial Valley: 833-236-4141

3. **Provider Directory** (Anyone can make a referral)
    - Use the below provider directory to find an Enhanced Care Management (ECM) provider for members:
        - Health Net Provider Directory
        - CalViva Health Provider Directory
        - Community Health Plan of Imperial Valley Provider Directory

To learn more about CS and its in-depth workflow, Go to the CalAIM Resources for Providers webpage.

For member resources, go to the following:

- Health Net CalAIM member webpage
- CalViva Health CalAIM member webpage

- Community Health Plan of Imperial Valley CalAIM member webpage

Community Supports Authorization Guides

CS authorization guides provide guidance to CS providers based on California Department of Health Care Services (DHCS) eligibility criteria and is different for each CS service. The authorization guides include the following information:

Program Overview	Services the members will receive with this community support
Eligibility	Eligibility criteria for the CS.
Authorization	Length of time the CS service is offered for the initial authorization and reauthorization (as applicable).
Required Documentation	Documentation that must be submitted to the Plan for authorization approval.
Codes	HCPCS codes that must be used for documenting the rendering of ECM and CS services.

CS authorization guides can be accessed on the CalAIM Resources for Provider website under *Forms and Tools*.

Enhanced Care Management (ECM)

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The Enhanced Care Management (ECM) benefit is a statewide benefit established by the Department of Health Care Services (DHCS) to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care. ECM providers are community-based entities with experience and expertise in providing intensive, in-person care coordination and care management services to individuals in one or more of the Populations of Focus and often employ those with lived experience in these populations. ECM will be offered primarily through in-person interaction where members and their families and support networks live, seek care, and prefer to access services. The goal of the ECM benefit is to improve the health and social outcomes of the member. The following are seven core ECM services available to enrolled members:

1. Outreach and engagement.
2. Comprehensive assessment and care management plan.
3. Enhanced care coordination.
4. Health promotion.
5. Comprehensive transitional care.
6. Member and family supports.
7. Coordination of and referral to community and social support services.

Refer to the DHCS ECM Provider Toolkit (PDF) to learn more about the seven core areas.

Eligibility Criteria

To be eligible for the ECM benefit, members must qualify for one or more of the identified ECM Populations of Focus and are not enrolled in duplicative services.

ECM Population of Focus	Eligibility Criteria
1. Homeless Families or Individuals Experiencing Homelessness	• Have significant health needs. • Are experiencing homelessness such as: ◦ Loss of housing ◦ Living in motels, hotels or shelters ◦ Having financial difficulties • Are at-risk of becoming homeless.
2. Individuals at Risk for Avoidable Hospital or Emergency Department (ED) Utilization	• Frequent visits to the emergency room. • Experience unplanned stays at hospitals or short-term nursing facilities.
3. Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs	• Getting services for mental health and substance use. • Experiencing social issues impacting their health, such as poverty, homelessness, access to health care, etc. • Frequently uses crisis services, ERs, urgent care and inpatient stays.
4. Individuals Transitioning from Incarceration Within the Past 12 Months	• Recently released from incarceration or a correctional setting. • Have at least one health condition such as: ◦ Mental illness ◦ Substance use disorder ◦ Chronic condition ◦ Intellectual or developmental disability (I/DD) ◦ Traumatic brain injury (TBI) ◦ HIV/AIDS ◦ Pregnant or postpartum

ECM Population of Focus	Eligibility Criteria
5. Adults Living in the Community Who Are at Risk for LTC Institutionalization	• Need skilled nursing care but can live in the community. • Able to live independently with support services. • Experience one complex social or environmental factor.
6. Adult Nursing Facility Residents Transitioning to the Community	• Want to move out of institutional care. • Can live safely and independently in the community.
7. Children/Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) With Additional Needs Beyond the CCS Condition	• Enrolled in CCS or CCS WCM; AND • Experience one social issue impacting their health such as: ◦ Food insecurity ◦ Housing instability or at-risk for homelessness ◦ History of ACEs, trauma and contacts with law enforcement.
8. Children/Youth Involved in Child Welfare	• Currently or recently in foster care, adoption, or family maintenance programs
9. Birth Equity Adults and Youth	• Are pregnant or in postpartum. • Experiencing disparities in healthcare based on race or ethnicity.

For additional information on the Population of Focus or eligibility criteria, refer to the DHCS ECM Policy Guide (PDF) or the Plan's ECM Provider Guide below:

- Enhanced Care Management (ECM) Provider Guide – Health Net (PDF)
- Enhanced Care Management (ECM) Provider Guide – CalViva Health (PDF)
- Enhanced Care Management (ECM) Provider Guide – Community Health Plan of Imperial Valley (PDF)

Referrals to ECM Service

Before making a referral, verify the member's eligibility with the Plan by checking the provider portal. Once determined that the member is eligible, use the appropriate method to make ECM referrals via the provider portal, findhelp, or provider services.

1. **Provider Portal,** Log in to the secure provider portal

   - Select Authorization from the top toolbar.
   - Complete sections 1-3 on the right panel:
     - Provider Request
     - Service Line
     - Finish Up (auto populates the member's information)
   - Click submit – you will receive a confirmation code

2. **Findhelp** (Non-contracted providers, members and community referrals)

   - Go to findhelp (Health Net and Community Health Plan of Imperial Valley) or findhelp (CalViva Health) to identify local resources
     - Log in/or create an account on findhelp
     - Select the ECM referral button on the homepage
     - Complete the referral and screener form

3. **Member Services** (Anyone can make a referral)

   - Contact applicable member services, Monday-Friday, 8 a.m. to 5 p.m.
     - Health Net: 800-675-6110
     - CalViva Health: 888-893-1569
     - Community Health Plan of Imperial Valley: 833-236-4141

4. **Provider Directory** (Anyone can make a referral)

   - Use the below provider directory to find an ECM provider for members:
     - Health Net Provider Directory
     - CalViva Health Provider Directory
     - Community Health Plan of Imperial Valley Provider Directory

5. **Fax ECM referrals** (Anyone can make a referral)

Submit a referral with the member's information that supports their ECM eligibility via fax to 800-743-1655. You can use the ECM referral form on the CalAIM Resources for Providers webpage, but it is not a requirement.

To learn more about ECM and its in-depth workflow, Go to the CalAIM Resources for Providers webpage.

For member resources, go to the following:

- Health Net CalAIM member webpage
- CalViva Health CalAIM member webpage
- Community Health Plan of Imperial Valley CalAIM member webpage

Community Health Worker Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Community Health Worker (CHW) services assist members with accessing preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and wellbeing.

CHWs may include individuals known by a variety of job titles, such as community health representatives, navigators, promotors, and other non-licensed public health workers, including violence prevention professionals.

Eligibility requirements

The Department of Health Care Services (DHCS) issued a statewide standing recommendation that all Medi-Cal members who meet the defined eligibility criteria for receiving CHW services would benefit from CHW services. This recommendation fulfills the federal requirements in section 440.130(c) of title 42 of the Code of Federal Regulations for a physician or other licensed practitioner of the health arts acting within their scope of practice to provide a written recommendation for preventive services. CHWs who use this standing recommendation for Medi-Cal members should note the standing recommendation and the member's eligibility criteria in their records.

CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits. Supervising providers should refer to the Provider Manual for guidance regarding telehealth.

Services include:

- **Health education:** Promote the member’s health or address barriers to physical and mental health care, such as providing information or instruction on health topics. Health education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve the member’s health or ability to self-manage their health conditions.
- **Health navigation:** Provide information, training, referrals, or support to help members access health care, understand the health care delivery system, or engage in their own care. This includes connecting members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or addressing health-related social needs. CHWs can also:
    - Serve as a cultural liaison or assist a licensed health care provider to participate in the development of a plan of care, as part of a health care team;
    - Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
    - Help the member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.
- **Screening and assessment**: Provide screening and assessment services that do not require a license and assist members with connecting to appropriate services to improve their health.

- **Individual support or advocacy:** Assists Medi-Cal members in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

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. If the parent or legal guardian of the member is not enrolled in Medi-Cal, the member must be present during the session.

Below are member eligibility criteria to qualify for CHW services:

- Currently enrolled in Medi-Cal.
- Diagnosed with one or more chronic physical or behavioral health conditions or suspected of having a mental health or substance use disorder.
- Rising risk of chronic disease, as shown by medical indicators (e.g., elevated blood pressure or glucose levels), but do not yet warrant diagnosis of a chronic condition.
- Have experienced a stressful life event identified through Adverse Childhood Experiences (ACEs) screening.
- Exhibit known risk factors such as domestic violence, intimate partner violence, tobacco use, excessive alcohol consumption, or drug misuse.
- Screened positive for unmet health-related social needs (e.g., housing or food insecurity).
- Had one or more emergency department visits in the past six months.
- Had one or more inpatient hospital stays (including psychiatric facilities) within the past six months or are at risk of institutionalization.
- Had a stay at a detoxification facility within the past year.
- Missed two or more medical appointments in the past six months.
- Expressed a need for help navigating the health system or coordinating resources.
- Requires preventive services such as immunizations, dental visits, or well-childcare visits.

Reimbursement

This standing recommendation authorizes CHWs to provide covered Medi-Cal CHW services including health education, health navigation, screening and assessment, and individual support and advocacy, which can be reimbursed using established current procedural terminology (CPT) billing codes noted in your contract.

Ongoing and extended services

Licensed providers are encouraged to develop a written plan of care when a need for multiple or ongoing CHW services is identified, and a written plan of care is required for continued CHW services after 12 units of care per Medi-Cal member in a single year from the initial date of service, which would constitute a new recommendation for more than the six hours authorized by the standing recommendation.

Member Access to CHW Services

Eligible Medi-Cal members can directly access CHW services by:

1. **Member Services** (Anyone can make a referral)

- Contact applicable member services, Monday-Friday, 8 a.m. to 5 p.m.
  - Health Net: 800-675-6110
  - CalViva Health: 888-893-1569
  - Community Health Plan of Imperial Valley: 833-236-4141

2. **Provider Directory** (Anyone can make a referral)

- Use the below provider directory to find an ECM provider for members:
  - Health Net Provider Directory
  - CalViva Health Provider Directory
  - Community Health Plan of Imperial Valley Provider Directory

Go to the CalAIM Resources for Providers page to learn more about CHW and its in-depth workflow.

Member Resources

Refer to the below for more information on CHW:

- Health Net member resource
- CalViva Health member resource
- Community Health Plan of Imperial Valley member resource

Reference:

Community Health Worker (CHW) Preventive Services Provider Manual (PDF)

Claims and Provider Reimbursement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes claims and provider reimbursement

Select any subject below:

- Remittance Advice and Explanation of Payment System
- Accessing Claims on Health Net Provider Portal
- Tracers
- Adjustments
- Balance Billing
- Billing and Authorization Procedures for Non-Benefit Codes
- Billing and Submission
- Capitated Claims Billing Information
- Claims Processing for DSNP in EAE Counties
- Telehealth Billing Requirement
- Emergency Claims Processing
- Emergency-related Claim Submissions
- Fee-For-Service Billing and Submission
- Professional Claim Editing
- Refunds
- Reimbursement
- Federally Qualified Health Centers Alternative Payment Methodology
- Targeted Rate Increase
- Payments to Medi-Cal Prohibited Entities

Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

The remittance advice (RA) and explanation of payment (EOP) system communicates Health Net's claims resolution and outcomes to participating hospitals. This automated system consolidates claim payments to providers and recognizes and recovers any overpayment allowed under the provider's contract.

Hospitals receive a RA and EOP from Health Net when any of the following occurs:

- Health Net pays, denies or contests a claim for services provided to a Health Net member
- For Medicare employer groups withholds a payment to recover a previous overpayment. A RA and EOP overpayment detail notification is sent to the provider. This notification does not apply to individual Medicare or Special Needs Plan (SNP) providers.

A RA and EOP notification lists payments Health Net makes to hospitals claim by claim. It is composed of the following:

- Subscriber identification number
- Patient name
- Patient account number - recorded on the CMS-1500 or UB-04
- Health Net claim identification (ID) number
- Service dates
- Total billed
- Contract adjustment
- Amount paid - same as contract adjustment
- Total claims payable
- Total check amount - total claims payable

Hospitals must carefully review all RA and EOP notifications to verify payments and denials. Health Net does not send letters on initial claim denials. Questions regarding RA and EOP notifications must be directed to the Provider Services Center.

Tracers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A tracer is a request for Health Net to research the status of a previously submitted claim that, according to the provider's records, has not been processed. If the claim has been processed (paid or denied), it should not be marked as a tracer. If the provider is disputing the payment amount or denial of a claim, it must be submitted as a provider dispute (refer to the Overview discussion in the Provider Appeals and Dispute Resolution section under the Appeals and Dispute Resolution topic for more information).

Identify a claim that is a tracer by writing or stamping "TRACER" prominently in a blank area of the claim form.

Tracers for Medi-Cal claims must be submitted within 12 months after the date of service and must include all necessary supporting documentation, such as other carrier payment information, chart notes and referral information. Tracers that are received after 12 months are denied for exceeding the timely filing deadline, unless providers can show proof (through such means as explanation of coverage or benefits, or correspondence) that the claim was received by Health Net and subsequently followed up in a timely manner by the provider.

Providers should include documentation with each tracer claim, showing the previous dates that the provider has submitted the claim and explain if the provider sent the claim to any addresses other that the designated Health Net Medi-Cal Claims address.

Participating providers may not balance-bill members at any time, including while tracer claims are under consideration.

Accessing Claims on the Provider Portal

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

To view and submit claims, log in to one of the following provider portals

Availity	Health Net
1. Log in, then go to *Claims & Payments* section from the main menu. 2. Select *Submit a Claim* or *Claim Status*.	1. Log in, then select the applicable line of business from the drop-down menu > *Go*. 2. Once you have checked the member's eligibility, select *Claims* located in the left-hand column. 3. Select the green *Create a New Claim* button to begin a new claim for this member.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website (HMO/PPO/Health Net Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley, Wellcare By Health Net) for details on what functions can be accessed through each portal.

Adjustments

Provider Type: Physicians | Ancillary

If a participating provider believes that a claim was processed inaccurately and wants to request an adjustment, the claim may be resubmitted to Health Net requesting reconsideration of the claim by following the provider dispute resolution process.

Balance Billing

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Balance billing is strictly prohibited by state and federal law under Title 22 California Code of Regulations section 53620, et seq. (the “Medi-Cal Fee Schedule”) and Health Net's Provider Participation Agreement (PPA).

Balance billing occurs when a participating provider balance bills Medi-Cal beneficiaries for amounts in excess of any Medi-Cal required copayments and deductibles for services covered under a member's benefit program, or for claims for such services denied by Health Net or the affiliated participating physician group (PPG). Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept Health Net's fee for these services as payment in full, except for applicable copayments, coinsurance, or deductibles.

Dual Special Needs Plan (D-SNP) members are not subject to copayments, so providers must not charge D-SNP members coinsurance, copayments, deductibles, financial penalties, or any other amount due to their Medi-Cal eligibility. Any amounts non-covered by the Medicare payment/reimbursement must be sent for review for possible secondary payment to the member’s Medi-Cal managed care plan (MCP) or directly to the Department of Health Care Services (DHCS) if not assigned to a Medi-Cal MCP for that date of service.

Providers can verify the member’s Medi-Cal MCP by checking the Medi-Cal Automated Eligibility Verification (PDF) .

Providers can refer to the Verifying and Clearing Share-of-Cost section for information regarding D-SNP members' share of cost (SOC) responsibility for certain services.

Health Net may cover a non-covered service if it is medically necessary. The provider must submit a pre-approval (prior authorization) request to Health Net with the reasons the non-covered benefit is medically needed.

Participating providers can bill members for services that are classified as non-covered and not medically necessary. Before these services are provided, members must be informed that they will not be covered by their plan. Additionally, members must sign a consent form acknowledging this information prior to receiving any non-covered services.

Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered.

A participating provider who exhibits a pattern and practice of billing members for covered services will be contacted by Health Net and is subject to disciplinary action in accordance with California state and federal law and Health Net’s Provider Participation Agreement.

For more information, select any subject below:

- 15-Day Letters

- Fee Prohibitions
- Missed Appointments

15-Day Letters

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A “15-day letter” is a formal written request for settlement of an unpaid claim. The applicable capitated provider is given 15 working days of an unpaid claim for capitated services rendered to a member. This is regardless of when the services were rendered (no time limitations).

The request for a 15-day letter is initiated when a Health Net member or provider has not been able to resolve a claim/ payment with the capitated Facility or the Participating Provider Group (PPG) for covered benefits. The servicing provider that is requesting the 15-day letter is required and responsible for providing all supporting documentation, including proof of timely filing when submitting claims with overdue payment for dates of service.

The plan advises its capitated providers to respond within 15 working days of the date listed on the 15-day letter about the disposition of the claim(s) so the plan may inform their member and servicing provider of the resolution. Any payment to the servicing provider must include a corresponding Explanation of Benefits (EOB) from the payee at risk.

If the capitated Facility or the Participating Provider Group (PPG) fails to respond to the 15-day letter or if the claim is not resolved satisfactorily within the time frame specified, the plan pays the claim and deducts the payment from the capitated provider's capitation check the following month.

Capitated providers are asked to produce a corrective action plan if the volume of 15-day letters exceeds the number permitted by the plan for more than three months. Capitated providers may be sanctioned if the volume of 15-day letters continues to exceed 0.2 percent of its enrollment by line of business. Sanctions may include freezing new enrollment and may ultimately result in termination of the capitation contract. Capitated providers are also advised by the Health Plan to check their capitation payments monthly for any capitation deductions to ensure that each 15-day letter(s) was received in the appropriate location or department for processing.

Fee Prohibitions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers are prohibited from charging Medi-Cal members for the completion of any form that is required by, or is necessary for the administration of, the Medi-Cal benefit. This includes, but is not limited to, CMS 1500 and UB-04 claim forms, health education behavioral assessment tools (HEBAT), health histories, patient consent forms, and medical record transfer forms.

The prohibition also extends to the completion of any form related to services covered under the Medi-Cal program. This may include sports physical forms for school athletics, physical exam forms for employment, school or preschool enrollment forms, tuberculosis (TB) testing, and health insurance forms. A provider may not

charge a member for completion of a form that certifies that a Medi-Cal-covered service was rendered or documents the findings of the covered service. For example, a provider is reasonably expected to complete a physical release form for a child entering a school athletic program, provided that the child is eligible for the service at the time of request. The provider is expected to complete the release form at no charge, qualifying the release with the date of the covered exam. The prohibition does not apply to the completion of forms and services that are not covered under the Medi-Cal program, in a case where the collection of payments is permitted under a contractual or legal entitlement. Providers also retain the right to charge reasonable fees for copying portions of or complete medical records for a member's use (does not apply if the provider is transferring records to another provider).

All medical services are covered under the Medi-Cal program, including urgent, emergent and preventive services, in addition to screenings, exams or treatments provided off-cycle from the usual periodicity schedule for the provision of pediatric preventive health care services. Preventive, well-child exams and services providers can use the tracking mechanism on the periodicity schedule for the provision of pediatric preventive health care services and as a reminder for when to deliver recommended services. For medically necessary interperiodic health assessments (MNIHAs), complete health assessments may be performed before the next regularly scheduled physical examination when the following situations exist:

- There is a need for a sports or camp physical examination
- The individual is in foster care or out-of-home placement
- There is a need for a school or preschool entrance examination
- There is a need for providing additional anticipatory guidance to the individual or the parent or legal guardian
- There is a history of perinatal problems
- There is evidence of significant developmental disability

Missed Appointments

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net providers are prohibited from charging a Health Net Medi-Cal member for a missed appointment. Medi-Cal managed care members are not share-of-cost beneficiaries and are not subject to copayments or deductibles for office visits, so they cannot be held accountable for these charges in the event of a missed appointment.

Billing and Authorization Procedures for Non-Benefit Codes

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Under current Medi-Cal policy, certain HCPCS and CPT codes may be listed as “non-benefit” and are not reimbursed under the standard Fee-for-Service (FFS) system. These codes are automatically denied unless deemed medically necessary and approved through prior authorization (PA).

Provider Responsibilities

1. Verify code status – Providers must verify whether a billing code is listed as “non-benefit” by consulting the Medi-Cal Treatment Authorization Request (TAR) and Non-Benefit list.
2. Prior authorization requirements:

- Providers must review Health Net’s or the delegated participating physician group’s (PPG’s) prior authorization requirements list before rendering services.
- If required, obtain PA before the service is provided. Failure to obtain required authorization may result in claim denial.

Claims Submission Guidelines

- If **PA is required and approved** – Submit the claim with the authorization number clearly indicated on the claim form.
- If **PA is not required** – Submit the claim using standard procedures.

Denied Claims and Dispute Resolution

If a claim is denied due to a “non-benefit” code and the provider believes the service should be covered:

- Initiate a provider dispute resolution (PDR) through Health Net or the delegated PPG.
- Include supporting documentation demonstrating medical necessity and any relevant authorization details.

PPGs Compliance

All delegated PPGs responsible for utilization management and claims payment must ensure their internal processes align with DHCS policy and Health Net requirements.

Billing and Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on claims billing and submission.

Select any subject below:

- Additions and Exceptions
- Claims Receipt Acknowledgement
- Claims Submission Requirements

- Clinical Information Submission
- CMS-1500 Billing Instructions
- Community-Based Adult Services Claims Submission
- National Drug Codes for Medi-Cal Claims
- Trauma Services
- UB-04 Billing Instructions

Additions and Exceptions

Provider Type: Hospitals

Outpatient Claims

The following are additions or exceptions to commercial billing rules. Facilities are required to follow these guidelines for Medi-Cal billing:

- Bill type is desired (a delay in claims payment will result if not provided)
- Revenue codes are required
- CPT and HCPCS codes are required
- Place of Service code (box 50 on the UB-04 form) is required if the bill type field is left blank
- Complete condition code if services are preventive, well-child screening services or family planning related
- Use A1 if services are preventive, well-child screening services
- Use A3 if services are family planning-sterilization related
- Use A4 if services are family planning-other related

Inpatient Claims

The following are additions or exceptions to commercial billing rules. Facilities are required to follow these guidelines for Medi-Cal billing:

- Revenue code is required
- Bill type is required
- Place of Service code (box 50) is required if the bill type field is left blank
- Type of Admission code (box 19) is required
- Source of Admission code (box 20) is required
- Complete condition code field if services are preventive, well-child screening or family planning related
- Use CPT codes and not ICD-10 codes in boxes 80 and 81

Claims Receipt Acknowledgement

Provider Type: Physicians | Ancillary | Hospitals

Health Net provides an acknowledgement of claims receipt, whether or not the claims are complete, within two business days for electronically submitted claims. For paper claims, Health Net provides an acknowledgement of claims receipt within 15 business days of receipt for HMO, Medi-Cal, PPO, and EPO. If a paper claim is paid or denied within 15 days, the Remittance Advice (RA) is considered an acknowledgement of claims receipt. A provider may obtain acknowledgement of claim receipt in the following manner:

HMO, PPO, EPO, and HSP claims: Electronic fax-back confirmation of claims receipt through the Health Net Provider Services Center interactive voice response (IVR) system, via a paper acknowledgement report mailed within 14 days of claims receipt and on the Health Net provider portal.

Medi-Cal claims: Confirmation of claims receipt through the provider portal of Health Net's website and by calling the Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center.

Claims received from a provider's clearinghouse are acknowledged directly to the clearinghouse in the same manner and time frames noted above.

Date of Receipt definition: Date of receipt is the business day when a claim is first delivered, electronically or physically, to Health Net's designated address.

Claims Submission Requirements

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) |Ancillary

Health Net encourages providers to submit claims electronically. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. Claims missing the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return. Nonstandard forms include any that have been downloaded from the Internet or photocopied, which do not have the same measurements, margins, and colors as commercially available printed forms.

Refer to un-clean claims for more information.

Acceptable Forms

For paper claims, Health Net only accepts the Centers for Medicare & Medicaid Services (CMS) most current:

- CMS-1500 form - complete in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, updated each July.
- CMS-1450 (UB-04) form - complete in accordance to UB-04 Data Specifications Manual, updated each July.

Other claim form types will be upfront rejected and returned to the provider. Providers should adhere to the claims submission requirements below to ensure that submitted claims have all required information, which results in timely claims processing.

Electronic Claims

For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction. Each claim submitted must include all mandatory elements and situational elements, where applicable. Secondary COB claims can be sent electronically with all appropriate other payer information and paid amounts.

Paper Claims

Paper claim forms must be typed in black ink with either 10 or 12 point Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Claims submitted on black and white, handwritten or nonstandard forms will be rejected and a letter will be sent to the provider indicating the reason for rejection. To reduce document handling time, providers must not use highlights, italics, bold text, or staples for multiple page submissions. Copies of the form cannot be used for submission of claims, since a copy may not accurately replicate the scale and optical character recognition (OCR) color of the form.

Health Net only accepts claim forms printed in Flint OCR Red, J6983 (or exact match) ink and does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

Professional Claims

Providers billing for professional services and medical suppliers must complete the CMS-1500 (02/12) form. The form must be completed in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual Version 5.0 7/17 at www.nucc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Institutional Claims

Providers billing for institutional services must complete the CMS-1450 (UB-04) form. The form must be completed in accordance with the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2018 at www.nubc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Medicare Billing Instructions

Medicare CMS-1500 and completion and coding instructions, are available on the CMS website at www.cms.gov.

Mandatory Items for Claims Submission

Refer to CMS-1500 Billing instructions or UB-04 Billing Instructions as applicable for complete description and required or conditional fields.

Reference guide for commonly submitted items

Form Fields	Electronic	CMS-1500	UB-04
Billing provider tax ID	Loop 2010AA REF segment with TJ qualifier	Box 25	Box 5
Billing provider name, address and NPI	Loop NM109 with XX qualifier	Box 33	Box 1
Subscriber (name, address, DOB, sex, and member ID required)	2000B and 2010BA	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Provider taxonomy		Box 33B and Box 24	Box 57
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	2000C and 2010CA	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Principal diagnosis and additional diagnoses	Loop 2300 HI segment qualifier BK (ICD9) or ABK (ICD10)	Box 21	Box 66
Diagnosis pointers (up to 4)	Loop 2410 SV107	Box 24E (A-L)	N/A
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A

Form Fields	Electronic	CMS-1500	UB-04
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76
Rendering provider	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)	NPI in Box 24J	N/A
Service facility information	Loop 2310C or 2310E NM1 with 77 qualifier (if differs from billing provider)	Box 32	N/A
Procedure code	Loop 2400 SV segment	Box 24D	Box 44 if applicable
NDC code	Loop 2410 LIN segment with N4 qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
UPN	Loop 2410 LIN segment with appropriate UP, UK, UN qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
Value codes (for accommodation codes, share of cost, etc.)	Loop 2300 HI segment with qualifier BE	N/A	Box 39, 40, 41
Condition codes	Loop 2300 HI segment with qualifier BG	N/A	Box 18-28

Form Fields	Electronic	CMS-1500	UB-04
COB-other subscriber or third party liability	Loop 2320, 2330A and 2330 B	Box 9, if applicable (requires paper EOB from other payer), 10, 11	Box 50-62 (requires paper EOB from other payer)
Claim DOS	Loop 2400 DTP segment with 472 qualifier	Box 24A	Box 45 for outpatient when required
Claim statement date	Loop 2300 with 434 qualifier	N/A	Box 6 from and through

Claims Rejection Reasons and Resolutions

The following are some claims rejection reasons, challenges and possible resolutions.

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
01	Member's DOB is missing or invalid	Enter the member's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10	Section 2 [1]Non-standard submission or equivalent
02	Incomplete or invalid member information	Enter the member's Health Plan member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social Security number (SSN) should not be used. Check eligibility online, electronically, or	CMS-1500 box 1a UB-04 box 60	Section 2 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		refer to the member's current ID card to determine ID numbers		
06	Missing/invalid tax ID	Include complete 9-character tax identification number (TIN)	CMS-1500 box 25 UB-04 box 5	Section 1a [1]Non-standard submission or equivalent
17	Diagnosis indicator is missing POA indicator is not valid DRG code is not valid	Ensure 9/0 ("9" for ICD-9 or "0" for ICD-10) appears in field 66 for all claims. Ensure present on admission (POA) indicators are valid when billed. Ensure a valid DRG code is used in field 71. POA valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at time of inpatient admission. Leave blank if cannot be determined	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
75	The claim(s) submitted has missing, illegible or invalid value for anesthesia minutes	When box 24 is completed, then box 24G must be completed as well	CMS-1500 box 24D and 24G	N/A
76	Original claim number and frequency code required	When submitting a corrected claim, for UB-04 box 64 and CMS-1500 box 22, you must reference the original claim. Claim numbers can be found on your Remittance Advice (RA)/ Explanation of Payment (EOP) or check claims status online. Do not include punctuation, words or special characters before or after the claim number. Submission ID from a reject letter is not a valid claim number. If not using frequency codes 7 or 8 leave boxes 64 and 22 blank. Submit contested claims to Medi-Cal Provider Contested Claims.	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit – Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)	UB-04 box 4	N/A
87	One or more of the REV codes submitted is invalid or missing	Include complete 4-digit revenue code	UB-04 box 42	N/A
92	Missing or invalid NPI	Enter provider’s 10-character National Provider Identifier (NPI) ID	CMS-1500 box 24J and 33A UB-04 box 56	Section 1b [1]Non-standard submission or equivalent
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National	CMS-1500 box 24D UB-04 box 43	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any of these elements are missing, the claim will reject		
A7	Invalid/missing ambulance point of pick- up ZIP Code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pickup (POP) ZIP in box 23 in addition to the addresses in 24 shaded area or box 32	N/A
A9	Provider name and address required at all levels	Include complete provider billing address including city, state and ZIP Code	CMS-1500 box 33 UB-04 box 1	Section 1a [1]Non-standard submission or equivalent
AK	Original claim number sent when the claim is not an adjustment	When submitting an initial claim, leave CMS 1500 box 22 and UB-04 box 64 blank. Any values entered in these boxes will cause a claim to reject.	CMS-1500 box 22 UB-04 box 64	Section 4 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank. (for description see Reject code 17)	UB-04 box 67–67Q and 72A–72C	N/A
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A	N/A
C6	Other Insurance fields 9, 9a, 9d, and 11d are missing appropriate data	If the member has other health insurance, box 9, 9a and 9d must be populated, and box 11d must be marked as yes. If this is not provided, the claim will be rejected	CMS-1500 box 9, 9a, 9d and 11d	N/A
AV	Patient's reason for visit should not be used when claim does not involve outpatient visits	Include patient reason for visit for bill type 013x, 078x, and 085x (outpatient) when Type of Admission/Visit (Box 14) is 1 (emergency), 2 (urgent) or 5	UB-04 box 70a, b, c	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		(trauma) and revenue code 045x, 0516 or 0762 are reported. Otherwise, do not populate		
HP	ICD-10 is mandated for this date of service	Submit with the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms according to the 5010 Guidelines requirement to bill this information. (for description see Reject code 17)	CMS-1500 box 21 UB-04 box 66	N/A
RE	Black/white, handwriting or nonstandard format	Use proper CMS-1500 or UB-04 form typed in black ink in 10 or 12 point Times New Roman font	N/A	N/A

[1]This is not a standard claim form like the CMS-1500 or the UB-04 claim forms; used to bill ECM and Community Supports services only.

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net routinely requires Medicare employer groups to include clinical information at the time of claim submission as follows:

- Evaluation and Management Services (E&M) - There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E&M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E&M services is appropriate. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The documentation of each patient encounter should include the following:

- Reason for the encounter and relevant history, physical examination findings, and any prior and additional diagnostic test results.
- Assessment, clinical impression or diagnosis.
- Medical plan of care.
- Date and legible identity of the observer.
- Any additional relevant information.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill higher level of evaluation and management service when a lower level of service is warranted.

Health Net reserves the right to request clinical records before or after claim payment to identify possible fraudulent or abusive billing practices, as well as any other inappropriate billing practice not consistent or compliant with the American Medical Association (AMA) CPT codes or guidelines, provided there is evidence such an investigation is warranted.

CMS-1500 Billing Instructions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

All claims from participating providers that are Health Net's responsibility must be submitted to Health Net Medi-Cal claims within 180 days from the last day of the month of the date services were rendered. Medicare Advantage, HMO and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Insurance program identification	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X"	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		in the box noted "Other"	
1a	Insured identification (ID) number	The nine-digit identification number on the member's ID card	Required
2	Patient's name (Last name, first name, middle initial)	Enter the patient's name as it appears on the member's ID. card. Do not use nicknames	Required
3	Patient's birth date and sex	Enter the patient's eight-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male or F= Female	Required
4	Insured's name	Enter the subscriber's name as it appears on the member's ID card	Conditional - Needed if different than patient
5	Patient's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101).	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		Second line - In the designated block, enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP +4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1	
6	Patient's relationship to insured	Always mark to indicate self if the same	Conditional - Always mark to indicate self if the same
7	Insured's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the insured's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		Second line - In the designated block, enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit zip code (ZIP + 4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1	
8	Reserved for NUCC	N/A	Not required
9	Other insured's name (last name, first name, middle initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
9a	Other insured's policy or group number	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan	Conditional REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan

Field number	Field description	Instruction or comments	Required, conditional or not required
9b	Reserved for NUCC	N/A	Not required
9c	Reserved for NUCC	N/A	Not required
9d	Insurance plan name or program name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name	Conditional REQUIRED if field 9 is completed
10 a, b, c	Is patient's condition related to:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in box 11	Required
10d	Claims codes (designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code	Conditional
11	Insured policy or FECA number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If box 10 a, b or c is marked Y, this field should be populated	Conditional REQUIRED when other insurance is available
11a	Insured date of birth and sex	Enter the eight-digit date of birth (MM/DD/YYYY) of the insured	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank	
11b	Other claims ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number For worker's compensation of property and casualty: Required if known. Enter the claim number assigned by the payer	Conditional
11c	Insurance plan name or program number	Enter name of the insurance health plan or program	Conditional
11d	Is there another health benefit plan	Mark Yes or No. If Yes, complete field's 9a-d and 11c	Required
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary	Conditional - Enter "Signature on File," "SOF," or the actual legal signature

Field number	Field description	Instruction or comments	Required, conditional or not required
		to process and/or adjudicate the claim	
13	Insured's or authorized person's signature	Obtain signature if appropriate.	Not required
14	Date of current: Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	Conditional
15	If patient has same or similar illness. Give first date.	Enter another date related to the patient's condition or treatment. Enter the date in the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
16	Dates patient unable to work in current occupation	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY)	Conditional
17	Name of referring physician or other source	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)	Conditional - Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)
17a	ID number of referring physician	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	Conditional REQUIRED if field 17 is completed
17b	NPI number of referring physician	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used	Conditional REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used
18	Hospitalization on dates related to current services		Conditional
19	Reserved for local use - new form: Additional claim information		Conditional
20	Outside lab/ charges		Conditional
21	Diagnosis or nature of illness or injury (related items A-L to item 24E by line). New	Enter the codes to identify the patient's diagnosis and/or condition. List no more	Required - Include the ICD indicator

Field number	Field description	Instruction or comments	Required, conditional or not required
	form allows up to 12 diagnoses, and ICD indicator	than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment	
22	Resubmission code / original REF	For resubmissions or adjustments, enter the original claim number of the original claim. New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	Conditional - For resubmissions or adjustments, enter the original claim number of the original claim
23	Prior authorization number or CLIA number	Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If authorization, then conditional If CLIA, then required If both, submit the CLIA number Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization.

Field number	Field description	Instruction or comments	Required, conditional or not required
			CLIA number for CLIA waived or CLIA certified laboratory services
24 A-G Shaded	Supplemental information	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract rate • For detailed instructions and qualifiers refer to Appendix IV of this guide	Conditional - The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate
24A Unshaded	Dates of service	Enter the date the service listed in field 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
24B Unshaded	Place of service	Enter the appropriate two-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website	Required
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency	Not required
24D Unshaded	Procedures, services or supplies CPT/ HCPCS modifier	Enter the five-digit CPT or HCPCS code and two-character modifier, if applicable. Only one CPT or HCPCS and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim	Required - Ensure NDC or UPIN is included if applicable

Field number	Field description	Instruction or comments	Required, conditional or not required
24 E Unshaded	Diagnosis code	In 24E, enter the diagnosis code reference letter (pointer) as shown in box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in box 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-10 codes for the date of service, or the claim will be rejected/denied	Required
24 F Unshaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line	
24 G Unshaded	Days or units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one	Required
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral	Conditional - Leave blank or enter "Y" if the services were performed as a result of an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) referral
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	Conditional - Enter the appropriate qualifier for EPSDT visit
24 I Shaded	ID qualifier	Use ZZ qualifier for taxonomy. Use 1D qualifier for ID, if an atypical provider	Required
24 J Shaded	Non-NPI provider ID#	Typical providers: Enter the provider taxonomy code that corresponds to the qualifier entered in box 24I shaded. Use ZZ qualifier for taxonomy code	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Atypical providers: Enter the provider ID number.	
24 J Unshaded	NPI provider ID	Typical providers ONLY: Enter the 10-character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (such as DME, independent lab, home health, RHC/FQHC general medical exam)	Required
25	Federal Tax ID number SSN/EIN	Enter the provider or supplier nine-digit federal tax ID number, and mark the box labeled EIN	Required
26	Patient's account NO	Enter the provider's billing account number	Conditional - Enter the provider's billing account number
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment. Refer to	Conditional - Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the

Field number	Field description	Instruction or comments	Required, conditional or not required
		the back of the CMS-1500 (02-12) claim form for the section pertaining to payments	provider accepts assignment
28	Total charge	Enter the total charges for all claim line items billed - claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	Required
29	Amount paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to	Conditional REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing

Field number	Field description	Instruction or comments	Required, conditional or not required
		the right of the vertical line	
30	Balance due	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	Conditional REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)
31	Signature of physician or supplier including degrees or credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
32	Service facility location information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (PO box numbers are not acceptable here.) First line - Enter the business/facility/ practice name. Second line- Enter the street address. Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 codes), include the hyphen	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
32a	NPI - Services rendered	Typical providers ONLY: REQUIRED if the location where services were	Conditional Typical providers ONLY: REQUIRED if the location where

Field number	Field description	Instruction or comments	Required, conditional or not required
		rendered is different from the billing address listed in field 33. Enter the 10-character NPI of the facility where services were rendered.	services were rendered is different from the billing address listed in field 33.
32b	Other provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
33	Billing provider INFO & PH#	Enter the billing provider's complete name, address (include the ZIP + 4 code), and telephone number. First line -Enter the business/facility/ practice name. Second line - Enter the street address. Do not use commas, periods, or other punctuation in the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line- Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e., (555)555-5555). NOTE: The nine digit ZIP code (ZIP + 4 code) is a requirement for paper and EDI claim submission	
33a	Group billing NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI .	Required
33b	Group billing other ID	Enter as designated below the billing group taxonomy code.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. Atypical providers: Enter the provider ID number	

Community-Based Adult Services Claims Submission

Ancillary

Community-Based Adult Services (CBAS) centers must submit claims for program services on a UB-04 (CMS-1450) form to ensure prompt, accurate claims processing.

CBAS centers can submit claims electronically using Health Net's payer identification (ID) number 95567. CBAS centers may use the clearinghouse of their choice. They may also submit paper claims to the Health Net Medi-Cal Claims Department.

National Drug Codes for Medi-Cal Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

In accordance with Department of Health Care Services (DHCS) requirements, providers must submit claims with a valid National Drug Code (NDC) in conjunction with the customary HCPCS Level I, II or III codes, when appropriate, on claims submitted for medication reimbursement. Claims received without the appropriate NDC and HCPCS codes are contested. For Medi-Cal claims, both the CMS-1500 and UB-04 claim forms require valid NDC information.

When the health plan receives a Medi-Cal claim with both an NDC and a HCPCS code, the health plan applies line-level claim edits to determine:

- Is the NDC valid?
- Is the HCPCS code valid?
- Is the NDC/HCPCS code combination valid?

If the response to any of the above questions indicates an invalid code or invalid code combination, the health plan will contest the claim to ask for corrected billing.

NDC Billing Requirements: Medication Billed Separate from Service

Providers are required to use a valid NDC when a medication is billed separate from a service. The following chart outlines the NDC requirements:

Type of Claim	NDC
Medicare/Medi-Cal crossover	Not required.
Fee-for-service Medi-Cal as primary	Required when the medication is billed independent of the service.
Medi-Cal as secondary (other health coverage)	Required when the medication is billed independent of the service.
California Children's Services (CCS)	Required when the medication is billed independent of the service.
Genetically Handicapped Persons Program (GHPP)	Required when the medication is billed independent of the service.
Presumptive eligibility	Required when the medication is billed independent of the service.
Cancer Detection Program: Every Woman Counts (CDP: EWC)	Required when the medication is billed independent of the service.

Compound Medications

Compound medications dispensed in an outpatient hospital environment are not exempt from the NDC billing requirement. Each medication dispensed should be entered on a separate line of the CMS-1500 or UB-04 claim form using the appropriate NDC and HCPCS Level I, II or III codes. Only the claim lines for the physician-administered medication is contested if the NDC information is missing or invalid. All other claim lines are processed accordingly.

Description of Medications with HCPCS Level III Codes

In addition to NDC billing requirements, providers are required to describe medications used with a HCPCS Level III code, such as Z7610 (miscellaneous supplies), or a procedure code, such as 90779 (therapeutic injection), in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form, or the Remarks field (Box 80) on the UB-04 claim form. Any medications administered or dispensed for such codes still require a description and valid NDC information on these forms.

Family PACT providers are exempt from reporting the NDC in conjunction with Z7610.

Trauma Services

Provider Type: Hospitals

Hospitals billing Health Net for trauma admissions, trauma care or other trauma-related services must submit complete documentation with the UB-04 (CMS-1450) and the itemized claim form at the time of billing. Submission of complete trauma service records assists Health Net with timely claims processing and payment. Failure to submit the required documentation can lead to delay in claims processing or denial of the claim.

The following documents may be required when billing any trauma-related services (documents may be handwritten or transcribed):

- Emergency room (ER) report.
- Trauma activation/trauma team involvement (for example, members or specialties).
- Complete clinical hospital records, if admitted.
- Admitting notes.
- Emergency medical services (EMS or paramedic) record.
- ER attending physician's report.
- All additional reports from any other physician.

Documentation for inpatient admissions must include the above documents and the following:

- Admission history and physical.
- Discharge summary.
- Operating room reports, if applicable.
- Complete clinical hospital records.
- All additional reports from any other physician.

UB-04 Billing Instructions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

All claims from participating providers that are Health Net's responsibility must be submitted to Health Net Medi-Cal claims within 180 days from the last day of the month of the date services were rendered. HMO, Medicare Advantage, and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and UB-04 form and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Unlabeled field	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state, and ZIP +4 Codes (include hyphen). Note: The 9 digit ZIP (ZIP +4 codes) is a requirement for paper and EDI claims. Line 4: Enter the area code and telephone number **ALERT: Providers submitting paper claims should left-align data in this field.	Required
2	Unlabeled field	Enter the pay-to name and address	Not required
3a	Patient control no	Enter the facility patient account/control number	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
3b	Medical record number	Enter the facility patient medical or health record number	Required
4	Type of bill	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit - Indicating the type of facility. 2nd Digit - Indicating the type of care. 3rd Digit- Indicating the bill sequence (frequency code).	Required
5	Fed Tax No	Enter the nine-digit number assigned by the federal government for tax reporting purposes	Required
6	Statement covers period from/through	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology,	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	
7	Unlabeled field	Not used.	Not required
8a	Patient name	8a - Enter the first nine digits of the identification number on the member's ID card.	Not required
8b		Enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Enter the patient's complete mailing address.	
9	Patient address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (NOT REQUIRED)	Required - Except line 9e county code
10	Birthdate	Enter the patient's date of birth (MMDDYYYY)	Required - Ensure DOB of patient is entered and not the insured)
11	Sex	Enter the patient's sex. Only M or F is accepted	Required
12	Admission date	Enter the date of admission for inpatient claims and date of service for outpatient claims (MMDDYY)	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.
13	Admission hour	Enter the time using two-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a..m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	082x require boxes 12–13 to be populated.
14	Admission type	Require for inpatient and outpatient admissions. Enter the one-digit code indicating the type of the admission using the appropriate following codes: • 1 - Emergency • 2 - Urgent • 3 - Elective • 4 - Newborn • 5 - Trauma	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
15	Admission source	Required for inpatient and outpatient admissions. Enter the one-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: • 1 - Physician referral • 2 - Clinic referral • 3 - Health maintenance referral (HMO) • 4 - Transfer from a hospital • 5 - Transfer from skilled nursing facility • 6 - Transfer from another health care facility • 7 - Emergency room • 8 - Court/law enforcement • 9 - Information not available For type of admission 4 (newborn): • 1 - Normal delivery • 2 - Premature delivery • 3 - Sick baby	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 4 - Extramural birth • Information not available	
16	Discharge hour	Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a.m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	Conditional - Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		billing period listed in field 6 using one of the following codes: • 01 - Routine discharge • 02 - Discharged to another short-term general hospital • 03 - Discharged to SNF • 04 - Discharged to ICF • 05 - Discharged to another type of institution • 06 - Discharged to care of home health service organization • 07 - Left against medical advice • 09 - Discharged/ transferred to home under care of a home IV provider • 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) • 20 - Expired or did not recover • 30 - Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment	

Field number	Field description	Instruction or comments	Required, conditional or not required
		is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown (hospice use only) • 43 - Discharged/ transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) • 50 - Hospice-Home • 51 - Hospice-Medical Facility • 61 - Discharged/ transferred within this institution to a hospital-based Medicare approved swing bed • 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part	

Field number	Field description	Instruction or comments	Required, conditional or not required
		units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility certified under Medicaid but not certified under Medicare • 65 - Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital • 66 - Discharged/ transferred to a critical access hospital (CAH)	
18-28	Condition codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric	Conditional REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual	
29	Accident state	N/A	Not required
30	Unlabeled Field	N/A	Not required
31-34 a-b	Occurrence code and occurrence date	Occurrence code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence date: REQUIRED when applicable or when a corresponding occurrence code is	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYY format	
35-36 a-b	Occurrence SPAN code and Occurrence date	Occurrence span code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (35-36a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence span date: REQUIRED when applicable or when a corresponding occurrence span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYY format.	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
37	Unlabeled field	REQUIRED for re-submissions or adjustments. Enter the DCN (document control number) of the original claim	Conditional REQUIRED for resubmissions or adjustments. Enter the DCN (document control number) of the original claim
38	Responsible party name and address	N/A	Not required
39-41 a-d	Value codes and amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	Conditional REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
42 Lines 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
42 Line 23	Rev CD	Enter 0001 for total charges.	Required
43 Lines 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	Required
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim)	Conditional - Enter the number of pages. (Limited to 4 pages per claim)
44 lines 1-22	HCPCS/Rates	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/ HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed

Field number	Field description	Instruction or comments	Required, conditional or not required
		HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract	
45 Lines 1-22	Service date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	Conditional REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
45 Line 23	Creation date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	Required
46 lines 1-22	Service units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
47 Lines 1-22	Total charges	Enter the total charge for each service line	Required
47 Line 23	Totals	Enter the total charges for all service lines	Required
48 Lines 1-22	Non-covered charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts	Conditional - Enter the noncovered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts
48 Line 23	Totals	Enter the total non-covered charges for all service lines	Conditional - Enter the total noncovered charges for all service lines
49	Unlabeled field	Not used	Not required
50 A-C	Payer	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	Required
51 A-C	Health plan identification number	N/A	Not required
52 A-C	REL information	REQUIRED for each line (A, B, C) completed in field 50.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'	
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services	Required
54	Prior payments	Enter the amount received from the primary payer on the appropriate line	Conditional - Enter the amount received from the primary payer on the appropriate line when Health Net is listed as secondary or tertiary
55	EST amount due	N/A	Not required
56	National Provider Identifier or provider ID	REQUIRED: Enter providers 10-character NPI ID	Required
57	Other provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
58	Insured's name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial	Required
59	Patient relationship	N/A	Not required
60	Insured unique ID	REQUIRED: Enter the patient's insurance ID exactly as it appears on the patient's ID card. Enter the insurance ID in the order of liability listed in field 50	Required
61	Group name	N/A	Not required
62	Insurance group no.	N/A	Not required
63	Treatment authorization code	Enter the prior authorization or referral when services require precertification	Conditional - Enter the prior authorization or referral when services require precertification
64	Document control number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding

Field number	Field description	Instruction or comments	Required, conditional or not required
		on the corresponding A, B, C line Applies to claim submitted with a type of bill (field 4), frequency of "7" (replacement of prior claim) or type of bill, frequency of "8" (void/cancel of prior claim). *Please refer to the reconsider/corrected claims section	A, B, C line reflecting Payer from field 50
65	Employer name	N/A	Not required
66	DX version qualifier	N/A	Required
67	Principal diagnosis code	Enter the principal/ primary diagnosis or condition using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service	Required
67 A-Q	Other diagnosis code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/ update of ICD-10CM	Conditional - Enter additional diagnosis or conditions that coexist at the time of admission

Field number	Field description	Instruction or comments	Required, conditional or not required
		Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 Codes for the date of service and carried out to its highest level of specificity - 4th or 5th digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied	
68	Present on admission indicator		Required
69	Admitting diagnosis code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest level of specificity - 4th or 5th digit. "E" codes and most "V" are NOT	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied	
70	Patient reason code	Enter the ICD-10-CM code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest digit - 4th or 5th. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied	Required
71	PPS/DRG code	N/A	Not required
72 a, b, c	External cause code	N/A	Not required
73	Unlabeled field	N/A	Not required
74	Principal procedure code/date	CODE: Enter the ICD-10 procedure code that identifies the	Conditional - Enter the ICD-10 procedure code that identifies the

Field number	Field description	Instruction or comments	Required, conditional or not required
		principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY)
74 a-e	Other procedure code date	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 procedure codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	Conditional REQUIRED on inpatient claims when a procedure is performed during the date span of the bill
75	Unlabeled field	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
76	Attending physician	Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following qualifier and ID number: • 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name	Required
77	Operating physician	REQUIRED when a surgical procedure is performed.	Conditional REQUIRED when a surgical procedure is performed. Enter the NPI and name of the

Field number	Field description	Instruction or comments	Required, conditional or not required
		Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following qualifier and ID number: • 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name.	physician in charge of the patient care
78 & 79	Other physician	Enter the provider type qualifier, NPI and name of the physician in charge of the patient care.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		• (Blank Field): Enter one of the following provider type qualifiers: • DN - Referring provider. • ZZ - Other operating MD. • 82 - Rendering provider. • NPI: Enter the other physician 10-character NPI ID. • QUAL: Enter one of the following qualifier and ID number, or 0B - State license number • 1G - Provider UPIN number • G2 - Provider commercial number	
80	Remarks	N/A	Not required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	Required
82	Attending Physician	Enter name or seven-digit provider number of ordering physician	Required

Capitated Claims Billing Information

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Providers who participate in Health Net's Medi-Cal program under a capitated agreement with a participating physician group (PPG) must follow the instructions below.

- Providers must contact their PPG to check for any special billing requirements that the providers' failure to follow could delay the processing of their claims, and to verify the billing address for claims submission.
- Providers have 180 days from the last day of the month of service to submit initial Medi-Cal claims. Exceptions for late filing are:
- New Medi-Cal claims between six-months and one-year-old are permitted without penalty for unknown eligibility status, antepartum obstetric care or a delay in delivery of a custom-made prosthesis
- Claims one-year-old or more are permitted without penalty for retroactive eligibility situations, court orders, state or administrative hearings, county errors in eligibility, Department of Health Care Services (DHCS) orders, reversal of appeal decisions on a Treatment Authorization Request (TAR) form, or if other coverage is primary

Capitated-Risk Claims

Capitated-risk claims received by Health Net through paper submissions are forwarded back to the PPG or third-party administrator (TPA) for processing.

Electronically Submitted Claims

Electronically submitted claims that are participating physician group (PPG) capitated-risk claims are forwarded to the PPG or third-party administrator (TPA) for processing. A claim fax summary is printed, batched and forwarded. A batch trailer sheet, indicating the number of claims within a batch, is sent.

To see claims status, please log in to the provider portal.

Denied Claims

Claims received by Health Net or an affiliated health plan for services that are the capitated risk of a participating physician group (PPG), hospital or other ancillary provider as applicable are forwarded by Health Net or the affiliated health plan to the PPG, hospital or ancillary provider for processing. This may delay payment by several days to several weeks.

All provider inquiries about claim status, payment amounts, or denial reasons should be directed to the capitated provider responsible for the services.

Members Notices About Incomplete Claims (applies only to HMO, PPO and Medi-Cal)

Claims received on or after January 1, 2026 must be reimbursed fully or partially within 30 calendar days of receipt. If a claim is incomplete, the physician or other provider must be notified as soon as possible, and no later than 30 calendar days after receiving the claim.

Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.

PPGs and hospitals delegated to pay claims must notify the member and provider in writing within 30 calendar days from receipt of the claim of an incomplete claim. Notices must specify:

- Date of denial notice.
- Member name.
- Provider name.
- Specific service.
- Date of service.
- Denied amount.
- Member responsibility amount.
- Reason for the denial - Claim denials for members must include a claim denial message.
- Provider and member appeals process and information, including plan name, address and telephone number for appeals.

Plan-Risk or Shared-Risk Claims

Plan-risk or shared-risk claims must be sent to Health Net for adjudication. Attach a copy of the Plan/Shared-Risk Cover Sheet to each group of claims the provider submits. Additionally, the claims should be separated and batched into plan or shared-risk services and claim types. All claims submitted to Health Net must be on CMS-1500, LTC form 25-1 or UB-04 claim forms, and must indicate the date of receipt by the participating physician group (PPG). Claims for plan-risk or shared-risk services must be submitted to Health Net.

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number located on the member's ID card
- Provider name and address
- ICD-10 diagnosis code
- Service dates
- Billed charge per service
- Current year CPT procedure or UB-04 revenue code
- Place of service or UB-04 bill type code
- Submitting provider tax identification number or National Provider Identifier (NPI) number
- Member name and date of birth as it appears on the member's ID card
- State license number of the attending provider

If a provider submits a claim directly to Health Net rather than the PPG and the claim includes both plan-risk services and capitated-risk services, Health Net processes the plan-risk services. Services that are the responsibility of the PPG are denied by Health Net and forwarded to the PPG for processing. The Explanation of Check contains the message, "Capitated services, no payment issued-claim sent to PPG/IPA, Hospital or Ancillary provider."

Claims for capitated services that are misrouted to Health Net are denied and forwarded to the capitated provider with a copy of the explanation.

In some instances, Health Net is able to split a claim that has both plan-risk and capitated-risk services (for example, chemotherapy provider claims). In these cases, a claim fax is attached to the original claim. The fax contains only those service lines that appear to be capitated risk. The message "POSSIBLE CAP RISK" appears in the member's address field (box 4 on the fax). These services do not appear on the explanation of check, but appear on the capitated-risk services report.

All other lines on the original claim document are assumed to be plan risk and are processed by Health Net. It is not necessary to return the claim for those plan-risk services not appearing on the fax.

If, after processing the services on the fax, the capitated provider determines that any of those services are actually plan risk (for example, out-of-area emergency), return them to Health Net for special handling and processing. Attach the Plan/Shared-Risk Services Cover Sheet and return those claims to Health Net.

- Excessive Fees by Hospital-Based Providers (HMO)
- Shared-Risk Claims (Medi-Cal (LA))
- Anesthesia Procedure Code Modifiers with the Minute Qualifier (HMO, PPO, Medicare, Medi-Cal)

Shared-Risk Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Shared-risk claims must be sent to Health Net or the affiliated health plan for adjudication. Additionally, the claims should be separated by plan or shared-risk services and claim types. All claims submitted to Health Net or Molina Healthcare must be on CMS-1500, LTC form 25-1, UB-92 or UB-04 claim forms and indicate the date of receipt by the participating physician group (PPG). Claims for plan or shared-risk services must be submitted to Health Net or Molina.

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number, which is located on the member's ID card
- Provider name and address
- ICD-10 diagnosis code
- Service dates
- Billed charge per service
- Current year CPT procedure or U-92 (CMS-1450) revenue code
- Place of service or UB-92 or UB-04 bill type code
- Submitting provider tax identification number and national provider identifier (NPI) number
- Member name and date of birth as indicated on the member ID card
- State license number of the attending provider

If a claim is sent directly to Health Net or its affiliated health plans, rather than the capitated PPG, and the claim includes both plan risk services and capitated-risk services, the plans process the plan risk services. Claims for services that are the PPG's responsibility are forwarded to them for processing.

Claims for capitated services that are misrouted to Health Net or an affiliated health plan are routed back to the appropriate PPG.

In some instances, Health Net is able to split a claim that has both plan and capitated-risk services (for example, chemotherapy provider claims).

Excessive Fees by Hospital-Based Providers

Provider Type: Participating Physician Groups (PPG)

When charges by hospital-based providers are for capitation services and the participating physician group (PPG) has encountered fees that appear to be excessive when compared to fees charged for similar services by local providers, the PPG is entitled to question the provider about the fee.

Of paramount importance in these instances is Health Net's legal obligation to provide medical care coverage to its members and to protect them from any indebtedness to a provider who is not satisfied with a reimbursement received for covered services. The member is, as always, obligated to pay any copayment amount specified in the Evidence of Coverage (EOC).

Health Net encourages PPGs to communicate with providers before paying less than the amount charged, in order to prevent problems for the member. If a PPG pays a hospital-based physician less than the amount charged and the provider bills the member for the difference, the PPG is required to pay that portion of the charge immediately. The PPG may initiate a peer review of the matter later through the local medical society.

Inform members that any bill received for care provided or authorized by the PPG is to be sent to the PPG. If a member ignores a bill and collection activities are initiated, both Health Net and the PPG are implicated in not having protected the member.

When a PPG encounters a charge it considers excessive, Health Net recommends the following steps:

1. Determine whether complications or other factors justify the charge. If there is justification, pay the amount billed and end the process. If there is no justification, proceed to the next step.
2. Contact the provider and attempt to resolve the difference. If there is no resolution, proceed to the next step.
3. Pay all outstanding charges, but notify the provider that this is being done under protest and that the PPG intends to seek a peer review of the matter by the local medical society.
4. Call the California Component Medical Societies for assistance in selecting the appropriate California county medical society to hear the protest. The correct county medical society is the one located in the same geographical area as the provider whose charge is in dispute.
5. Call the county medical society and ask for instructions for submitting cases for peer review.
6. If the PPG is informed that a member has been contacted by a collection agency, in addition to paying all outstanding charges, inform the collection agency in writing that the PPG is responsible for paying for the service and that the PPG has made payment, but that the validity of the charge is

in dispute. State that the disputed excessive fee is to be subjected to a medical society peer review. Request that, in view of these facts, the collection agency take no action that might impair the credit rating of the member.

Anesthesia Procedure Code Modifiers with the Minute Qualifier

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Professional anesthesia capitated encounters billed with specific modifiers must use the minute qualifier, MJ. If you use the unit qualifier, UN, an edit will reject the encounter. The edit applies regardless of the date of service.

This change follows the Health Insurance Portability and Accountability Act (HIPAA) 5010 HIPAA 837 Companion Guide.

Use the MJ qualifier with these modifiers:

- AA
- AD
- QK
- QS
- QX
- QY
- QZ

Modifiers, other than the ones listed above, can process with the UN qualifier and not cause an edit.

If a professional encounter claim is sent with the above listed modifiers and the UN qualifier, the edit display will read: ANESTHESIA QUALIFIER IS INCORRECT. Resend a corrected capitated encounter with the MJ qualifier.

Claims Processing for DSNP in EAE Counties

Provider Type: Participating Physician Groups (PPG)

Participating physician groups that are responsible for claims that are Medicare covered services must forward claims that have Medi-Cal covered services to Health Net within 10 business days for the Plan to process as a secondary claim. The secondary claim requires a copy of the Provider Explanation of Benefits (EOB) or Remittance Advice (RA) from the primary payer. Include the information that the claim was forwarded to the Plan in the EOB or RA. Do not deny the claim without checking both Medicare and Medi-Cal covered services.

You can submit the secondary claim to the Plan following Standard Claims Submission requirements. You can also submit a paper claim to the Health Net Medi-Cal Claims Department or the Health Net Medicare Advantage Claims Department.

Telehealth Billing Requirement

Provider Type: Participating Physician Groups (PPG), Physicians, Ancillary, Hospitals

When billing for a covered service delivered appropriately through a telehealth modality, providers must use the appropriate American Medical Association (AMA) CPT and HCPCS codes that are most descriptive for the service delivered.

For Medi-Cal members, bill for telehealth services in accordance with theDHCS Provider Manual Telehealth requirements.

For Commercial members:

- Use the normal place of service code (11, 23, etc.) – excluding FQHC/RHCs.
  - Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Pricing using the Medicare physician fee schedule will result in payment parity in either situation for commercial claims.
- Use appropriate modifiers – excluding FQHC/RHCs.
  - Modifier 95 (synchronous, interactive audio and telecommunications systems); or
  - Modifier GQ (asynchronous store and forward telecommunications systems).

For Medicare members:

- Bill in accordance with CMS requirements.
- Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Any related pricing using the Medicare physician fee schedule will apply the applicable Medicare rate for the place of service code used (facility rate for place of service "02" and non-facility rate for place of service "10") in accordance with CMS guidelines

Below are some examples (not exhaustive) of benefits or services that would not be appropriate for delivery via a telehealth modality:

- Performed in an operating room or while the patient is under anesthesia.
- Require direct visualization or instrumentation of bodily structures.
- Involve sampling of tissue or insertion/removal of medical device.
- Require the in-person presence of the patient for any reason.

Emergency Claims Processing

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net, its participating physician groups (PPGs) and hospitals are required to reimburse each complete emergency claim or portion of each claim as soon as possible, but not later than 45 business days after receipt of the complete claim. A PPG or hospital may contest or deny a claim or portion of a claim by notifying the provider in writing that the claim is contested or denied within 45 business days after receipt of the claim. The notice must identify the portion of the claim that is contested by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim is denied must identify the portion of the claim that is denied, and the specific reasons for the denial.

If a claim or portion of a claim is contested on the basis that the PPG or hospital has not received information reasonably necessary to determine payer liability for the claim, the PPG or hospital has 45 business days after receipt of this additional information to complete reconsideration of the claim. If the claim being reconsidered is not reimbursed within the respective 45 business days after the PPG's or hospital's receipt of the additional information, the PPG or hospital must pay interest or late charges.

A PPG or hospital may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim as long as the PPG or hospital pays interest.

Complete Emergency Claims

A complete emergency claim meets the following definitions:

- A paper claim from a hospital is deemed complete when submitted on a completed UB-04 and includes submission of a legible emergency room (ER) report and other reasonable relevant information requested.
- An electronic claim from a hospital is deemed complete when submitted on an electronic equivalent to the UB-04 and reasonable relevant information is requested. If Health Net or the PPG requests a copy of the ER report, Health Net or the PPG may also request additional reasonable relevant information, at which time the claim is deemed complete.
- A claim from a provider is deemed complete when submitted on a completed CMS-1500, or its electronic equivalent, and reasonable relevant information is requested.

Delegation

The obligations of Health Net, to ensure that claims are processed in a timely manner and with appropriate interest and late charges, if appropriate, are not waived when Health Net requires its PPGs to pay claims for covered services. Health Net may assign, by written contract, the responsibility to pay interest and late charges to PPGs or other contracting entities.

Interest Charged for Late Payment

The late payment by a PPG or hospital on a complete emergency claim, or portion thereof, that is neither contested nor denied, must automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at 15 percent per year for the period of time that the payment is late. If the late payment does not automatically include interest, an additional $10 is paid to the provider.

If Health Net fails to notify the provider of service in writing of a denied or contested claim, or portion thereof, and ultimately pays the claim in whole or part, computation of the interest begins 45 business days after the date the claim was originally received.

Exceptions

Payment of interest or late charges does not apply to claims where there is evidence of fraud and misrepresentation, where the patient is determined to be ineligible for coverage, or instances where Health Net has not been granted reasonable access to information under the provider's control. Health Net specifies, in a written notice sent to the provider within the 45-business-day time frame, which of these exceptions apply to the claim.

Emergency-related Claim Submissions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

In emergency-related situations whereby the Department of Health Care Services (DHCS) guidelines are silent regarding claims submission, Health Net will follow the Centers for Medicare & Medicaid Services (CMS) coding and billing guidelines to ensure compliance and consistency in our practices.

Fee-For-Service Billing and Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general fee-for-service (FFS) claims billing and submission information.

Select any subject below:

- Electronic claims Submission
- FFS Claims Submission

Electronic Claims Submission

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

For electronic claim submissions check the current member identification (ID) for the correct payer ID.

The benefits of electronic claim submission include:

- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.
- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

Reports

For successful electronic data exchange (EDI) claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from the EDI vendor
- Confirmation/rejection reports from the EDI clearinghouse
- Confirmation/rejection reports from Health Net

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed/viewed. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

For questions regarding electronic claims submission, contact the Health Net EDI Department.

FFS Claims Submission

Provider Type: Physicians

When submitting fee-for-service (FFS) claims, provide all required information accurately. Health Net requires that all FFS professional claims be submitted on the CMS-1500 claim form for Medicare Advantage (MA) HMO, HMO, POS, and PPO members within 120 calendar days from the date of service or in accordance with the terms of the Provider Participation Agreement (PPA).

Submit all paper claims and supporting documentation to the appropriate Health Net Claims Department (Medicare Claims, Medi-Cal claims and HMO claims).

Professional Claim Editing

Physicians

Health Net has a contractual relationship with Cotiviti to provide a technology solution for professional claim edit policy management. Using Cotiviti's services, Health Net has the ability to apply advanced contextual

processing for application of Health Net edit logic. Health Net also uses another editing vendor, Verscend, to perform a secondary review after Cotiviti.

The process is as follows:

- Health Net customizes and controls the selection of all edit policy.
- Claims are transferred through various interfaces to Cotiviti every night.
- Cotiviti reviews each claim in the file and renders coding recommendations based on Health Net's edit policy.
- After Cotiviti review, if there are any unedited lines remaining, they are sent to Verscend for a secondary review.
- Once all reviews are complete edit recommendations from the vendors are then applied to the claims.

Cotiviti and Verscend also provide management support services, including edit policy advisory services. The vendor's Medical Policy teams conduct ongoing research into payment policy sources, including, but not limited to, the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and other specialty academies, to provide Health Net with the necessary information to make informed decisions when establishing edit policy.

Refunds

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on refunds, including overpayment procedures and third-party liability recovery.

Select any subject below:

- Overpayment Procedures

Overpayment Procedures

If a provider is aware of receiving an overpayment made by Health Net, including, but not limited to, overpayments caused by incorrect or duplicate payments by Health Net, errors on or changes to the provider billing or payment by another payer who is responsible for primary payment, the provider must refund the overpayment amount to the Health Net Overpayment Recovery Department within 60 days, (or the terms of the *Provider Participation Agreement* (PPA)) in which the overpayment was identified with a copy of the applicable Remittance Advice (RA) and a cover letter indicating why the amount is being returned. If the RA is not available, provide member name, date of service, payment amount, Health Net member identification (ID) number, provider tax ID number, and provider ID number.

When Health Net determines that an overpayment has occurred, Health Net notifies the provider of services in writing within 365 days of the date of payment on the overpaid claim through a separate notice that includes the following information:

- Member name
- Claim ID number
- Clear explanation of why Health Net believes the claim was overpaid
- The amount of overpayment, including interest and penalties

The 365-day time period does not apply to overpayments caused in whole or in part by fraud or misrepresentation on the part of the provider.

The provider of service has 30 business days to submit a written dispute to Health Net if the provider does not believe an overpayment has occurred. In this case, Health Net treats the claim overpayment issue as a provider dispute.

- Include a copy of the RA that accompanied the overpayment or the refund request letter to expedite Health Net's adjustment of the provider's account. If neither of these documents are available, the following information must be provided: member name, date of service, payment amount, Health Net member ID number, vendor name and number, provider tax ID number, provider number, vendor number and reason for the overpayment refund. If the RA is not available, it may take longer for Health Net to process the overpayment refund.
- Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department. If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net, such as HMS, Optum, Rawlings, or GB Collects, the provider should follow the overpayment refund instructions provided by the vendor.

Health Net may recoup uncontested overpayments by offsetting overpayments from payments for a provider's current claims for services if:

- The provider's Provider Participation Agreement (PPA) authorizes it to offset overpayments from payments for current claims for services.
- Otherwise permitted under state laws.

A written notification is sent to the provider of service if an overpayment is recouped through offsets to claim payments. The notification identifies the specific overpayment and the claim ID number.

Hospital Overpayments

If Health Net has incorrectly paid a hospital as the primary rather than as the secondary carrier, attach a copy of the primary carrier's explanation of benefits (EOB) with a copy of Health Net's RA highlighting the incorrect or duplicate payments and include a check for the overpaid amount. Also include a written explanation indicating the reason for the refund (for example, other coverage, duplicate or other circumstances). Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department.

Reimbursement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general provider reimbursement information.

Select any subject below:

- Emergency Claims
- Emergency-Based and Post-Stabilization Services
- Endoscopies Classification Reimbursement
- Pharmacist Services
- Reimbursement Timelines and Penalties for Late Claims

Emergency Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For claims received on or after January 1, 2026, Health Net, and its delegated and capitated participating physician groups (PPGs) and hospitals (payers), are required to reimburse, deny or contest each complete emergency claim or portion of each claim as soon as practical, but not later than 30 calendar days after receipt of the complete claim. Payers may contest or deny a claim or portion of a claim by notifying the provider in writing that the claim is contested or denied within 30 calendar days after receipt of the claim. If a claim is contested, the notice must identify the portion of the claim that is contested by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim is denied must identify the portion of the claim that is denied, and the specific reasons for the denial.

If a claim or portion of a claim is contested on the basis that a payer has not received information reasonably necessary to determine payer liability for the claim, the payer has 30 calendar days after receipt of this additional information to complete reconsideration of the claim. If reconsideration of the claim (including payment, if appropriate), is not completed within the respective 30 calendar days after the payer's receipt of the additional information, the payer must pay statutory interest and any other applicable penalties described in California Health and Safety Code section 1371.35(b).

Complete Emergency Claims

A complete emergency claim is defined as follows:

- A paper claim from a provider is deemed complete when submitted on a completed UB-04 and includes submission of a legible emergency room (ER) report and other reasonable relevant information requested
- An electronic claim from a provider is deemed complete when submitted on an electronic equivalent to the UB-04 and other requested reasonable relevant information has been received. If the payer requests a copy of the ER report, the payer may also request additional reasonable relevant information
- A claim from a provider is deemed complete when submitted on a completed CMS-1500, or its electronic equivalent, and any requested reasonable relevant information has been received

Delegation

The obligations of Health Net to ensure compliance with claims settlement laws are not waived when Health Net contracts with delegated and capitated PPGs or hospitals that agree to assume risk and pay claims for covered services.

Interest Charged for Late Payment

For claims received on or after January 1, 2026 Late paid claims must include interest at the rate of 15% per annum beginning with the first calendar day after the 30-calendar day period.

Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.

Prior to January 1, 2026 A payer's late payment of a complete emergency claim, or portion thereof, that is neither contested or denied, must automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at 15 percent per year for the period of time that the payment is late. If the late payment does not automatically include interest, an additional $10 is paid to the provider of service.

If the responsible payer fails to notify the provider of service in writing of a denied or contested claim, or portion thereof, and ultimately pays the claim in whole or in part, computation of the interest begins 45 business days after the date the claim was originally received.

Exceptions

Payment of interest or late charges does not apply to claims where there is evidence of fraud and misrepresentation or instances where a payer has not been granted reasonable access to information under the provider's control. Health Net specifies, in a written notice sent to the provider within the 30-calendar-day time frame, which of these exceptions apply to the claim.

Emergency-Based and Post-Stabilization Services

Provider Type: Participating Physician Groups (PPG) | Hospitals

Claims for all emergency and approved post-stabilization acute inpatient services at all nonparticipating hospitals, including public and out-of-state hospitals, are paid using the diagnosis-related group (DRG) pricing payment methodology in accordance with 42 CFR 438.114 and APL 19-008. The All Patient Refined DRGs (APR-DRGs) pricing methodology is used to assign DRGs to claims.

To the extent acute rehabilitation services are provided at nonparticipating hospitals on an emergency or post-stabilization basis, Medi-Cal managed care plans may not pay more than the statewide per diem rate that DHCS is developing.

Health Net pays claims for participating hospitals based on *Provider Participation Agreement* (*PPA*).

Refer to www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx for additional information on DRG.

Health Net's Prestabilization Services Policy

The following defines Health Net's policy on prestabilization services:

1. The first day of all emergency admissions is prestabilization.
2. When a claim is billed with specific revenue codes or bed type and the emergency room stay is greater than one day, the days for which these bed types and services are used are considered prestabilization:
    - Intensive care unit (ICU), coronary care unit (CCU), pediatric ICU, and neonatal ICU (NICU) levels III and IV
    - Certain obstetrics services up to and including the day of delivery

Health Net's Post-Stabilization Services Policy

Any services not defined under the prestabilization services policy section above and claims submitted with subsequent hospital days thereafter are paid according to the most recent APL 13-004, *Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based on Diagnosis Related Groups* .

Endoscopies Classification Reimbursement

Provider Type: Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net uses the Endoscopy Matrix to classify an outpatient endoscopy as a diagnostic test or therapeutic (surgical) procedure, regardless of place of service. If the Provider Participation Agreement (PPA) does not include CPT codes specific to endoscopies identifying them as diagnostic testing or therapeutic (surgical) procedures, providers should refer to the Endoscopy Matrix (PDF). Once the provider has determined whether the endoscopic procedure is a diagnostic test or therapeutic (surgical) procedure, the claim is processed as follows:

- Diagnostic test - Health Net determines financial responsibility and reimbursement methodology according to the Division of Financial Responsibility (DOFR) for diagnostic testing in the PPA.
- Therapeutic (surgical) procedure - Health Net determines financial responsibility and reimbursement methodology according to the DOFR for therapeutic (surgical) procedures in the PPA.

If the PPA includes specific reimbursement language regarding endoscopies that is inconsistent with the information above, Health Net determines financial responsibility according to the language in the PPA. The matrix is not intended to be used to determine a patient's covered benefits or copayment obligations.

Pharmacist Services

Provider Type: Participating Physician Groups (PPG)

Pharmacists may bill for covered services that are within the pharmacist's scope of practice and follow certain conditions for members. Pharmacists must be reimbursed 85% of the Medi-Cal fee schedule for these services under the member’s medical benefit.

Participating physician groups (PPGs) must pay pharmacists for services that are within their professional scope. This applies to pharmacist services delivered in both in-network pharmacies and, if the member has this covered in their pharmacy benefit, out-of-network pharmacies.Pharmacists will only be reimbursed under the following conditions:

- Services performed are within the lawful scope of practice of the pharmacist.
- The member’s coverage provides reimbursement for identical services performed by other licensed health care providers.

PPGs are responsible for reimbursing duly licensed pharmacist delivered services under their Division of Financial Responsibility for the category of the service description.

Reimbursement Timelines and Penalties for Late Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Claims received on or after January 1, 2026 must be reimbursed fully or partially within 30 calendar days of receipt. If a claim is incomplete, the physician or other provider must be notified as soon as possible, and no later than 30 calendar days after receiving the claim.

Interest and Penalty Payments for Late Claims

Late paid claims must include interest at the rate of 15% per annum beginning with the first calendar day after the 30-calendar day period.

Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.

Member Complaints

Member complains about a delay or denial of payment of a claim must be treated as a grievance, subject to Health Net’s grievance process. Refer to the Grievances section below for more information.

Grievances (HMO)

Grievances (PPO)

Grievances (Medi-Cal)

Federally Qualified Health Centers Alternative Payment Methodology

Provider Type: Participating Physician Groups (PPG)

Federally Qualified Health Centers (FQHCs) participating in the Department of Health care Services (DHCS) Alternative Payment Methodology (APM) can move away from the traditional Prospective Payment System (PPS) to a front-loaded reimbursement method that more closely aligns with evolving practice needs and the effective delivery of health care services. Participating FQHCs:

- Receive monthly payments equivalent to their total projected PPS payment entitlement in the form of an APM per member per month (PMPM) rate.
- Are reimbursed across all assigned members attributable to each managed care plan with whom the participating FQHC has contracted.

This system aims to prioritize high-quality and cost-effective care that is coordinated, team-based, convenient to access and best meets members' needs.

More information about the APM for FQHCs is available from the Department of Health Care Services.

Payment Scenarios for contracted and non-contracted FQHCs with Health Net

If a participating physician group (PPG) has a member who is being treated at an FQHC that is participating in the APM, and the FQHC is:

- **Contracted** with Health Net, the PPG should not make any additional payments to the FQHC as the cost of the service is included in the APM PMPM.
- **Not contracted** with Health Net, the PPG will need to pay the PPS rate for those services.

Targeted Rate Increase

Provider Type: Participating Physician Groups (PPG)

Pursuant to the 2023 Budget Act and AB 118 (Chaptered 42, Statutes of 2023), the Department of Health Care Services (DHCS) is increasing reimbursement rates for contracted providers to no less than 87.5% of the lowest California-specific Medicare allowable for certain Medi-Cal covered physician services.

Eligible providers and services include the following

TRI category	Eligible provider types	Eligible claim forms	Contract status
Primary/ general care	• Physicians • Physician Assistants • Nurse Practitioners • Podiatrists • Certified Nurse Midwives • Licensed Midwives • Doula Providers • Psychologists • Licensed Professional Clinical Counselor • Licensed Clinical Social Workers • Licensed Marriage and Family Therapists	CMS 1500	Contracted Network Provider (Does not include SCA, LOA)
Obstetric	Any/all	CMS 1500 (professional)/UB04 (facility)/nonstandard invoice	Contracted Network Provider (Does not include SCA, LOA)
Non-Specialty Mental Health Services	Any/all	CMS 1500 (professional)/UB04 (facility)/nonstandard invoice	Contracted Network Provider (Does not include SCA, LOA)

TRI payment calculation methodology

TRI payment calculation methodology

Step 1: Calculate current contract + Prop 56 Physician Services payment amount	Step 2: Determine the TRI fee schedule amount	Step 3: Pay using the greater amount from steps 1 and 2, and apply final "Lesser of Charges"

Billed $80, contract $40 Lesser of = $40 Prop 56 Physician Services payment = $30 Total = $70	**Greater than** the TRI fee schedule TRI $50	PPG pays the current contracted rate + Prop 56 Physician Services payment **Payment = $70**
Billed $80, contract $40 Lesser of = $40 Prop 56 Physician Services payment = $30 Total = $70	**Less than** the TRI fee schedule TRI $100	Payment is based on the TRI fee schedule price, but the final "Lesser of" will affect payment. **Payment before "Lesser of" = $100 Payment after "Lesser of" = $80**

Attestation requirement

Health Net requires PPGs to attest to complying with TRI requirements, including confirmation that rendering providers are paid in accordance with the APL. Health Net will provide an attestation form with PPGs amended contract to be signed by the PPG's finance executive.

Payments to Medi-Cal Prohibited Entities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

As of July 4, 2025, the use of federal Medicaid funds is temporarily restricted for certain providers identified as Prohibited Entities. These restrictions apply for one year and affect both direct and indirect payments.

Additionally, the Federal District Court issued two separate Preliminary Injunctions (PIs) that modified the Temporary Restraining Order (TRO) originally issued on July 7, 2025. However, both PIs were stayed by the First Circuit Court of Appeals on September 11, 2025.

- **July 21, 2025**: A PI was issued but did **not** extend relief to California providers. The stay issued on September 11, 2025 does not alter the claim submission guidance for providers with or without PI relief.
- **July 28, 2025**: A second PI granted relief to **all Planned Parenthood affiliates in California**.

Prohibited Entities

A provider may be classified as a Prohibited Entity if they meet all of the following criteria:

- Operate as a nonprofit focused on family planning or reproductive health.
- Provide abortion services, except in cases of rape, incest, or life-threatening conditions.

- Received over $800,000 in Medicaid payments during fiscal year 2023.

Permitted activities

All Medi-Cal and Family Planning, Access, Care, and Treatment (PACT) providers, including those affected by H.R. 1, may continue to:

- Assist patients with **Presumptive Eligibility for Pregnant People (PE4PP)** and **Family PACT enrollment**.
- Accept eligible patients.
- Deliver services under current Medi-Cal rules, including the **prohibition on billing patients directly**.

Claims and payment guidance

For providers with PI Relief

In California, the only providers granted PI relief are all Planned Parenthood affiliates, per the July 28, 2025 PI. Continue submitting claims for all services rendered on July 4 through September 10, 2025. For services rendered on or after September 11, 2025, continue submitting claims for abortion-related services only. Do not submit claims for non-abortion service.

For providers without PI relief

Continue to submit claims only for abortion-related services rendered on or after July 4, 2025. These must be submitted separately and are reimbursed by the State General Funds. Claims must:

- Be submitted separately from other services.
- Include only abortion-related services and directly related ancillary care.
- Be reimbursed by State General Funds and are not impacted by H.R. 1.

Additional guidance

- Providers delegated for claims processing may continue processing claims for services rendered on or before July 3, 2025, for all providers, including Prohibited Entities.
- Providers delegated for claims processing may continue processing claims for providers with PI relief for services rendered on or after July 4, 2025, until further court instruction.
- Providers not classified as Prohibited Entities may continue submitting claims as usual.

Claims Coding Policies

Physicians | Hospitals | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes Health Net's claims coding process and policies.

Select any subject below:

- Claim Editing
- Bilateral Procedures
- Bundled Services and Supplies (State Health Programs)
- Co-Surgeons (State Health Programs)
- Incident to Services
- Provider-Preventable Conditions

Claim Editing

Provider Type: Physicians

Health Net verifies physician and outpatient facility codes using internal and vendor-sourced HIPAA-compliant code editing tools. The software detects, corrects, and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier and place of service codes against correct coding guidelines. These principles are aligned with a correct coding “rule.” When the software audits a claim that does not adhere to a coding rule, a recommendation known as an “edit” is applied to the claim.

While code editing software is a useful tool to ensure provider compliance with correct coding, it does not wholly evaluate all clinical patient scenarios. Consequently, Health Net uses clinical validation by a team of experienced nursing and/or coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with Modifier 25 and Modifier 59 for clinical circumstances which justify separate reimbursement for the service performed.

Code Editing and the Claims Adjudication Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis. As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history. The software may make the following recommendations:

Deny: Code editing rule recommends denial of a service line. The appropriate explanation code is documented on the provider’s explanation of payment along with reconsideration/appeal instructions.

Pend: Code editing rule recommends that the service line pend for clinical review and/or validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider’s explanation of payment along with reconsideration/appeal instructions.

Replace and Pay: Code editing rule recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged and a new line is added to reflect the software’s recommendations. For example, an incorrect CPT code is billed for the member’s age. The software denies the original service line billed by the provider and adds a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider’s billing, as the original billing remains on the claim.

Claims Editing Software Updates

Claims editing software is updated quarterly to incorporate the most recent medical practices, coding principles, industry standards and annual changes to CPT and CMS guidelines.

Edit Sources

Claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research, etc.

The software applies edits that are based on the following sources:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include column 1/column 2, medically unlikely edits (MUE), mutually exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments.
- Public domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, etc.).
- CMS Claims Processing Manual CMS Medicaid NCCI Policy Manual State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources, such as HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources
    - CPT Manual
    - AMA Website
    - Principles of CPT Coding
    - Coding with Modifiers CPT Assistant
    - CPT Insider's View
    - CPT Assistant Archives
    - CPT Procedural Code Definitions
    - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations
    - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
    - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
    - Etc.
    - State-specific policies and procedures for billing professional and facility claims Health Plan policies and provider contract considerations.

Code Editing Software

- **ClaimsXten**
    - ClaimsXten™ is a software application that edits claims for adherence to Centene Corporation policies, reimbursement coverage policies, benefit plans, and industry-standard coding practices based mainly on CMS and AMA guidelines. ClaimsXten facilitates accurate claim processing for medical and behavioral claims submitted on a CMS 1500 claim form and for certain claims submitted on a UB04 claim form. Code editing within ClaimsXten is based on assumptions about the most common clinical scenarios for services performed by a health care professional for the same patient, and the logic within ClaimsXten is based on

a thorough review by doctors of current clinical practices, specialty society guidance, and industry standard coding.

- **Cotiviti**
  - Cotiviti PCI offers claims editing solutions that validate, identify and review claims to comprehensively address Fraud Waste and Abuse, reducing waste and improving payment accuracy. This process detects common errors such as duplicates, improper frequency, the unbundling of services, and inappropriate modifier use.
  - Cotiviti PCI uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify when additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify separate payment for the service billed.

Claims Editing Principles

Unbundling - PTP Practitioner and Hospital Edits

Unbundling refers to two or more procedure codes used to report a service when a single, more comprehensive code should have been used. The less comprehensive code is denied. As part of the National Correct Coding Initiative (NCCI) to prevent inaccurate claims payment, CMS has designated combinations of codes that should not be billed together. CMS developed Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by providers. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component of the column I code. While these codes should not typically be billed together, there are circumstances when a modifier may be appended to the column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed. PTP practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers. PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

Also within CMS NCCI guidelines, MUEs reflect the maximum number of units that a provider would typically bill for a single member on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information and clinical judgment.

Code Bundling Rules Not Sourced to CMS NCCI Guidelines

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest Relative Value Units (RVU) is considered the reimbursable code.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an Evaluation and Management (E/M) service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 000, 010, or 090 day global surgical period.

Procedures assigned a 090 day global surgery period are defined as a major surgical procedure. If an E/M service is provided on the same date of service as a the major surgical procedure decision to perform the surgical procedure, then the E/M service would be separately reportable with using the Modifier 57, Decision for Surgery. Any other E/M service provided on the same date of service are not separately reportable and would be included in the payment for the surgical procedure under the global period. E/M services for a major procedure (90-day period) that are reported 1 one day preoperatively on the same date of service or during the 90-day postoperative period are not recommended for separate reimbursement.

Procedures assigned a 000 or 010 global surgical period are defined as minor procedures. E/M services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement. E/M services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent E/M service included in all surgical procedures.

Global Maternity Editing

Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days). E/M services are not recommended for separate reimbursement if the procedure code includes antepartum and/or postpartum care.

Diagnostic Services Bundled to Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and therefore are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member’s lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member’s lifetime. A frequency edit is applied when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider that is a duplicate to the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of

service. Finally, the software analyzes multiple services within the same range of services performed on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Bilateral Procedures

Provider Type: Physicians

Bilateral procedures are procedures that are performed on both sides of the body at the same operative session or on the same date of service. Health Net's list of codes eligible for bilateral reimbursement is based on the Centers for Medicare and Medicaid Services (CMS) list. Health Net also follows CMS payment methodology wherein the allowable rate of reimbursement for bilateral procedures is either 150 percent of the rate that would be allowable if the procedures were only performed on one side of the body or 100 percent of the rate for each side.

To report bilateral procedures for codes that allow 150 percent payment for both sides, use modifier -50 (bilateral procedure) on appropriate codes in the surgical series (10021-69979) and the medicine series (90281-99602).

When billing for these bilateral procedures, the applicable procedure code should be reported on two separate lines, one with the base procedure code, and one with the procedure code and modifier -50.

To report bilateral procedures, for codes that allow 100 percent payment for each side, report the procedure code twice with modifier RT (right) on one line and modifier LT (left) on another line on appropriate codes in the radiology series (70010-79999), and appropriate codes in the medicine series (90281-99602).

Bilateral procedures fall into one of three categories:

- Procedures that may not be reported bilaterally (it is inappropriate to report the following types of procedures with modifier -50 or RT/LT):
    - Procedures that are bilateral in nature
    - Procedures that cannot be performed bilaterally based on anatomy
    - Procedures on parts of the body that have multiple units on both sides (fingers and toes)
    - Procedures specifying unilateral in the code description if there is an existing code for the bilateral procedure
    - Procedures specifying bilateral in the code description
    - Procedures specifying unilateral or bilateral in the code description
- Procedures paid at 150 percent of the allowed amount for both sides*
- Procedures paid at 100 percent of the allowed amount for each side*

* May be subject to reduction by the multiple procedure reduction rule.

Documentation Requirements

Health Net does not require documentation at the time of claim submission; however, if the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Bundled Services and Supplies (State Health Programs)

Provider Type: Physicians

Services and supplies that are covered but considered included in a related service are denied or bundled into the payment for the related service. Health Net follows the Centers for Medicare and Medicaid Services (CMS) bundled services policy with some exceptions.

The following codes are exempt from the CMS bundled services rule. These codes are classified as always bundled by CMS; however, they are not routinely bundled by Health Net. (These codes may be subject to bundling policies outside of the CMS bundled services rule.)

- 36416: Collection of capillary blood
- 99070: Supplies and materials (non-routine only)
- 99100: Anesthesia for extreme age
- 99116: Anesthesia with hypothermia
- 99135: Anesthesia with controlled hypotension
- 99140: Anesthesia complicated by emergency conditions
- 99358: Prolonged physician service; first hour
- 99359: Prolonged physician service; each additional 30 minutes

Health Net considers other services that are not part of the CMS bundled services policy as always included in a more primary procedure.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Co-Surgeons (State Health Programs)

Provider Type: Physicians

Health Net's list of procedures eligible for co-surgeon reimbursement is based in part on the Centers for Medicare and Medicaid Services (CMS) co-surgeon policy. Co-surgeon charges are not allowed for procedures denoted by CMS with the following indicators on the National Physician Fee Schedule: Indicator 0 ("co-surgeon not permitted") or indicator 9 (concept does not apply).

According to the American Medical Association (AMA) CPT definition of modifier -62, co-surgeons are two surgeons that work as primary surgeons performing distinct parts of the procedure. They each bring a different skill set to the procedure, so are not merely assisting one another.

Each surgeon must bill the same CPT code with modifier -62. When a claim is received without modifier -62 and there exists a previously processed claim for the same procedure code with modifier -62, Health Net adds modifier -62 to the second claim.

Each surgeon is reimbursed 62 percent of the allowed amount for the procedure, but is not reimbursed when billing as each other's assistant for a procedure. Multiple procedures are subject to the multiple procedure reduction rule.

If a separate surgical assistant is used, he or she must bill the same CPT code as the surgeon and reimbursement is based on 20 percent of the allowable reimbursement rate for the surgeon. Surgeons who perform additional procedures should bill separate codes without modifier -62. These codes are reimbursed at 100 percent of the allowed amount, subject to the multiple procedure reduction rule.

Surgeons may bill as assistants on each other's additional procedures only if they are not billing as primary for their own additional procedure. Surgeons may not bill as primary and assistant for the same member on the same date of service.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Services

- AMA CPT Book
- CMS National Policy

Incident to Services

Provider Type: Physicians

The Centers for Medicare and Medicaid Services (CMS) defines "incident to" services as those services furnished as an integral, although incidental, part of the physician's personal professional services.

A physician may be reimbursed for "incident to" services performed by auxiliary personnel only when an employer relationship exists between the physician and auxiliary personnel.

When these procedures are performed in an inpatient or outpatient hospital setting, they are denied as "incident to" the physician's service.

Health Net administers the CMS list of procedures that are "incident to" the physician's professional services when performed in a hospital setting.

The following are examples of services on the CMS "incident to" services list:

- Immunizations and therapeutic injections
- Chemotherapy administration
- IV infusion
- Allergy testing and immunotherapy

For a complete list of codes/services, refer to the CMS website at www.cms.gov. The rationale for "incident to" services can be found in Publication 100-4 Medicare Claims Processing, Chapter 12, Section 30.5.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Provider-Preventable Conditions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Section 2702 of the federal Affordable Care Act (ACA) requires all providers to report all provider-preventable conditions (PPCs) that occur during treatment of Medi-Cal beneficiaries that did not exist prior to the provider initiating treatment and regardless of whether the provider seeks reimbursement for services to treat the PPC.

The Centers for Medicare & Medicaid Services (CMS) defines two types of PPCs:

- Health care-acquired conditions (HCACs), also known as hospital-acquired conditions (HACs). These should be reported on a UB-04 claim form when they occur in an inpatient acute care hospital, using designated ICD HAC codes with the accompanying not present on admission (POA) indicator code N.
- Other provider-preventable conditions (OPPCs).These should be reported when they occur on a UB-04 or CMS-1500 claim form as billed procedure code modifiers in any health care setting related to a surgery or invasive procedure.

Unlike HCACs, OPPCs are not confined to an inpatient setting but may occur in either an inpatient or outpatient setting. Outpatient settings include hospitals, outpatient departments, clinics, ambulatory surgical centers

(ASCs), federally qualified health centers (FQHCs), and physicians' offices. CMS and the Department of Health Care Services (DHCS) identify three OPPCs for Medi-Cal:

- Surgery/invasive procedure performed on the wrong body part
- Surgery/invasive procedure performed on the wrong patient
- Wrong surgery/invasive procedure

Affected Providers

Inpatient acute care hospitals must report all PPCs and OPPCs. All other facilities that conduct surgery or invasive procedures only report OPPCs. If a facility has both an acute inpatient care hospital unit and a skilled nursing facility (SNF) unit, the facility must report PPCs and OPPCs.

Reporting Instructions

DHCS requires providers to actively report all PPCs for Medi-Cal beneficiaries on the DHCS secure online reporting portal. Providers must report all PPCs when the provider first learns the patient had a PPC and confirms the patient is a Medi-Cal beneficiary. DHCS understands this might be after the patient has been discharged, including discovery during coding and billing.

After completing the online form, providers can use the Print Screen button to create a paper copy for submission to Health Net. Providers must fax this information to Health Net Clinical Review Unit via secure fax at 1-877-808-7024. Providers must include a fax coversheet and mark it Protected Health Information: Confidential.

ICD HAC Lists

PPCs are found on the designated ICD HAC Lists, as follows:

- ICD-10 HAC List - Refer to the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html under the Downloads section and select the current year.
- ICD-9 HAC List - Refer to the CMS website at www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/downloads/fy_2013_final_hacscodelist.pdf.

Present-On-Admission Indicators

The POA indicator is a required field on the UB-04 and defines whether the condition was present at the time of admission or occurred during the inpatient hospital stay. The POA indicator N must be assigned to HAC-identified ICD diagnosis code sets on all inpatient claims.

OPPC Modifiers

Providers must also report OPPC modifiers in any health care setting on the UB-04 and CMS-1500 using the appropriate modifier below:

- PA - Surgery/invasive procedure performed on the wrong body part
- PB - Surgery/invasive procedure performed on the wrong patient
- PC - Wrong surgery/invasive procedure

Payment Reduced or Prohibited

Section 2702 of the ACA reduces or prohibits payments to health care providers for PPCs and OPPCs. To comply with CMS's ruling and guidance from DHCS, Health Net and its delegated participating physician groups (PPGs) are required to evaluate claims as follows.

PPCs

Health Net and its delegated PPGs evaluate UB-04 inpatient acute hospital claims, specific to billed PPCs (ICD HAC Codes), identifying PPCs that are ineligible for payment. Based on All Patient Refined Diagnosis Related Groups (APR-DRG), the reimbursement methodology payment is adjusted to reflect non-reimbursement for the HAC.

OPPCs

Health Net and its delegated PPGs evaluate all procedure claims (UB-04 and CMS-1500), specific to OPPC Modifiers (PA, PB and PC), and do not reimburse for the services rendered.

Health Net or its delegated PPG informs the submitting provider of nonpayment of PPC-related services, when applicable, via a notification transmitted with the Remittance Advice.

Compliance and Regulations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section covers general information for providers on compliance and regulation requirements.

Select any subject below:

- Mandatory Data Sharing Agreement
- Provider Marketing Guidelines
- Communicable Diseases Reporting
- DMHC-Required Statement on Written Correspondence
- Federal Lobbying Restrictions
- Health Net Affiliates
- Material Change Notification
- Nondiscrimination
- Drug Utilization Review Requirements

Mandatory Data Sharing Agreement

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The state of California established the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) to oversee the electronic exchange of health and social services information in California.

Entities listed below must sign a data sharing agreement (DSA). To sign the DSA, go to https://signdxf.powerappsportals.com.

Participating entities that must sign a DSA include:

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities.
- Clinical laboratories.
- Acute psychiatric hospitals.

The Plan may apply a corrective action plan if the agreement is not signed.

Provider Marketing Guidelines

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers are responsible for making sure member-facing materials meet respective marketing guidelines:

- Marketing Guidelines for Providers Serving Medi-Cal members (PDF)
- Marketing Guidelines for Providers Serving CalViva Health Medi-Cal Members (PDF)
- Marketing Guidelines for Providers Serving Community Health Plan of Imperial Valley Medi-Cal Members (PDF)

Communicable Diseases Reporting

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

To protect the public from the spread of infectious, contagious and communicable diseases, every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, are required by law to notify the local health department (LHD). A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

The term health care provider includes physicians and surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, and dentists.

Notification

Providers must report cases of communicable diseases using the Confidential Morbidity Report (PDF) . They must send a completed copy of the report to the Communicable Disease Control division of the County Health Department. The time frame for reporting suspected cases of communicable diseases varies according to disease and ranges from immediate reporting by telephone or fax to seven days by mail.

The notification must include the following, if known:

- Name of the disease or condition being reported
- Date of onset
- Date of diagnosis
- Name, address, telephone number, occupation, race or ethnic group, Social Security number (SSN), age, sex, and date of birth for the case or suspected case
- Date of death, if death has occurred
- Name, address and telephone number of the person making the report

HIV Reporting Requirements for Laboratories

The following document applies only to Ancillary providers.

HIV is a reportable disease under California state law. Laboratories are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer for the local jurisdiction where the health care provider is located and the requesting provider within seven calendar days.

Laboratories must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express, registered mail or other traceable mail
- Person-to-person transfer with the local health officer or their designee

Laboratories may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail. Laboratories should contact the local county health department for information and reporting forms.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV
- A component of HIV
- Antibodies to, or antigens of, HIV, including:
    - HIV antibody (HIV-Ab) test
    - HIV p-24 antigen test
    - Western blot (Wb) test
    - Immunofluorescence antibody test

Testing laboratories generate a report that consists of the following information:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Name, address and telephone number of the health care provider and the facility that submitted the biological specimen to the laboratory, if different
- Name, address the telephone number of the laboratory
- Laboratory report number as assigned by the laboratory
- Laboratory results of the test performed
- Date biological specimen was tested in the laboratory
- Laboratory Clinical Laboratory Improvement Amendment (CLIA) number

Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing site, other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

HIV Reporting Requirement for Providers

HIV is a reportable disease under California state law. Health care providers are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer within seven calendar days.

Providers must complete an HIV case report for each confirmed HIV test not previously reported and send it to the local health officer for the jurisdiction where the health care provider facility is located.

Providers must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express, or registered mail or other traceable mail
- Person-to-person transfer with the local health officer or their designee

Providers may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV
- A component of HIV
- Antibodies to, or antigens of, HIV, including:
    - HIV antibody (HIV-Ab) test
    - HIV p-24 antigen test
    - Western (Wb) blot test
    - Immunofluorescence antibody test

A health care provider that orders a laboratory test used to identify HIV, a component of HIV, or antibodies to or antigens of HIV must submit to the laboratory a pre-printed laboratory requisition form that includes all documentation specified in 42 CFR 493.1105 (57 FR 7162, Feb. 28, 1992, as amended at 58 FR 5229, Jan. 19, 1993) and adopted in Business and Professions Code, Section 1220.

The person authorized to order the laboratory test must include the following when submitting information to the laboratory:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Date biological specimen was collected
- Name, address and telephone number of the health care provider and the facility where services were rendered, if different

Most laboratories are also required to report confirmed tests to the local health office; however, this does not relieve the provider's reporting responsibility. Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing sites other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

Reporting Requirements for Hepatitis and Sexually Transmitted Infections

When a provider reports a case of hepatitis or a sexually transmitted infection (STI), the report must include the following information, if known:

- Hepatitis information including the type of hepatitis, type-specific laboratory findings, and sources of exposure
- STI information on the specific causative agent, syphilis-specific laboratory findings, and any complications of gonorrhea or Chlamydia infections

Tuberculosis Reporting and Care Management

Tuberculosis (TB) reporting is done immediately by telephone or fax to expedite the process. The Confidential Morbidity Report form (PDF) should be used to notify the local health department's Communicable Disease Reporting Divisions. When reporting a case of TB, the health care provider must provide information on the diagnostic status of the case or suspected case; bacteriological, radiological and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons; and a list of the anti-tuberculosis medications administered to the member. In addition, a report must be made any time a person ceases treatment for TB, including when the member fails to keep an appointment, relocates without transferring care, or discontinues care. Further, the local health officer may require additional reports from the health care provider.

The health care provider who treats a member with active TB must maintain written documentation of the member's adherence to their individual treatment plan. Reports to the local health officer must include the individual treatment plan, which indicates the name of the medical provider who specifically agreed to provide medical care, the address of the member, and any other pertinent clinical or laboratory information that the local health officer may require.

In addition, each health care provider who treats a member for active TB must examine or arrange for examination of all persons in the same household who have had contact with the member. The health care provider must refer those contacts to the local health officer for examination, and must promptly notify the local

health officer of the referral. The local health officer may impose further requirements for examinations or reporting.

Prior to discharge from an inpatient hospital, health care providers must report any cases of known or suspected TB to the local health officer and receive approval for discharge. The local health officer must review and approve the individual treatment plan prior to discharge.

Tuberculosis Care Management

When requested by the primary care physician (PCP) or local county health TB control officer, the Care Management Department provides assistance with coordination of the member's care. All cases referred to the Care Management Department are managed by gathering demographic and medical information. The care managers analyze the data, assess the member's needs, identify potential interventions, and follow the interventions with the member, family and health care team, within the limits of confidentiality. Following the evaluation, the care manager notifies the provider about the member's eligibility for the Care Management Program.

For more information, select any subject below:

- Primary Care Physician Responsibilities

Primary Care Physician Responsibilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Primary care physicians (PCPs) are responsible for preventive care counseling and education for their assigned members. Counseling and education is documented in the medical record of each member. Health Net distributes brochures on communicable disease topics to PCP offices.

DMHC-Required Statement on Written Correspondence

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. The DMHC requires that all written correspondence that could result in a member appeal or grievance, including claim denial letters, contain the following statement with the department's phone numbers, the department's TDD line, the department's Internet address, and the plan's phone number in 12-point boldface type in the following regular type statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department.

Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

The applicable Member Services Department telephone number for each line of business should also be included.

Federal Lobbying Restrictions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

United States Code Title 31, Section 1352, prohibits the use of federal funds for lobbying purposes in connection with any federal contract, grant, loan, cooperative agreement, or extension, or continuation of any of them. Participating providers are required to develop and comply with filing procedures as follows:

- File a declaration with the plan certifying that no inappropriate use of federal funds has occurred or will occur (use Certification for Contracts, Grants, Loans, and Cooperative Agreements Form (PDF)). This extends to any subcontract a participating provider may have that exceeds $100,000 in value. In these cases, the participating provider is required to collect and retain these declarations
- File a specific disclosure form if non-federal funds have been used for lobbying purposes in connection with any line of business (use Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF))
- File quarterly updates, such as a disclosure form at the end of any calendar quarter in which disclosure is required or in which an event occurs that materially affects the previously filed disclosure form

While the statute and related regulations do not specify that the $100,000 limit mentioned in the first bullet is to be calculated annually, the plan believes it reasonable to apply the $100,000 threshold to the term of the Provider Participation Agreement (PPA). If the PPA term is for one year, renewable automatically if not terminated, the threshold would renew at the beginning of each new one-year term. If it is a multiyear term, the calculation of the threshold would be based on the payments received throughout the multiyear term.

Participating providers who complete the Certification for Contracts, Grants, Loans, and Cooperative Agreements Form should send it directly to their assigned provider relations and contracting specialist.

Participating providers are required to comply with applicable state laws and regulations and plan policies and procedures. The contents of the operations manuals are supplemental to the PPA and its addendums. When the contents of the operations manuals conflict with the PPA, the PPA takes precedence.

Health Net Affiliates

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Below is a listing of certain Health Net affiliates. Health Net affiliates and subsidiaries, including those listed below, as well as any other subsidiary or affiliate of Health Net not listed, may opt to periodically access the *Provider Participation Agreement* (*PPA*) for covered services delivered by providers under those benefit programs in which providers participate.

- Arizona Complete Plan
- California Health and Wellness Plan
- Health Net Community Solutions, Inc.
- Health Net Federal Services, LLC.
- Health Net Health Plan of Oregon, Inc.
- Health Net Insurance Services, Inc.
- Health Net Life Insurance Company
- Health Net of California, Inc.
- Managed Health Network, Inc.
- MHN Government Services, Inc.
- Network Providers LLC.
- Wellcare of California, Inc.

Material Change Notification

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

In accordance with AB 2907 (ch. 925, 2002) and AB 2252 (ch. 447, 2012), Section 1375.7 (c)(3) of the Health and Safety Code and Section 10133.65 (d)(3) of the Insurance Code, the health care provider's Bill of Rights, the plan is required to give notice at least 45 business days in advance to participating providers, including dental providers in reference to coverage of medical services only, when the plan intends to amend a material term of a manual, policy or procedure document referenced in the Provider Participation Agreement (PPA). The term material is defined as a provision in a contract to which a reasonable person would attach importance in determining the action to be taken with respect to the provision. If the change is required by federal or state law or an accreditation entity, a shorter notice period may apply.

The plan informs participating providers of material changes through provider updates and letters and announcements on the provider website. Once finalized, such changes are incorporated into the provider operations manuals. Information sent to providers through provider updates and letters is also added to the text of the appropriate operations manuals. The provider has the right to negotiate and agree to material changes. If an agreement cannot be reached, the provider has the right to terminate the PPA prior to implementation of the material change.

Nondiscrimination

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The following nondiscrimination requirements apply.

Employment

The plan and its participating providers must comply with the provisions of the Fair Employment and Housing Act (FEHA) (California Government Code, Section 12900 and following) and the regulations set forth in the California Code of Regulations, Title 2, Chapter 2, commencing with Section 7286.0 and following. The plan and its participating providers may not unlawfully discriminate against any employee or applicant for employment because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender. In addition, the plan and its participating providers ensure the following:

- Evaluation and treatment of employees and applicants for employment is free of such discrimination
- Written notice of obligations under this clause is given to labor organizations with which the plan or its participating providers have a collective bargaining or other agreement

Health Programs and Activities

The following requirements apply[1, 2]:

- Participating providers must add plan-specific nondiscrimination notices and taglines in significant publications and communications issued to members. To obtain additional information refer to Health Industry Collaboration Effort (HICE) website. If you are not able to locate specific notices or taglines, contact the Delegation Oversight Department.
- If necessary, participating providers must assess and enhance existing policies and procedures to ensure effective communication with members.
- Participating providers must ensure programs or activities provided through electronic or information technology, such as websites or online versions of materials, are accessible to individuals with disabilities. If necessary, participating providers must assess and enhance website compliance with Title II of the ADA.
- Participating providers must notify the plan immediately of a discrimination grievance submitted by a member and continue to follow the plan's existing issue write-up procedures for detection and remediation of non-compliance. Additionally, participating providers must comply with the plan, regulatory or private litigation research, investigations, and remediation requirements.
- Participating providers must assess and enhance, if necessary, existing language assistance services to ensure they are compliant.
- Participating providers must implement, enhance and reinforce prohibitions on exclusions, denials or discrimination such as in design, operation or behavior of benefits or services on the basis of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy,

sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender. Additionally, they must implement, where applicable:
    - Medical necessity reviews for all gender transition services and surgery.
    - Program or activity changes to avoid discrimination where necessary.
    - Plan design changes where necessary, such as removing categorical gender or age exclusions.
    - Additionally, providers must remove prohibited categorical exclusions and denial reasons, and update nondiscrimination policies and procedures to include prohibitions against discrimination on the basis of sex, including gender identity and sex stereotyping.
- Mandatory provider and staff civil rights and/or cultural sensitivity training.
- Participating providers can consider implementing the following:
    - Ability to capture gender identity.

[1] For Medicare Advantage and Commercial products: In addition to the State of California nondiscrimination requirements and in accordance with Section 1557, 45 CFR Part 92 of the Affordable Care Act of 2010 (ACA).

[2] For Medi-Cal and Dual Special Need Plans: In addition to the State of California nondiscrimination requirements, and in accordance with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 including sections 504 and 508, as amended; Titles I, II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes.

Drug Utilization Review Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

The health plan and entities delegated to fill prescriptions for outpatient drugs (“applicable entities”) must:

- Operate a drug utilization review (DUR) program.[1]
- Submit the following to the Department of Health Care Services (DHCS):
    - Updated policies and procedures that address each of the requirements detailed below.
    - Annual DUR Report.

Claims review requirements

The requirements include the topics listed below.

Concurrent utilization alerts:

- Describe the process for claims review (retrospective) that monitors when the member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. The Plan and applicable entities are provided claims data, including for antipsychotic medications. The Plan and applicable entities are expected to perform, retrospectively, regular care management activities,

including a review of concurrent use of opioid and antipsychotic medications, and take action accordingly on issues of concern to them.

What's excluded from the program:

- The above described claims review requirements do not apply to the Plan members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; Plan members who are receiving opioid agonist medications for treatment of substance use disorder; or other individuals the state elects to treat as exempted from such requirements.

Monitoring of antipsychotic medications used by children

The Plan and applicable entities are required to have a process to monitor and manage appropriate use of all psychiatric drugs to include antipsychotics, mood stabilizers and anti-depressant medications for all children under age 18 and all foster children. Based on the DUR program monitoring findings, the DUR program must have a process to address and improve concerning findings.

Identification of fraud, waste and abuse

Describe the process for identifying and addressing fraud and abuse of controlled substances by members, health care providers who are prescribing drugs to members, and pharmacies dispensing drugs to members. Also describe the actions that will be taken based on issues identified through program-monitoring findings.

[1]The DUR program must comply with Medicaid-related DUR provisions contained in section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R. 6, the SUPPORT Act, P.L. 115-271).

Consent

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on provider requirements for obtaining consent for medical treatment and services.

Select any subject below:

- Consent for Breast and Prostate Center Treatment
- Consent for Treatment
- Human Sterilization and Informed Consent

Consent for Breast and Prostate CancerTreatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Breast Cancer Treatment Information and Consent Requirements

Health and Safety Code 109275 requires primary care physicians to provide a summary discussing alternative breast cancer treatments and their risks and benefits to women upon diagnosis of breast cancer. The National Cancer Institute provides a wealth of information for consumers to learn about breast cancer and treatment options. Links are also available from the Medical Board of California. .

- Breast Cancer Treatment
- Male Brest Cancer Treatment
- Breast Cancer During Pregnancy

The summary does not supplant the physician's duty to obtain the member's informed consent. In addition to providing a standardized summary, physicians should discuss the risks, benefits and possible alternatives to any planned procedures with the member and document the discussion in the medical record.

Prostate Cancer Treatment Information to Members

Providers are required to tell members receiving a digital rectal exam that a prostate-specific antigen (PSA) test is available for prostate cancer detection.

The National Cancer Institute provides information about the detection, symptoms, diagnosis, and treatment of prostate cancer on their website.

The Prostate Cancer Foundation Prostate Cancer Patient Guides provides information to patients on prostate cancer treatment options, and are available at The Prostate Cancer Foundation's website. This booklet must be given by physicians upon examination of the prostate gland, to certain patients as specified by The Medical Board of California.

Consent for Treatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A member has the right to refuse any recommended medical procedure and to have sufficient information to make consent informed and meaningful. A legal guardian must make all medical decisions on behalf of a member who is not competent to make his or her own decisions.

If the physician or a court of competent jurisdiction determines that a member requires a representative other than a legal guardian to make medical decisions, that representative must be one of the following (in the order stated):

- Person designated under a Durable Power of Attorney for Health Care (DPAHC)
- Conservator specifically authorized by a court to make health care decisions
- Next of kin
- Any other surrogate designated consistent with applicable laws
- A person appointed by a court or, if the member is a minor, someone lawfully authorized to represent the minor

Physicians are responsible for providing members with sufficient information in lay terms, so that they can make informed decisions. All information must be disclosed that allows a reasonable person in the member's position to accept or reject a recommended procedure.

When to Use a Consent Form

Simple and common procedures, such as blood tests or urinalysis, do not require use of a consent form (except when required by law, such as for sensitive services). Consent does not need to be obtained if an emergency exists.

A consent form is used in conjunction with a thorough discussion with the member in order to obtain informed consent for any surgical, special diagnostic or special therapeutic procedure or when there is a statutory requirement. Any member requiring translation services must receive the form. Physicians must document in the member's medical record that the oral discussion leading to consent took place. Informed consent must be obtained in writing and must be signed by the member or legal representative. Consent forms must include:

- Member's name
- Physician's name
- Name of the procedure to be performed
- Authorization for a specified physician and assistants to perform a specified procedure
- Written explanation of the nature of the procedure, expected benefits of the procedure, expected discomfort, complications, or risks to the member, description of any alternative methods of treatment, and description of what will likely happen if the procedure is not performed
- Member's signature or legal representative's signature along with a copy of the legal document granting legal representation. A relative's signature, in the case of a documented existing medical emergency, does not need a court order
- Date and time
- Witness' signature

Providers with questions about legal consent should seek legal counsel. This explanation does not supplant advice of counsel.

Human Sterilization and Informed Consent

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers must inform Medi-Cal members before they undergo sterilization procedures and providers must obtain the member's consent.

Sterilization performed because pregnancy would be life-threatening to the mother (therapeutic sterilization) is included in this requirement; however, sterilization that is the unavoidable secondary result of a medical procedure, and the procedure is not being done in order to achieve it, is not. Procedures that would ordinarily require consent are excluded if the member is already sterile.

Required Information

Providers must provide members to be sterilized with the Department of Health Care Services (DHCS)-published brochure on sterilization before obtaining consent. The following are the only sterilization information booklets approved by DHCS:

- Permanent Birth Control for Women
- Metodo Anticonceptivo Permanente Femenino
- Permanent Birth Control for Men
- Metodo Anticonceptivo Permanente Masculino

Providers can log in to the DHCS website to download and print the booklets.

A physician or designee who obtains consent for the sterilization procedure must offer to answer any questions the member may have regarding the procedure. In addition, all of the following must be discussed with the member seeking to be sterilized:

- A full description of available alternative methods of family planning and birth control
- A description of benefits or advantages that may be expected as a result of the sterilization
- A thorough explanation of the specific sterilization procedure to be performed, including information on whether the procedure is established or new
- The name of provider performing the procedure. If another provider is substituted, the member must be notified prior to anesthesia of the new provider's name and the reason for the change
- Advice that the sterilization procedure is considered irreversible
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthesia
- Approximate length of hospital stay, recovery time and any cost to the member
- Advice that the sterilization will not be performed for at least 30 days (except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is fully met)
- Advice that the member is free to withhold or withdraw consent at any time before the procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the member might be entitled

The provider must fully and correctly complete the Consent Form DHCS 8649 after discussing the above topics with the member. Refer to the Certification of Informed Consent for Reproductive Sterilization discussion below for about completing the Consent Form DHCS 8649.

Certification of Informed Consent for Reproductive Sterilization

The Department of Health Care Services (DHCS) Consent Form DHCS 8649 [DHCS 8649-Consent for Sterilization (English) (PDF), DHCS 8649-Consent for Sterilization (Spanish) (PDF)] is the only form approved by DHCS for certification of informed consent. Before obtaining consent and completing the DHCS 8649 for any sterilization procedure, a provider or providers' designee must discuss and furnish the following information to the member seeking sterilization:

- A full description of available alternative methods of family planning and birth control.
- A description of benefits or advantages that may be expected as a result of the sterilization.
- A thorough explanation of the specific sterilization procedure to be performed, including information on whether the procedure is established or new.
- The name of the provider performing the procedure. If another provider is substituted, the member must be notified of the new provider's name and the reason for the change prior to anesthesia.
- Advice that the sterilization procedure is considered irreversible.
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthesia.
- Approximate length of the hospital stay, recovery time and any cost to the member.
- Advice that the sterilization will not be performed for at least 30 days (except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is met).
- Advice that the member is free to withhold or withdraw consent at any time before the procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the member might be entitled.

The provider must fully and correctly complete the DHCS 8649 after discussing the above topics with the member. Please follow the DHCS Sterilization Consent Form Instructions:

Providers must attach a fully completed informed consent form to all sterilization procedure claims. Claims for sterilization procedures are not paid unless the informed consent form is attached.

Providers must note in the member's medical record that the provider gave the member the DHCS-published brochure about sterilization and a copy of the consent form. Providers must retain a copy of the signed consent form in the member's medical record.

Conditions Under Which Sterilization May Be Performed

Sterilization may be performed only if:

- The member is at least age 21 at the time consent is obtained.
- The member is not mentally incompetent.
- The member is able to understand informed consent.
- The member is not institutionalized.
- The member has voluntarily given informed consent in accordance with all prescribed requirements.

- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization.

Refer to the Exceptions to Time Limitations discussion below for information regarding the time requirement in the case of emergency abdominal surgery or premature delivery.

Conditions Under Which Informed Consent May Not Be Obtained

Informed consent may not be obtained while the member to be sterilized is:

- In labor or within 24 hours postpartum or post-abortion.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or other substances that affect the member's awareness.

Exceptions to Time Limitations

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if at least 72 hours have passed after the member gave written informed consent to be sterilized and the written informed consent to be sterilized was given at least 30 days before the member originally intended to be sterilized, or the written informed consent was given at least 30 days before the expected date of delivery.

Informed Consent Process Requirements, Documentation and Noncompliance

The following criteria must be met for compliance with the informed consent process for Health Net members:

- The informed consent process must be conducted either by a physician or the physician's designee
- Suitable arrangements are made to ensure that the information is effectively communicated to a member who is deaf, blind or otherwise disabled
- An interpreter is provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent
- The member to be sterilized is permitted to choose a witness who is present when consent is obtained
- The sterilization operation is requested without fraud, duress or undue influence

Medical Record Documentation

There must be documentation in the progress notes of the member's medical record that a discussion regarding sterilization has taken place, including the answers given to specific questions or concerns expressed by the member.

The original signed consent form must be filed in the medical record. A copy of the signed consent form must be given to the member, and a copy placed into the member's hospital medical record at the place where the service is performed (for example, hospital or outpatient surgery center). Providers must also note the fact that the Department of Health Care Services (DHCS)-published brochure on sterilization and a copy of the consent form were given to the member.

If the procedure is a hysterectomy, a copy of the Hysterectomy Informed Consent (PDF) form must be placed in the medical record. The form is obtained from the hospital performing the procedure.

Office Documentation

All participating providers are responsible for maintaining a log of all sterilization procedures performed. This sterilization procedures log (PDF) must indicate the member's name, the date of the sterilization, the member's medical record number, and the type of procedure performed.

Non-Compliance

The Health Net Public Programs Quality Improvement (PPQI) Department monitors participating providers for compliance with the consent process for sterilization. Deficiencies are to be remedied through corrective action and follow-up auditing. DHCS also performs audits for compliance. Health Net, its affiliated plans, and DHCS are required to refer non-compliant providers to the California Board of Medical Quality Assurance.

Special Considerations for Hysterectomy

A hysterectomy may not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a Hysterectomy Informed Consent (PDF) form must be completed in addition to the other required forms.

Coordination of Benefits

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information for providers on coordination of benefits.

Select any subject below:

- Overview

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Coordination of benefits (COB) is required before submitting claims for members who are covered by one or more health insurers other than Medi-Cal. Medi-Cal is always the payer of last resort, including Medicare and TRICARE.

COB Claim Submission and Payment

Submission of a COB Claim

Coordination of benefits (COB) claims must be submitted within 180 days following the date that the member and provider receive the other coverage's Explanation of Benefits (EOB).

When the provider learns that a Health Net Medi-Cal member has other group health coverage, the provider must:

- File the provider claim with the primary carrier first
- After the primary carrier has paid, submit a copy of the explanation of payment or EOB with the claim to Health Net or the responsible capitated subcontractor, if one exists

Payment Calculations

As the payer of last resort, Health Net's Medi-Cal plan coordinates benefits. In order for Health Net to document records and process claims correctly, include the following information on all coordination of benefits (COB) claims:

- Name of the other carrier
- Subscriber identification number with the other carrier

How to bill Medi-Cal after billing other health coverage

The provider must present acceptable forms of proof to the Plan that all sources of payment have been exhausted, which may include:[1]

- A denial letter from the other health coverage (OHC) for the service.
- An EOB that shows the service is not covered by the OHC.

Prior authorization for out-of-network providers

Where a benefit is not covered by the member’s primary insurance and the service is covered and requires authorization by Health Net Medi-Cal, an out-of-network provider may leverage a letter of agreement (LOA) or similar mechanism. Without an LOA or similar agreement, the provider may be at risk for billed amounts exceeding the allowable FFS rate. [1]

Follow these guidelines to bill Medi-Cal after OHC[2]

1. Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.
2. Medi-Cal will not pay the balance of a provider’s bill when the provider has an agreement with the OHC carrier/plan to accept the carrier’s contracted rate as payment in full.
3. An EOB or denial letter from the OHC must accompany the Medi-Cal claim.
4. The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any OHC payment. Refer to claim form completion instructions in the Medi-Cal provider manual for more information.
5. When you bill, use Medi-Cal-approved HCPCS codes, CPT® codes and modifiers.
6. Do not bill with HCPCS codes, CPT codes or modifiers where OHC paid, but which Medi-Cal does not recognize or allow.

7. If services normally require a Treatment Authorization Request (TAR), the related procedures must be followed. Refer to the Prior Authorization list for more information.

[1]Information taken or derived from *Medi-Cal Managed Care Enrollment and What this Means for Members and Providers* fact sheet.

[2]Information taken or derived from Medi-Cal Provider Manual, Part 2. files.medi- cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/othhlth.pdf.

Dual Health Net Coverage

Dual Health Net coverage refers to members that are covered under two Health Net plans. Claims must be submitted to the primary plan first. The Health Net Medi-Cal plan is the secondary coverage under coordination of benefit (COB) rules. The secondary claim must be submitted with the primary Health Net remittance advice, identification and group numbers, indicating the primary Health Net identification number in the Other Coverage box.

Copayments

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Counties Covered

- Los Angeles
- San Diego

This section includes general information on the collection and verification of copayments.

Select any subject below:

- Verifying and Clearing Share-of-Cost

Verifying and Clearing Share-of-Cost

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers must access the Medi-Cal eligibility verification system to determine whether a Health Net member must pay a share-of-cost (SOC). Providers may access the eligibility verification system through the Point of Service device, Affiliate Computer Services (ACS) by telephone or under Transactions on the Medi-Cal website at www.medi-cal.ca.gov. The eligibility inquiry message includes SOC dollar amount and any remaining SOC, if applicable. Members with unmet SOC are enrolled with Health Net in a pended status and the eligibility verification system will indicate Potential Health Net Member.

Providers may collect SOC payments from members on the date of service, or allow them to pay at a later date or through an installment plan. SOC installment plans are between the provider and the member. Health Net does not reimburse providers for SOC payments not paid by the member.

Providers must perform an SOC transaction to clear SOC immediately on receiving payment or accepting obligation from the member for services rendered. Clearing SOC means that the Medi-Cal eligibility verification system shows the member has paid or obligated for entire SOC amount owed. To clear SOC, providers must access the Medi-Cal eligibility verification system and enter the following:

- Provider number
- Provider identification number (PIN)
- Member identification number
- Beneficiary identification card (BIC) issue date
- Billing code and service charge

The SOC information is updated and a response is displayed on the screen or delivered over the telephone. Providers must continue to clear SOC until it is completely cleared. Once SOC is met and the eligibility verification system is updated, members' status will change to Active and eligibility is retroactive to the first of the month.

Credentialing

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes Health Net's provider credentialing process.

Select any subject below:

- Application Process
- Site Evaluations

Application Process

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Practitioners or organizational providers subject to credentialing or recredentialing and contracting directly with the Plan must submit a completed Plan-approved application. By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes the Plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review.

- Releases the Plan and its independent contractors, agents and employees from any liability connected with the credentialing review.
- Must submit a completed Council of Affordable Quality Healthcare (CAQH) ProView Application.
- Upon receipt of the completed application from the practitioner, receive an acknowledgment letter from the Credentialing department within seven calendar days of receipt (excluding holidays).

AB 1041 Credentialing Timelines

In accordance with AB 1041, and consistent with Health Net's internal implementation timeline, Health Net will make a credentialing determination within 90 calendar days of receipt of a complete application, effective October 2026.

If a credentialing determination is not made within the 90-calendar-day timeframe, the practitioner or provider will be provisionally approved for up to 120 calendar days unless one or more of the following apply:

The practitioner or provider has disciplinary actions reported by a licensing board.

There are adverse actions or malpractice reports in the National Practitioner Data Bank (NPDB).The practitioner or provider has not been credentialed by Health Net within the previous five years.

Credentialing Timelines

The Plan makes a credentialing determination within 90 calendar days of receipt of a completed credentialing application, including all required third-party verifications. See California Health & Safety Code Sections 1374.198 and 1380.2 (AB 1041 (2025)).

If a credentialing determination is not made within 90 calendar days, the practitioner or provider will be provisionally approved for up to 120 calendar days unless one or more of the following apply:

- The practitioner or provider has disciplinary actions reported by a licensing board.
- There are adverse actions or malpractice reports in the National Practitioner Data Bank.
- The practitioner or provider has not been credentialed by the Plan within the previous five years.

Standards of Practitioners

All practitioners participating in the Plan's network must comply with the following standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing and practitioners due for recredentialing must complete all items on a CAQH credentialing application and supply supporting documentation, if required. The verification time limit for a Plan-approved application is 120 days. Applications are available at the CAQH for the ProView Credentialing link.

Supporting documentation includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate or Chemical Dependency Services (CDS) certificate, as applicable. The DEA and/or CDS registration must be issued in the state(s) in which the practitioner is contracting to provide care to the members.

- Continuous work history for the previous five years with a written explanation of any gaps of a prescribed time frame (initial credentialing only).
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one participating hospital or surgery center, contracted hospitalist group or a documented coverage arrangement with a credentialed, participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers – $1 million/$3 million; organizational providers – $3 million/$10 million.
- The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely.

Additionally, the practitioner must be absent from:

- The Medicare Opt-Out Report if treating members under the Medicare lines of business.
- The Office of the Inspector General's sanctions list of individuals and entities if treating Medicaid and Medicare members.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.
- The Excluded Parties List System (EPLS) through the System for Award Management (SAM) Report.
- The Medi-Cal Suspended and Ineligible Provider listing.
- The Medicare Preclusion List.
- State licensing medical board for disciplinary actions/restrictions.
- Restricted Provider Database.

Limitation on Requests for Additional Information

Effective January 1, 2028, requests for additional information during the credentialing or recredentialing process are limited to information necessary to clarify or verify data submitted through the CAQH credentialing application, in accordance with AB 1041. Providers must respond to such request within 10 business days.

Credentialing Responsibility, Oversight and Delegation

The Plan may delegate participating physician groups' (PPGs) or other entities' responsibility for credentialing and recredentialing activities. Credentialing procedures used by these entities may vary from Plan procedures, but must be consistent with health plan, state and federal regulatory requirements and accrediting entity standards.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the oversight of delegated activities must meet or exceed plan standards. The Plan oversees delegated responsibilities on an ongoing basis through an annual audit, or more frequent, review as applicable.

The Plan can revoke the delegation of any or all credentialing activities if the delegated PPG or entity is deemed noncompliant with established credentialing standards. The Plan retains the right, based on quality

issues, to terminate or restrict the practice of individual practitioners, providers and sites, regardless of the credentialing delegation status of the PPG.

Each delegated practitioner, or behavioral healthcare provider losing delegated credentialing status must complete the Plan's initial credentialing process within six months of the transition date.

Hiring Non-Participating Providers

The following document applies only to Physicians and PPGs.

To comply with applicable federal and state laws and regulations, all participating providers in the Plan's network must comply with the following standards when hiring a non-participating provider to provide services to Plan members. Participating providers must be able to demonstrate that each non-participating provider has supporting documentation that includes:

- Current, unencumbered state medical license.
- Valid, unencumbered DEA certificate or CDS certificate, as applicable.
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Malpractice insurance coverage that meets these standards: Individual providers – $1 million/$3 million; organizational providers – $3 million/$10 million.
- Absent of any sanctions that would not allow them to see a Medicare member.

The Plan's participating providers are responsible for ongoing monitoring of sanctions and validating licensing. All participating providers are required to comply with applicable federal, state and local laws and regulations as well as the policies and procedures outlined in the Provider Participation Agreement (PPA).

Practitioner types noted as technicians or assistants to contracted practitioners are exempt from the credentialing process.

Recredentialing for Practitioners

The plan's credentialing program establishes criteria for evaluating continuing participating practitioners. This evaluation, which includes applicable primary source verifications, is conducted in accordance with the health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners that meet and maintain the standards for participation requirements are retained in the network.

CAQH Mandatory Submission Requirement

Effective January 1, 2028, all credentialing and recredentialing applications for applicable commercial lines of business must be submitted exclusively through CAQH in compliance with AB 1041.

Practitioners due for recredentialing must re-attest all items on the CAQH application and supply supporting documentation, if required. Documentation includes, but is not limited to:

- Current state medical license.
- Attestation to the ability to provide care to members without restriction.

- Valid, unencumbered DEA certificate or CDS certificate, if applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state.
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one participating hospital or surgery center, or a documented coverage arrangement with a credentialed or participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers – $1 million/$3 million; organizational providers – $3 million/$10 million.
- Trended assessment of practitioner's member's complaints, quality of care, and performance indicators.

Investigations

The Plan investigates adverse activities indicated in a practitioner or provider's initial credentialing or recredentialing application materials or identified between credentialing cycles. The Plan may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. The Plan may require a practitioner or provider to supply additional information regarding any such adverse activities. Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board.
- Current or past chemical dependency or substance abuse.
- Health care fraud or abuse.
- Member complaints.
- Substantiated quality of care concerns activities.
- Impaired health.
- Criminal history.
- Office of Inspector General Medicare/Medicaid sanctions.
- Federal Employees Health Benefits Program debarment.
- System Award Management (SAM), inclusive of Excluded Parties List System (EPLS).
- The Medi-Cal Suspended and Ineligible Provider listing.
- Substantiated media events.
- Trended data.

At the Plan's request, a practitioner or provider must assist the Plan in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within the prescribed time frames.

Primary Source Verification for Credentialing and Recredentialing

The Credentialing Department obtains and reviews information on a credentialing or re-credentialing application and verifies the information in accordance with the primary source verification practices. The Plan requires PPGs to which credentialing to obtain primary source information (outlined below)* in accordance with the standards of participation, state and federal regulatory requirements, and accrediting entity standards.

The Scope of Practitioners included in the Credentialing/Recredentialing Program

- Medical physicians (MD)
- Doctor of Osteopathic Medicine (DO)
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Oral surgeons (DDS/DMD)
- Doctor of Naturopathic Medicine (ND)
- Chiropractors (DC)
- Psychologist (PSY)
- Podiatrists (DPM)
- Mid-level practitioners (non-physicians)
- Licensed Clinical Social Worker (LCSW)
- Marriage and Family Therapist (MFT)
- Marriage and Family Child Counselor (MFCC)
- Applied Behavioral Analyst (ABA) Qualified Autism Service Provider (QASP)
    - Must hold a Bachelor's Degree (BCaBAs) or a Master's or higher (BCBA/BCBA-D) from an accredited school per requirements of the Behavioral Analyst Certification Board.
    - Must hold a clear, unrestricted Board Certification as either a BCaBA, BCBA, or BCBA-D through the Behavioral Analyst Certification Board. In states where an ABA license exists, the Plan requires an ABA license. All BCaBAs must deliver services under a group practice.
- Mental Health Counselor (MHC)
- Acupuncturist (AC)
- Audiologists (AUD)
- Speech Pathology or Therapist (SP/ST)
- Mid-Wife (Non-Physician Medical Practitioner)
- Nurse Practitioner – Mental Health (APRN)
- Optometry (OD)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Clinical Pharmacist (CP)

Primary Source Verification

The following information is collected for each applicant. The documentation will be current and verified within 120 days of submission to the credentialing chairperson (Clean File Review) or the Credentialing Committee for review and approval:

- License
- DEA (as Applicable)
- 5-years of work history, with no gaps > 6-months (Initial Credentialing only)
- Malpractice insurance coverage
- Education/training (initial credentialing only)
    - Medical school
    - Post graduate training
    - Residency
    - Fellowship
    - Masters-level training
    - Completed and qualified training as issued by the applicable state licensing board
- Board certification
- Hospital privileges (as applicable)
- Sanctions
- Claims history (National Practitioner Data Bank)

- Performance data/member complaints/grievances (recredentialing or practitioners losing delegation only)

Practitioner's Rights

Right of Review Request for Current Network Status

- A practitioner has the right to review information obtained by the Plan for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (for example, malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.
- A practitioner may request to review such information at any time by sending a written request via letter or fax to the credentialing manager or supervisor. The credentialing manager or supervisor notifies the practitioner within 72 hours of the date and time when such information is available for review at the Credentialing Department. Upon written request, the Credentialing Department provides details of the practitioner's status in the initial credentialing or recredentialing process.

Notification of Discrepancy

- Practitioners are notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board-certification expiration when one or more of these examples have not been self-reported by the practitioner on their application. Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

- A practitioner who believes that erroneous information has been supplied to the Plan by primary sources may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed explanation, to the Credentialing Department manager or supervisor. Notification to the Plan must occur within 48 hours of the Plan's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of their credentials file. Upon receipt of notification from the practitioner, the Plan re-verifies the primary source information in dispute. If the primary source information has changed, a correction is made immediately to the practitioner's credentials file. The practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax.
- The practitioner may then provide proof of correction by the primary source body to the Credentialing Department via letter or fax within 10 business days. The Credentialing Department reverifies primary source information if such documentation is provided. If after 10 business days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.

Practitioner's Office Standards

General practitioner office standards

- Office must be professional and secular.
- Signs identifying office must be visible.
- Office must be clean.
- Office must be free of pests.
- Office must have a separate waiting area with adequate seating.
- Practitioner must see patients within 15 minutes of the scheduled appointment time.
- Clean restrooms must be available.
- Office environment must be physically safe.
- Practitioners must have a professional and fully confidential phone line and answering machine or voicemail greeting. Practitioners must ensure their voicemail boxes are routinely cleared and able to accept incoming messages.
- Practitioner’s after-hours voicemail message must include emergency instructions advising members to contact 911 for medical emergencies.

Additional standards for practitioner home office (Behavioral Health Only):

- Office must have a separate entrance for clients/patients.
- Office must be used only for business and may not be used as part of living area.
- There must be a waiting area separate from living area.
- There must be a restroom separate from living area.
- Practitioner must have a separate phone line that is not accessible to other household residents or household staff.

Approval, Denial or Termination of Credentialing Status

The Credentialing Committee or physician designee reviews rosters of delegated and non-delegated practitioners and organizational providers meeting all Plan criteria and approves their admittance or continued participation in the network.

A peer review process is used for practitioners with a history of adverse actions, member complaints, negative quality improvement (QI) activities, impaired health, substance abuse, health care fraud and abuse, criminal history, or similar conditions to determine whether a practitioner should be admitted or retained as a participant in the network.

Practitioners are notified within 60 calendar days of all decisions regarding denial, limitation, suspension, or termination of credentialing status consistent with health plan, state, and federal regulatory requirements and accrediting entity standards. This notice includes information regarding the reason for denial determination. If the denial or termination is based on health status, quality of care or disciplinary action, the practitioner is afforded applicable appeal rights. Practitioners who have been administratively denied are eligible to reapply for network participation as soon as the administrative matter is resolved.

Failure to respond to recredentialing requests may result in the practitioner's administrative termination from the network.

For providers approved for participation, including those approved on a provisional basis as permitted under applicable law, the Plan will activate the provider promptly and notify the provider of activation within 10 business days, in accordance with California AB 1041.

For providers approved for participation, including those approved on a provisional basis as permitted under applicable law, Health Net will activate the provider promptly and notify the provider of activation within 10-business days, in accordance with California Assembly Bill (AB) 1041.

Appeals

Practitioners, whose participation in the Plan's network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons, are provided notice and an opportunity to appeal. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from, the network.

The notice of altered participation status will be provided in writing to the affected practitioner and include:

- The action proposed against the practitioner by the Credentialing or Peer Review committee.
- The reason for the action.
- The Plan policies or guidelines that led to the committee's adverse determination.
- Detailed instructions on how to file an appeal (informal reconsideration or formal hearing).

A practitioner may choose to engage in an informal appeal and provide additional information for the Credentialing Committee's consideration or move directly to a formal fair hearing. Affected practitioners who are not successful in overturning the original committee’s decision during an informal reconsideration is automatically afforded a fair hearing, upon request in writing, within 30 days from the date of notice of the denial.

A practitioner must request a reconsideration or fair hearing in writing. The Plan's response to the request will include:

- Dates, times and location of the reconsideration or hearing.
- Rules that govern the applicable proceedings.
- A list of practitioners and specialties of the committee or fair hearing panel.

The composition of the fair hearing panel must include a majority of individuals who are peers of the affected practitioner. A peer is an appropriately trained and licensed physician in a practice similar to that of the affected practitioner.

Affected practitioners whose original determinations are overturned are granted admittance or continued participation in the Plan's network. The decision is forwarded to the affected practitioner in writing within 14 calendar days of the fair hearing panel's decision.

Affected practitioners whose original determinations have been upheld are given formal notice of this decision within 14 days of the fair hearing panel's ruling. The actions are reported to the applicable state licensing board and to the National Practitioner Data Bank within 14 days of the hearing panel's final decision.

Practitioners who have been denied or terminated for quality-of-care concerns must wait a minimum of five years from the date the adverse decision is final in order to reapply for network participation. At the time of the reapplication, the practitioner must:

- Meet all applicable Plan requirements and standards for network participation.
- Submit, at the request of the committee or Credentialing Department, additional information that may be required to confirm the earlier adverse action no longer exists.
- Fulfill, according to applicable current credentialing policies and procedures, all administrative credentialing requirements of the Plan's credentialing program.

Organizational Providers Certification or Recertification

An organizational provider is an institutional provider of health care that is licensed by the state or otherwise authorized to operate as a health care facility. Examples of organizational providers include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and ambulatory surgical centers (ASCs).

Below are the credentialing requirements for organizational providers:

- The submission of an application which affirms the completeness and truthfulness of representations made in the application.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes the Plan to obtain information regarding the applicant's qualifications, competence or other information relevant to the credentialing review.
- Releases the Plan and its independent contractors, agents and employees from any liability connected with the credentialing review.
- Organizational providers are recertified every 36-months to ensure eligibility requirements.
- The Organizational provider is not required to submit an application for recertification.

Organizational providers that require assessments by the Plan or its delegated entities include:

- Hospitals
- Home health, hospice and home infusion providers
- Skilled Nursing Facilities (SNF)
- Free-standing and ASCs, including abortion clinics
- Dialysis/End-Stage Renal Disease (ESRD) care providers
- Hospices
- Clinical laboratories
- Office-based surgery suites
- Ambulatory psychiatric and addiction disorder facilities and clinics
- Acute care, behavioral health in hospitals, or other freestanding psychiatric hospitals or treatment facilities
- Comprehensive outpatient rehabilitation facilities
- Physical therapy and speech pathology providers
- Portable X-ray suppliers
- Radiology/imaging centers
- Advanced Diagnostic Imaging (ADI)
- Behavioral health/psychiatric disorder facilities (inpatient, residential, ambulatory, and clinics.)
- Sleep study centers

- Urgent care centers
- Federally Qualified Health Centers, Indian Health Centers and Rural Health Clinics
- Community-Based Adult Services (CBAS) centers
- Occupational therapy
- Outpatient self-management training providers
- Other providers as deemed necessary
- Intermediate Care Facility
- Telehealth provider
- CalAIM- Community Supports Provider – Vetting Only
- Enhanced Care Management

CalAIM - Community Supports Provider/In Lieu of Services Provider.**

Non-traditional providers are not certified or credentialed. They require vetting to ensure acceptance into the Plan's network. Note, if a traditional provider, hospital, ancillary, PPG or practitioner oversee the non-traditional provider, the provider is responsible to ensure they meet the needs to join the Plan's network.

- Assisted Living Facility (ALF) Transitions
- Asthma Remediation
- Day Habilitation Program
- Environmental Accessibility Adaptions (Home Modifications)
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Housing Transition Navigation Services
- Medically Tailored Meals or Medically Supportive Foods
- Personal Care and Homemaker Services
- Recuperative Care (Medical Respite)
- Respite Services
- Short-Term Post Hospitalization Housing
- Sobering Centers
- Transitional Rent

CalAIM – Enhanced Care Management Provider**

Community Health Worker - Provider**

The facility is exempt from the certification process if the individual practitioners within this clinic are individually contracted/credentialed.

** Non-traditional care facilities are required to submit a vetting attestation only and must be licensed to operate in the state and comply with all applicable federal and state requirements.

Providers contracting directly with the Plan must submit a completed, signed Plan-approved hospital or ancillary facility credentialing application and any supporting documentation to the plan for processing. The documentation, at a minimum, includes:

- Evidence of licensure; state, county, fictitious name permit or license exemption.
- Evidence of accreditation
- If not accredited, evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an site survey prior to being issued a state license. Accepted agency surveys include those performed by the state Department of Health and Human Services (DHHS), Department of Public Health (DPH) or Centers for Medicare & Medicaid Services (CMS).

- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess a current city license, fictitious name permit, certificate of need, or business registration.
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent DHHS/DPH site survey as described above is required. A favorable site review consists of compliance with quality-of-care standards established by CMS or the applicable state health department. The Plan obtains a copy of each surgery center's site survey report and ensures each provider has received a favorable rating. This may include a completed plan of correction and DHHS corrective action plan of the plan of correction acceptance letter.
- Overview of the facility's quality assurance/quality improvement program upon request.
- CBAS are exempt from accreditation but require a Department of the Aging - Site Survey.
- Urgent care, physical therapy, Community Support providers, Enhanced Care Management providers, and Intermediate Care Facilities are exempt from accreditation and site surveys.

Terminated Contracts and Reassignment of Members

The Plan notifies members as required by state law if a practitioner's contract participation status is terminated. The Plan oversees reassignment of these members to another participating provider where appropriate.

Site Evaluations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net or its designee conducts a full-scope facility site review (FSR) for all contracting Medi-Cal primary care physician (PCP) office sites. FSRs may be conducted upon initial contract and then cyclically every three years or earlier as new locations are identified (such as when a PCP moves office locations). Additionally, FSRs are completed as a response to member complaints relating to any practice facility issues, regardless of practitioner specialty.

Events that initiate an investigation to conduct a site visit include, but are not limited to:

- Physical accessibility.
- Physical appearance.
- Adequacy of waiting and examining room space.

When there is an event that initiates a site investigation, a Health Net registered nurse from State Health Programs or a designee conducts a full-scope FSR using an approved California Department. of Health Care Services Managed Care Quality and Monitoring Division Facility Site Review Tool, which assesses the following:

- Access and safety.
- Personnel.
- Office management.
- Clinical services.

- Preventive services.
- Infection control.
- Medical record-keeping practices.
- Medical record documentation.

The FSR tool has multiple criteria and includes critical elements related to patient safety, access, medication administration, and infection control. Exempt pass is 90 percent and above, conditional pass is 80-89 percent and a fail is 79 percent and below. Corrective action plans (CAPs) are required for any deficiencies in the critical elements and if the facility site review score is 89 percent and below. Specific time frames for the CAP must be met.

Participating providers who refuse the FSR or do not complete the CAP within a specified time frame are referred to the Health Net credentialing committee for administrative denial or termination, which applies to the Medi-Cal line of business only. Sites that have complied with the CAP requirements remain in the Health Net network.

Refer to the Facility Site Review under the Quality Improvement section for more information.

Denial Notification

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information for claims and service denials.

Select any subject below:

- Letter Translation Assistance for Members
- Notification Delays
- Required Elements for Member Notification Letters
- Required Elements for Provider Notification Letters
- Requirements for Notification of Utilization Management Decisions

Letter Translation Assistance for Members

Provider Type: Physicians | Participating Physician Groups (PPG)

All Notice of Actions (NOAs) issued to members whose preferred language is one of the threshold languages must be fully translated per DHCS APL 21-011 and the Medi-Cal Contract. An English NOA does not meet the requirement of notification even if it is sent within the required turnaround time. Additionally, Health Net provides no-cost telephonic interpretation services to all Medi-Cal members who receive NOA letters from Health Net or an affiliated participating physician group (PPG) even if the member's preferred language is not one of the threshold language in the county of residence.

This service is available through the Health Net Health Equity Department and is offered as a supplement to translation and interpretation services provided by the member's PPG.

Health Net requests that PPGs with delegated utilization management (UM) functions attach a Health Net Language Assistance Notice (PDF) , Community Health Plan of Imperial Valley (CHPIV) Language Assistance Notice (PDF) or CalViva Health Language Assistance Notice (PDF) for denial or modification notifications sent to Health Net, CHPIV and CalViva Health Medi-Cal members. Refer to the Health Industry Collaboration Effort (HICE) website at www.iceforhealth.org/home.asp for HICE-approved NOA letter templates.

When a member calls the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) requesting translation or interpretation services, if Health Net did not issue the letter, a Health Net Member Services representative contacts the member's PPG and requests a copy of the denial or modification letter that was sent to the member. The PPG must submit the letter to Health Net within 48 hours in an editable format and at or below a 6th grade reading level.

Notification Delays

Participating Physician Groups (PPG) | Hospitals

Financial penalties may be imposed on Health Net by regulators if specified time limits are not met. Reasonable delays include Health Net or the participating physician group (PPG) with delegated utilization management (UM) functions experiencing the following:

- Have not received requested information reasonably necessary to determine the medical necessity of the services requested
- Requires a consultation with an expert reviewer
- Have requested an additional examination or test on the member (provided the test is reasonable and consistent with good medical practice)
- Health Net or PPGs with delegated UM functions are required to notify both the provider and member in writing about the delay, either immediately or as soon as Health Net or the PPG with delegated UM functions becomes aware that it will not meet the time requirement but no later than the expiration of the allowed time, whichever comes first.

The provider must also be notified initially by telephone. Refer to the Health Industry Collaboration Effort (HICE) website to obtain the ICE Notice of Action (NOA) template located under Approved HICE Documents. The notification delay letter must include the reason for the delay, specific information pertaining to the additional information or consultation being requested, and the anticipated date of the decision. The requesting provider must be advised that:

“In accordance with Section 1367.03(a)(5)(H):

- If this delay to obtain additional information and resulting delay *will* have a detrimental impact on the health of the member, you *must* contact the Plan.
- If this delay will *not* have a detrimental impact on the health of the member, you *must* document this in the member record.”

Once the additional information is received, the same time limits apply.

health net

For cases where expert consultation is required to made the initial decision

Type of request	Notification
Non-urgent pre-service	If a consultation is required by an expert reviewer, upon the expiration of the five business days or as soon as Health Net becomes aware that the five business day time frame will not be met, whichever occurs first, practitioner and member will be notified of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 15 calendar days from the date of the delay notice to the practitioner and member).
Post-service	If a consultation is required by an expert reviewer, upon the expiration of the 30 calendar days or as soon as Health Net becomes aware that we will not meet the 30 calendar day time frame, whichever occurs first, practitioner and member will be notified of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 15 calendar days from the date of the delay notice to the practitioner and member).

Required Elements for Member Notification Letters

Provider Type: Participating Physician Groups (PPG) | Hospitals

Communications regarding decisions to approve requests must state the specific health care service approved. The notice of action (NOA) letters, developed by the California Department of Health Care Services (DHCS) as required by SB 59 (1999, Chapter 539), are to be used when notifying Medi-Cal managed care members of adverse service authorization decisions. Refer to the Healthcare Industry Collaboration Effort (HICE) website at www.iceforhealth.org/library.asp to view the NOA templates located under Approved ICE Documents.

Member notification letters indicating a denial, delay modification or termination of service must include:

Approvals

- Specify the health care service/s approved

Denials/Modifications

- The decision to deny or modify the request.

- Clear and concise explanation of the reasons for the decision
- A description of the criteria or guidelines used, including a reference to the specific regulation or authorization procedure(s), that supports the decision, as well as an explanation of the criteria or guidelines.
    - If the decision was based on medical necessity, the NOA must include a reference to the clinical criteria that has not been met.
    - If the denial is related to a member who has a terminal illness, a description of alternative treatment, drug, services or supplies covered by the Plan, if any.
    - Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or criteria on which the denial decision was based.
    - Notification to the member that if a medical or vocational expert's advice was obtained related to their case, they may be provided the identity of these experts, upon request.
    - Additional information as required by state or federal regulations including Member "Your Rights" under Medi-Cal Managed Care, Nondiscrimination Notice and Notice of Availability .
    - "Your Rights" attachment.

Delays/Deferrals

- The decision to delay or defer the request due to missing information or the need for a same specialty review.
- Specify the additional information requested; requesting only that information which is reasonably necessary to make a decision.
- Provide the anticipated date of decision.
- "Your Rights" attachment.
- PPGs may use the HICE NOA templates for provider notifications, in which case the NOAs are modified to include the name and direct telephone number of the health care professional responsible for the decision to deny, delay, modify, or terminate requested services.

Additional Requirements

Member notification letters to Medi-Cal managed care members are subject to additional requirements following the decision by the federal district court in Jackson v. Rank (E.D.Cal.1986).

In addition to the requirements stated above, member notification of deferral, denial, modification, or termination of requests for prior authorization for payment of services must inform the member of the following:

- The member's right to, and method for obtaining, a state hearing to contest the denial, deferral or modification action
- The member's right to self-representation at the state hearing, or to be represented by legal counsel, friend or other spokesperson
- The action taken by Health Net or PPG on the request for prior authorization and the reason for such action, including the underlying contractual basis or Medi-Cal authority
- Health Net's name and address of the health plan and the state toll-free telephone number for obtaining information on legal service organizations for representation

If the member's preferred language is one of the threshold languages in the county of residence, then the NOA must be fully translated at the time of decision per DHCS APL 21-011. The HICE NOA template includes the required DMHC statement. Providers may also refer to the DMHC Required Statement for additional requirements.

Required Elements for Provider Notification Letters

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Communications regarding decisions to approve requests must state the specific health care service approved.

Provider notification letters indicating a denial, delay or modification of service must include:

- A clear and concise explanation of the reasons for the decision
- A description of the criteria or guidelines used, including a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guidelines.
    - The requesting provider must be advised that:
        - "In accordance with Section 1367.03(a)(5)(H):
        - If this delay to obtain additional information and resulting delay *will* have a detrimental impact on the health of the member, you *must* contact the Plan.
        - If this delay will *not* have a detrimental impact on the health of the member, you *must* document this in the member record."
        - If the decision was based on medical necessity, the notification must include a reference to the clinical criteria that has not been met.
        - If the denial is related to a member who has a terminal illness, a description of alternative treatment, drug, services or supplies covered by the Plan, if any.
- Information on filing a grievance (or appeal)
- The name and direct telephone number (or extension) of the physician or otherwise qualified and licensed health care professional responsible for the decision

In the case of a denial, the referring provider must be given an opportunity to discuss the denial with the physician who made the denial decision. Refer to the Healthcare Industry Collaboration Effort (HICE) website at www.iceforhealth.org/home.asp to view the Denial File Fax Back template located under Approved HICE Documents. An expedient method for this purpose is to complete a Denial File Fax-Back Sample, including the name and telephone number of the physician who denied the service when faxing back the denial information.

Requirements for Notification of Utilization Management Decisions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net and its participating physician groups (PPGs) to which utilization management (UM) functions have been delegated are required to comply with timeliness standards for UM decisions and notifications. Health Net

has adopted the timeliness standards approved by the Health Industry Collaboration Effort (HICE) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the HICE website at www.iceforhealth.org/home.asp to locate the Approved HICE Documents for the commercial and Medi-Cal ICE UM Timeliness Standards.

The National Committee for Quality Assurance (NCQA) counts the time from the date when Health Net receives the request, regardless of whether it is during business hours. Non-urgent requests may be processed on the next business day. Refer to Notification Delays for notification timelines when expert consultation is required to made the initial decision.

Disenrollment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information and procedures regarding member disenrollment requirements.

Member Disenrollment Procedure

The following document applies only to Participating Physician Groups (PPG), Hospitals, and Ancillary Providers.

A member may disenroll at any time and without cause by contacting the Health Care Options (HCO) enrollment contractor, who then issues disenrollment forms directly to the member.

Members in a mandatory aid code must simultaneously re-enroll in another health plan or the HCO enrollment contractor assigns them a health plan. Members in non-mandatory aid codes may choose a new health plan or return to the Medi-Cal fee-for-service (FFS) program.

Disenrollment of a member is mandatory when:

- Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the Federal lock-in option, if applicable.
- Member’s eligibility for enrollment with the health plan is termed or eligibility for Medi-Cal has ended, including the death of the member.
- Member's enrollment violated state marketing and enrollment laws, and DHCS or member requested dis-enrollment.
- Member requests disenrollment as a result of plan merger or reorganization.
- Member moves out of the plan's approved service area.
- Member's Medi-Cal aid code changes to an aid code not covered under the health plan

Health Net continues to be responsible for the member's health care until disenrollment is approved by the Department of Health Care Services (DHCS), not the plan. The disenrollment request may take 30 days to complete.

Provider Request to Disenroll a Non-Compliant Member

To request disenrollment of a member, providers must contact the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties). Providers are asked to describe the circumstances leading them to request the Member Non-Compliant disenrollment and may be asked to submit documentation regarding their requests.

On notification, the Health Net Medi-Cal Member Non-Compliance Unit, the Customer Service Advocate (CSA) will contact the member and provide guidance. If necessary, the CSA will reassign the member to a new primary care physician (PCP) within the plan.

A provider-initiated member non-compliant disenrollment request based on the breakdown of the provider-member relationship is considered good cause, only if one or more of the following circumstances occur:

- The member is repeatedly verbally abusive to plan providers, ancillary or administrative staff, or other plan members.
- The member physically assaults a plan provider, staff person or plan member, or threatens another person with a weapon. In this instance, the provider is expected to file a police report and bring charges against the member at the time of the incident.
- The member is disruptive to provider operations in general.
- The member habitually uses providers not affiliated with Health Net for non-emergency services without required authorizations.
- The member has allowed fraudulent use of the Health Net identification card to receive services from Health Net providers.
- The member is non-compliant with prescribed medication or treatment.
- The member has multiple missed appointments.

Provider non-compliant request is a formal written complaint from a contracted provider (PCP, PPG, Specialists, Health Care Services, other Health Net units) against a member who exhibits inappropriate behavior. The Provider is required to fax a detailed letter regarding the member non-compliance incident including specific details such as:

- Who: (Member Full Name and Cin#)
- What: (Type of non-compliance)
- When: (Dates and times)
- Where: (Did the incident take place?)

The letter must provide details of what the provider has done to manage the member’s behavior such as providing the member with education, to bring them back into complying. This includes referrals to pain management, case management, mental health etc.

If the letter is not received within 30 days from the time the non-compliance incident is reported to the health plan, the case will be closed.

Formal letter and all supporting document’s must be faxed or mailed to Non-Compliance Unit.

Eligibility

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains information on eligibility requirements and how to determine eligibility for members.

Select any subject below:

- Eligibility Verification
- Children
- Share of Cost for Medi-Cal Members

Eligibility Verification

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

When a patient seeks medical attention from a participating physician group (PPG), hospital or other provider, that provider must attempt to determine eligibility before providing care. If the provider verifies eligibility according to the steps outlined below, the provider is compensated even if the patient is later determined to be ineligible. If the provider does not verify eligibility, the Plan does not accept financial responsibility for any services performed on an ineligible patient.

Member eligibility is verified at the time that the identification (ID) card is issued; however, a member's possession of an ID card does not guarantee their eligibility. In cases where a member has lost an ID card or where eligibility may be in question, providers can verify eligibility as follows:

- Online through one of the following provider portals:
  - Health Net: Log in, select *Eligibility* at the top of the page, select *Eligibility Check*.
  - Availity Essentials: Log in, go to the *Patient Registration* section, select *Eligibility and Benefits*

  Patient History provides specific member eligibility, copayments, claims status and other services. Providers may also search by dates of service to refine the search.

- Refer to the interactive voice response (IVR) system by phone, 24 hours a day, seven days a week (not applicable to Behavioral Health providers) and follow the prompts for Health Net Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center (for Fresno, Kings and Madera counties). Select the appropriate option to verify a member's eligibility, copayments, benefits, claims status, and more.
- Via Point of Service (POS) device, Affiliate Computer Services (ACS) or claims and eligibility real-time systems (CERTS) available through the Medi-Cal eligibility website at www.medi-cal.ca.gov:
  - Providers who have access to EDS POS devices may swipe the member's Medi-Cal Beneficiary Identification Card (BIC) through the device to get information about the member's current eligibility status, health plan affiliation, and PCP name and phone number. Providers may also use ACS, an automated interactive voice response system, to verify eligibility, share of cost and other services using a touch-tone phone and PIN

        - If further information is required about the member's PCP or PPG affiliation, providers may call the Eligibility Verification Line as listed on www.medi-cal.ca.gov
    - CERTS is available online to verify eligibility for pharmacy providers
- Another option is available online through TransUnion® MedConnect website at www.meddatahealth.com/login.aspx for those providers who have an account. Providers may log in and enter the member's Plan ID number to get information about current eligibility, health plan affiliation and assigned primary care physician (PCP).
- Eligibility verification via the provider's clearinghouse. Health Net is a Phase I- and Phase II-certified entity with the Council for Affordable and Quality Healthcare (CAQH) Committee on Operating Rules (CORE) for eligibility responses. Providers contact their vendor/clearinghouse to submit transactions via this method using an EDI transaction or clearinghouse product.

For dual special needs plan (D-SNP) member eligibility information, refer to Dual-Eligible Medicare Beneficiaries.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website (HMO/PPO/Health Net Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley, Wellcare By Health Net) for details on what functions can be accessed through each portal.

Children

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Newborn Coverage

Babies born to a Medi-Cal mother are covered for the month of birth and the following month. Some newborns will have their own client index numbers (CINs) and are loaded in the system separately. Newborns who do not have separate CINs are still deemed eligible under the mother's Medi-Cal beneficiary identification card (BIC) or CIN during the month of delivery and the following month. No separate capitation is paid for the newborn during these two months.

Newborns in foster care are also eligible for shared mother/child coverage during the month of birth and the following month. Foster parents of newborns must present a photocopy of the natural mother's BIC or CIN to obtain covered services for the newborn during the month of delivery and the following month.

Share of Cost for Medi-Cal Members

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Certain Medi-Cal members may be required to pay, or agree to pay, a monthly share of cost (SOC) toward their medical expenses before Medi-Cal becomes financially responsible. SOC is similar to a deductible. Typically, a Medi-Cal member's SOC is determined by the county welfare department and is based on the member's

income in excess of maintenance need levels, which is defined as the amount of an individual's income that Medi-Cal determines is used to cover living expenses, such as food, clothing and housing. Medi-Cal rules require that members pay income in excess of their maintenance need level toward medical bills before Medi-Cal begins to pay.

Determining SOC

Providers must access the Medi-Cal eligibility verification system to determine whether a member must pay an SOC. The message returned by the eligibility system includes the SOC dollar amount the member must pay. After accessing the system via one of the following methods, the system sends a message to the provider, indicating the member's SOC:

- Point of service (POS) device.
- Automated Eligibility Verification System (AEVS), which is an interactive response system that allows providers to verify current member eligibility or for the prior 12 months, obtain information about SOC, identify any service restrictions placed on the member, and clear SOC liability.
- State-approved vendor software.
- Medi-Cal website at www.medi-cal.ca.gov.

Meeting SOC

When the provider verifies a member's eligibility and an SOC is indicated for the member, it will be under one of two scenarios, as follows:

- Met share of cost - This means the member is active with Health Net and SOC has been met. In order for a certification date to display in the Medi-Cal Eligibility Data System (MEDS), a county eligibility worker must manually add information for each member, each month. AEVS accesses the most current member information for a specific month of eligibility. After eligibility is confirmed, a 10-character eligibility verification confirmation (EVC) number is provided. Health Net recommends that providers enter the EVC in the remarks area of the claim; however, the EVC is not required for claims processing.
- Unmet share of cost - This means the member is a potential Health Net member for which SOC has not been met. These members must pay their SOC in order to be eligible for services with Health Net. Health Net designates these members as eligible when Health Net is listed as the health plan, but the SOC has not been met. The member is listed as "Cancelled Pending a Potential Enrollee."

  If the member has not met SOC, no EVC number is provided unless the member is dually eligible (eligible for services under more than one aid code). For a dually eligible member who is eligible for certain services with no SOC and the remaining services with an SOC, the aid code and corresponding eligibility message and an EVC number are given in the eligibility response for the non-SOC aid code only. An SOC message is then given for the SOC aid code.

Certifying SOC

Medi-Cal does not provide payment for provider services until the member's monthly SOC has been certified online. Certifying SOC means that the Medi-Cal eligibility verification system shows the member has paid or become obligated (as defined in the Obligating Payment section below) for the entire monthly dollar SOC amount owed.

Clearing SOC

When a member has fulfilled his or her SOC, the provider must access the Medi-Cal eligibility verification system and enter his or her provider number, provider identification number (PIN), member identification number, member identification card (BIC) issue date, billing code, and service charge. This clears the member's SOC responsibility. SOC information is updated, and a response is displayed on the screen or relayed over the telephone.

Several clearance transactions may be required to fully certify SOC. In other words, providers must continue to clear SOC until it is completely certified. Clearing SOC is also referred to as "spending down" the SOC. Providers must perform an SOC clearance transaction immediately upon receiving payment or accepting obligation from the member for services rendered. Delays in performing the SOC clearance transaction may prevent the member from receiving other medically necessary services.

Providers should submit only one SOC clearance transaction for each rendered service used to clear the member's SOC, even if a payment plan is used to meet the obligation. All medically necessary health services, including medical services, supplies, devices and prescription medications, whether Medi-Cal covered or not, can be used to meet SOC for Medi-Cal and County Medical Services Program (CMSP) purposes.

Autocertification of SOC

In some cases, such as with long-term care (LTC) services, auto-certification can occur and a certification date will not be displayed for SOC members in MEDS. The auto-certification process works when the Statewide Automated Welfare Systems (SAWS) sends a transaction to MEDS that allows the SOC to be automatically certified each month and leaves it up to the facility to collect the SOC. This allows the member to be enrolled in the health plan.

When a provider checks eligibility and receives an EVC for services, this is an indication that the SOC has been met. If the member has not met the SOC, MEDS will show a health care plan (HCP) status code of 55 with eligibility verification requiring SOC spend down.

Although there may be no certification date for a member, they are still managed care- or plan-eligible regardless of if the member has met their SOC.

Obligating Payment

Providers may collect SOC payments from members on the date that services are rendered, or providers may allow a member to obligate payment for rendered services. Obligating payment means the provider allows the member to pay for the services at a later date or through a payment plan. The provider must use obligated payments to clear SOC. SOC obligation agreements are between the member and the provider and should be in writing and signed by both parties for protection. There is no reimbursement for SOC payments obligated but not paid by the member.

Frequently Asked Questions

Q: Is it an error that members are being enrolled into Health Net when their SOC has not been met yet?

A: No, it's not an error that members are being enrolled into Health Net when their SOC has not been met yet. Members are determined to be eligible for enrollment into the plan. Eligibility is activated in the plan whenever the member's SOC has been satisfied. These members have a status code of 55, which states that they are eligible for Medi-Cal through the plan but must first satisfy their SOC.

Q: Is there a process in which members can be enrolled in Health Net before they have fully met their SOC and pay their SOC amount directly to the managed care plan?

A: Yes, there is a process by which members are enrolled in Health Net before they have fully met their SOC, and this process is performed on a county level. The SOC is never directly paid to the managed care plan; the SOC is always paid at the location where the member receives his or her services. The provider will report to the plan that the member's SOC has been satisfied, which triggers activation of eligibility for that month. At that point, the plan will begin paying for medical services incurred.

Q: If a member shows an active enrollment and an SOC that has not been certified, why is the member showing an HCP Stat 01 (enrolled in plan) instead of a 55 hold?

A: This could be an indication of an LTC member, in which the eligibility has been automatically certified on the first of the month, and has been coded correctly in MEDS (eligibility status beginning with a 1 or 2). The screen displays correct eligibility, and the member should have no issues receiving medical services. With most LTC members, their SOC gets certified on the first of the month when their bill gets paid. Even though the provider inquiry screen displays "LTC SOC/Spend down," an EVC number is provided, which is an indication that the SOC has already been certified and a billing number is provided to bill Medi-Cal eligible services.

Q: When a member is in LTC, does the system automatically certify the SOC or is it the facilities' responsibility?

A: SOC is certified differently for LTC members with specific aid codes. The system will automatically certify the SOC, in some cases. LTC facilities may be required to perform SOC clearance transactions when a recipient with an unmet SOC is admitted, or when a recipient's SOC exceeds the total charges of the Medi-Cal rate for a given month's stay. Providers receiving an eligibility verification that indicates a member has an LTC SOC should not clear the SOC online; the member is automatically eligible as of the first of the month. The facility does not need to clear the SOC first but can bill the member for the SOC amount.

For more information about using the Medi-Cal website, access the Quick Start Guide on the Medi-Cal website at www.medi-cal.ca.gov/pubs/quickstart.htm.

Eligibility Reports

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains information on eligibility reports to assist providers with determining eligibility.

Select any subject below:

- Eligibility Reports
- Molina Member Eligibility Reports

Eligibility Reports

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Capitation Eligibility Reports provide information about member assignment to participating physician groups (PPGs) and hospitals (when applicable) for members enrolled in all lines of business.

Health Net generates Capitation Eligibility Reports twice a month, on approximately the 3rd and the 16th day of the month. Reports generated at the beginning of the month reflect member eligibility as of the first of the month. Reports generated mid-month include any retroactive member eligibility to date.

Other health coverage information

Medi-Cal managed care plans (MCPs) are required to be the payer of last resort for services when a member has other health care coverage (OHC). PPGs can access the necessary OHC information on PPGs Capitation Eligibility Report ACE_RPT_BRM_42P SEQ. The reports will help PPGs to correctly identify OHC and avoid unnecessary costs.

Do not process claims for a member whose Medi-Cal eligibility report indicates OHC, other than an OHC code of A or N, unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly.

To obtain OHC activity, refer to the report sections below:

- **Detail Record**: Provides member information.
- **COB Record**: Provides OHC demographic information.

When a claim is denied due to the presence of OHC, the minimum OHC information in your notifications to providers must include, but is not limited to:

- The name of the OHC provider (COB Carrier Name on the eligibility report).
- Contact or billing information.

120-day initial health appointment report

Health Net also generates the following report to help Medi-Cal providers keep track of members who need Department of Health Care Service (DHCS)-required examinations:

- 120-Day Initial Health Appointment Report - Lists members who have not had an initial health appointment (IHA) according to Health Net encounter data. Unlike eligibility reports, the 120-Day IHA report includes the number of days the member has been enrolled in Health Net's Medi-Cal plan and the member's age.

Report layout

Additional information on eligibility report field descriptions is available as follows:

- Data File Record Layout BRM_42 (PDF).
- Frequently Asked Questions (PDF)

Capitation Eligibility Report

The Capitation Eligibility Report (BRM 42I and 42P) lists alphabetically all members eligible for at least one day in the reporting month. Participating physician groups (PPGs) must use this report to verify that a member is eligible to receive services for the dates of service.

PPGs may use the Eligibility Report in conjunction with the Remittance Detail Report to verify that they have received the correct Capitation payment, and that the Capitation payment includes members added retroactively. The summary portion of this report lists the number of members or contracts eligible with the PPG at least one day during the month and at month's end. The Eligibility Report is distributed monthly by site level but may be requested at a physician level or consolidated level for Primary PPGs.

Terminated members appear on the report during the month of termination and the following month. Members who were assigned to and terminated from a PPG during the same month (due to events such as retroactive PCP change or inappropriate assignment) display the same date for the Effective Date and Termination Date fields.

The file also displays the member's Medi-Cal redetermination date for use in identifying members who are nearing the date of Department of Health Care Services (DHCS) redetermination of their eligibility for Medi-Cal benefits and may need to reapply.

Molina Member Eligibility Reports

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information is applicable to Los Angeles County only.

Primary care physician (PCP) transfers between Molina Healthcare and Health Net are effective on the first of the following month. Members cannot request a transfer while hospitalized. Retroactive transfers are not allowed unless it is requested by the Department of Health Care Services, or if both parties (Molina/Health Net) agree to the retroactive transfer only.

The following outlines the transfer process of the PCP between Health Net and Molina and between Molina and another Molina PCP:

From Health Net to Molina –

1. Member action: Call Health Net Member Services at 800-675-6110 to request a transfer to Molina.
2. Health Net agent actions:
    - Confirm the member's intent to transfer to Molina.
    - Process the primary care physician (PCP) changes to Molina with a future effective date (first of the following month).
    - Inform the member of the transfer to Molina.
    - Provide the Molina Member Services number at 888-665-4621 to the member.
    - Share member details and PCP assignment through the daily 834 member eligibility file sent to Molina.

From Molina to Health Net –

1. Member action: Call Molina Member Services at 888-665-4621 to request a transfer to Health Net.
2. Molina agent actions:
    - Confirm the member's intent to transfer to Health Net.
    - Provide the Health Net Member Services number at 800-675-6110 and perform a warm transfer to ensure the member receives assistance.
3. Heath Net agent actions:
    - Process the PCP changes to Health Net with a future effective date (first of the following month).
    - Inform the member of the transfer to Health Net.
    - Terminate the member via the monthly 834 member eligibility file sent to Molina.

From a Molina PCP to a new Molina PCP

1. Member action:Call Health Net Member Services at 800-675-6110.
2. Health Net agent actions:
    - Confirm the member is with Molina.
    - Inform the member that they are assigned to Molina.
    - Provide the Molina Member Services number at 888-665-4621 and transfer the member. If a member has difficulties reaching Molina or connecting with an agent, perform a warm transfer to ensure the member receives assistance.
3. Molina agent action: Handle the PCP change internally.

If a member arrives at a PCP's office to receive care and does not appear on the current month's eligibility listing, the provider should contact the Molina Healthcare Provider Services and Inquiry Unit.

Emergency Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on emergency care services.

Select any subject below:

- Coverage Explanation
- Additional Monitoring Responsibilities
- Request for Authorization to Provide Post-Stabilization Services at Non- Participating and Participating Hospitals
- Out-of-Area Emergency or Urgently Needed Care
- PPG Responsibilities
- Procedures to Report System & Protocol Failures

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Emergency and urgent care services are covered anywhere in the United States, including the United States Territories. Emergency, urgent, or any other health care services provided outside of the United States are not covered, except for emergency care requiring hospitalization in Canada and Mexico.

Members could be referred to seek medical support by reaching Health Net's 24 hours Nurse advice line (N24) to speak with a nurse. Providers may contact the Health Net Medi-Cal Provider Services Department, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) with questions.

If a medical emergency occurs, members should be directed to the nearest emergency room for care or call 911. Members are encouraged to use the 911 emergency response system as appropriate. Members should notify their primary care physician (PCP) as soon as possible. Emergency services are available 24 hours a day, 7 days a week.

If a member goes to the emergency room and the doctor or nurse tells the member to contact their PCP because the member does not need emergency care, they should call their doctor immediately for direction.

Refer to the following Behavioral Health definition in the glossary for more information.

- Psychiatric emergency medical condition
- Life Threatening Emergency
- Non-Life Threatening Emergency
- Urgent
- Routine
- Emergency Services and Care

Emergency Department Medical Screening Exam

A medical screening exam (MSE) is an initial assessment of a member to determine whether an emergency condition exists and whether the member should be treated in the emergency department or may be safely treated at another level of care. Hospital emergency departments are required to evaluate all members seeking care. An MSE performed by a physician, nurse practitioner (NP), registered nurse (RN), or physician assistant (PA) in an emergency department does not require prior authorization regardless of the outcome.

Physicians Authority for Discharge

All members are discharged from an emergency facility only on the order of a treating physician.

Timely Follow-Up Care

When an emergency department determines that a medical emergency exists, appropriate treatment must be provided until the member’s condition is stabilized. Once, stabilized, authorization for continued care must be obtained.

If the member requires inpatient admission after stabilization, a request must be submitted to the Plan by contacting the post stabilization authorization request line for admission. Post stabilization care applies when the member is clinically stable but requires ongoing inpatient treatment beyond observation level of care. Refer to the Department of Managed Health Care (DMHC) Services All Plan Letter 23-009 and DMHC All Plan Letter 24-012 for complete guidance.

If the member is not stabilized and requires admission, the standard notification of the admission process must be followed. For additional information, refer to Notification of Hospital Admissions.

If the medical staff at the hospital emergency department determines that the condition is not an emergency, the member is responsible for arranging follow-up care with the PCP. Members are ordinarily given written instructions in the emergency department that state whether follow-up care is needed and, if so, how soon they need to be seen by their PCP. A sample instruction letter, Medi-Cal Member Instructions for Post-Emergency Care (PDF), is available for use. Emergency departments should also contact the member's PCP to arrange for follow-up care; particularly in circumstances where there are active or ongoing care needs or care coordination issues. PCPs must provide timely follow-up care to members when emergency care is deemed not necessary in an emergency department after a Medical Screening Examination (MSE) or if follow-up care is indicated after treatment in the emergency department. PCPs should see members within the time frame suggested by the hospital emergency department instructions.

After-Care Instructions

Emergency departments are responsible for providing written post-emergency care instructions to all members seen in an emergency room. Refer to the Emergency Department MSE discussion above for the most current information about post-emergency care instructions and timely follow-up care.

Refer to Psychiatric emergency medical condition or Emergency for more information.

Medical Emergency in Primary Care Facility

If a medical emergency occurs anywhere in the primary care facility, a physician should be summoned immediately by calling "code blue in room X." (or other designated terminology)

The physician who arrives first determines the need for basic life support or emergency medical services (EMS). Dial 911 if EMS are required. If a physician is not readily available, the highest-ranking medical staff should determine the need for cardiopulmonary resuscitation (CPR) and EMS.

Mid-level practitioners (physician assistants (PAs) and nurse practitioners (NPs)) are not permitted to administer advanced cardiac life support techniques, whether alone or under the supervision of a physician. They may, however, administer basic life-support (BLS) and perform the following:

- Start IV with solution of normal saline
- Administer oxygen
- Insert airway

The following basic emergency medical supplies and equipment must be available in all facilities:

- Benadryl 50 mg/ml
- Adrenaline 1:1,000/cc
- Nitrostat 1/150 gr. (0.4 mg)
- Solu-Medrol 40 mg/1 cc Mix-o-Vial
- Airways - three sizes (small, medium and large)
- Pediatric and adult Ambu bag

Emergency Transportation

If a member in a facility has a medical emergency requiring hospitalization, the attending physician must arrange ambulance transportation by a licensed ambulance company to the nearest emergency room.

If there is no contracting emergency transportation service and emergency transportation is needed, dial 911 or other local emergency number to obtain ambulance service. The receiving hospital calls for authorization when the member arrives.

Notification Requirements

Emergency departments must notify the member's primary care physician (PCP) whenever a member requires an emergency room visit. If an emergency care visit results in the member being admitted to the facility, the emergency department is required to notify Health Net's hospital notification department within 24 hours or the next business day. If the PPG is fully capitated for inpatient care and the notification is received by Health Net, it will be referred to the appropriate PPG for authorization.

For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. Notification, for a member assigned to Molina Healthcare and regarding an emergency care visit resulting in the member being admitted to the facility, may be given by telephone or by faxing a copy of the face sheet to Molina Healthcare. Notification to Health Net is not required.

Additional Monitoring Responsibilities

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

When a participating primary care physician (PCP) is contacted by an out-of-area provider to determine benefit coverage for a Health Net member, the participating PCP must:

- Verify that the member has Health Net coverage.
- Verify that the member receives health care services from the PCP.
- Inform the out-of-area provider that Health Net only covers out-of-area emergency admissions (less any applicable copayments or deductibles).
- Provide any follow-up care or obtain out-of-area authorization from Health Net.

The out-of-area provider or PCP is responsible for notifying the Hospital Notification Unit of all out-of-area emergency hospitalizations. The Medical Management Department monitors the out-of-area emergency hospital care, conducts concurrent review and determines whether the member can be transferred safely into the service area.

Claims are retrospectively reviewed to determine medical necessity and eligibility for payment of out-of-area services.

Request for Authorization to Provide Post-Stabilization Services at Non- Participating and Participating Hospitals

Participating Physician Groups (PPG) | Hospitals

Health Net is responsible for the coverage and payment of emergency services and post-stabilization care services to the hospital that furnishes the services. This can be a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

The hospital's request for authorization is required once the member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for post-stabilization care. A patient is "stabilized," or "stabilization" has occurred, when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Hospitals are required to provide the treating physician and/or surgeon's diagnosis and any other relevant information reasonably necessary for Health Net to decide whether to authorize post-stabilization care or to assume management of the patient's care by prompt transfer.

How to request Post-Stabilization Authorization

Who Must Request Authorization

The requirement to request authorization for post-stabilization care applies to both in-network and out-of-network hospitals.

How to Request Authorization

To request authorization for post-stabilization care, the hospital must call the Health Net Hospital Notification Unit.

What Does Not Satisfy the Requirement

- Notifying Health Net of emergency room treatment or admission alone does not meet the requirement to request authorization for post-stabilization care.
- Contacting any other Health Net phone number, fax number, or website does not satisfy this requirement.
- Contacting the member's participating physician group (PPG) does not satisfy this requirement.

Do not contact the member's PPG or any other Health Net contact point to request authorization for post-stabilization care.

When Post-Stabilization Authorization Does Not Apply

Post-stabilization authorization requirements do not apply if the member has not yet been stabilized after emergency services and requires medically necessary continued stabilizing care.

Participating Physician Groups (PPGs) Role and Responsibility

Participating physician groups (PPGs) must immediately notify the Health Net Hospital Notification Unit when:

- They receive a request for authorization for post-stabilization services from a non-participating hospital, or
- The request comes from a participating hospital but the PPG is not delegated for inpatient services,
- They receive any hospital request to authorize post-stabilization services for members who received emergency services.

A PPG in a dual-risk arrangement with a hospital is fully responsible for utilization management (UM) for members to whom the dual-risk relationship applies. Such UM includes eligibility verification, issuing authorizations or tracking numbers, and coordinating transfers or discharges. The PPG must immediately notify Health Net of any member admissions to non-participating hospitals to support Health Net in meeting regulatory requirements, which mandates a response within 30 minutes of a request for post stabilization services.

Health Net contacts the hospital with the information needed to either initiate member's transfer or authorize post-stabilization care. Pursuant to Health and Safety Code section 1262.8 (b)(3), hospitals must, once the member's emergency condition is stabilized, provide Health Net with the treating physician's identity and diagnosis and relevant medical information. This allows Health Net to coordinate with the PPG to manage the member's care through either transfer or authorization of medical necessary post stabilization services.

Under Health and Safety Code section 1317.1(j) a patient is "stabilized" or "stabilization" has occurred when, in the treating provider's judgment, the patient's condition is such that, within reasonable medical probability, no significant deterioration is likely or occur during or as a result of the patient's transfer or release. For hospitals outside of California, post-stabilization services are not subject to prior authorization, as they are considered part of emergency services under the No Surprises Act.

Refer to Emergency Services for more information specific to the member's health plan.

Failure to request post-stabilization authorization

Health Net may contest or deny claims for post-stabilization care following treatment in the emergency department or following an admission through a hospital's emergency department when Health Net does not have a record of the hospital's request for post-stabilization care via phone or a record that Health Net provided the hospital an authorization for such services.

CCS-eligible conditions (Medi-Cal members)

If a patient's Health Net identification (ID) card indicates enrollment through Medi-Cal, the member is under age 21, and services are related to a California Children's Services (CCS)-eligible condition, the hospital should still request post-stabilization authorization from Health Net's HNU using the procedure described above.

Required documentation

All requests for authorization, and responses to requests, must be documented. The documentation must include, but is not limited to:

- Date and time of the request.
- Name of the provider making the request.
- Name of the Health Net representative responding to the request.

Conditions of financial responsibility

Health Net is financially responsible for post-stabilization care services that are not pre-authorized, but are administered to maintain, improve, or resolve the member's stabilized condition if the Plan:

- Does not approve or disapprove a request for post-stabilization care within 30 minutes.
- Cannot be contacted.
- Is unable to reach an agreement with the treating provider concerning the member's care and a Plan physician is not available for consultation.

If this situation applies, the Plan must give the treating provider the opportunity to consult with a Plan physician. The treating provider may continue with care of the member until a Plan physician is reached or one of the following criteria is met:

- A Plan physician with privileges at the treating provider's hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility for the member's care through transfer;
- The Plan and the treating provider reach an agreement concerning the member's care; or
- The member is discharged

Behavioral health emergencies

- **Marketplace/IFP (Ambetter HMO and PPO) and Employer Group HMO/POS and PPO members:** Health Net covers mental health and substance use disorder treatment that includes behavioral health crisis services provided to a member by a 988 crisis call center, mobile crisis team or other behavioral health crisis services providers, regardless of whether that provider or facility is in network or out of network. Hospitals must call the Hospital Notification Unit to request authorization for members' post-stabilization care once they are deemed stable but require facility-based care.
- **Medi-Cal members:** Post-stabilization care in a general acute hospital is the Plan's responsibility. Once the member is admitted to an inpatient psychiatric facility following a psychiatric emergency, and stabilized, then the benefit falls under the responsibility of County Mental Health Plans (MHP).

County Mental Health Plan information is available through the Department of Health Care Services. Health Net will coordinate with the County Mental Health Plan to transition the member once appropriate.

Response time to requests

The Plan must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If a response to approve or disapprove the request is not provided within 30 minutes, the post-stabilization care request is considered authorized. This applies to any participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Out-of-Area Emergency or Urgently Needed Care

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

For information on out-of-area emergency or urgently needed care, refer to the Emergency Services, Coverage Explanation section.

PPG Responsibilities

Participating Physician Groups (PPG)

This section describes participating physician groups' (PPGs') responsibility when a member seeks emergency services.

Select any subject below:

- Notification of Admission
- Emergency Room Closures

Notification of Admission

Provider Type: Participating Physician Groups (PPG)

The treating emergency department of a participating hospital is required to complete and send the hospital face sheet to Health Net's Hospital Notification Department for hospital admissions. The participating physician group (PPG) is required to notify the Health Net Medical Management Department and supply the PPG authorization number if treatment has been authorized.

For notification of hospital admission from a non-participating hospital, refer to the Hospital Request for Authorization to Provide Post-Stabilization Services.

24-Hour Access

The California Health and Safety Code and the California Code of Regulations, Title 28 section 1300.67(g)(1) requires that the participating physician group (PPG) provide uninterrupted access to medical services 24 hours a day, seven days a week.

Emergency Room Closures

Participating Physician Groups (PPG)

Within 30 days of Health Net or its participating physician groups (PPGs) receiving notice that an acute care hospital intends to reduce or eliminate its emergency services, affected PPGs must notify members by mail. Health Net works with affected PPGs to help them comply with this requirement.

Procedures to Report System & Protocol Failures

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Emergency department provider will contact Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) if they experienced a failure in utilizing the Health Plan's systems and/or emergency services protocols. Health Plan will work with Provider to ensure any corrective action is implemented to resolve the issue.

Encounters

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information about encounter data submission.

Select any subject below:

- Overview
- Dual-Risk Contracts Encounter Data Submission
- Encounter Reporting
- Error Notification
- Noncompliance with Encounter Data Submission
- Professional and Institutional Capitated Encounter Submission Requirements

Overview

Provider Type: Participating Physician Groups (PPG) | Ancillary | Hospitals

To comply with the requirements of the Department of Health and Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), the California Department of Health Care Services (DHCS), the California Disproportionate Share Hospital (DSH) Program, the Managed Risk Medical Insurance Board (MRMIB), and the National Committee for Quality Assurance (NCQA), Health Net requires information from its providers on members' use of health services.

Capitated participating physician groups (PPGs), hospitals and ancillary providers are required to provide complete encounter data about professional services rendered to Health Net members. These services include office visits; X-rays; laboratory tests; surgical procedures; anesthesia; physician visits to the hospital; inpatient,

outpatient, emergency room, out-of-area, or skilled nursing facility (SNF) services; and all professional referral services. Capitated participating facilities (and physician groups with dual-risk contracts) are required to provide encounter data no less than monthly about institutionally-based services rendered to Health Net members.

Encounter data submissions must include all member-paid cost-share amounts, such as copayments, coinsurance and deductibles, applicable to the member's benefit. In addition, any rejected encounter data must be corrected and resubmitted in order for complete information and correct member-paid cost-share amounts to be captured and accumulated. Encounter data submission is also an integral part of the Health Net Quality of Care Improvement Program (QCIP) (applicable only for HMO and Point of Service (POS) products) and Healthcare Effectiveness Data and Information Set (HEDIS®). Refer to the Quality Improvement (QI) topic for more information about QCIP.

Dual-Risk Contracts Encounter Data Submission

Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) who are contracting for dual risk are responsible for submitting encounter data to Health Net monthly for all professional and hospital services in a complete, accurate and timely manner. Health Net requires PPGs to submit their encounter data according to the terms of the Provider Participation Agreement (PPA).

The following applies to Medicare dual-risk contracts:

- The Centers for Medicare & Medicaid Services' (CMS') payment methodology is a risk-adjusted payment rate based on hospital encounter data submitted to the health plans. Payment is based on demographic factors and reported health conditions. Payments for members with no reported conditions are reduced, while payments for members with specific reported conditions can be significantly increased. For the hospital to receive increased payments, the condition needs to be reported via encounter data. Failure to report these encounters can have significant impact on the PPG's and hospital's revenues.
- CMS requires hospitals to submit full UB-04 data. Providers needing assistance should contact the Capitated Claims/Encounter Department.
- Upcoding of ICD-10 diagnosis codes is not allowed. CMS audits hospital medical records to ensure that this does not occur.
- Continue to include the Medicare HCPCS code on the UB-04 form for each hospitalized member.

Inpatient Admissions

In accordance with the PPA, Health Net and the member's PPG require notification to Health Net and the applicable PPG of a member's inpatient admission within 24 hours for the following types of admissions:

- Acute inpatient
- Skilled nursing facility (SNF)
- Inpatient rehabilitation

- Inpatient hospice

Error Notification

Participating Physician Groups (PPG) | Ancillary | Hospitals

Encounter data submitted to Health Net can fail at the file level or the encounter level. If there is a file failure, the submitter is notified by the Capitated Claims/Encounter Department. The file must be corrected and resubmitted.

If the encounter file passes on to encounter level edits, the following reports are produced:

- Claims/Encounters Control Summary Reports - reports receipt/accept/reject totals for reconciliation.
- Encounter/Claims Rejection Report - identifies specifics for encounters that failed edits and require correction and resubmission.

Contact the Capitated Claims/Encounter Department if record-specific resubmission cannot be generated.

Noncompliance with Encounter Data Submission

Participating Physician Groups (PPG) | Ancillary | Hospitals

Capitated providers, facilities and facilities with dual-risk contracts are contractually required to submit data for all services provided. Ongoing, uncorrected noncompliance with encounter data requirements is reported to the Health Net Delegation Oversight Committee (DOC).

Professional and Institutional Capitated Encounter Submission Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers may submit encounters to Health Net through an authorized electronic data interchange (EDI) clearinghouse, utilizing Snip level 1-5. To initiate or discuss the submission of encounter data files, contact the Capitated Claims/Encounter Department.

All professional and institutional encounters must be submitted in an electronic format. For additional information about how to submit encounters electronically, refer to 837 Institutional Transaction Standard Companion Guide (PDF), 837 Professional Standard Companion Guide (PDF) or 837 5010 Professional & Institutional Standards for Trading Partners (PDF).

Capitated providers are contractually required to submit complete and correct data for all professional and institutional services performed. Before submitting encounter data, the submitter should contact the Health Net Encounter Department to discuss submission format and data requirements. Health Net currently accepts the ANSI 837 5010 X12 format.

All data should be submitted according to the terms of the *Provider Participation Agreement (PPA).* If the participating physician group (PPG) does not submit data within this time frame, the PPG is excluded from incentive programs.

Enrollment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information and procedures regarding member enrollment.

Select any subject below:

- Member Enrollment
- Use of Social Security Numbers

Member Enrollment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Department of Health Care Services (DHCS) established the Health Care Options (HCO) referral process to provide Medi-Cal beneficiaries with information on the benefits of receiving health care services through managed care plans and to help the beneficiary choose a managed care plan. The HCO enrollment contractor is also responsible for assigning beneficiaries who fail to choose a health plan on the Medi-Cal Choice form.

Beneficiaries who have questions regarding the enrollment process can be referred to the HCO enrollment contractor.

Initial Eligibility or Annual Redetermination

The HCO enrollment contractor sends an enrollment packet to all Medi-Cal beneficiaries who do not make a choice at an HCO enrollment contractor presentation. The enrollment packet contains provider directories, a health plan comparison chart, enrollment instructions, Medi-Cal Choice form, and Medi-Cal Choice booklet.

Medi-Cal Choice Form for Enrollment

The beneficiary must select a health plan in his or her designated county and complete and mail back the Medi-Cal Choice form to the HCO enrollment contractor within 30 days of receiving the Medi-Cal Choice form from the HCO enrollment contractor. If the beneficiary does not select a health plan, the HCO enrollment contractor assigns one based on DHCS criteria.

Health plans and affiliated physicians may not submit Medi-Cal Choice forms on behalf of Medi-Cal beneficiaries. The HCO enrollment contractor mails enrollment forms directly to Medi-Cal beneficiaries.

Auto Assignments

The HCO enrollment contractor notifies the applicant or beneficiary in writing of the assignment to a Medi-Cal health plan at least 10 business days prior to submitting the documents to the DHCS. If the assignment is not appropriate, or if the beneficiary wishes to enroll in a different Medi-Cal health plan, the beneficiary must contact the HCO enrollment contractor to enroll in another Medi-Cal health plan. If a beneficiary chooses a health plan but neglects to choose a primary care physician (PCP), the health plan automatically assigns a PCP. Refer to the Primary Care Physician Selection and Assignment discussion under the Member Rights and Responsibilities topic for additional information.

Member Information Mailed

A packet containing provider directories, a health plan comparison chart, enrollment instructions, Medi-Cal Choice form, and Medi-Cal Choice booklet is mailed to new members by the state's enrollment contractor.

New Member Files

Health Net receives an enrollment tape from the HCO enrollment contractor and a Medi-Cal Eligibility Data System (MEDS) tape from DHCS. The HCO enrollment contractor data is uploaded into Health Net's computer system to create a new member record, and the MEDS tape is run against the new member record to update eligibility. This process creates a new member file for the purpose of producing identification cards.

Identification Card and Member Material Distribution

Health Net sends new members a welcome letter and packet, which includes the Evidence of Coverage (EOC), provider directory, preventive care services, and other important plan information. The materials are in the language preference indicated by the member. The ID cards and the new member packets are mailed within seven days of the member's effective date of enrollment.

Member Identification Number

Health Net has adopted the Client Index Numbers (CINs), issued by the Department of Health Care Services (DHCS), as the identification (ID) numbers for all Health Net Medi-Cal managed care members. The CIN is formatted as an alphanumeric code, beginning with eight digits followed by a letter at the end.

In compliance with California law (SB 168 (ch. 720, 2001)), the CIN replaces the member's Social Security number (SSN) as the member ID number on most member-oriented materials and communications, including member ID cards.

Provider-oriented materials, including eligibility reports and other health plan correspondence, include both the member's CIN and SSN for identification purposes. Health Net also continues to use SSNs for internal verification and administrative purposes as allowed by law

Use of Social Security Numbers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The plan has implemented the use of alternate identification (ID) numbers for all members to replace the member's Social Security number (SSN) as the subscriber or member ID number on most member-oriented materials and communications, including member ID cards.

The purpose of this change is to comply with SB 168 (ch. 720, 2001), which prohibits any person or agency (excluding state or local agencies) from any of the following:

- Publicly posting or displaying an individual's SSN.
- Printing a member's SSN on any card needed to access products or services, such as a member ID card.
- Requiring members to transmit their SSNs over the Internet unless the connection is secure or the SSN is encrypted.
- Requiring members to use their SSNs to access a website, unless a password or unique ID number is also required to access the website.
- Printing a member's SSN on any materials that are mailed to the member, unless required by state or federal law.

Exceptions established by SB 1730 (ch 786, 2002) include applications, forms and other documents sent by mail for the following:

- As part of an application or enrollment process.
- To establish, amend or terminate an account, contract or policy.
- To confirm the accuracy of the SSN.

These exceptions are subject to restrictions established by AB 763 (ch. 532, 2003), which prohibits the printing of the SSN, in whole or in part, on a postcard or any other type of mailer that does not require an envelope and allows the SSN to be visible without opening the mailer.

Provider-oriented materials, including eligibility reports and other health plan correspondence, includes both the member's alternate ID number and SSN for identification purposes. The plan also continues to use SSNs for internal verification and administration purposes as allowed by law.

Participating providers are subject to the same regulations.

Refer to the discussion of subscriber/member ID numbers under the Enrollment topic for more information on ID number format.

ID Cards

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information about member identification (ID) cards for Health Net plans, as well as sample ID cards.

Select any subject below:

- Member ID Card

Member ID Card

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A new identification (ID) card is automatically sent when:

- A new member enrolls
- A member changes his or her name, physician or participating physician group (PPG)
- The medical plan changes at renewal and the copayment changes

Refer to the samples below to view a picture and descriptions of the fields. Note: for some ID cards, there are two versions available, and either version should be accepted.

- Identification cards (Medi-Cal mainstream) (PDF) or (Medi-Cal mainstream) (PDF)
- Identification cards (Medi-Cal CalViva Health) (PDF) or Medi-Cal CalViva Health) (PDF)
- Identification cards (Medi-Cal Community Health Plan of Imperial Valley) (PDF) or (Medi-Cal Community Health Plan of Imperial Valley) (PDF)

These are sample ID cards only. The information included in them is subject to change. Providers should refer to a member's ID card when they present for services for current benefit and health plan information.

Medical Records

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains information regarding medical records. Select any subject below:

- Medical Records
- Confidentiality of Medical Records
- Medi-Cal Medical Records Review
- Medi-Cal Medical Record Documentation
- Medi-Cal Medical Record Documentation Standards
- Medical Records Performance Measurements
- Advance Directive

Medical Records

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers are required to maintain member medical records in a manner that is current, detailed, complete, and organized. In addition, medical records must reflect all aspects of member care, be readily available to health care providers and provide data for statistical and quality-of-care analysis. Health Net and its participating providers must maintain active books, records, documents, and other evidence of accounting procedures and practices for 10 years for Medi-Cal and five years for Commercial. An active book, record or document is one related to current, ongoing or in-process activities and referred to on a regular basis to respond to day-to-day operational requirements.

The following retention events must also be considered in reference to the required timeframes in which medical records must be maintained by providers. These retention requirements are based on Health Net's current Corporate Records Retention Schedule:

- Pediatric medical records must be maintained for10 years for Medi-Cal and five years for Commercial, seven years after age 21
- Hospitals, acute psychiatric hospitals, skilled nursing facilities (SNFs), primary care clinics, and psychology and psychiatric clinics must maintain medical records and exposed X-rays for a minimum of seven years following patient discharge, except for minors
- Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than seven years

Health Net must ensure maintenance of all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 10 years for Medi-Cal and five years for Commercial from the end of the fiscal year in which Health Net's contract expires or is terminated with a member.

Standards for the administration of medical records by participating providers are established by the Quality Improvement Health Equity Committee (QIHEC). The standards form the basis for the evaluation of medical records by Health Net. Medical records for primary care physicians (PCPs) may be selected for evaluation as part of the annual delegation oversight assessment.

Health Net requires participating providers to have a written policy in place that provides for the protection of confidential protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism designed to safeguard medical records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about member information to maintain confidentiality.

Provision of Medical Records

The following applies to these counties: Los Angeles, Amador, Calaveras, Inyo, Mono, Tuolumne , Sacramento, San Joaquin, Stanislaus, Tulare.

Participating physician groups (PPGs), physicians, hospitals and ancillary providers are required to provide Health Net with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net can make claims and benefit determinations for Health Net utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Right to Audit and Access Records, including Electronic Medical Records (EMR)

Access to Records and Audits by Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records when Health Net or its designated representative requests access to them in order to audit, inspect, review, perform chart reviews, and duplicate such records.

For on-Exchange plans and the Medicare line of business, if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice.

For Medi-Cal if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When Health Net requests access to electronic medical records (EMR), the provider will grant the health plan access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the health plan for this access.

Written Protocols

Participating providers are required to have systems and procedures in place that provide consistent, confidential and comprehensive record-keeping practices. Written procedures must be available upon Health Net's request for:

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included
- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)
- Formal system for the availability and retrieval of medical records - Policy and procedure must allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - Policy and procedure must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with state laws and regulations (for providers who see commercial health plan patients)
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicare patients)
- Preventive care guidelines for pediatric and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of member information

Provision of Medical Records (CalViva Health)

The following applies to these counties: Fresno, Kings, Madera.

Participating physician groups (PPGs), physicians, hospitals, and ancillary providers are required to provide Health Net and CalViva Health with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net and CalViva Health can make claims and benefit determinations for utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Provision of Medical Records (Community Health Plan of Imperial Valley)

The following applies to Imperial County.

Participating physician groups (PPGs), physicians, hospitals, and ancillary providers are required to provide Health Net and Community Health Plan of Imperial Valley (CHPIV) with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net and CHPIV can make claims and benefit determinations for utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Confidentiality of Medical Records

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, claims and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. Written authorization from the member or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the health plan.

Health Net requires participating providers to have a written policy in place that provides for the protection of confidential protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a

functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about member information to maintain confidentiality.

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PHI is considered confidential and encompasses any individual health information, including demographic information collected from a member, which is created or received by Health Net and relates to the past, present or future physical, mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member or there is a reasonable basis to believe the information may be used to identify the member. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written member authorization.

Confidentiality of Medical Information

Sensitive services are defined as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924-6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

Assembly Bill 1184 (2021), amends the Confidentiality of Medical Information Act to require health care plans to take additional steps to protect the confidentiality of a subscriber's or enrollee's medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

These steps include:

- A protected individual (member) is not required to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care.
- Not disclose a member's medical information related to sensitive health care services to the primary subscriber or other enrollees, unless the member's authorization is present.
- Notify the subscriber and enrollees that they may request confidential communications and how to make the request. This information must be provided to "enrollees" at initial enrollment and annually.
- Respond to confidential communications requests within:
    - 7 calendar days of receipt via electronic or phone request or
    - 14 calendar days of receipt by first-class mail
- Communications (written, verbal or electronic) regarding a member's receipt of sensitive services should be directed to the member's designated mailing address, email address, or phone number. For protected individuals who may not have designated an alternative mailing address, the provider and/or Plan is required to send the communications to the address or phone number on file in the name of the protected individual.
- Confidential communication includes:
    - Bills and attempts to collect payment.
    - A notice of adverse benefits determinations.
    - An explanation of benefits notice.

- A plan's request for additional information regarding a claim.
- A notice of a contested claim.
- The name and address of a provider, description of services provided, and other information related to a visit.
- Any written, oral, or electronic communication from a plan that contains protected health information.

Medical information includes immigration status and place of birth

In accordance with Senate Bill 81, medical information and protected health information (PHI) explicitly includes immigration status (past or present) and place of birth, when such information is known or collected. **These data elements must be treated with the same level of confidentiality and protection** as all other individually identifiable health information under the Confidentiality of Medical Information Act (CMIA) and HIPAA.

Agencies Must Be Authorized To Receive Medical Records

The relationship and communication between a participating provider and member is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and protected health information (PHI), whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

Prohibition on disclosure for immigration enforcement

Disclosure of protected health information (PHI), including medical information such as immigration status and place of birth, for immigration enforcement purposes is strictly prohibited unless required by federal law.

Health Net and its affiliated entities must not, to the extent possible, allow access to patient information or facilities for immigration enforcement activities unless a valid judicial warrant or court order is presented.

Requirements for a Valid Authorization for Release of Information

Providers must obtain signed authorization from the member to use or disclose the member's medical information. You also need to give instructions to members on how to access additional copies or digital versions of the signed authorization. The signed authorization must:

- Be written in plain language and no smaller than 14-point font.
- Be dated and signed with an electronic or handwritten signature by the member or person authorized to act on behalf of member.
- Specify the type of individuals authorized to disclose information about the member.
- Specify the nature of the information authorized to be disclosed.
- State the name or functions of the persons or entities authorized to receive the information.
- Specify the purposes for which the information is collected.
- Specify the length of time the authorization shall remain valid.

- State an expiration date or event. The expiration date for a valid signature is up to one year unless the person signing the authorization requests a specific date beyond a year, or the authorization is related to an approved clinical trial1 after which the provider, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

Real Time Data Exchange of Health Information

The following entities shall exchange health information or provide access to health information to and from every other of these same entities in real time as specified by the California Health and Human Services Agency pursuant to the California Health and Human Services Data Exchange Framework data sharing agreement for treatment, payment, or health care operations.

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities that currently maintain electronic records.
- Health care service plans and disability insurers that provide hospital, medical, or surgical coverage that are regulated by the Department of Managed Health Care or the Department of Insurance, and Medi-Cal managed care plans contracted with the State Department of Health Care.
- Clinical laboratories regulated by the State Department of Public Health.
- Acute psychiatric hospitals.

Exceptions

The exchange of health information described above does not apply to:

- Physician practices of fewer than 25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.
- Abortion and abortion-related services.

Basic Principles

Protected health information (PHI) may be shared with participating providers in the same facility only, on a need-to-know basis, and may be disclosed outside the facility only to the extent necessary such release is authorized.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), PHI, whether it is written, oral or electronic, is protected at all times and in all settings. Disclosure of PHI must have prior written member authorization. Health Net participating providers only release PHI without authorization when:

- Needed for payment
- Necessary for treatment or coordination of care
- Used for health care operations (including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, appeals and grievances, utilization management, quality improvement, and disease or care management programs)
- Where permitted or required by law

Health Net and participating providers may transmit PHI to individuals or organizations, such as pharmacy or disease management vendors, who contract to provide covered services to members. PHI cannot be intentionally shared, sold or otherwise used by Health Net, its subsidiaries, participating providers, or affiliates for any purpose other than for payment, treatment or health care operations or where permitted or required by law without an authorization from the member.

AB 715 (ch. 562, 2003) supports compliance with HIPAA and applicable state laws relating to use of PHI for marketing. Marketing is defined as a communication about a product or service that encourages recipients to purchase or use the product or service. Health plans, providers, pharmaceutical benefit managers, and disease management entities are prohibited from using PHI to market a product or service unless the communication meets one of the exceptions described below:

- Written or oral communication whereby the communicator receives no compensation from a third party
- Communications made to a current member solely for the purpose of describing a provider's participation in an existing health care provider network or health plan network to which the member subscribes
- Communications made to a current member solely for the purpose of describing products, services, payment, or benefits for the health plan to which the member subscribes
- Communication to describe a plan benefit or an enhancement or replacement to a benefit
- Communications describing the availability of more cost-effective pharmaceuticals
- Compensation communications tailored to a specific individual that educate or advise them about disease management or life-threatening, chronic or seriously debilitating conditions if:
    - The member receiving the communication is notified in writing that the provider, contractor or health plan has been compensated, and identifies the source of the compensation
    - The communication must include information on how the member can opt out of receiving further communications by calling a toll-free number and must be written in 14 point font or larger. No communication can be made to a member who has opted out after 30 days from the date of the request
- Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release PHI regarding sensitive conditions, Health Net and participating providers must obtain written authorization from the member (or authorized representative) stating that information specific to the sensitive condition may be disclosed.

In the event the member is unable to give authorization, Health Net or the participating provider accepts the authorization of the person holding power of attorney or any other authorized representative in order to release information or have access to information about the member. Refer to the Procedure discussion for more information regarding authorized representatives.

Members may obtain their own medical records upon request. Adult members have the right to provide a written addendum to the medical record if the member believes that the record is incomplete or inaccurate. Members may request that their PHI be limited or restricted from disclosure to outside parties or may request the confidential communication of their PHI to an alternate address. Members may file a grievance with respect to any concerns they have regarding confidentiality of data.

Procedure

Participating providers, policies and procedures governing the confidentiality of medical records and the release of protected health information (PHI) must address levels of security of medical records, including the:

- Assurance that the files are secure and not accessible to unauthorized users
- Indication of who has access to the medical records
- Identification of who may execute different database functions for computerized medical records
- Assurance that staff is trained with respect to the Health Insurance Portability and Accountability Act (HIPAA), privacy requirements and related policies
- Signed confidentiality agreements on file from staff who have access to medical records
- Assurance that photocopies or printouts of the medical records are subject to the same control as the original record
- Designation of a person to destroy the medical record when required

Release of medical information guidelines must address:

- Requests for PHI via the telephone
- Demands made by subpoena duces tecum
- Timely transfer of medical records to ensure continuity of care when a Health Net member chooses a new primary care physician (PCP)
- Availability and accessibility of member medical records to Health Net and to state and federal authorities or their delegates involved in assessing quality of care or investigating enrollee grievances or other complaints
- Availability and accessibility of member medical records to the member in a timely manner in accordance with industry standards and best practices
- Requirements for medical record information between providers of care:
    - A physician or licensed behavioral health care provider making a member referral must transmit necessary medical record information to the provider receiving the member referral
    - A physician or licensed behavioral health care provider furnishing a referral service provides appropriate information back to the referring provider
    - A physician or licensed behavioral health care provider requesting information from another treating provider as necessary to provide care. Treating physicians or licensed behavioral health care providers may include those from any organization with which the member may subsequently enroll

An authorization form must be in plain language and contain the following to be HIPAA-compliant:

- A specific and meaningful description of the information to be used or disclosed
- The name of the person or entity authorized to make the requested use or disclosure
- The name of a person or entity to which the use or disclosure may be made
- A description of each purpose or use for the information. If the individual requests the authorization for their own purposes, the description here may read simply "at the request of the individual"
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- The signature of the individual and the date
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation
- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization, unless a valid exception applies (such as, pre-enrollment

underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule

Visitor access and immigration enforcement procedures

- Participating providers must have in place procedures for monitoring, documenting, and receiving visitors to ensure compliance with privacy and security standards.
- Staff must be trained to immediately notify facility management, administration or legal counsel upon receiving any request for access to the site or to a patient for immigration enforcement purposes.
- Requests for review of documents or access to nonpublic areas must be directed to designated personnel and must not be granted unless accompanied by a valid judicial warrant or court order.
- Participating providers must clearly define and designate nonpublic areas, including treatment spaces and locations where protected health information is discussed, using signage, access controls or mapping.
- Denials of access to nonpublic areas for immigration enforcement should be witnessed and documented by at least one staff member.

Medi-Cal Medical Records Reviews

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's Facility Site Review (FSR) Compliance Department conducts periodic medical record reviews (MRRs) to measure provider compliance with current Department of Health Care Services (DHCS) medical record documentation standards.

The Health Net FSR Compliance Department continually develops and offers materials to simplify the documentation process. Refer to Facility Site Review to obtain materials about legal and regulatory requirements on providers' responsibilities, such as:

- The Facility Site Review Tool.
- The Facility Site Review Standards.
- The Medical Record Review Tool
- The Medical Record review Standards

These materials and other items are available assist providers in understanding and complying with the required documentation standards.

Medical Record Review Scheduling, Frequency, Scoring, and Compliance

Health Net and all other managed care health plans are required to collaborate in conducting medical record reviews (MRRs). On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a primary care physician (PCP) site. When needed, the plan administers a corrective action plan (CAP). The collaborative effort serves to reduce the frequency of audits of the PCP's office by eliminating unnecessary duplication by multiple plans. Health Net's State Health Programs Quality Improvement Department is responsible for conducting collaborative reviews on behalf of Health Net.

Representatives from the responsible plan contact the provider office prior to the MRR to discuss audit policies and procedures. A packet containing documentation materials is sent to the provider prior to the site review to enable the office to prepare for the audit. Copies of the MRR tool and related regulatory requirements are available at The Department of Health Care Services (PDF).

The responsible plan shares the audit results and CAP with the other participating health plans. DHCS reviews the results of MRRs and may audit a random sample of provider offices to ensure they meet DHCS standards.

MRRs of new providers are conducted within 90 calendar days from the date members are first assigned to the provider. An extension of an additional 90 calendar days may be granted if the provider has fewer than 10 assigned members.

Written results are provided to the provider within 10 days of the close of the audit by the health plan. A passing score for the MRR is 90%. Providers receiving scores between 80 and 89% (considered a conditional pass) on an MRR audit are required to complete a corrective action plan (CAP). Providers may be re-reviewed in 12 months, or sooner, if deemed appropriate, to assess compliance with the CAP.

For an initial medical record review (MRR), new members are not assigned to a PCP who receives a non-passing score (below 80%) until all corrections are verified and the CAP is closed. Providers who do not comply with the CAP within the established time frames are removed from the network.

After the initial audit, participating providers are re-audited at least every three years. A full-scope site audit, which includes both the MRR and Facility Site Review (FSR), is conducted at this time. Providers must receive a conditional passing score of at least 80% on both reviews. Medical record review audit results are shared among Medi-Cal managed care plan. Sites receiving a non-passing score from one plan are considered to have a non-passing score by all other Medi-Cal managed care plan.

Practitioners who do not comply with a CAP or fail to achieve threshold in three consecutive audit are forwarded to Health Net's Credentialing Committee for administrative termination. The termination is applicable to the Medi-Cal contracting line of business and practice locations and remains in effect for three years from the date of the committee's final decision.

Medical Record Documentation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement Health Equity Committee (QIHEC) develops standards for the administration and evaluation of medical records. Participating providers are required to comply with all medical record documentation standards.

Health Net requires participating providers to maintain medical records in a manner that is accurate, current, detailed, complete, organized, in accordance with industry standards and best practices, and permits effective and confidential member care and quality review. Medical records must reflect all aspects of member care, be

readily available to health care providers and provide data for statistical and quality-of-care analysis. Medical records may be selected for evaluation as part of the annual delegation oversight assessment.

Medi-Cal Medical Record Documentation Standards

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal providers are required to meet both Health Net and the Department of Health Care Services (DHCS) Medi-Cal medical record documentation standards. The following documentation guidelines are excerpts, but not limited to only these criteria and must be followed and all of the elements must be included in the medical records of Medi-Cal members.

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing-impaired persons, individual personal biographical information, emergency contact, and identification of the member's assigned primary care physician (PCP). If a primary language other than English is noted and forms in the member’s medical record are in another language, there must be an English version of that form in that member’s medical record also.
- The refusal or request of interpreter services by an LEP-speaking health plan member must be documented in the medical record. Providers are required to document in the medical record the refusal of qualified interpreter services and the preference of a health plan member to use an adult family member or friend as an interpreter.
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies and reactions, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the ofference of advanced health care directive information and education to members 18 and older must be included and reviewed every 5 years.
    - Telephone advice - notation of the date of the call, time, details of the conversation, and signature and title of the staff member handling the call.
    - Urgent and emergency documentation - notation of the date, time, means of arrival, history of illness or accident, physical findings, diagnostic tests, treatment received, diagnostic impression, and discharge summaries.
- Coordination of care - Notation of missed appointments, follow-up care and outreach efforts, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans.
- Preventive care - All new Medi-Cal members must receive an Initial Health Appointment (IHA), which includes an age-appropriate history and physical examination within 120 days of enrollment. This includes risk assessments such as Adverse Childhood Experiences (ACEs), Social Determinants of Health (SDOH) with 120 days of enrollment and yearly thereafter.
    - Members may be seen initially during a visit for episodic care. Regardless of the reason for the initial visit, the PCP or other provider within the primary care setting, should conduct the IHA at the first health care contact and document the assessment in the medical record.
- Adult preventive care and anticipatory guidance, according to the United States Preventive Services Task Force (USPSTF) - Notation of periodic health evaluations, assessment of immunization status, vaccine administration documentation and vaccine information status

publication date, tuberculosis screenings and testing, blood pressure and cholesterol screenings, Chlamydia screenings for sexually active females to age 25 or at risk, and mammograms and Pap tests for females, colon CA screening, obesity, diabetes, osteoporosis, Hep B & C, HIV, sexually transmitted infections (STI), alcohol/drug/tobacco and intimate partner violence screening.

- Pediatric preventive care and anticipatory guidance, according to the AAP - Notation of age-appropriate physical exams; immunizations specified and within AAP and Healthcare Effectiveness Data and Information Set (HEDIS®) requirements; anticipatory guidance for age-appropriate levels; vision, hearing, lead, and tuberculosis screenings and testing; and nutrition and dental assessments, depression, suicide risk, sudden cardiac arrest and sudden cardiac death, STI, alcohol/drug/tobacco screening.
- DHCS requires providers to document each member's need for Advisory Committee on Immunization Practices (ACIP)-recommended immunizations as part of all regular health visits and to report the administration of immunizations within 14 days.
    - Providers must enroll in and use the California Immunization Registry (CAIR) website at CAIRweb.org to report and track patient immunization records online.
- Perinatal preventive care - notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, including a timely prenatal visit within the first trimester; initial and subsequent comprehensive prenatal assessments (ICA) and trimester reassessments; postpartum visit four to six weeks after delivery - this interval may be modified according to the needs of the member, such as HEDIS timelines of 21-56 days after delivery; individualized care plan (ICP); domestic violence and abuse screenings; human immunodeficiency virus (HIV), alpha fetoprotein (AFP), and genetic screenings; Women, Infants, and Children (WIC) referrals; and assessments of infant feeding status, maternal depression, psycho social, family planning.

Medical Record Performance Measurements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net monitors medical record documentation through a variety of measures, which includes, but is not limited to, various quality initiatives, data collection by way of primary care physician (PCP) medical record audits, and records collected through the Healthcare Effectiveness Data and Information Set (HEDIS®) process. Data is aggregated and analyzed at least annually. Opportunities for improvement are identified and appropriate interventions are implemented based on compliance levels established for each individual activity. Interventions may include sending providers updates, educational or reference materials, creating template medical record forms, and provider and staff education and training. Participating providers are required to obtain a performance level of at least 80% on the medical record performance measures for a conditional pass.

Advanced Directives

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

An “Advanced Health Directive” is a legal form that allows the member to designation a representative; a person they want make decisions on their behalf or if loose the capacity to make decisions. Additionally, the member can also name people that they do not want to make decisions on their behalf, if they lose the capability to speak or loose the capacity make decision for themselves. The member can ask a family member or a primary care physician or someone they trust to help fill out the form. Members have certain rights regarding a “Advanced Health Directive”: The right to learn about changes to the law regarding Advanced Health Directives; The right to have their Advanced Health Directive be placed in their medical record; and The right to change or cancel their Advanced Health Directive at any time.

Member Rights and Responsibilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on member rights and responsibilities.

Select any subject below:

- Overview
- Advance Directives
- Member Confidentiality
- PCP Selection and Assignment
- Member Cost-Sharing Protections

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members have the right to expect a certain level of service from their health care providers. Members are also responsible for cooperating with providers in obtaining health care services. These member rights and responsibilities apply to members' relationships with Health Net, and all participating providers responsible for member care.

Health Net members are notified of their rights and responsibilities via the annual member mailing and the Evidence of Coverage (EOC). The following text is taken directly from the Health Net Medi-Cal member's handbook.[1]

All counties excluding CHPIV and CalViva Health (Imperial, Fresno, Kings and Madera counties)

Health Net members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits. Call your doctor's office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information.** You are responsible for giving correct information and as much as you can to all of your providers, and Health Net. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor. Work with your doctor to develop and agreeingagree on goals, doing. Do your best to understand your health problems, and following. Follow the treatment plans and instructions you both agree on.
- **Use the emergency room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrong-doing.** You are responsible for reporting health care fraud or wrong-doing to Health Net Community Solutions. You can do this without giving your name by calling Health Net Fraud and Abuse Hotline toll-free at 866-685-8664.The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

These are your rights as a member of Health Net

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities.
- To get fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about Health Net's member rights and responsibilities policy.
- To be able to choose a primary care provider within Health Net's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for Health Net's decision to deny, delay, terminate (end), or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get free interpreting and translation services for your language.
- To ask for free legal help at your local legal aid office or other groups.
- To formulate advance directives.

- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Health Net and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll (drop) from Health Net and change to another health plan in the county upon request.
- To access minor consent services.
- To get free written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Health Net, your providers or the state.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency care outside Health Net's network pursuant to federal law.
- To request an Appeal of a denied claim up to 60 days from the date on the notice you receive. This notice is called the “Notice of Adverse Benefit Determination (NABD).” The Appeal process is through the State Fair Hearing. You can also ask how to continue with your health care during the Appeal process.

Fresno, Kings, Madera Counties

CalViva Health members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits. Call your doctor's office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information.** You are responsible for giving correct and as much information as you can to all of your providers, and CalViva Health. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor. Work with your doctor to develop and agree on goals. Do your best to understand your health problems. Follow the treatment plans and instructions you both agree on.
- **Use the emergency room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrong doing.** You are responsible for reporting health care fraud or wrong doing to CalViva Health. You can do this without giving your name by calling the CalViva Health Fraud and Abuse Hotline toll-free at 866-685-8664. The Fraud Hotline operates 24 hours a day, 7 days a week. All calls are strictly confidential.

These are your rights as a member of CalViva Health

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities.
- To get fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about CalViva Health's member rights and responsibilities policy.
- To be able to choose a primary care provider within CalViva Health's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for CalViva Health's decision to deny, delay, terminate (end) or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get free interpreting and translation services for your language.
- To ask for free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with CalViva Health and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll (drop) from CalViva Health and change to another health plan in the county upon request.
- To access minor consent services.
- To get free written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by CalViva Health, your providers, or the state.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection care and emergency services outside CalViva Health's network pursuant to federal law.
- To request an Appeal of a denied claim up to 60 days from the date on the notice you receive. This notice is called the “Notice of Adverse Benefit Determination (NABD).” The Appeal process is through the State Fair Hearing. You can also ask how to continue with your health care during the Appeal process.

Imperial County

Community Health Plan of Imperial Valley members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits. Call your doctor's office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information.** You are responsible for giving correct and as much information as you can to all of your providers, and to Community Health Plan of Imperial Valley. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor. Work with your doctor to develop and agree on goals. Do your best to understand your health problems. Follow the treatment plans and instructions you both agree on.
- **Use the emergency room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrong doing.** You are responsible for reporting health care fraud or wrong doing to Community Health Plan of Imperial Valley. You can do this without giving your name by calling Community Health Plan of Imperial Valley Fraud and Abuse Hotline toll-free at 866-685-8664. The Fraud Hotline operates 24 hours a day, 7 days a week. All calls are strictly confidential.

These are your rights as a member of Community Health Plan of Imperial Valley :

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities.
- To get fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about Community Health Plan of Imperial Valley’s member rights and responsibilities policy.
- To be able to choose a primary care provider within Community Health Plan of Imperial Valley’s network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for Community Health Plan of Imperial Valley’s decision to deny, delay, terminate (end) or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get free interpreting and translation services for your language.
- To ask for free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Community Health Plan of Imperial Valley’s and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.

- To disenroll (drop) from Community Health Plan of Imperial Valley's and change to another health plan in the county upon request.
- To access minor consent services.
- To get free written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Community Health Plan of Imperial Valley's, your providers or the state.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency care outside Community Health Plan of Imperial Valley's network pursuant to federal law.
- To request an Appeal of a denied claim up to 60 days from the date on the notice you receive. This notice is called the "Notice of Adverse Benefit Determination (NABD)." The Appeal process is through the State Fair Hearing. You can also ask how to continue with your health care during the Appeal process.

[1] The actual statements of member rights and responsibilities are in accordance with the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) and may vary slightly from what is listed. In addition to member rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, creed, ancestry, religion, language, sex, marital status, sexual orientation, gender identity, age, health status, physical or mental disability, or any identification with any other persons or groups defined in Penal Code 422.56.

Advanced Directives

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

An advance directive is a formal document, written in advance of an incapacitating illness or injury in which one can assign decision-making for future medical treatment. California legally recognizes the durable power of attorney for health care (DPAHC) and the Natural Death Act declaration as advance directives for adults.

The DPAHC designates a person to make health care decisions if the principal becomes mentally incapacitated. The Natural Death Act allows an adult to sign a declaration declining life-sustaining treatment, including artificially administered nutrition and hydration, if the person becomes terminally ill or permanently unconscious.

According to AB 2805 (ch. 579, 2006), a written advance health care directive is legally sufficient if all the following requirements are satisfied:

- The advance directive contains the date of its execution

- The advance directive is signed either by the member or in the member's name by another adult in the member's presence and at the member's direction
- The advance directive is either acknowledged before a notary public or signed by at least two witnesses who satisfy the requirements of Sections 4374 and 4675 of the California Probate Code
- If the advance directive is acknowledged before a notary public, and a digital signature is used, the digital signature must meet all of the following requirements:
    - It either meets the requirements of Section 16.5 of the Government Code and Chapter 10 (commencing with Section 22000) of Division 7 of Title 2 of the California Code of Regulations, or the digital signature uses an algorithm approved by the National Institute of Standards and Technology
    - It is unique to the person using it
    - It is capable of verification
    - It is under the sole control of the person using it
    - It is linked to data in such a manner that if the data are changed, the digital signature is invalidated
    - It persists with the document and not by association in separate files
    - It is bound to a digital certificate

For additional information on Advance Directive, refer to the member's Evidence of Coverage (EOC).

Physician Responsibilities for Documenting Life-Sustaining Procedures

Complete documentation is essential whenever life-sustaining procedures are withheld or withdrawn, and must include:

- Member diagnosis and prognosis, including test results or other evidence for the attending physician's opinion and a second opinion confirming attending physician's conclusions
- Whether the member is likely to regain mental function and the facts on which determination of the member's mental incapacity was based
- A statement that the member or surrogate has been fully informed of the facts and the consequences of withholding or withdrawing life-sustaining procedures and that the surrogate decision-maker has consented to the withholding or withdrawing of such procedures
- A copy of any durable power of attorney for health care (DPAHC) declaration or non-statutory living will signed by the member
- Any desires verbally expressed by the member and a description of any discussion with family members or other surrogate
- A copy of a certified letter of guardianship or conservatorship (when one exists)
- Clear written orders to withhold or withdraw specific medical procedures

Member Confidentiality

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, and treatment are confidential and are to be conducted discreetly. Written authorization from the member or an authorized legal representative must be obtained before medical records are released to anyone not directly concerned with care, except as permitted or necessary in the administration of the health plan or shared with California regulatory and federal agencies, healthcare providers, and healthcare oversight entities.

Office Procedure

All participating providers must maintain an office procedure that guards against unauthorized disclosure of confidential member information. This procedure should contain the following elements:

- Written authorization from the member or a legal representative before medical records are made available to anyone not directly concerned with care, except where otherwise permitted or required by law or subpoena
- All signed authorizations for release of medical information, which have been reviewed for specific authorization and for any limitations
- Each medical record, which has been reviewed prior to making it available to anyone other than the member or legal representative
- Only the portion of the medical record specified in the authorization, which has been made available to the requester and is separated from the remainder

Any portion of the medical record not covered by the authorization must be withheld.

Physicians are encouraged to have their office staff sign a confidentiality statement to ensure that they understand their responsibility in maintaining member confidentiality.

Release of Medical Information Form

All providers should maintain a properRelease of Medical Information form (PDF) for all record requests in the member's medical record.

PCP Selection and Assignment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Selection Criteria

Newly enrolled members must choose a PCP within 30 days from the time they become a member of Health Net. If the member does not select a PCP, Health Net will choose one within 10 miles or 30 minutes of the member’s residence. The member can choose the same PCP or different PCPs, for all family members within Health Net, if the PCP is available.

If the member has a doctor they want to keep, or if the member wants to find a new PCP, they can go to the Provider Directory for a list of all PCPs and other providers in the Health Net network. The Provider Directory has other information to help the member choose a PCP. If the member needs a Provider Directory, the member can call the Member Services Department. The member may also find the Provider Directory on the Health Net website at www.healthnet.com

Primary Care Physician Changes

Fresno, Kings, Madera Counties

Health Net reimburses fee-for-service (FFS) Medi-Cal primary care physicians (PCPs) only for services provided to a Medi-Cal member assigned to the PCP at the time the care is provided. When a member seeks care from a PCP to whom the member is not assigned, a change in PCP assignment must be made prior to providing care in order for the claim to be paid. This is done by either calling the CalViva Health Member Services or CalViva Health Provider Services department or by having the provider or the member complete and fax the Request for PCP-PPG Change form – English (PDF) or Request for PCP-PPG Change form – Spanish (PDF) with the following information to the CalViva Health Member Services Department:

- The form must be completely filled out
- The provider must include the effective date the member changed to a new requested PCP/PPG
- The member or the member's legal guardian's signature must be on the Request for PCP/PPG Change form (changes can only be made if the form is signed and acknowledged by the member or member’s legal guardian).
- The Requested PCP Change form may take up to 15 days from the date of faxing the form for the PCP/PPG change to be completed and reflect on Health Net’s portal.

Allow five days from the date of faxing the form for the PCP change to be entered into Health Net's records.

Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne Counties

Members requesting a primary care physician (PCP) change may complete a Request for PCP-PPG Change form – English (PDF) or Request for PCP-PPG Change form – Spanish (PDF) and fax it to the Health Net Medi-Cal Member Services, or contact the Medi-Cal Member Services Department by phone to request the change.

Imperial County

Members requesting a primary care physician (PCP) change may complete a Request for PCP-PPG Change form – English (PDF) and fax it to the Community Health Plan of Imperial Valley Member Services – English or

Request for PCP-PPG Change form – Spanish (PDF) or contact the Medi-Cal Member Services Department by phone to request the change.

Member Cost-Sharing Protections

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

1. Pursuant to The Social Security Act section 1932(b)(6) and 42 USC section 1396u-2(b)(6), Health Net and all of its subcontractors must not hold a member liable for any of the following:
    - Debts of Health Net in the event of Health Net's insolvency;
    - Payment for covered services provided by Health Net if Health Net has not received payment from the Department of Health Care Services (DHCS), or if a provider, under an agreement or other arrangement with Health Net, fails to receive payment from either DHCS or Health Net; or
    - When payments to a provider that furnishes covered services under an agreement or other arrangement with Health Net are in excess of the amount that normally would be paid by the member if the service had been received directly from Health Net.
2. Health Net, including its network providers and subcontractors, must not bill a member for any covered services provided under this contract. Health Net must assure that all network provider agreements include requirements whereby the member must be held harmless for charges for any covered services.
3. Health Net and its network providers are prohibited from imposing on members cost-sharing requirements. Health Net's subcontractor agreements and network provider agreements must specify that a provider agrees to accept Health Net's reimbursement as payment in full for services rendered to members.

Prescription Drug Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following medications are covered under Health Nets Medi-Cal plan:

- Medications administered while the member is hospitalized or in an emergency room
- Medications administered in a providers office or infusion center billed through the medical benefit
- Home infusion or other medication-related services billed through the medical benefit

The following medications are covered by the Medi-Cal Rx program

- Self-administered and provider-administered medications listed on the Medi-Cal Rx Contract Drug List (CDL) and billed through a pharmacy
- Self-administered and provider-administered medications not listed on the Medi-Cal Rx CDL billed through a pharmacy (prior authorization may be required)

- Medications prescribed by a psychiatrist that are on the Medi-Cal Rx CDL and filled at a participating Medi-Cal Rx pharmacy
- A 72-hour supply of a covered medication in a medical emergency.
- Medical supplies, including personal home-use blood pressure monitors and blood pressure cuffs for use with personal, home blood pressure monitoring devices, and therapeutic continuous blood glucose monitors are a covered benefit under Medi-Cal Rx.

Medications for the treatment of AIDS and HIV are excluded from Health Nets coverage responsibilities and are covered under the DHCS Medi-Cal FFS program and Medi-Cal Rx. Refer to the discussion of carve-out medications in this section for more information.

Health Net Medi-Cal does not cover health care services for California Childrens Services (CCS)-eligible conditions, but they are covered under the CCS program. Prescriptions written for children with CCS active conditions need to be written by a CCS-paneled provider and billed directly to CCS.

Due to the passage of federal legislation (HR 3971), where federal financial contribution has been discontinued for all medications used to treat sexual or erectile dysfunction, the state of California has decided to discontinue coverage of such medications under the Medi-Cal program, unless used to treat a condition other than sexual or erectile dysfunction.

Carve-Out Medications

The Department of Health Care Services (DHCS) has carved out selected psychotherapeutic, coagulation factors, HIV-related medications and medications to treat alcohol or drug dependence from Health Nets coverage responsibilities. These medications are covered by the Medi-Cal Rx program. Pharmacies bill Medi-Cal Rx directly for these medications.

For a list of carved-out AIDS and HIV treatment medications, refer to the Excluded Medications for HIV and AIDS discussion in the AIDS Waiver Program section of the Public Health topic.

For a list of carved-out psychotherapeutic medications, refer to the Excluded Psychotherapeutic Medications discussion in the Mental Health section of the Public Health topic.

Health Net Medi-Cal does not cover health care services, including prescription medications, for California Childrens Services (CCS)-eligible conditions, but they are covered under the CCS program. Prescriptions written for children with CCS-active conditions must be written by a CCS-paneled provider and billed directly to CCS.

Medi-Cal Rx Contract Drug List

The Medi-Cal Rx Contract Drug List (CDL) is available on Health Nets provider portal, located under Pharmacy Information Drug Information for California State Health Programs. The Medi-Cal Rx CDL is found on the Medi-Cal Rx website.

Certain medications on the Medi-Cal Rx CDL require prior authorization for coverage. Medications not found on the Medi-Cal Rx CDL may require prior authorization.

Prior Authorization can be requested in the following ways:

- By going to cover my meds.

- By logging into the portal and submitting the PA through our Prior Authorization tool. Login from the provider portal and access the secured Prior Authorization tool.
- By sending a completed PA form through fax to Medi-Cal Rx fax number.
- By submitting a NCPDP P4 Transaction through Pharmacy POS system.
- By sending a completed PA form through mail to Medi-Cal Rx Customer Service Center

For additional information, refer to the Medi-Cal Rx Options for PA Submission Guide.

Medi-Cal Rx will notify providers of the status of prior authorization requests.

Special Infant Formula

Nutritional supplements and replacements are a conditional benefit for Health Net's Medi-Cal members and may be covered subject to prior authorization. Requests for oral formula that are obtained under the pharmacy benefit should be submitted to Medi-Cal Rx. Requests requiring a pump, supplies needed to administer the formula, or formula that cannot be billed through the pharmacy should be submitted to Health Net Medi-Cal Health Services Department.

Depending on capitation status, the request is then forwarded to the Health Net Medi-Cal Health Services Department or to the appropriate participating physician group (PPG) to facilitate further prior authorization.

Special infant formula requests for members with conditions that make them eligible for services through public health carve-out programs must be referred to the public health program agencies. Such carve-out programs include California Children's Services (CCS) and Genetically-Handicapped Persons Program (GHPP).

In Los Angeles County, practitioners affiliated with Molina Healthcare, a subcontracting health plan, must follow Molina's prior authorization requirements when requesting special infant formulas for Health Net members assigned to Molina Healthcare. Contact the Molina Pharmacy Department for more information.

Prior Authorizations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on prior authorizations requirements.

Select any subject below:

- Requesting Prior Authorization or Coordinating a PCP Referral
- Advanced and Cardiac Imaging
- Notification of Inpatient Admissions
- Prior Authorization
- How to Secure Prior Authorization on Health Net Provider Portal
- Request for Prior Authorization Form
- Services Not Requiring Prior Authorization
- Peer-to-Peer Review Requests
- Prior Authorization Requirements
- Prior Authorization Requirements (LADHS)

Requesting Prior Authorization or Coordinating a PCP Referral

Provider Type: Physicians | Hospitals | Ancillary

Refer to the Prior Authorization (PA) Requirements List to determine which services require prior authorization and for information on where to submit PA requests based on the type of service, drug, device or procedure. For services not delegated to participating physician groups (PPGs), providers must follow applicable requirements in the Medi-Cal Fee-for-Service Health Net, CalViva Health and Community Health Plan of Imperial Valley (CHPIV) request forms. For Molina members, providers must follow Molina Health Care prior authorization requirements.

Primary care physicians (PCPs) are responsible for coordinating and monitoring referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Health Net does not require prior authorization for most in-network specialist visits and in-network diagnostic services.

To request prior authorization from Health Net for services not delegated to the PPG and coordinate a PCP referral for services:

- The PCP completes the request form and sends it to the specialist. This ensures that the member is seeking services from in-network providers, helps monitor the care provided to members and provides instructions to the specialist regarding authorized services.
- The PCP and specialist retain a copy of the inpatient or outpatient prior authorization request form in the member's chart.
- Fax a copy of the inpatient or outpatient prior authorization request form to Health Net – Prior Authorization unless stated differently in the Prior Authorization (PA) requirements. You can also request authorization by phone or through the Health Net provider website.
    - This ensures that Health Net identifies case management needs and assists the member with coordination of care, when appropriate.
    - This also enables Health Net to assist in the detection of and referral to appropriate agencies for carve-out services, such as California Children's Services (CCS).
- Specialists submitting paper claims to Health Net must include the prior authorization request form with the claim.
    - This supports the PCP-to-specialist referral and helps prevent delays in payment.
- Specialists submitting electronic claims must indicate the name of the referring provider in box 23 of the CMS-1500 claim form.

The PCP or specialist must give Health Net as much advance notice as possible when requesting prior authorization. For routine elective inpatient or outpatient services, fax requests for prior authorization at least seven calendar days before the anticipated date of service. It is recommended not to schedule services prior to receiving the review decision. The Medical Management Department needs time to notify the provider of the review decision prior to the services being rendered.

Required Information

Submit the following information when requesting prior authorization:

- Member's name
- Member's identification number
- Member's date of birth
- Diagnosis
- Requesting physician's name, address, phone and fax numbers, and contact person
- Place where services are provided
- Physician's name (physician receiving referral), ancillary provider name and facility name
- Procedures
- Date of service

Health Net reviews the information and issues a determination to the member/provider. If the service is authorized, the provider is notified with the authorization number.

Submission of Prior Authorization Requests

Fax the prior authorization request form to Health Net – Prior Authorization Department or delegate described in the Prior Authorization (PA) Requirements list. You can also request authorization by phone or through the Health Net provider website

For the following behavioral health decision-making definitions, refer to the Glossary section.

- Non-Urgent Pre-Service Decision
- Post-Service Decision
- Urgent Decision
- Urgent Concurrent Review Decision
- Urgent Pre-Service Decision

Advanced and Cardiac Imaging

Provider Type: Physicians

Health Net partners with Evolent Specialty Services, Inc. (Evolent), to provide utilization management (UM) services, including prior authorization determinations for certain advanced and cardiac imaging for fee-for-service Medi-Cal members.

Prior Authorization Requirements

The following outpatient procedures require prior authorization from Evolent, with the exception of emergency room, urgent care, and observation setting for advanced and cardiac imaging:

- Advanced imaging:
  - Computed tomography (CT)/computed tomography angiography (CTA)
  - Magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA)
  - Positron emission tomography (PET) scan
- Cardiac imaging:

- Coronary computed tomography angiography (CCTA)
- Myocardial perfusion imaging (MPI)
- Multigated acquisition (Muga) scan

Prior Authorization Requests

Prior authorization requests must be submitted to Evolent online or by telephone as follows. Evolent does not accept fax submissions.

- Online - Post-log in at www.RadMD.com, 24 hours a day, 7 days a week, except when maintenance is performed once every other week after business hours.
- Evolent, available Monday through Friday, from 8 a.m. to 8 p.m.

Expedited authorization requests may only be submitted by telephone.

To expedite the request process, providers must have the following information ready before logging in to the Evolent website or calling (*denotes required information):

- Name and office telephone number of ordering provider*
- Member name and identification (ID) number*
- Requested examination*
- Name of provider office or facility where the service will be performed*
- Anticipated date of service (if known)
- Details justifying the examination*
- Symptoms and their duration
- Physical exam findings, including findings applicable to the requested services, conservative treatment the member has already completed (such as physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, and medication)
- Results and/or reports of preliminary procedures already completed (such as X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, and specialist evaluation)
- Reason the study is being requested (such as further evaluation, rule out a disorder)

The following information may also be requested:

- Clinical notes
- Reports of previous procedures
- Specialist reports/evaluation

How to Secure Prior Authorization on the Provider Portal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

To submit prior authorization requests online:

Availity Essentials	Health Net
1. Log in, then go to the appropriate section for prior authorizations, typically found under *Patient Registration* or *Authorizations*. 2. Follow the prompts to enter the required member and service information, then click *Submit* to complete the prior authorization request.	1. Log in, then select the applicable line of business from the drop-down menu > *Go.* 2. Once you have checked the member's eligibility, select the member's blue hyperlinked name > *Authorizations.* 3. Complete the required information to request prior authorization, including submitting the appropriate Smart Sheet for which a link can be found under the Authorizations tab. Access prior authorization tools and resources on the Health Net website . You can find information on: • Validation tools. • Prior authorization requirements lists. • Inpatient and outpatient forms.

Note: The Health Net and Availity provider portals may not offer the same functions. Please refer to the Provider Access Guide: Availity and Health Net Provider Portals + Website (HMO/PPO/Health Net Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley, Wellcare By Health Net) for details on what functions can be accessed through each portal.

Notification of Inpatient Admissions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

All inpatient admissions must be brought to the attention of the Health Net Hospital Notification Unit within 24 hours of the admission or one business day when an admission occurs on a weekend. Hospital admission notification does not replace the authorization process. These notifications may be submitted by faxing the member's admission face sheet to the Health Net Hospital Notification Unit. Failure to notify according to the requirements in the Provider Participation Agreement (PPA) may result in a denial of payment.

Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Prior authorization ensures medical necessity of services, level of care, the use of participating providers, and is intended to prevent unanticipated denials of coverage.

Refer to the PA Requirements List to determine which services require prior authorization and for information on where to submit PA requests based on the type of service, drug, device or procedure.

Health Net has delegated the prior authorization process to some participating physician groups (PPGs). Prior authorizations for members assigned to a capitated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose prior authorization requirements that conflict with the member's right to self-refer for services. Refer to the PPG for authorization requirements.

When to submit prior authorization requests to local county CCS agency

Specialists are required to send copies of consultation and treatment plans to the member's primary care physician (PCP) and all participating providers are required to refer any services related to a California Children's Services (CCS)-eligible condition to the local county CCS agency for authorization. CCS-eligible services must be provided by a CCS-paneled provider at CCS-approved facilities.

Request for Prior Authorization Form

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Refer to the Prior Authorization (PA) Requirements List and Forms to determine which services require prior authorization (PA) and for information on where to submit PA requests based on the type of service, drug, device or procedure.

- The following forms are the primary method used by Health Net to manage the referral and authorization process for fee-for-service (FFS) providers directly contracting with Health Net.
- Providers are required to complete all fields on the form as follows to expedite the process of these requests.
    - Inpatient (IP):
        - Inpatient California Medi-Cal Prior Authorization – Medi-Cal (PDF)
        - Inpatient California Medi-Cal Prior Authorization – Community Health Plan of Imperial Valley
        - Inpatient California Medi-Cal Prior Authorization – CalViva Health (PDF)
    - Outpatient (OP)
        - Outpatient California Medi-Cal Authorization – Medi-Cal (PDF)
        - Outpatient California Medi-Cal Prior Authorization – Community Health Plan of Imperial Valley
        - Outpatient California Medi-Cal Authorization – CalViva Health (PDF)

- If the number of units or visits is not indicated in the Professional field, only one visit is authorized by Health Net. That visit must take place within 60 days of the order date. If more than one consultation is required, another request must be submitted to Health Net for review.
- Designate the type of request (urgent or elective).
- Designate service requested to determine prior authorization requirements.
- ICD-10 codes and CPT codes and descriptions are required fields.

- Providers must attach all pertinent medical information in order for the request to be reviewed for medical necessity.

Services Not Requiring Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Prior authorization is not required for the following services, and services may be obtained from any qualified in-network or out-of-network provider:

- Emergency services
- Minor consent services which include treatment for the following:
  - Under age 12
  - Pregnancy and pregnancy related services
  - Family planning services
  - Sexual assault services
  - Age 12 and older - under 21
  - Pregnancy and pregnancy related services
  - Family planning services
  - Sexual assault services
  - Infectious, contagious, or communicable disease diagnosis and treatment
  - Sexually transmitted diseases (or infections) prevention, diagnosis, and treatment
  - Drug and alcohol abuse treatment and counseling
  - Outpatient mental health treatment and counseling. Minors may obtain outpatient mental health services, if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.
  - Intimate partner violence
- Adult sensitive care services:
  - Family planning and birth control including sterilization for adults 21 and older
  - Pregnancy testing and counseling and other pregnancy related services
  - HIV/AIDS prevention and testing
  - Sexually transmitted infections prevention testing and treatment
  - Sexual assault care
  - Outpatient abortion services
- In-network outpatient therapy and medication management services for mild to moderate distress due a mental health disorder.
- Refer to the CPSP for more information about locating a CPSP provider.

Note: Specialty mental health services and select substance use disorder services are covered by the county mental health program. If coordination assistance with the county mental health program is needed, contact Medi-Cal Member Services (Medi-Cal, CalViva Health, CHPIV). Referral and prior authorization are not required for Comprehensive Prenatal Services Program (CPSP) services. Services may be obtained from any participating CPSP providers.

A member or provider is not required to obtain prior authorization for Non-Emergency Medical Transportation (NEMT) services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or embedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Other services that do not require prior authorization include:

- Outpatient Hospice Service:
  - **Outpatient hospice services**: Prior Authorization **is not required** for routine home care, continuous home care and respite care, or hospice physician services provided by in-network hospice providers. Submit all required documentation (see below) via encrypted email.

Required documentation:

- Certification of the patient's terminal illness;
- Medi-Cal Hospice Program Election form (PDF);
- Revocation of hospice election, documenting the patient's decision to discontinue hospice care;
- Copy of the written initial plan of care;
- Written prescription signed by the patient's attending physician, which includes justification for general inpatient level of care;
- Face-to-face encounter document that verifies clinical evaluation for continued eligibility; and
- Transfer summary when the patient changes health plan carriers.

Refer to APL 25-008 for additional information

- Certain services for American Indian members, including:
  - An American Indian member can obtain covered services from an out-of-network Indian health care provider without requiring a referral from a network primary care provider (PCP) or prior authorization.
  - MOA 638 Indian Health Services facilities or provider , whether in the Plan's network or out-of-network, can provide referrals directly to network providers without a referral from a network PCP or prior authorization. An American Indian member may receive services from an out-of-network Indian health care provider even if there are in-network Indian health care providers available.
- Department of Health Care Services (DHCS)-required immunizations when provided from the local health department (LHD) (LHD must submit immunization records with any claim)
- Basic prenatal care with a participating in-network obstetrician.
- Preventive services from a participating provider.
- California Prenatal Screening (PNS)
- Services for emergency medical conditions.
- Not applicable to PPGs - Specialist referral (initial referral to participating specialist).
- Not applicable to PPGs - Second opinion from a participating physician or other provider
- Urgently needed services when the member is outside their county
- Certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider
- Biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (must be FDA-approved)
- COVID-19 diagnostic and screening testing by a participating provider
- Services that are rendered under the Children and Youth Behavioral Health Initiative fee schedule
- Initial mental health and substance use disorder assessments

- Adult preventive immunizations from a participating provider

Health Net has delegated the prior authorization process to some participating physician groups (PPGs). Prior authorizations for members assigned to a capitated PPG are subject to any additional rules imposed by the PPG. Refer to the PPG for authorization requirements. PPGs may not impose prior authorization requirements that conflict with the member's right to self-refer for certain services.

Peer-to-Peer Review Requests

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Plan aims to promote treatment that is specific to the member's condition and consistent with medical necessity, clinical practice, and appropriate level of care. An authorization request will be denied if the information provided does not meet the coverage requirements for the requested medical treatment. The Plan will notify the provider and the member of the reason for the adverse determination.

Providers may contact the Plan to discuss the adverse determination with a medical director (known as peer-to-peer review or P2P) using the instructions below.

Peer-to-peer reviews may not be used in certain situations

The peer-to-peer review does not apply to:

Appeals. Once you or a member submits an appeal, you cannot request a peer-to-peer review. If the member submits the appeal for an adverse determination you have issued, we will reach out to you for any additional information you may have.

Post-discharge. For adverse concurrent review determinations, you must request a peer-to-peer review prior to the member’s discharge. Once the member has been discharged from a facility, you cannot request a peer-to-peer review. If a member is discharged on the weekend, please call prior to discharge and leave a message for your peer-to-peer request to be considered timely. Beyond this time, an appeal may be filed.

Initial adverse determinations beyond five business days. You have five business days to request a peer-to-peer review following issuance of an adverse prior authorization determination. Beyond this time, an appeal may be filed.

How to request a peer-to-peer review

Contact the applicable Peer-to-Peer Review Request Line with the necessary information available to request a peer-to-peer review.

Product Descriptions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information about Health Net health plans.

Select any subject below:

- Medi-Cal Managed Care

Medi-Cal Managed Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Department of Health Care Services (DHCS) administers the state's Medi-Cal managed care programs. Medi-Cal managed care differs from commercial managed care in that it integrates private health care with publicly funded health programs.

Health Net's Medi-Cal managed care service area includes the counties of Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne. Additionally, Health Net is a subcontracting health plan for CalViva Health in Fresno, Kings and Madera counties and Community Health Plan of Imperial Valley (CHPIV) in Imperial County.

In Amador, Calaveras, Inyo, Los Angeles, Mono, San Joaquin, Stanislaus, Tulare and Tuolumne counties, Medi-Cal beneficiaries have the option of enrolling in Health Net, the mainstream or commercial plan in the state's Two-Plan Managed Care Program.

In Los Angeles County, Health Net subcontracts with Molina Healthcare to provide care for approximately one-half of Health Net's Medi-Cal beneficiaries. For Health Net members assigned to Molina, providers must follow the prior authorization and utilization management (UM) procedures of Molina for its assigned members, or the procedures of Molina’s participating physician group (PPG) for their capitated members.

CalViva Health is the local initiative health plan for the Medi-Cal managed care counties in Fresno, Kings and Madera. CalViva Health is partnering with Health Net to serve Medi-Cal beneficiaries in these counties. Under the direction of the Fresno-Kings-Madera Regional Health Authority, CalViva Health selected Health Net as its contractor to provide administrative and network services under the Two-Plan model expansion in the three-county region. Health Net continues to hold most provider network contracts in Fresno, Kings and Madera counties as CalViva Health's subcontractor.

CHPIV is the Local Health Authority (LHA) for Medi-Cal managed care in Imperial County. CHPIV is a full-service health plan contracting with the Department of Health Care Services (DHCS) to provide services to Medi-Cal managed care enrollees under the Single Plan model in all ZIP Codes in Imperial County. CHPIV contracts with Health Net to provide certain administrative and health care services to CHPIV members on CHPIV’s behalf. Health Net holds most provider contracts in Imperial County as CHPIV’s subcontractor.

Health Net Medi-Cal members in Sacramento County participant in the Geographic Managed Care (GMC) program. The benefits under the GMC program are very similar to the Two-Plan Managed Care program benefits with a few minor variations.

Provider Oversight

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on provider oversight requirements and monitoring.

Select any subject below:

- Provider Oversight Overview
- Appeals and Grievances
- Calendar of Required PPG Submissions
- Conditions of PCP Panel Closures by Health Net
- Corrective Action Plan
- Credible Allegations of Fraud
- Fraud, Waste and Abuse
- Provider Enrollment Requirement Through DHCS
- Monitoring Provider Exclusions
- Subdelegated Functions
- Contractual Financial and Administrative Requirements
- Delegated Medical Management
- Facility and Physician Additions, Changes and Deletions
- Service and Quality Requirements
- Participating Physician Group (PPG) Performance Management

Provider Oversight Overview

Participating Physician Groups (PPG)

Health Net measures, monitors and oversees provider compliance and requires corrective actions when deficiencies are identified. Delegation may be revoked and the provider's contract terminated if the corrective action process does not resolve the deficiency.

In addition to routine data collection, monitoring, evaluation and analysis, the Third Party Risk Management staff is available to assist providers with:

- Alerting the delegated entity regarding possible areas of below standard performance
- Sharing information regarding regulations
- Developing corrective action plans (CAPs)
- Sharing best practices
- Offering guidance regarding on-site review by outside agencies
- On-going training upon request

Delegation Oversight Committee

The Delegation Oversight Committee (DOC) meets quarterly and is chaired by the CA Compliance Officer. The purpose of the Delegation Oversight Committee is to provide a forum for discussion of the delegates' performance and to address significant risks with health plan leadership from various departments.

Topics of the DOC include oversight activities, audit results, corrective actions and recommendations of the Delegation Oversight Workgroup (DOW) which is a subcommittee led by the Third Party Risk Management team. As needed, the DOC will discuss remedial actions such as increasing oversight or revoking delegation.

Claims Processing, Utilization Management, Compliance Program and Credentialing/ Recredentialing

The Third Party Risk Management team has established issue management processes with escalation steps to address continued substandard performance with health plan policies, contractual obligations and/or regulatory requirements.

Steps may include discussions with delegates during Joint Operations Meetings (JOMs) and leadership discussions via DOW and DOC. Our Delegates' ongoing performance with plan policies, contractual obligations and regulatory requirements is shared with leadership through monthly reporting and discussed during DOW, DOC and ad hoc escalation meetings.

Member Complaints, Appeals & Grievances

The Health Net Member Services or Appeals & Grievances departments work to resolve individual member complaints. All member complaints and inquiries are entered into Health Net's Appeals & Grievances System of records for tracking, and reports are generated quarterly to allow for tracking and profiling within and between providers. The quarterly complaint report aggregates the type of complaint by PPG and by region. Health Net's Credentialing Committee, regional medical directors (RMDs), the Delegation Oversight director, and Quality Improvement (QI) staff review the reports that are sent quarterly to the Quality Improvement Health Equity Committee (QIHEC). A corrective action plan (CAP) is implemented, if necessary, and tracking and follow-up evaluations continue to monitor the success of the action plan.

Member complaints with potential quality of care issues are reviewed by the Health Net Clinical Appeals & Grievances Department as part of the appeals and grievances process, which conducts an investigation of each issue and tracks trends for quality of care issues by provider, PPG and type of issue. Provider-specific cases are prepared and presented to the Health Net Peer Review Committee for review and action.

During the investigation of potential quality of care issues, the QI specialist may request additional information, medical records or implementation of provider-specific action plans from the PPG. Noncompliance with these requests may lead to sanctions, such as freezing enrollment of Health Net members until the issue is resolved or possible termination of the Health Net contract.

Preventive Care Guidelines

Health Net provides feedback to PPGs on their preventive care services, in an effort to encourage delivery of such services. Techniques include quality of care and service report cards, discussions at physician forums, onsite meetings with PPG staff, and financial incentives to increase the amount of preventive care services. Member education is also part of this effort.

Health Net requires that PPGs and participating primary care physicians (PCPs) follow the clinical practice guidelines recommended by the United States Preventive Services Task Force (USPSTF), the American Congress of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) in the treatment of Health Net members. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. As always, the judgment of the treating physician is the final determinant of member care.

Refer to the preventive care guidelines discussion under the Benefits topic for more information.

Notice to Change PPA

If a participating provider needs to request a change to the information currently in their Health Net Provider Participation Agreement (PPA), the request must be made in writing. The request can be made in one of the following ways:

- Certified U.S. mail with a return receipt requested, postage prepaid
- Overnight courier
- Fax

The request should be sent to Health Net's main corporate address.

Appeals and Grievances

Provider Type: Participating Physician Groups (PPG)

Health Net does not delegate member appeals or grievances, except for Molina. The Health Net State Health Programs Quality Improvement Health Equity Committee (QIHEC) reviews quarterly Medi-Cal appeals and grievance reports to assess emerging patterns of appeals and grievances, and to formulate potential plan policy/process changes and/or procedural improvements.

For more information on member appeals or grievances, refer to the discussions of Member Appeals and Grievances.

Outpatient Pharmacy Benefits and Services Carve Out

Medi-Cal Outpatient Pharmacy benefits and services transitioned from managed care to the state's responsibility under the pharmacy benefit program known as Medi-Cal Rx. Appeals and grievances for these benefits and services are the responsibility of Medi-Cal Rx.

Disputes regarding the denial of a referral or a prior authorization request should be directed to DHCS State Fair Hearing and not to Health Net. If Health Net receives a grievance related to these services, Health Net will

redirect those grievances to Medi-Cal Rx contractor, Magellan Medicaid Administration, Inc. (Magellan), in a timely manner and in the manner outlined by DHCS.

If Health Net receives an appeal related to these services, the DHCS State Fair Hearing process is responsible. Health Net will redirect those appeals to the DHCS State Fair Hearing. Any appeals and grievances related to physician-administered drugs would be Health Net's responsibility to address through the Appeals and Grievance process.

Calendar of Required Participating Physician Groups (PPG) Submissions

Provider Type: Participating Physician Groups (PPG)

Documents to be Submitted	Due Date
Financial Statements (Annually Audited)	150 days after close of fiscal year
Financial Statements (Quarterly Updates)	45 days after close of quarter
Monthly Encounter Data Submission	Within 30 days of end of month of service

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
UM	Complex Case Management (COM, MCL, MCR)	Complex Case Management Report	Quarterly	15th of the month following the end of the quarter
UM	Commercial	UM Authorization Source Data - COMM	Monthly	15th calendar day of the following month
UM	Commercial	Specialty Referral Access Timeliness - COMM	Quarterly	15th of the month following the end of the quarter

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
UM	Special Needs Plan - Dual & Chronic	Special Needs Plan MOC Report - Case Management	Monthly	15th calendar day of the following month
UM	Medi-Cal, Medi-Cal CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal Molina	UM Authorization Source Data - MCAL, MOLN, CALV	Monthly	15th calendar day of the following month
UM	Medi-Cal, Medi-Cal CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal Molina	Specialty Referral Access Timeliness - MCAL, MOLN, CALV	Quarterly	15th of the month following the end of the quarter
UM	Medicare (HMO-H0562, SAP-H3561)	Standard and Expedited Organization Determinations (OD)	Monthly	15th calendar day of the following month
UM	Medicare (HMO-H0562, SAP-H3561,	UM Reopens	Quarterly	15th of the month following the end of the quarter
UM	Medicare (HMO-H0562, SAP-H3561), Commercial, Medi-Cal, Medi-Cal CalViva, Medi-	UM Work Plan	Annually Semi-annual Quarterly	All LOB Initial - Annual: February 15 MCR & COMM - Semi-annual: August 15 Medi-Cal, Medi-Cal Molina

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
	Cal Community Health Plan of Imperial Valley and Medi-Cal Molina			and CalViva - Quarterly: Last day of the month following the end of the quarter
Claims	Medicare (HMO-H0562, SAP-H3561)	Provider Dispute Organization Determinations - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561)	Organization Determinations Claims - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561	Claims Reopens	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	AB72 IDRP Delegated Contact List	Annually	31-Oct-22
Claims	Commercial	Claims Organization Determinations-COMM	Monthly	15th calendar day of the following month
Claims	Commercial	Provider Disputes Organization Determinations - COMM	Monthly	15th calendar day of the following month
Claims	Commercial	Federal Employee Health Benefit Program (FEHBP) Claim Reports	Semi-annual	Semi-annual - April 1 and October 1

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
Claims	Commercial	Provider Dispute Summary Report - COMM	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	Claims Settlement Practice Report - COMM	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	Timeliness Summary Reports - COMM	Quarterly	15th calendar day of the following month after each quarter end.
Claims	Medi-Cal, Medi-Cal_CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal_Molina	Claims Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month
Claims	Medi-Cal, Medi-Cal_CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal_Molina	Provider Disputes Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month
Claims	Medi-Cal	Provider Dispute Summary Report - MCAL	Quarterly	30th of the month following the end of the quarter

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
Claims	Medi-Cal	Claims Settlement Practice Report - MCAL	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal	Timeliness Summary Reports - MCAL	Quarterly	30th calendar day of the following month after each quarter end.
Claims	Medi-Cal CalViva	Claims Settlement Practice Report - CALV	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal CalViva	Provider Dispute Summary Report - CALV	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal CalViva	Timeliness Summary Reports - CALV	Quarterly	30th calendar day of the following month after each quarter end.
Claims	Medi-Cal Molina	Claims Settlement Practice Report - MOLN	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal Molina	Provider Dispute Summary Report - MOLN	Quarterly	30th of the month following the end of the quarter

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
Claims	Medi-Cal Molina	Timeliness Summary Reports - MOLN	Quarterly	30th calendar day of the following month after each quarter end.
Claims	ALL LOBs	Notification - Change of Principal Officer	As applicable	Immediate upon change of officer
Credentialing	Medi-Cal	Credentialing Report	Quarterly	15th of the month following the end of the quarter.
Credentialing	Commercial Medicare	Credentialing Report	Semi-annual	February 15 August 15

Organization Determinations

If a participating physician group (PPG) or hospital is delegated for Utilization Management (UM), it must submit monthly to the Plan (Delegation Oversight team) the completed Organization Determination (OD) template provided by the Plan. The template is to be provided for each line of business and should include all authorizations that a determination was completed in the previous month.

If a PPG or hospital is delegated for Claim processing they must submit monthly to the Plan (Delegation Oversight team) the complete OD template and for each line of business that includes all claims (received and claims in addition where a determination was made in the previous month. Additionally, quarterly a summary report should be submitted for processed claims and disputes using the Monthly Timeliness Report (MTR), Provider Dispute Resolution (PDR) & Claims Settlement Practices Report (STML) forms posted on the Health Industry Collaborative Effort (HICE).

The Plan uses the information from the PPGs to fulfill reporting requirements to the regulators such as the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

Reporting Elements & Submission

All reporting elements including instructions, data dictionary and templates are included in the template workbook provided by the plan.

All reports should be submitted through the secure file transfer protocol (SFTP). Access has been granted to the PPG users responsible for reporting.

The Plan does delegate responsibility for complex case management to those providers with a dual-risk contract who meet the requirement as delineated by the National Committee for Quality Assurance (NCQA). With the exception of Molina, the Plan does not delegate responsibility functions; all PPGs are required to participate in and cooperate with QI activities, including Healthcare Effectiveness Data and Information Set (HEDIS®), access surveys, disease management, and other quality initiatives.

To access the current year UM/QI report templates, workplans and instruction, visit the Health Industry Collaboration Effort (HICE).

Conditions of PCP Panel Closures by Health Net

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net established the member assignment threshold for an individual primary care physician (PCP) to a maximum of 2,000 members in compliance with standards established by the California Department of Managed Health Care (DMHC) and California Department of Health Care Services (DHCS). An individual PCP may employ up to four physician extenders. Members assigned to a PCP and his or her extenders may not exceed 4,000 members combined. Each extender has a maximum capacity of 1,000 members.

Health Net ensures compliance by continuously monitoring our network for capacity limits and the full-time-equivalent member-to-physician ratios as follows:

- PCPs - 2,000:1
- Physician extenders - 1,000:1

Health Net may close participating PCPs' panels to new Health Net members when PCPs without physician extenders have more than 2,000 Health Net members assigned to them.

Health Net reviews the following to determine the appropriateness of the panel size, and contacts the participating physician group (PPG) or PCP to assess the PCP's status.

- PCP status: active, prior patients or full capacity
- Physician extenders (allows for an additional 1,000 members per PCP, up to four extenders)
- PCP practice located in rural area with few PCPs

Health Net sends notification to PCPs advising of panel closures once they exceed the maximum capacity. Health Net monitors access and availability and reopen the panel to additional member assignments when the number of members assigned to the PCP's panel falls within acceptable standards.

Corrective Action Plan

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a delegated entity is not in compliance with the Plan policies, contractual obligations or regulatory requirements, the Third Party Risk Management may implement a corrective action process to correct the deficiencies.

- Delegate is notified of deficiency and requested to submit a corrective action plan (CAP) to address the deficiency and implement monitoring measures to avoid reoccurrence of deficiency.
  - The auditor reviews the CAP for appropriateness and completeness and notifies the delegate of whether the CAP is approved.
  - If the Plan does not approve the CAP, the delegate is notified and asked to revise and resubmit the CAP to the Plan.
- If the delegate does not submit a CAP, or complete the actions in their CAP in a timely manner, the deficiency may be escalated to the Delegation Oversight Workgroup (DOW), Compliance and Network Management Leadership and or at a JOM to discuss deficiencies or to recommend further actions.
- If the delegate remains deficient it may be escalated to the Delegation Oversight Committee (DOC) to take formal actions up to and including de-delegation.

Credible Allegations of Fraud

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal managed care plans (MCPs) must take certain actions when the Department of Health Care Services (DHCS) has determined that a credible allegation of fraud exists against a participating MCP network provider. To comply with this regulation, Health Net adheres to the course of action described below upon receipt of information that DHCS has determined a credible allegation of fraud exists against a participating provider.

Requirements

If Health Net is notified that a credible allegation of fraud has been identified against a participating provider relating to the provision of Medi-Cal services, Health Net takes one or more of the following four actions and submits supporting documentation to DHCS:

1. Terminates the provider from its network.
2. Temporarily suspends the provider from its network pending resolution of the fraud allegation.
3. Temporarily suspends payment to the provider pending resolution of the fraud allegation.
4. Conducts additional monitoring, including audits of the provider's claims history and future claims submission for appropriate billing.

If Health Net elects the fourth action, Health Net follows the steps below and submits documentation to DHCS:

Step 1: Immediately implements enhanced monitoring as follows:

- Monitors relevant claims, claim lines, and encounter data, and completes the initial review within 30 calendar days.
- Provides weekly updates to DHCS until a determination is made as to whether an onsite visit is necessary.

- Makes an initial determination as to whether an onsite visit is necessary after completing the initial review of relevant claims/encounter data. Health Net consults with DHCS on the need for an onsite review within 10 business days of completing the initial review. Health Net is required to obtain DHCS approval if the initial determination concludes an onsite visit is not warranted.

Step 2: If Health Net's initial determination identifies a potential incident(s) of fraud, waste or abuse, or otherwise validates DHCS's credible allegation of fraud finding, Health Net must:

- Commence an audit for the subject provider or subcontractor within 10 business days of validating the credible allegation of fraud, waste or abuse, or within 10 days of validating DHCS's credible allegation of fraud. The audit must be conducted earlier if Health Net identifies activity that warrants immediate action.
- Provide DHCS with a copy of the final audit report and findings within 45 days.
- Provide DHCS with a copy of the corrective action plan it has imposed on the Medi-Cal provider, which will include specific milestones and timelines for completion.
- Provide DHCS with biweekly updates related to the corrective action plan.
- Audit the provider or subcontractor again within six months of closing the corrective action plan to confirm amelioration of the findings.
- Terminate the provider from Health Net's network should there be repeat findings that are significant in nature. Health Net is required to obtain approval from DHCS in situations where the provider is not to be terminated from Health Net's network.
- Provide DHCS with an outline of oversight activity that Health Net will conduct to ensure there is no further fraud, waste or abuse.

Delegated providers

Health Net's delegated providers are required to adhere to the course of action described above upon receipt of information that DHCS has determined a credible allegation of fraud exists against a participating provider.

If the delegated provider elects to terminate a participating provider from its network upon notification from DHCS that a credible allegation of fraud has been found against the participating provider relating to the provision of Medi-Cal services, the delegated provider must notify the Health Net regional Provider Network Management Department in writing, pursuant to the requirements of the provider's Health Net Provider Participation Agreement (PPA). Delegated providers that elect to not terminate a participating provider from its network must provide an explanation for electing this option and are required to continue to monitor the provider and provide the Health Net Provider Network Management Department with a report of oversight activity that is being conducted.

Delegated providers are required to have policies and procedures to detect and deter FWA, including a compliance program as defined in Title 42 CFR section 438.608(a). PPGs must comply with all applicable state and federal laws and regulations, including state and federal false claim acts.

PPGs must report any suspected case of FWA to Health Net within 10 calendar days through the Health Net Fraud Hotline. Additionally, if a PPG receives information about a change in circumstances that may affect a member’s eligibility (e.g., a change in residence or income or the death of a member) they must promptly contact the Health Net Medi-Cal Provider Services Center Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center.

Health Net Delegation Oversight will monitor and evaluate your compliance to all requirements through:

- Health Net annual Compliance audit

- Review of Compliance program policies and procedures including:
  - Compliance program description (requirements defined in Title 42 CFR section 438.608(a))
  - Mechanisms for detection and prevention of FWA
  - Training program for employees and providers
  - Plan for routine internal monitoring
  - Disciplinary guidelines for non-compliance
- Proof of process execution (meeting minutes, staff interviews, logs, etc.)
- Evidence of routine monitoring

- Additional activities as identified

Fraud, Waste and Abuse

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net takes the detection, investigation, and prosecution of fraud, waste and abuse (FWA) very seriously, and has a FWA program that complies with the State of California and federal laws.

Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes fraud under applicable federal or state law, including 42 CFR section 455.2 and W&I Code section 14043.1(i).

Waste is the overutilization or inappropriate utilization of services and misuse of resources.

Abuse means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medi-Cal program.

Some of the most common FWA practices include:

- Unbundling of codes.
- Up-coding services.
- Excessive use or misrepresentation of quantity or units.
- Claims for services not rendered or failure to adequately document services.
- Services provided by non-credentialed providers without documentation indicating supervised services.
- Intentional misrepresentation of services rendered.
- Deliberate application for duplicate reimbursement.
- Intentional improper billing practices.
- Provision of unnecessary services.
- Failure to maintain adequate records to substantiate services.
- Failure to provide services that meet professionally recognized standards of health care.
- Conducting excessive office visits or writing excessive prescriptions.

Health Net, in conjunction with its parent company, Centene, operates a FWA Special Investigations Unit (SIU). Health Net routinely conducts audits to ensure compliance with billing regulations. Health Net has developed a proactive FWA prevention program designed to collect, analyze and evaluate data in order to identify

suspected FWA. Detection tools have been developed to identify patterns of problematic healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers and other common schemes. SIU performs retrospective and prospective investigations which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. Health Net is required to recoup all identified overpayments after review of claims and medical records.

These actions may include but are not limited to:

- Education.
- Corrective Action Plan.
- Utilization review.
- Prepayment review.
- Recoupment of identified overpayments.
- Termination of provider agreement or other contractual arrangement.
- Referral of potential FWA to the California Department of Health Care Services, the California Department of Justice, and any other applicable agencies.

Health Net is required to report any findings of suspected FWA under its Medi-Cal Plans to the state.

Providers and their office staff are legally required to report suspected cases of FWA to Health Net. Reports of suspected FWA may be made anonymously to the Health Net Fraud Hotline.

Provider Enrollment Requirement Through DHCS

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers who wish to participate in Health Net's Medi-Cal Network must be enrolled in Medi-Cal through the Department of Health Care Services (DHCS) in an approved status in accordance with DHCS regulations.

Monitoring and Enrollment

Health Net continues to monitor Medi-Cal enrollment status for participating providers, and first-tier, downstream and related entities (FDRs). In addition, delegated participating physician groups (PPGs) who are contracting with Health Net must verify that their network of providers involved in servicing Medi-Cal members are enrolled in Medi-Cal through DHCS.

DHCS enrollment applications can be located by provider type at DHCS.

Monitoring Provider Exclusions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusions lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program enrollees under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2) 438.610(b) and 1903(i)(2) of the Act, except as permitted under 42 CFR 1001.1801 and 1001.1901, and employing or contracting with excluded parties to provide services to these enrollees. Health Net requires that its participating physician groups (PPGs), hospitals, ancillary providers, and physicians frequently monitor federal and state exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health care programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP), and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM) website.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

Health Net and Provider Responsibilities

Health Net is required to monitor federal and state exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net's plans. Health Net’s contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, RPD, FEHBP and EEDP exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid or Part C and Part D related activities. Health Net, its contracted providers, and their downstream subcontractors or delegated entities must frequently monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website at https://oig.hhs.gov/exclusions.

The current LEIE is available on the OIG-HHS website. Frequently asked questions (FAQs) and additional information about the LEIE are available at OIG.

Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > Resources > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR and search WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file.

Providers on the RPD list will be terminated from the Medi-Cal line of business only.

Claims Payment For Excluded Parties

Health Net, its PPGs, vendors, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except for emergency services provided by excluded providers under certain circumstances, see 42 CFR § 1001.1801 and 42 CFR §1001.1901. Providers contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Health Net or CMS.

Regulatory Citations for Excluded Requirements

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), 1001.1801, and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Fresno, Kings and Madera

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program enrollees under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2) 438.610(b) and 1903(i)(2) of the Act, except as permitted under 42 CFR 1001.1801 and 1001.1901, and employing or contracting with excluded parties to provide services to these enrollees. CalViva Health requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists. This communication provides the names of each federal exclusion list, governing regulations and CMS guidance, including links to publicly available exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP) and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP), as referenced through the System for Award Management (SAM) website.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

CalViva Health and Provider Responsibilities

CalViva Health is required to monitor federal and state exclusion lists to ensure that CalViva Health is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in CalViva Health's Medi-Cal plans. Contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, RPD, FEHBP and EEDP exclusion lists prior to hiring or contracting with

any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid-related activities. Medicaid managed care entities, their subcontractors and other delegated entities must frequently monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website at https://oig.hhs.gov/exclusions.

The current LEIE is available on the OIG-HHS website. Frequently asked questions (FAQs) and additional information about the LEIE is available at OIG.

Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > Resources > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

CalViva Health, its PPGs, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except for emergency services provided by excluded providers under certain circumstances. Contracting providers must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from CalViva Health or CMS.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR and search WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file.

Regulatory Citations for Excluded Requirements

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), 1001.1801, and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Imperial Valley

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program enrollees under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2) 438.610(b) and 1903(i)(2) of the Act, except as permitted under 42 CFR 1001.1801 and 1001.1901, and employing or contracting with excluded parties to provide services to these enrollees. Community Health Plan of Imperial Valley requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists. This communication provides the names of each federal exclusion list, governing regulations and CMS guidance, including links to publicly available exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP) and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP), as referenced through the System for Award Management (SAM) website. Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

Community Health Plan of Imperial Valley and Provider Responsibilities

Community Health Plan of Imperial Valley is required to monitor federal and state exclusion lists to ensure that Community Health Plan of Imperial Valley is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Community Health Plan of Imperial Valley's Medi-Cal plans. Contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, RPD, FEHBP and EEDP exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid-related activities. Medicaid managed care entities, their subcontractors and other delegated entities must frequently monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website

The current LEIE is available on the OIG-HHS website. Frequently asked questions (FAQs) and additional information about the LEIE is available at OIG. Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > Resources > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction. Community Health Plan of Imperial Valley, its PPGs, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except for emergency services provided by excluded providers under certain circumstances. Contracting providers must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Community Health Plan of Imperial Valley or CMS.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR and search WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file.

Regulatory Citations for Excluded Requirements

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901, 1001.1801, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Sub-Delegated Functions

Provider Type: Participating Physician Groups (PPG)

For delegated entities that subcontract with another entity to carry out delegated quality management (QI), utilization management (UM), member connections, and credentialing and recredentialing functions, the Third Party Risk Management is enforcing the following National Committee for Quality Assurance (NCQA) requirements:

- QI for quality management
- UM for utilization management
- MEM for member connections
- CR for credentialing and recredentialing

The Plan performs audits and requires that delegated entities demonstrate how they ensure that the subcontractor performing delegated QI, UM, member connections, and credentialing and recredentialing functions on the delegated entities behalf is meeting NCQA standards and any additional regulatory state and/or federal requirements. More specifically, the Plan requires proof of an agreement between the provider group and subcontractor entity that delineates the rights and responsibilities of each party and requirements for review of subdelegated activities.

Definitions

The current Health Plan Standard and Guidelines, published by NCQA, define delegation and sub delegation as follows:

- Delegation - Occurs when the organization (Health Net) gives another entity (such as a participating physician group (PPG) or independent practice association (IPA) the authority to carry out a function that the organization would otherwise perform.
- Sub delegation - Occurs when the organization's delegate (such as a PPG or IPA that contracts with Health Net to perform a specific function) gives a third entity the authority to carry out a delegated function.

Contractual Financial and Administrative Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on contractual financial and administrative requirements.

Select any subject below:

- Financial Statements
- Financial Survey Filing Requirements
- Physician Incentive Plan
- PPG Networking Contractual Requirements
- Use of Performance Data

Financial Statements

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net monitors and evaluates the financial viability of its delegated and capitated participating providers and maintains adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent (section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR)).

All providers with a capitated Provider Participation Agreement (PPA) are required to submit their annual financial statements to Health Net 150 days after the close of the participating physician group's (PPG's) or hospital's fiscal year. PPGs and hospitals are further required to submit to Health Net quarterly financial updates, prepared by the provider organization and reflecting year-to-date activity, within 45 business days after the close of the calendar quarter or most recent quarter, if provider's fiscal year is different from calendar year.

PPGs' and hospitals' financial statement packets should include:

- Signed Health Net financial certification form (for quarterly unaudited financials only).
- DMHC quarterly and-or annual financial survey report forms as detailed in subsection 1300.75.4.2(b) and (c) of Title 28 of the California Code of Regulations (CCR) including:
    - balance sheet
    - an income statement
    - a statement of cash-flow
    - a statement of net worth
    - cash and cash equivalent
    - receivables and payables
    - risk pool and other incentives
    - claims aging
    - notes to financial statements
    - enrollment information
    - mergers, acquisitions and discontinued operations
    - the incurred but not reported (IBNR) methodology
    - administrative expenses
    - footnote disclosures (for annual audited financial survey)

For nonprofit entities, refer to subsection 1300.75.4.2(b) and (c) of the California Code of Regulations for additional requirements.

PPGs and hospitals must submit these quarterly financial updates and annual audited financial statements to the Third Party Risk Management Office (TPRMO).

PPGs and hospitals must also ensure compliance with Health Net's financial solvency standard benchmarks and related contractual requirements to make sure their financial status is stable and not deteriorating over time. If the PPGs and hospitals fail to meet the financial solvency standard, and it is determined by Health Net that a corrective action plan (CAP) is needed, the PPGs and hospitals must submit a CAP within 30 days from the date of request. Below are the 14 financial solvency review standard benchmarks that must be met:

Provider Type	Category	Standard
PPG, Hospital	Working Capital	Must be positive
PPG, Hospital	Tangible Net Equity	Must be positive
PPG	Required Tangible Net Equity	Refer to 1300.76(c)(1) of Title 28 of CCR
PPG	Cash to Claims Ratio	= or > 0.75
PPG, Hospital	Cash to Payable Ratio	= or > 0.50
PPG, Hospital	Profit Margin Ratio	> 0.00
PPG	Medical Loss Ratio	= or < 0.85
PPG, Hospital	Debt-to-Equity Ratio	= or < 1.0
PPG, Hospital	Accounts Receivable Turnover	= or > 11.81
PPG, Hospital	Average Days to Collect	= or < 30 days
PPG	Average Claims Liability	between 2.5 & 3.5 months
PPG	General and Administrative Expenses	= or < 0.15
Hospital	Total Operating Expense	= or < 1.0
PPG, Hospital	Total Z-Score	= or > 1.81

If the PPG is determined to be noncompliant, a corrective action plan (CAP) must be filed simultaneously with the financial survey to the Department of Managed Health Care (DMHC).

PPGs With Sub-Delegating Risk Arrangements

PPGs with sub-delegating risk arrangements are required to monitor and evaluate the financial viability of their delegated and capitated participating providers and maintain adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent according with section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR) and with Health Net's financial benchmark as outlined above. When requested by Health Net, PPGs are required to provide copies of their monitoring policies and procedures within 30 days of Health Net's request.

Financial Survey Filing Requirements

Participating Physician Groups (PPG) | Hospitals

The following Department of Managed Health Care (DMHC) filing requirements are included for those participating physician groups (PPGs) that assume financial risk on a capitated or fixed periodic payment basis for the cost of health care services rendered to health plan members (sections 1300.75.4, 1300.75.4.2, 1400.75.4.7, 1300.75.4.8, and 1300.76 of Title 28 of the California Code of Regulations (CCR)).

PPGs and hospitals must submit the quarterly and annual audited financial statements to Health Net's Third Party Risk Management Office (TPRMO).

Filing Types	Requirements	Filing Period	Filing Deadline
Quarterly Financial Survey	PPGs submit an electronic quarterly financial survey report to DMHC and Health Net no later than 45 calendar days following the close of each quarter of its fiscal year. (Note: PPGs with financial statements prepared in the fiscal year submit the most recent quarter.) Hospitals submit quarterly financial surveys to Health Net directly. (Note:	Q1 Q2 Q3 Q4	May 15 August 15 November 15 February 15

Filing Types	Requirements	Filing Period	Filing Deadline
	Hospitals with financial statements prepared in the fiscal year must submit the most recent quarter.)		
Annual Financial Survey	PPGs submit an electronic annual audited financial survey including auditors notes and opinion letter to DMHC and Health Net not more than 150 calendar days after the close of PPG's fiscal year determined by the DMHC, and based upon PPG's annual audited financial statement prepared in accordance with generally accepted auditing standards. Hospitals submit annual audited financial surveys including auditors notes and opinion letter to Health Net directly.	Annual	May 31

If a PPG organization reports deficiencies in any of the six DMHC grading criteria listed below, the PPG must submit a self-initiated corrective action plan (CAP) proposal in an electronic format to DMHC and Health Net (section 1300.75.4.8 of Title 28 of the CCRs). The grading criteria are:

- tangible net equity (TNE): must be positive
- required tangible net equity: Positive TNE shall be at least equal to the greater of:
  - (A) one percent (1%) of annualized revenues; or,
  - (B) four percent (4%) of annualized non-capitated medical expenses.
- working capital: must be positive
- cash-to-claims ratio: 0.75
- claims timeliness percentage: 95%

- incurred but not reported (IBNR) methodology, both documented and used in estimation of IBNR liabilities: three months

Late Filing for Financial Survey Requirements

Health Net is required by the DMHC to follow up on late filing of the financial survey (section 1300.75.4.5 of Title 28 of the CCR). As soon as the PPG files with DMHC, the PPG must immediately submit the confirmation of the filing to the TPMRO. Late-filing PPGs can be downloaded from the DMHC website.

Physician Incentive Plan

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The California Department of Managed Health Care (DMHC), the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) require that providers and health plans furnish to requesting members general information regarding the contractual incentive plans currently in place. Information provided would be general information on how the provider is reimbursed for delivering covered services. Specific financial information is not required.

PPG Networking Contractual Requirements

Participating Physician Groups (PPG)

Participating physician groups (PPGs) may contract with providers to furnish necessary services to members. The California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS) require health plans to collect and review the contract and subcontract templates at least annually to ensure that they contain required elements and wording and do not contain prohibited elements or wording. Contract and subcontract templates, with a cover letter, must be submitted on request and on issuance of a new template.

PPG Network

PPGs must provide the plan with a list of names, practice locations, federal tax identification numbers, professional practice names, and the business hours for all member physicians and other participating providers who contract with the PPG. The list must be submitted in a form acceptable to the plan as stated in the Provider Participation Agreement (PPA).

Proof of Executed Contracts

DMHC requires the plan to ensure that all providers in the network have executed contracts. The plan requires that the cover page and signature page of each provider and physician contract be submitted on execution, on credentialing or re-credentialing, and on request to the provider relations and contracting specialist (formally provider network administrator (PNA)) assigned to the PPG.

Provider Education

Each PPG is responsible for having a written process that assists in timely distribution of plan policies, procedures, manuals, updates, newsletters, and reports. PPGs are required to:

- Publish and distribute provider operations manuals and updates to all providers, taking steps to ensure that new providers receive these materials promptly.
- Maintain provider and member service education programs for each primary care physician's (PCP's) office.

Use of Performance Data

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net is subject to various statutory, regulatory and accreditation requirements, and must ensure that all agreements comply with any such mandates. Accreditation from the National Committee for Quality Assurance (NCQA) is critical to both the health plan and network providers and ensures that Health Net meets the highest possible standards of excellence and care.

One of the requirements of NCQA is that Health Net may use practitioner performance data for quality improvement activities. Therefore, Health Net's contract templates have been updated with the following language:

National Committee for Quality Assurance Health Plan Accreditation Standards and Quality Assessments and Improvements. Each Provider agrees to: (i) cooperate with Quality Management and Improvement (“QI”) activities; (ii) maintain the confidentiality of Covered Persons’ information and records pursuant to the Agreement; and (iii) allow the Company to use Provider’s performance data. Moreover, each Provider shall participate in, cooperate with, and its performance shall be measured in accordance with applicable quality measures and criteria, including but not limited to, Company Policies, Office of the Patient Advocate, STARS and External Accountability Set.

Delegated Medical Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on delegated medical management.

Select any subject below:

- Overview
- Delegation
- PPG Responsibilities for Referral Tracking

Overview

Provider Type: Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) with delegated utilization management (UM) status are required to consistently meet Health Net's UM standards related to inpatient care, outpatient care, discharge planning, care coordination, retrospective review, and timeliness of authorizations and denials. Health Net's UM standards are updated as necessary to comply with standards established by federal and state regulatory agencies and accreditation entities, such as the National Committee for Quality Assurance (NCQA). Delegation of UM activities allow for autonomy based on PPG capabilities and creates accountability to Health Net. Health Net audits PPGs for accountability and reporting of PPG activities.

Health Net conducts annual audits and ongoing oversight and monitoring of delegated activities.

Multidisciplinary medical management staff may perform additional ongoing operational assessments. Based on the PPGs performance and abilities, Health Net may modify delegation status.

The regional medical director (RMD), regional network director (RND) and/or Third Party Risk Management staff contacts the PPG prior to a change in delegation status. The PPG may also request an additional assessment or change in delegation status from the RMD or RND.

Program Description

PPGs with delegated responsibilities for UM are required to have a written UM program that documents all facets of the delegated authority. All decisions regarding approval or denial of health care services under delegation are made in accordance with the PPG UM program, which includes a UM committee review process.

PPGs with delegated functions are required to use standardized, nationally recognized UM criteria, such as InterQual® Guidelines, to ensure consistent decision-making at all levels of review. The UM program must specify the medical criteria and process used to determine medical necessity. The PPG must consider age, comorbidities, complications, treatment progress, psychosocial situation, and home environment (when applicable) when applying medical criteria. The PPG must also consider characteristics of the local delivery system available to a particular member, such as skilled nursing facilities (SNFs) and access to local hospitals and home health care.

The PPG UM program is evaluated annually by the UM Compliance Auditor for compliance with Health Net standards and is required to be approved by the governing board of the PPG annually, with written documentation of review and approval. Health Net's UM standards are updated as necessary to comply with standards established by federal and state regulatory agencies and accreditation entities, such as the NCQA when applicable.

A PPG's UM program should provide evidence that internal procedures for UM are operationally sound, and include documentation that:

- A physician is designated to ensure that necessary authorization procedures are performed.
- Authorizations for elective and urgent health care services are within established time standards.
- Utilization deliberations and decisions are available and accomplished daily. A summary report of utilization activities is reviewed by the PPG UM committee.
- Documentation of the UM process includes the decision, member notification, and provider notification. In the case of a denial, the specific reason for the denial, including the specific utilization review criteria or benefit provision used in the determination, an alternative treatment plan and the appeal process must be included.
- Timely, documented member notification of approval or denial is on record.
- Weekly logs of hospital admissions and denials must be submitted to the Health Net Notification Unit.
- UM system controls are in place and meet NCQA guidelines.

Additional guidelines for elements that should be addressed in the PPG UM program description are incorporated in the oversight activities for evaluating structural and process elements. The responsibilities of Health Net and delegated providers are outlined in the UM-Delegation Agreement.

Policy Development

The utilization management (UM) criteria or guidelines used to determine whether to authorize, modify, or deny health care services must be evaluated at least annually and updated, as necessary. For Medi-Cal and Commercial lines of business, written policies and procedures must include disclosures pertaining to the use and oversight of the AI, algorithm or other software tool used in the UM determination process.

UM Committee

Each PPG is required to have a UM committee that meets not less than quarterly, and more frequently if necessary. UM committees that are responsible for authorization decisions are required to meet more frequently. The UM committee's purpose and responsibilities must be written and on file. The committee minutes must be on file and available for review by Health Net on request.

Delegated Evaluation of Emergency Services

If an injury or illness requires emergency services, members are instructed to call 911 or go to the nearest hospital or urgent care center. When emergency services are received, members must contact their primary care physician (PCP) or participating physician group (PPG) as soon as possible to notify them of the emergency services received.

Emergency services are a covered benefit if a prudent layperson, acting reasonably, believes that the condition requires emergency medical treatment or if an authorized representative, acting for the organization, has authorized the emergency services or directed the member to the emergency room. .

A prudent layperson is a person who is without medical training and who draws on their practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

PPGs of facilities are required to notify the Hospital Notification Unit if an inpatient admission is required at a hospital. The plan requires notification from the PPG or the facility within 24 hours of admission if it occurs on a weekday, or the next business day if the admission occurs on a weekend or holiday. This applies to all shared-risk and fee-for-service (FFS) PPGs, inpatient facilities and PPGs regardless of risk arrangement.

Encounter Data

Health Net requires submission of encounter data for the purpose of conducting a retrospective review. Encounter data is collected across the provider network for both outpatient and inpatient services. Participating physician group (PPG)-specific data is analyzed and compared to plan-wide data in order to identify more effective methods for management of health care resources.

Aggregate data analysis allows the PPG to assess overall trends of utilization. Reports of all services approved following the PPG utilization management (UM) program are submitted to Health Net through encounter data. The encounter data system assists in tracking and trending utilization patterns across Health Net's provider network. A successful encounter-reporting schedule is important to assure that service data is submitted to Health Net in an accurate and timely manner. Contact the Encounter Department for assistance. Failure of the PPG to submit timely and accurate data, as well as failure to meet these standards, results in development of a corrective action plan (CAP).

Shared Risk UM Responsibilities

Shared risk is assigned to participating physician groups (PPGs) that have demonstrated the capacity to manage selected operational functions. These groups have agreed to a shared-risk agreement for institutional services. The plan performs selected oversight of the PPG management of delegated services and shared management responsibility. Refer to the discussions in the Provider Evaluation for Delegation section for more information about the standardized program reviews.

PPG Responsibilities

In a shared-risk relationship, PPGs are responsible for the following:

- Conducting prospective, concurrent and retrospective reviews with advice from and guidance by medical management when requested or needed.
- Cooperating with medical management on all out-of-area admissions, including but not limited to, repatriation.
- Reporting inpatient admissions within 24 hours or on the next business day.
- Conducting concurrent reviews and providing findings and recommendations on level of care and lengths of stay for each inpatient admission within 24 hours or on the next business day.
- Assisting in identification of coordination of benefits (COB) and third-party payer information.
- Having a written utilization management (UM) program description and plan approved by the plan. The program and plan are evaluated annually for effect on members and providers and are reviewed and approved by the governing body of the PPG, with signature and minutes documenting the approval.

- Establishing a UM committee comprised of board-certified providers, who make decisions regarding the approval or denial of health care services to members.
- Using standardized nationally recognized UM criteria to ensure consistent medical necessity determination at all levels of review and interrater reliability (IRR) for all individuals involved in the UM process.
- Having written specific procedures for prospective, concurrent and retrospective reviews and case management that are supervised by qualified medical professionals and physician consultants from the applicable specialties of medicine and surgery. Physicians used to assist in medical necessity determinations are certified by one of the American boards of medical specialties.
- Having UM program policies and procedures, which specifically outline member and provider notification of medically necessary determinations, including approvals and denials. The PPG clearly documents and communicates the reasons for each denial, including the specific utilization review criteria or benefits provision used in the determination. The denial process is clearly outlined and includes an appeal process. For Medi-Cal and Commercial lines of business, written policies and procedures must include disclosures pertaining to the use and oversight of the AI, algorithm or other software tool used in the UM determination process.
- Having a denial policy and procedure and member letters that include required regulatory statements indicating how the member can appeal directly to the plan.
- Having a denial process that includes specific regulatory language indicating that participating providers (for example, physicians, inpatient facilities and ancillary providers) may appeal directly to the plan.
- Conducting daily inpatient reviews to provide review information to a designated utilization and/or care management nurse upon request. Review information can be submitted by telephone or fax. The plan, to the extent necessary and at its own discretion, may assist the PPG in performing concurrent reviews, coordinating the discharge plan, determining medical necessity and appropriate level of care, and consulting on quality improvement screening when the health plan identifies concerns related to under- or over-utilization.
- Administering member coverage based on member's Evidence of Coverage (EOC).
- Participating with the plan in meetings as scheduled.
- Actively collaborating with Care Management to maximize effectiveness in managing the member's care.
- Providing valid, reliable and timely encounter data as requested and complying with the UM program.
- Conducting reporting and analysis semi-annually for commercial members and quarterly for Medicare Advantage members, which includes:
    - Acute inpatient bed days/1,000, admits/1,000, average length of stay.
    - Skilled nursing facility (SNF) bed days/1,000, admits/1,000, average length of stay.
    - Emergency room visits/1,000.
        - Outpatient surgery cases/1,000
- Preparing action plans for any outlier UM indicators.

Refer to other discussions in the Provider Delegation topic for additional information, including a calendar of required submissions.

PPG Responsibilities Regarding Nonparticipating Hospitals

If a nonparticipating hospital emergency room department or the nonparticipating provider calls the member's PPG or primary care physician (PCP) to request authorization for medically necessary post-stabilization care, the PPG or PCP should immediately notify the Hospital Notification Department. Do not issue an authorization

or tracking number or confirmation of eligibility to the nonparticipating hospital. (This does not apply to Medicare Advantage HMO members.)

(Note: A PPG in a dual risk relationship with a hospital is responsible for complete utilization management (UM) for members to which the dual risk relationship applies. Such UM includes confirming eligibility, issuing authorizations or tracking numbers to nonparticipating hospitals, and arranging for member transfers or discharges, as appropriate. A PPG participating in a dual risk relationship should notify the plan of any member admissions to nonparticipating hospitals.)

Plan Responsibilities

In a shared-risk relationship, the plan is responsible for the following:

- Assigning a UM nurse to receive concurrent reviews from PPGs (by telephone or onsite) on selected cases, or, as required for the purpose of assisting in arranging for the provision of care at the correct level and in members' discharge planning.
- Assigning a regional medical directors (RMDs) and provider relations & contracting specialist (formally provider network administrator) to act as a liaison with network providers to resolve contractual, operational and service problems.
- Having the Member Services Department function as a liaison between members and the PPG.
- Performing member satisfaction surveys and initiating intervention as needed.
- Assigning an auditor to conduct pre-contractual evaluations, annual evaluations, and perform oversight and monitoring of the PPG to evaluate the PPG's UM program, including a review of denial and appeal process, and assisting the PPG in complying with these policies, state and federal regulations and accreditation standards.
- Providing non-participating hospitals in California with one contact telephone number to call to request authorization to provide post-stabilization services to a patient who has received emergency services. After receiving the required information from the PPG, Health Net contacts the nonparticipating hospital with directions for transferring the patient or an authorization for medically necessary post-stabilization care. If the telephone call is not returned within 30 minutes, authorization is deemed to be granted (pursuant to enactment of Assembly Bill 1203 (2008), which amended Health and Safety Code section 1262.8 (b)(3) and section 1371.4. (This does not apply to Medicare Advantage HMO members.).

Integrated organization determination for DSNP members in Exclusively Aligned Enrollment (EAE) counties

Dual Special Needs Plan (DSNP) contractors are required to provide integrated organization determination for the DSNP members in Exclusively Aligned Enrollment (EAE) counties. For DSNP members in EAE counties, the authorization for the services requested need to be reviewed for **both** Medicare and Medi-Cal benefits to determine eligibility for the service requested. PPGs that are delegated to perform the Medicare services shall not deny prior authorization as “not a covered benefit” without checking both Medicare and Medi-Cal covered services (refer to the list of services below).

DSNP prior authorization timelines

PPGs should forward prior authorizations for the services that are not covered under Medicare but that are covered under Medi-Cal to Health Net within the following timelines:

- For standard requests, forward to Health Net within 1 business day upon receipt of the request.
- For expedited requests, forward to Health Net within 24 hours upon receipt of the request.

Fax authorizations to Health Net Medi-Cal Prior Authorization Department fax number

Fax prior authorizations to the Medi-Cal fax number listed under Health Net – Prior Authorization Department and include:

- The date and time that the service request was initially received.
- The clinical decision that was used to make the initial determination.

Services not covered under Medicare but covered under Medi-Cal

CalAIM Community Supports

- Asthma remediation
- Community transition services/nursing facility transition services to a home
- Day habilitation programs
- Environmental accessibility adaptation (home modification)
- Housing deposit (up to $6,000)
- Housing tenancy and sustaining services
- Housing transition navigation
- Medically tailored meals
- Nursing facility transition/diversion to assisted living facilities
- Personal care services and homemaker services
- Recuperative care
- Respite services
- Short-term post-hospitalization housing
- Sobering centers

Long Term Services and Supports

- Community Based Adult Services
- Long-term Care
- Durable Medical Equipment (DME) that is covered by Medi-Cal

Scenarios where PPGs would be responsible for sending out the Applicable Integrated Plan (AIP) Coverage Decision Letter

Refer to the below table to see the scenarios where PPGs are responsible for sending out the AIP Coverage Decision Letter. This will help PPGs determine when to forward the authorizations to the Plan and when to send the Applicable Integrated Plan Coverage Decision Letter for DSNP members in EAE counties.

Scenario	Delegated PPG	Health Plan
Eligibility denial	Deny and send AIP coverage decision letter.	N/A
Medical necessity denial	Deny and send AIP coverage decision letter.	N/A

Scenarios where PPGs would be responsible for forwarding the request to the Health Plan

Scenario	Delegated PPG	Health Plan
Benefit denial	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.
Out of network	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.

Delegation

Provider Type: Participating Physician Groups (PPG)

Health Net evaluates structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information on these elements.

Health Net may delegate responsibility for activities associated with UM and Care Management services to its PPGs. Prior to participating with Health Net, and at least annually thereafter, Health Net conducts a review of each PPG. Health Net evaluates the provider's facility and ability to deliver high-quality health care consistently and perform necessary administrative functions. Based on the audit scores and findings, if certain thresholds and criteria are met, the Delegation Oversight Committee (DOC) may deem it proper to delegate certain specific functions to the PPG to perform. If approved for delegation, a delegation agreement is forwarded to the PPG for signature. The delegation agreement includes a matrix that delineates the specific responsibilities delegated to, and accepted by, the PPG.

Upon delegation, Health Net may delineate specific and certain medical management functions for performance improvement. Performance improvement plans shall be shared with PPGs at regular intervals. Health Net and PPG medical directors are required to afford and actively participate in implementation of performance improvement plans.

Health Net systematically monitors and tracks provider compliance for all delegated providers because Health Net remains accountable to state and federal regulatory agencies for provider compliance even if certain functions are delegated.

Delegation Program Monitoring and Evaluation

Health Net may delegate responsibility for activities associated with utilization management (UM) and Care Management to participating providers. The DOC determines delegation status for each of the above functions, based initially on the results of pre-delegation comprehensive evaluation.

The DOC renders delegation decisions and provides guidance regarding delegation responsibilities through reports of annual audit results, oversight and monitoring, and periodic reviews of PPG specific data as reported from the Health Net Quality Improvement (QI) staff. This data includes, but is not limited to, complaints, access audit performance, member satisfaction results, and other quality of care data. Health Net may revoke, partial

or complete delegation at any time if the committee determines that the PPG is no longer capable of performing delegated functions.

The DOC communicates delegation decisions for new PPGs or additional lines of business, as well as any recommendations and requests for root cause analysis and/or corrective action plans, to the PPG in writing by a series of standardized letters. The letters describe the functions or activities for which delegation is approved or denied, a delegation agreement, a delineation of the responsibilities of the PPG and the health plan, and the time frames for responses and submission of any required corrective plans. Health Net always remains accountable for all care and service delivered to members.

Delegation agreements for existing delegates are updated and signed as needed.

Health Net and PPGs may schedule operations meetings based on PPG requests or business needs identified by Health Net. Other criteria affecting PPG performance may necessitate additional meetings as determined by representatives. The meetings are multidisciplinary and provide a forum for both parties to discuss operational issues and PPG performance measures, which may include: access audit results, accreditation updates, UM audit results, care management audit results, appeals and grievance issues, denial issues, medical management issues, claims issues, eligibility, encounter data submission, pharmacy issues, required submissions report, provider profiles, and other information relevant to the member population served. Representatives from the PPG, Health Net and participating hospitals (if any) are included in the meetings.

Screening of prospective, concurrent and retrospective quality issues is conducted by the Quality Improvement staff upon notification of potential quality of care concerns. Indicators that may be reviewed include:

- Access - delay in authorization
- Access - delay in diagnosis
- Access - delay in service
- Communication
- Continuity of care
- Denial or delay of referral or authorization
- Denial of treatment
- Emergency services
- Encounter data submission
- Financial viability
- Inadequate care
- Inappropriate care or treatment
- Inappropriate denial of treatment
- Messy or unsanitary environment
- Misdiagnosis or inability to diagnose
- PPG claims and UM timeliness
- Physician incentive plan reporting
- Provider education
- Refusal to treat or care for members
- Rude, inappropriate or insensitive behavior
- Satellite addition and deletion
- Unprofessional and unethical behavior
- Urgent issues
- Utilization, credentialing and claims delegation oversight

Transitioning Delegated Functions

Delegated providers interested in transitioning any of their delegated functions, such as utilization management, claims, care management, or credentialing, to a new or different subcontracted entity or management services organization (MSO) must request approval from Health Net a minimum of 90 calendar days in advance of the anticipated transition date.

Submit written requests to your Provider Network Management (PNM) representative at least 90 calendar days in advance of the transition with the following information:

- Name of the new entity
- Delegated functions to transition to the new entity
- Contact name with contact information at the new entity
- Date of proposed transition

Approval or denial of the delegation transition to another entity is provided by Health Net once Health Net performs a comprehensive assessment and evaluation of the new entity.

Delegated providers are prohibited from initiating any transition plans to the new entity without Health Net's prior approval. Failure to comply with adequate notification and approval can jeopardize a provider's participation in Health Net's provider network.

Revoking Delegation

The DOC may, prior to any of the steps discussed in the Corrective Action Plan topic, decide to revoke delegation or send Health Net staff to the PPG for oversight and to assist in achieving compliance. When revoking delegation, Health Net follows written policies and procedures to ensure that there is no adverse effect on members.

Program Evaluation for Delegation

Oversight of PPG

Oversight of PPG operations includes annual ongoing review and monitoring of the written description of the utilization management (UM) program and operational assessment. PPG oversight includes, but is not limited to:

- Monitoring of denials.
- Compliance with health care criteria.
- Compliance with Health Net's approval and denial decision timelines standards.

During the assessment, the UM auditor reviews policies and procedures, including the UM program to validate adherence to compliance standards. The UM auditor will provide the PPG with details on all findings and request the PPG to outline a plan for improvement, where needed. The UM auditor will review this plan and verify that it is appropriate based on the failures identified prior to approval.

Additional PPG documentation may be requested to complete the evaluation. The completed evaluation, with recommendations from the UM auditor, is reviewed and presented to the Delegation Oversight Workgroup (DOW) and forwarded to the Delegation Oversight Committee (DOC). PPGs with extensive improvement plans are monitored closely until the changes are effective. A non-compliant PPG may be referred to the DOC for

further action. Status reports are made to the DOC. PPGs not able to maintain the required standards are referred to the DOC for possible revocation of specified delegated activities.

In the event that a PPG disagrees with audit findings or the delegation decision of the DOC, the PPG may present the issue in dispute, in writing, to the chairperson of the DOC within 10 business days of receipt of the determination.

Delegation Assessments

PPG's UM program are evaluated pre-contractually and at least annually thereafter. To guide the assessment and provide consistency, Health Net uses a standard set of evaluation criteria driven by regulatory requirements and guidelines. Criteria is applied based on the lines of business delegated to the PPG.

The UM auditors will perform these evaluations. The UM auditor communicates with PPGs regarding the UM and care management (CM) program and standards. The UM auditors are the principal liaison for regulatory requirements between Health Net and the PPGs and play an integral role in helping PPGs maintain compliance with Health Net's expectations.

Delineation of Delegation Responsibilities

Structural elements are basic requirements that must be developed in order to maintain an effective utilization management (UM) program. These elements are developed and approved to provide a process to support UM activities. The elements of a provider's UM program are reviewed, revised and approved annually. Refer to the Utilization Management (UM)-Delegation Agreement for more information.

Revocation of Delegated Medical Management

Health Net reserves the right to revoke delegated status when the PPG has failed to meet and maintain established standards. Capitation payments may be adjusted when revocation of medical management functions occurs.

Delegated Review Processes - Concurrent, Prospective and Retrospective

Participating physician group (PPG) utilization review (UR) staff should perform concurrent reviews daily. PPGs may be required to communicate their concurrent review findings to Health Net medical management staff daily, or as requested by the Utilization Management (UM) and Care Management (CM) staff. The objective of PPG concurrent reviews is to assess clinical information during a member's hospital stay, coordinate the discharge plan, assist in determining medical necessity at the correct level of care, and perform the quality improvement screening.

The first review occurs within 24 hours of admission to confirm that the member is in the appropriate setting and is receiving medically necessary care, and to begin discharge planning. The PPG utilization management nurses review the member's continued stay using standardized nationally recognized criteria, such as InterQual® Guidelines. If a concurrent review does not confirm the need for continued stay, alternative care or a less acute level of care must be considered.

PPGs must develop processes to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Health Net is responsible for a concurrent review of out-of-area admissions for delegated PPGs, except for PPGs with financial responsibility for out-of-area services, according to the PPG's Provider Participation Agreement (PPA). Refer to the Out-of-Area Services discussion for more information. PPGs are responsible for working with Health Net to determine and facilitate the transfer of a member back into the network when appropriate, and the member is stable.

Prospective Review Process

A prospective review is performed to determine the medical necessity of elective referrals to specialty or ancillary care, inpatient admissions and outpatient procedures.

Requests for prior authorization of elective referrals, admissions or procedures are received by the participating physician group (PPG) from the primary care physician (PCP) or specialist. The PPG determines medical necessity through the use of standardized nationally recognized criteria and approves or denies the request. Refer to the Referrals and Prior Authorization topics for additional information.

Performance standards for turn-around times for review of, determination and decision notification for requests for prior authorization vary by line of business and the urgency of the request. Refer to the Utilization Management Timeliness Standards for Commercial, Medi-Cal and Medicare plans on the Health Industry Collaboration Effort (HICE) website at www.iceforhealth.org/library.asp.

The PPG is obligated to provide oversight and documented monitoring of the utilization review process for medical appropriateness whenever this process is performed by a sub-delegated review organization. The PPG may not sub-delegate a function or activity to an entity whose delegation status with Health Net is currently denied or revoked for that function or activity. PPGs must notify Health Net prior to any sub-delegation agreement.

The UM auditor periodically educates the PPG on plan tools, provides performance data, and evaluates performance. Failure to meet the standards results in PPG to create and action plan to remediate all findings. The PPG will submit an action plan for approval by the UM auditor, who will review the action plan to ensure it is appropriate to address all findings. Once approved, the PPG must update the UM auditors of the status of each action plan. Once completed, the UM auditor will decide if retesting is required for the issue.

Retrospective Review Process

A retrospective review is conducted on individual cases and with aggregate decision data. An individual case review helps to identify specific matters arising from an episode of care (for example, emergency room claims are reviewed for medical necessity and coverage). Problems identified through the retrospective review process are communicated to the PPG to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Utilization Management Responsibilities

Dual risk is restricted to participating physician groups (PPGs) with a dual-risk capitation agreement with the plan for professional and hospital services that have successfully met the plan performance standards. These groups have comprehensive administrative systems and have demonstrated an ability to perform utilization and care management activities effectively. At least annually, Health Net performs standardized program reviews of

these PPGs to assess performance. Refer to the discussions in the Provider Evaluation for Delegation section for more information about the standardized program reviews.Delegation Oversight Interactive Tool.

PPG Responsibilities

In a dual-risk relationship, PPGs are responsible for the following:

- Having an effective, comprehensive utilization management (UM) and care management (CM) program in place that includes a UM committee comprised of actively practicing providers.
- Performing prospective, concurrent and retrospective reviews of medical care consistent with Health Net's goals and objectives.
- Cooperating with Health Net on medical management of all out-of-area admissions.
- Providing valid and reliable encounter data in a timely manner as requested and complies with the UM program.
- Reporting and analysis, including, but not limited to, the following:
    - Bed days/1,000, admits/1,000, length of stay (semi-annually for commercial and quarterly for Medicare)
        - For Health Net membership
        - For all managed care membership
    - Mental health (not applicable to Medi-Cal)
        - Days/1,000
        - Admits/1,000
        - Length of stay
    - Adoption of UM criteria
    - Monitor quality and timeliness of UM decisions and notifications
    - Approval and denials
    - Communication with members
- Preparing action plans for any out-of-the-ordinary UM indicators.
- Identifying children with potential California Children's Services (CCS)-eligible conditions and making referrals to the appropriate CCS county programs (applicable to Medi-Cal only).
- Having a written UM program description and plan approved by Health Net. The program and plan are evaluated annually for effect on members and providers and are reviewed and approved by the governing body of the PPG with signature and minutes documenting the approval.
- Having specific written procedures for precertification, concurrent and retrospective reviews, and care management that is supervised by qualified medical professionals and physician consultants from the applicable specialties of medicine and surgery. Physicians used to assist in medical necessity determinations are certified by one of the American boards of medical specialties.
- Having a UM committee composed of providers that makes determinations regarding approval or denial of health care services to members.
- The PPG's UM program and policies and procedures specifically outline member and provider notification of medically necessary determinations, including for approvals and denials. The denial process is clearly outlined and includes an appeal process.
- The PPG denial policy and procedure and member letters include required regulatory statements that clearly indicate the reason for the denial, alternative treatment suggestions and how the member can appeal directly to Health Net.
- The PPG denial process includes required regulatory statements that inform participating providers (for example, physicians, inpatient facilities, and ancillary providers) that they may appeal directly to Health Net.
- The PPG uses standardized nationally recognized UM medical review criteria to ensure consistent medical necessity determinations and interrater reliability (IRR) for all individuals involved in the UM process.

- The PPG and PPG-hospital affiliates report encounter data monthly. Care management cases (shared risk only) are reported to the Medical Management staff at the point of identification. Dual-risk PPGs delegated to perform complex case management according to NCQA standards are assessed annually for compliance with those standards. Refer to the Care Management section in the Utilization Management section for additional information on criteria for referral to the care management program.
- The PPG assists in identification of coordination of benefits and third-party payer information (not applicable to Medi-Cal).
- The PPG participates with Health Net in meetings as scheduled.
- The PPG administers member coverage based on the member's Evidence of Coverage (EOC).
- Failure of the PPG to meet the under- and over-utilization standards results in development of a corrective action plan that is submitted to Health Net for review and approval.
- PPG representatives participate with Health Net medical management committees as requested.

Refer to other discussions in the Delegation Oversight topic for additional information, including a calendar of required submissions.

Health Net Responsibilities

In a dual-risk relationship, Health Net is responsible for the following:

- Contracting with the PPG for delegated UM functions.
- Assigning a UM auditor to conduct pre-contractual evaluations, annual evaluations, and perform oversight and monitoring of the PPG to evaluate the PPG's UM program, including a review of denial and appeal process, and assisting the PPG in complying with these policies, state and federal regulations and accreditation standards.
- During the pre-contractual assessment with the PPG, the UM auditor validates the PPG UM program adheres to the plan utilization and care management delegation criteria.
- Review and approval of the PPG UM program and conducting an annual audit of the PPG, including a review of denial files. If the PPG is not able to maintain the required standard of medical management, the Delegation Oversight Committee (DOC) may recommend revocation of specific delegated activities.
- A provider engagement and network specialist (formally provider network administrator) and a regional medical director (RMD) acts as a liaison with the PPG to resolve all contractual, operational and ongoing service problems.
- Oversight and monitoring when the PPG is delegated to perform complex care management for its dual-risk membership.
- PPG performance is monitored to determine if members are receiving timely medical services.

Requirements for PPGs Utilization Management Process

Health care service plans (HCSPs) and participating physician groups (PPGs) to which utilization management (UM) functions are delegated are required to employ and designate a senior medical director with an unrestricted California license to be responsible for ensuring that the UM processes are in compliance with the statute.

The name and direct telephone number (or extension) of the health care professional making the decision to delay, deny or modify a request for authorization of payment of service must be included in the notification letter to the requesting provider.

Health care service plans and PPGs to which UM functions are delegated are required to maintain telephone access for providers to request authorization for payment of health care services.

Timeliness Requirements for UM Decision Making

The health care service plan and its PPGs to which utilization review (UR) functions have been delegated are required to comply with standards established by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the HICE website to locate the Approved HICE Documents for the appropriate UM Timeliness Standards.

Disclosure of UM and UR Processes

Health care service plans (HCSPs) (or delegated participating physician groups (PPGs)) and disability insurers are required to disclose the UM and UR processes and criteria the plan and its delegated PPGs use to authorize, modify, defer, or deny health care services when requested by health care providers, members or the public.

Disclosures must be accompanied with the following text in its entirety:

"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Health care service plans and PPGs may charge reasonable fees for copying and postage costs and may make the information available electronically.

PPG Responsibilities for Referral Tracking

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating physician groups (PPGs) delegated for utilization management (UM) functions are required to develop and implement policies and procedures for tracking whether Health Net members actually obtained services authorized pursuant to a referral.

In accordance with the California Department of Health Care Services (DHCS) requirements, Health Net requires PPGs to track member compliance with referrals within their network. PPGs may consider generating monthly reports on outstanding or expired referrals. These reports can be used at both the PPG and primary care physician (PCP) level to monitor completion and follow-up on referrals for specialty services.

Health Net's medical program managers (MPMs) monitor delegated PPGs for compliance with this responsibility as part of the PPG's annual UM audit and continuous oversight activities.

Facility and Physician Additions, Changes and Deletions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

- Overview
- Closure and Termination
- Conditions of PCP Office Closures
- Hospitals Adequate Supplies and Staffing
- Facility Decertification Notification Requirement
- Member Notification for Specialist Termination
- Provider Online Demographic Data Verification
- Provider Outreach Requirement
- Mandatory Notification Requirements for PPG Downstream Hospital Terminations

Overview

Participating Physician Groups (PPG) | Ancillary | Hospitals

A participating provider that expands its capacity by adding new or satellite facilities or new participating physicians or other subcontracting providers must notify Health Net in writing at least 90 days before the addition. According to the terms of the Provider Participation Agreement (PPA), the participating provider agrees that Health Net has the right to determine whether the new or satellite facilities or the new participating physicians are acceptable to Health Net.

Addition of New Physicians, Providers or Facilities

Until Health Net approves new subcontracting providers (for example, primary care physicians (PCPs), specialists and ancillary providers), the providers are not allowed to provide covered services under the Health Net PPA. Health Net must be notified in writing at least 90 days before the addition.

Health Net is free to deny participation to any new subcontracting providers and is not obligated to state a cause or explain the denial of the addition or provide the facility, provider or subcontracting providers with any right to appeal or any other due process. Health Net's decision in these cases is final and binding.

In addition, hospitals, ancillary providers and participating physician groups (PPGs) are responsible for providing Health Net with copies of the standard agreements used for their subcontractors. Health Net reviews these standard agreements to ensure compliance with regulatory requirements[1] and directs the facility to make

any changes required in order to meet the requirements. Health Net requires hospitals, ancillary providers and PPGs to send sample forms to Health Net for review if they make any changes to their standard agreements or replace them with new standard agreements.

Hospitals, ancillary providers and PPGs must provide Health Net with a copy of the signature page for each subcontractor. Physicians or other subcontractors must be credentialed before they are added to Health Net's network. Hospitals, ancillary providers and PPGs must also provide Health Net a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals, ancillary providers and PPGs are also responsible for informing Health Net when they cease to use a specific subcontractor or when they add a new subcontractor. Health Net periodically sends each hospital, ancillary provider and PPG a list of the physicians or subcontractors Health Net shows as active and under contract with the participating provider. Hospitals, ancillary providers and PPGs are required to review this list and notify Health Net of any additions or deletions. At least monthly, hospitals, ancillary providers and PPGs must provide Health Net with a list of additions, deletions and address changes, as well as a complete listing annually.

For PPGs only, the Active Physicians Listing is available monthly on the Health Net provider website as an administrative report. Select Provider Reports under Welcome. This report provides PPGs a means to review and revise their records on a monthly basis and communicate physician demographic changes and terminations to Health Net. Additionally, this listing is used by the Health Net Provider Network Management Department to validate PCP and specialist information with the PPG on a quarterly basis.

Hospitals, ancillary providers and PPGs must furnish Health Net copies of any amendments to a contract with a participating provider within 20 days of execution.

[1]Medicare Managed Care Manual, Chapter 11, Section 100.4.

Appeals and Grievances

Provider Type: Participating Physician Groups (PPG)

Health Net does not delegate member appeals or grievances, except for Molina. The Health Net State Health Programs Quality Improvement Health Equity Committee (QIHEC) reviews quarterly Medi-Cal appeals and grievance reports to assess emerging patterns of appeals and grievances, and to formulate potential plan policy/process changes and/or procedural improvements.

For more information on member appeals or grievances, refer to the discussions of Member Appeals and Grievances.

Outpatient Pharmacy Benefits and Services Carve Out

Medi-Cal Outpatient Pharmacy benefits and services transitioned from managed care to the state's responsibility under the pharmacy benefit program known as Medi-Cal Rx. Appeals and grievances for these benefits and services are the responsibility of Medi-Cal Rx.

Disputes regarding the denial of a referral or a prior authorization request should be directed to DHCS State Fair Hearing and not to Health Net. If Health Net receives a grievance related to these services, Health Net will

redirect those grievances to Medi-Cal Rx contractor, Magellan Medicaid Administration, Inc. (Magellan), in a timely manner and in the manner outlined by DHCS.

If Health Net receives an appeal related to these services, the DHCS State Fair Hearing process is responsible. Health Net will redirect those appeals to the DHCS State Fair Hearing. Any appeals and grievances related to physician-administered drugs would be Health Net's responsibility to address through the Appeals and Grievance process.

Conditions of PCP Office Closures

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating primary care physicians (PCPs) may close their practices to new members while remaining open to members of other insured or managed health care plans, provided certain conditions are met:

- The PCP must establish a certain numerical or percentage threshold beyond which they no longer accepts new members.
- The PCP may close their panel to new members once the threshold is met, provided that the number of members of the PCP exceeds the number of patients who are members of any other single insured or managed health care plan at the time the PCP wants to close their practice to plan members.
- Health Net has established a threshold in compliance with regulatory and accreditation requirements.

If a patient of the PCP, while a member of another health care plan, joins the plan, the PCP must continue to accept the member even if the PCP practice is closed to new plan members.

PCPs must provide the plan with any documentation or information reasonably requested to demonstrate to Health Net that the above conditions are being met prior to closing the practice to new members.

A PCP may close their practice to all new patients from all insurance or health plans at any time.

Hospitals Adequate Supplies and Staffing

Hospitals

Hospitals must maintain adequate supplies and staffing levels to ensure that they are fully equipped to provide comprehensive care to all patients who need medical attention.

If a hospital's capacity to provide complete care is compromised, including any facility issues or labor actions that may affect available resources, they are required to promptly notify their Provider Engagement Network Specialist (PENS).

This notification is essential for Health Net to be able to act and work to minimize any potential impact on patient care. Prioritizing these actions helps hospitals meet patient needs and maintain health care standards.

Facility and Physician Additions, Changes and Deletions | Facility Decertification Notification Requirement

Ancillary

Health Net is required to end contracts with network providers and subcontractors who have been decertified or whose participation has been revoked from the Medi-Cal and Medicare programs.

The California Department of Public Health (CDPH) is responsible for decertifying licensed long-term care (LTC) facilities. LTC facilities that receive a decertification notice from CDPH must take these steps:

1. Notify their Health Net Provider Network Management representative to begin the contract termination process.
2. Help with the transition planning for Health Net members in the LTC facility's care.

Affected LTC facilities

These requirements apply to any of these LTC facility types:

- Skilled nursing facilities (SNFs)
- Intermediate care facilities
- Congregate living health facilities
- Nursing facilities
- Pediatric day
- Respite facilities

Health Net's responsibilities

Upon notice from the LTC facility, Health Net:

- Ends its contract with the LTC facility within five business of the notice.
- Develops and submits a member transition plan to the DHCS.
- Suspends all payments for services provided after the effective date of the decertification notice.
- Informs all affected contracted providers and members of the decertified LTC facility.
- Coordinates care for members as required by federal and state law, and Health Net's contract with DHCS.

Immediate closure of LTC facilities by CDPH

In these cases, CDPH handles the transition of all affected members residing in the LTC facility. Health Net tracks the transition of members and coordinates care as needed.

Closure and Termination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating physician groups (PPGs) are required to notify the Health Net Regional Provider Network Management Department in writing at least 90 days in advance of the date that a subcontracting provider does the following:

- closes the medical practice
- terminates the relationship with the PPG

For Medi-Cal plans, Health Net must notify Medi-Cal members in writing within 15 calendar days of receipt of a primary care physician (PCP) termination or changes in PCP locations or after any unforeseen provider changes have been reported to Health Net. The notice to Medi-Cal members must be approved by the Department of Health Care Services (DHCS) prior to release, and is sent by U.S. mail, with instructions on selecting a new PCP.

Health Net may allow a member to continue using a terminated provider when:

- A member had been receiving care for an acute or chronic condition, in which case care by the terminated provider is covered for 90 days or longer, if necessary, for a safe transfer of the member.
- A member is pregnant, in which case care by the terminated provider is covered until postpartum services related to the delivery are completed or longer, if necessary, for a safe transfer of the member.

The terminated provider is subject to the same contractual terms and conditions imposed prior to termination until medical care to the member is completed. These terms and conditions include, but are not limited to:

- credentialing
- hospital privileging
- utilization review
- peer review
- compensation

Refer to the Transition of Care topic for more information.

PPG, Physician and Hospital Termination

In order to comply with the provider termination regulations of the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC), participating hospitals, participating physician groups (PPGs) and physicians are required to notify Health Net's regional Provider Network Management Department, in writing, pursuant to the requirements of their *Provider Participation Agreement (PPA).*

Health Net offers transition of care assistance to members who request to complete a course of treatment of covered services by a terminated provider. Refer to the Transition of Care Assistance discussion under the Utilization Management topic.

Member Notification for Specialist Termination

Participating Physician Groups (PPG)

Delegated participating physician groups (PPGs) must have a written policy regarding member notification when a specialist terminates their contract. The written policy must include the following elements:

- PPGs must notify the plan 90 days prior to a specialist terminating (or as stated in the PPG's Provider Participation Agreement (PPA)).
- PPGs must identify members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist.
- Identified members must be notified by the PPG in writing and the notification must be made immediately upon notification of termination, but no later than 30 calendar days prior to the effective date of the specialist's termination.
- PPGs must help members transition to a new specialist within the PPG's network of participating providers.

If a member with an acute care condition has questions or concerns regarding the continuation of services from the terminating specialist, advise the member to call the Health Net Member Services Department, Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Member Services Department.

Templates for Only Medicare and DSNP Member Notifications

To notify Medicare and DSNP members when a specialist terminates, PPGs must use the applicable template in the table below approved by the Centers for Medicare & Medicaid Services.

Template	H-contract	Product
Medicare Provider Termination Notification Template-MA H0562	H0562	Medicare Advantage
Medicare Provider Termination Notification Template-DSNP H3561	H3561	Dual Special Needs Plans: • Wellcare Dual Align

		• Wellcare CalViva Dual Align • Wellcare Dual Liberty

Provider Online Demographic Data Verification

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website under Find a Provider. According to the terms of the Provider Participation Agreement (PPA), participating providers are required to provide a minimum of 30 days advance notice of any changes to their demographic information. If the change pertains to the status of accepting new patients or no longer accepting new patients, you must notify Health Net or the applicable PPG within five business days.

If a provider who is not accepting new patients is contacted by a member or potential member seeking to become a new patient, the practitioner must direct the member or potential member to both Health Net for additional assistance in finding a provider, and, if applicable, to the Department of Managed Health Care (DMHC) to report any inaccuracies with Health Net's directory.

Providers directly contracting with Health Net must notify Health Net of changes to their demographic information to by completing the online form or by reaching out to your provider relations and contracting specialist (formally provider network administrator). The online form is available on the provider website. Providers must have privileges to update and submit changes online.

Providers contracting through a PPG must notify the PPG directly of changes, and the PPG notifies Health Net. PPGs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS).

If a provider sees patients at multiple locations, the provider should review address, phone number, fax number, and office hours for all locations to ensure data accuracy.

Demographic Information

Providers' demographic data information should include the following:

- Name
- Alternate name
- Address
- Telephone number
- Fax number

- License number
- National Provider Identifier
- Office hours

- Patient age ranges (lowest to highest) seen by provider
- Specialty
- Email address - used for members and is Health Insurance Portability and Accountability Act (HIPAA) compliant

- Practice website
- Hospital affiliation
- Languages other than English spoken by the physician
- Languages other than English spoken by the office staff

- Panel status - Accepting new patients, accepting existing patients, available by referral only, available only through a hospital or facility, not accepting new patients
- Handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/scale (T) - if accessibility is not yes to all, then indicate no

Provider Outreach Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net is required to contact directly contracting practitioners biannually, including physicians and other health professionals such as physical therapists (PTs), occupational therapists (OTs) and podiatrists; and annually contact PPGs, hospitals and ancillary providers to validate the accuracy of the information for each provider listed in Health Net's provider directories. The notification includes:

- The information Health Net has in its directories for the provider, including a list of networks and products in which the provider participates.
- A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.
- Instructions on how the provider can update information including the option to use an online interface to submit verification or changes electronically which generates an acknowledgment from Health Net.
- A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the directories is current and accurate or to provide an update to the information required to be in the directories, including whether the provider is accepting new patients for each applicable Health Net network or product. Note: this requirement does not apply to general acute care hospitals. If Health Net does not receive an affirmative response and confirmation from the provider that the information is current and accurate, or as an alternative, receive updated information from the provider within 30 business days, the following will occur:
    - Health Net takes no more than an additional 15 business days to verify whether the provider's information is correct or requires updates. Health Net documents the receipt and outcome of each attempt to verify the information.
    - If Health Net is unable to verify whether the provider's information is correct or requires updates, Health Net notifies the provider 10 business days prior to removal that the provider

will be removed from provider directories. The provider is removed from the provider directories at the next required update of the provider directories after the 10 business-day notice period. A provider is not removed from the provider directories if they respond before the end of the 10 business-day notice period. This requirement does not apply to general acute care hospitals.

Health Net will sometimes work with an outside vendor (i.e., Symphony Provider Directory) to reach out to providers to validate practitioner participation and demographic data. Providers are required to respond to requests from Health Net, and/or may update changes as needed directly with Symphony.

Provider Status Change Notification Requirements

Providers are required to inform Health Net or the applicable PPG within five business days when either of the following occurs:

- The provider is not currently accepting new patients, when they had previously accepted new patients.
- The provider is currently accepting new patients, when they had previously not accepted new patients.

Additionally, if a provider who is not accepting new patients is contacted by a member or potential enrollee seeking to become a new patient, the provider is required to direct the member or potential enrollee to both Health Net for additional assistance in finding a provider and to the appropriate regulator listed below to report any inaccuracy with the provider directories.

Regulator	Contact Information	Line of Business
Department of Managed Health Care (DMHC)	1-888-466-2219 1-877-688-9891 (TDD) www.hmohelp.ca.gov	HMO, POS, HSP, Medi-Cal
California Department of Insurance (CDI)	1-800-927-4357 www.insurance.ca.gov	EPO, PPO

PPGs must have policies in place that establish and implement processes to collect, maintain and submit provider demographic changes to Health Net within the required turnaround times.

Report of Inaccurate Information in Directories

When Health Net receives a report indicating that information listed in its provider directories is inaccurate by a potential enrollee, member, regulator or provider, Health Net promptly investigates the reported inaccuracy and, no later than 30 business days following receipt of the report, either verifies the accuracy of the information or updates the information in its provider directories, as applicable.

At a minimum, Health Net does the following:

1. Contacts the affected provider no later than five business days following receipt of the report.
2. Documents the receipt and outcome of each report, including the provider's name, location, and a description of Health Net's investigation, the outcome of the investigation, and any changes or updates made to the provider directories.
3. If changes to Health Net's directories are required as a result of the plan's investigation, the changes to the online provider directories must be made within the weekly turnaround time. For printed provider directories, changes must be made no later than the next required update or sooner if required by federal law or regulations.

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), Health Net will omit a provider, provider group or category of providers similarly situated from the directory if one of the below conditions is met.

- The provider is currently enrolled in the Safe at Home program.
- The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.
- A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.
- Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Providers must complete and sign the Directory Removal for At-Risk Providers form – Health Net (PDF), Directory Removal for At-Risk Providers form – Community Health Plan of Imperial Valley (PDF) or Directory Removal for At-Risk Providers form – CalViva Health (PDF) to be omitted from the directory.

Mandatory Notification Requirements for PPG Downstream Hospital Terminations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating physician groups (PPGs) must notify the Health Net when a contracted hospital terminates from their network for any reason, including but not limited to:

- Partial terminations
- Constructive terminations
- Novations
- Non-renewals
- Contract assignments

Timely notification allows Health Net to:

- Maintain accurate provider directories.
- Meet regulatory reporting and member notification requirements.
- Ensure appropriate continuity of care protections for impacted members.

Block transfer filings

Hospital network terminations that may impact member access or continuity of care require Health Net to submit a block transfer filing to the Department of Management Healthcare (DMHC).

Note: A terminating hospital may not be removed from the network until approval of the Block Transfer Filing has been obtained from the DMHC.

Notification timing and submission

PPGs must notify their assigned Provider Engagement network specialist as soon as a hospital termination is known or anticipated, including planned non-renewals or early terminations, at least 180 days in advance. This must include termination details and effective dates.

Required information

PPGs must submit termination-related information using a standardized form at least 120 business days prior to the termination. The form will be provided by the PPG's assigned Provider Engagement network specialist. Required information includes, but is not limited to:

- Hospital termination notice and effective date.
- Hospital extension notice (if applicable).
- Enrollee notification materials and distribution timing.
- COC approach and impacted members.
- Scope and impact of the termination, including affected lines of business.

Noncompliance

Failure to provide timely and complete notification may result in corrective action and may also affect the PPG's delegation status.

Service and Quality Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

- Access to Care and Availability Standards (Medi-Cal Statewide)
- Access to Care and Availability Standards (CalViva Health)
- Access to Care and Availability Standards (Community Health Plan of Imperial Valley)
- Open Clinical Dialogue
- Claims Denials
- Claims Payment Requirements

- Authorization and Referral Timelines
- Continued Access to Non-Participating Providers for SPD Members
- Eligibility and Data Entry Requirements
- Quality Improvement Problem Resolution

Access to Care and Availability Standards (Medi-Cal Statewide)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne

Health Net's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), behavioral health care, urgent care, ancillary services, and emergency care, are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards.

These access standards are regulated by the California Department of Managed Health Care (DMHC), and Department of Health Care Services (DHCS). The National Committee for Quality Assurance (NCQA) monitors medical standards for access to and availability of care and sets behavioral health time-elapsed appointment access standards.

Note: Behavioral health and chemical dependency services are administered by Health Net.

Health Net and its participating providers are required to demonstrate that, throughout the geographic regions of Health Net's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible within reasonable timeframes.

Additionally, Health Net and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within a reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practice. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Health Net members are notified annually, via member newsletters or the Evidence of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioners' (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards.

PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and an SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards.

During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be used to provide members with clear and simple instructions on after-hours access to medical care. Additionally, Medi-Cal participating providers must offer hours of operation to Medi-Cal members that are no less than the hours of operation offered to patients from other lines of business or to Medi-Cal fee-for-service (FFS) beneficiaries.

Behavioral Health Facility Access and Availability

Per their contract with Health Net, network facilities should be available and accessible to members during reasonable hours of operation. Emergency care, where applicable, should also be available and accessible 24 hours a day. Facility information regarding hours of operation is collected every two years via Health Net's facility application for recredentialing. Facilities must notify Health Net of any changes in their hours of operation or lapses in accessibility or availability as needed.

After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, 7 days a week, and PCPs are required to have appropriate licensed professional back-up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instructions about after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should return phone calls and pages within 30 minutes and be available 24 hours a day, 7 days a week. The PCP or on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room, as medically necessary.

Additionally, Health Net provides triage and/or screening services 24 hours a day, 7 days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, 7 days a week.

After-Hours Script Template

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues.

Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has

designed an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can use as a guide for staff answering the phone.

For PPGs or physicians who use an automated answering system/answering machine, this template can be used as a script to advise members how to access care. The script includes basic information that members need to access after-hours care, and modifications can be made according to PPGs' and physicians' needs.

Health Net makes the script available in the following threshold languages:

- Arabic (PDF)
- Armenian (PDF)
- Chinese (traditional) (PDF)
- Chinese (simplified) (PDF)
- English (PDF)
- Farsi (PDF)
- Hmong (PDF)
- Khmer (Cambodian) (PDF)
- Korean (PDF)
- Russian (PDF)
- Spanish (PDF)
- Tagalog (PDF)
- Vietnamese (PDF)

After-hours scripts are available in alternate formats and additional languages upon request by calling the Customer Contact Center. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide phone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain a member's condition so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member or to determine when a member needs to be seen by a licensed medical professional.

Unlicensed phone staff should have clear instructions about the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

Health Net encourages answering services to follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.

- If language assistance is needed, offer the member interpreter services, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return phone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered an authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact the Health Net Hospital Notification Unit within 24 hours or the next business day of the admission, including instances where prior authorization has already been obtained.
- The answering service should document all calls. Answering services frequently have a high staff turnover, so providers should monitor the answering service to ensure emergency procedures are followed.

Triage and/or Screening Services/Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), Health Net provides 24-hour-a-day, 7 days a week triage or screening services by phone. This program is a service offered in conjunction with the PCP and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour phone service for urgent/emergent instructions, medical condition assessment and advice. The Health Net Member Services Department coordinates member access to the service, if necessary.

The program allows California registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide instruction on home and care techniques and general health information.

Health Net ensures that phone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. Health Net provides triage or screening services for Medi-Cal members through medical advice lines as follows:

- Triage and/or screening services/nurse advice help is available to members 24 hours a day, 7 days a week through Health Net's Member Service Department phone line displayed on the back of the member's ID card. A representative connects the member to triage and/or screening services/nurse advice after verifying eligibility.

Facility Access for Persons with Disabilities

Health Net and its participating providers and practitioners do not discriminate against members who have physical or mental disabilities. Participating providers are required to provide reasonable access for members with disabilities in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Minor's Consent for Services

As defined in 42 CFR 2.14 (a) the term "minor" means a person who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, age 18. Minors under age 18 may consent to medical care related to:

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent or prior authorization to access or obtain. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent.

Plan Medi-Cal members under the age of 18 may access Minor Consent Services as follows:

- Pregnancy testing (is considered to be a family planning service and may be obtained from any qualified provider in or out-of-network), counseling and family planning. Obstetrical care for pregnancy must be accessed through an in-network provider.
- Contraception services such as birth control (excludes sterilization).
- Abortion services (for children ages 12 and older without parental consent or court permission) - American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997).
- Services for rape and other sexual assault, treatment and collection of medical evidence.
- HIV/AIDS counseling, prevention, testing and treatment. Sexually transmitted infection prevention, testing, and treatment including sexually transmitted diseases such as syphilis, gonorrhea, chlamydia, and herpes simplex (for children ages 12 and older) - CFC §6926.
- Substance use disorder treatment for drug and alcohol abuse including screening, assessment, intervention, and referral services (for children ages 12 and older) treatment and counseling - FAM §6929(b). Members are entitled to confidential, timely referral to the county drug and alcohol program.
- Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill (AB) 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent or guardian consent is necessary for maintenance narcotic replacement therapy.
- Skeletal X-ray - a health care provider may take skeletal X-rays of a child without the consent of the child's parent/legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of it - Cal. Penal Code §11171.2.
- General medical, psychiatric or dental care if all of the following conditions are satisfied: (1) The minor is age 15 years or older; (2) The minor is living separate and apart from his or her parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence; (3) The minor is managing their own financial affairs, regardless of the source of the minor's income. If the minor is an emancipated minor, they may consent to medical, dental and psychiatric care - FAM § 6922(a) and § 7050(e).

Minor's consent for services – Mental health services

Medi-Cal members under the age of 18 receive timely access to these services (except substance abuse and specialty mental health services which are carved-out from the Plan's contract responsibility) from any qualified in or out-of-network providers. To access substance abuse treatment services, Plan Medi-Cal Members ages 12 or older receive timely, confidential referral to these services through local county alcohol and other drug programs. To receive timely, confidential referral to carved-out specialty mental health care, Plan Medi-Cal members ages 12 or older must be mature enough to participate intelligently and where either:

1. A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the following requirement is satisfied:
    - The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.

2. A professional person offering residential shelter services, whether as an individual or as a representative of an entity, shall make their best efforts to notify the parent or guardian of the provision of services.
3. The mental health treatment or counseling of a minor shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person shall consult with the minor before determining if parent/guardian involvement is appropriate. The professional person who is treating or counseling the minor shall state in the patient record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.
4. The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian. The minor's parents or guardian are not liable for payment for any residential shelter services provided unless the parent or guardian consented to those services.
5. Minors are not authorized to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

Facility Site Review

Health Net provides PCPs with office policies and procedures to use as templates for the facility site reviews (FSRs). Refer to the Medi-Cal FSR PCP office management policy and procedure templates for more information. During Health Net's facility review process, a finding of any obvious physical barrier to accessibility for disabled members is noted. If any obvious physical barrier is found, Health Net discusses potential resolutions with the provider or PPG administrator. The provider indicates the resolutions on the facility site review (FSR) corrective action plan.

Appointments and Referrals

Members are instructed to call their PCP directly to schedule appointments for routine care, except in the case of a life-threatening emergency. Health Net members must seek most care through their PCP. If a member has not selected a PCP, Health Net assigns one. The PCP is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care (including emergency behavioral health care).
- Urgent care sought outside the service area, and under unusual or extraordinary circumstances provided in the service area when the participating medical provider is unavailable or inaccessible.
- Obstetrics and gynecology (OB/GYN) for preventive care, pregnancy care or gynecological complaints.
    - Female members have the option to directly access a participating women's health specialist (such as an OB/GYN or certified nurse midwife) for routine and preventive covered health care services for women (such as breast exams, mammograms and Pap tests).
- Out-of-area renal dialysis services
- Members with chronic life-threatening, degenerative or disabling conditions or diseases that require continuing specialized medical or behavioral health care, which qualify for a standing referral to a specialist under Health Net's national policy requirements. For example, a member with HIV/AIDS, renal failure, or acute leukemia may seek a standing referral to a qualified, credentialed specialist.
- Health Net is responsible to cover outpatient mental health services for members with mild to moderate mental health conditions not covered by the county mental health plan as specialty

mental health services. Some of the services are provided by the PCP. Members may be eligible to self-refer to a behavioral health practitioner out-of-network through the mental health departments of members' counties of residence, depending on their Medi-Cal benefit coverage. Refer to Behavioral Health section for more information.
- Medi-Cal members may seek sensitive services, such as minor consent services, and family planning, sexually transmitted diseases and HIV testing and counseling services from qualified participating or out-of-network family planning providers, the local health department (LHD) and/or family planning clinics. Sensitive services for minors include sexual assault (including rape), drug or alcohol abuse, family planning, sexually transmitted infections, and behavioral health care.
- Medi-Cal members may access LHD clinics for immunizations.

Missed Appointments

According to Health Net's Medical Records Documentation Standards policies and procedures (KK47-121230), missed appointment follow-up and outreach efforts to reschedule must be documented in the member's record. When an appointment is missed, providers are required to attempt to contact the member a minimum of three times, via mail or phone.

Appointment Rescheduling

According to the DMHC timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care; and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice.

If the licensed applicable health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered. The provider will notify the member of this decision, including an explanation of their right to file a grievance with Health Net. The record must be available to the DHCS upon request.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers including seldom used or unusual specialty services) in a Health Net service area, Health Net and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
- Member costs for medically necessary referrals for out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

Providing members with a list of potentially available out-of-network providers does not meet the requirement to arrange for medically necessary services from an out-of-network provider. To ensure members have access to services within geographic and timely access standards, Health Net and its participating providers are responsible for doing the following:

- Contact the out-of-network provider on behalf of the member to find out when appointments are available for medically necessary services.
- Schedule any initial and follow-up appointments for the member with an out-of-network provider.

These requirements do not prohibit Health Net or its delegated PPGs from accommodating a member's preference to wait for a later appointment from a specific participating provider. If a member prefers to wait for a later appointment, document it in the relevant record.

Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within Health Net's service area 24 hours a day, seven days a week.

Providing Emergency and Urgent Care Services in the PCP's Office

The physician, registered nurse (RN), or physician assistant (PA) on duty is responsible for evaluating emergency and urgent care members in the office and making the decision to further evaluate and treat,

summon an ambulance for transport to the nearest emergency room, directly admit to the hospital, or refer to a same-day visit at another provider or urgent care facility.

Provider Phone Assessment

Phone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs, and nurse practitioners (NPs)) and only in accordance with established standards of practice.

Telehealth

Telehealth services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between Health Net and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the originating site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member.

The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

Interpreter Services

In order to comply with applicable federal and state laws and regulations, Health Net requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services.

Cultural Considerations

Health Net and its participating providers, including long-term support services (LTSS) providers, must ensure that services are provided in a culturally competent manner to all members, including those who have limited-English proficiency (LEP), limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Prior Authorization Processes

Health Net requires prior authorizations to be processed and completed in a manner that ensures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered.

For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [28 CCR 1300.67.2.2(c)(5)(B)], more commonly known as urgent pre-service requests, must be conducted concurrently, or the prior authorization turnaround timeline must be shortened to allow sufficient time to communicate the outcome to the member and/or the referring provider and ensure an appointment is offered to the member within 96 hours of the request. Refer to the Prior Authorization section for further information. For detailed information refer to Authorization and Referral Timelines.

Note: Requests Received after business hours:NCQA counts the time from the date when Health Net receives the request, whether or not it is during business hours. Non-urgent requests may be processed during the next business day.

Quality Assurance

Health Net has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, Health Net monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, Health Net reviews and evaluates the information available to Health Net regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service phone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

Health Net's participating providers (including delegated providers) are contractually required to participate in all timely access or accreditation surveys and studies administered by or on behalf of regulatory agencies such as DHCS, DMHC and the Centers for Medicare & Medicaid Services (CMS).

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible for monitoring data provided by Health Net regarding their provider adherence to the following standards as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Health Net Medi-Cal Plans Medical Appointment Access Standards

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments for primary care - regular and routine care (PCP)	Appointment within 10 business days of request	70%
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care services (SCP & Other) that require prior authorization	Appointment within 96 hours of request	70%
First prenatal visit (both PCP and SCP)	Appointment within 2 weeks of request	70%
Well-child visit	Appointment within 2 weeks of request	70%
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request	70%
After-hours care (PCP)	Ability to contact on-call physician after-hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%
Provider office phone callback during normal business hours	Provider callback within 1 business day	90%
Phone answer time at provider's office	Within 60 seconds	90%
Non-urgent appointment with a physician in a skilled nursing	Amador, Calaveras, Inyo, Tulare, Mono, Tuolumne,	80%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
facility (SNF) or intermediate care facility (ICF)	Counties: Within 14 calendar days of request San Joaquin, Stanislaus Counties: Within 7 business days of request Los Angeles, Sacramento Counties: Within 5 business days of request	

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Availability Surveys (PAHAS) conducted via phone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Net Medi-Cal Plans Appointment Access Standards - Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care[1]	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life-threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2] Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

Health Net investigates and implements corrective action when timely access to care as required by Health Net's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.05) are not met.

Health Net uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one of or more metrics are noted as being non-compliant:

- Appointment Access - PPGs that do not meet Health Net's 80% rate of compliance/performance goal in one or more of the appointment access metrics.
- After-Hours Access - PPGs that do not meet Health Net's 90% rate of compliance with one or more of the after-hours metrics.

PPG Notification of a CAP

Health Net provides the following:

- PPGs receive a description of the identified deficiencies, the rationale for the corrective action and the contact information of the person authorized to respond to provider concerns regarding the corrective action.
- Feedback to the PPGs regarding the accessibility of primary care, specialty care and phone services, as necessary.

CAP Minimum Requirements

- Each PPG is required to send in a written improvement plan (IP) to include what interventions will be implemented for each deficiency to improve access availability. The IP must include:
  - Date of implementation of the IP.
  - Department/person responsible for the implementation and follow-up of the IP.
  - Anticipated date that the IP is expected to produce outcomes that result in the standard meeting regulatory agency time frame compliance.
- The PPG is to return the IP within 30 calendar days.
- The PPG is to return the signed Provider Notification of Timely Access Results Attestation that attests that the PPG has notified their providers of their individual results and of their responsibilities of compliance related to timely access.
- Providers and PPGS deemed non-compliant will be encouraged to attend a Timely Access Training session as part of the CAP process. Health Net will notify all non-compliant providers/PPGs of the training schedule and will suggest that the provider/PPG sign up for one session. Attendance at the training will be documented. A “Timely Access Provider Training” certificate is to be completed after attending the training.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to the PNM and Contracting departments for further action.

Availability Standards

Health Net provides established availability standards and performance goals for providers. At least annually, Health Net measures, evaluates and reports geo-access and provider availability. Listed below are Health Net's performance goals for geo-access and provider availability-related criteria:

Geo Access and Provider Availability Standards*

DMHC Standards

Provider Type	DMHC
PCP	15 miles/30 minutes*

Provider Type	DMHC
Hospital	15 miles/30 minutes*
Ancillary	reasonable distance from PCP

*Time or distance standards are from the members' residence.

There are no DMHC regulatory standards for Ancillary, other than reasonable distance. Health Net has set the following standards for Ancillary to be reviewed at 90 percent within 15 miles or 30 minutes from the PCP locations.

DMHC County Size Categories by Population

Size Category	HNCS
Large Metro	Los Angeles and Sacramento
Metro	San Joaquin, Stanislaus, and Tulare
Micro	Amador and Tuolumne
Rural	Calaveras
CEAC	Inyo

Specialist 90% Threshold - Standard in Miles

County Designation	Specialist Group 1	Specialist Group 2
Large Metro	15^	15^^
Metro	20*	25*
Micro	55	65
Rural	55	65
CEAC	100	125

Specialist Group 1: cardiovascular disease, dermatology, gastroenterology, neurology, obstetrics/gynecology, oncology, ophthalmology, podiatry, pulmonology, surgery-general, and surgery-orthopedic.

Specialist Group 2: allergy/immunology, endocrinology, hematology, nephrology, otolaryngology, pain medicine, physical medicine and rehabilitation, radiation oncology, rheumatology, and urology.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- Large Metro County – ^20 and ^^35 miles
- Metro County – *35 and **45 miles

Mental Health 90% Threshold - Standard in Miles

County Designation	Psychiatrist	MHP
Large Metro	15*	15
Metro	20*	15~
Micro	55	35
Rural	55	35
CEAC	100	65

Psychiatrist means a physician reported as one of the following specialist physician types: psychiatry, child and adolescent psychiatry, consultation-liaison psychiatry, geriatric psychiatry or addiction psychiatry.

MHP (Mental Health Professionals) means a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, or Psychologist.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- * for Large Metro Psychiatry – 20 miles
- ** for Metro Psychiatry – 35 miles
- ~ for Metro MHPs- 20 miles

Physician/Practitioner to member Ratios

CA DMHC: COMMERCIAL/HEALTH BENEFIT EXCHANGE:	
PCP	PHYSICIAN
1 FTE PCP/ 2,000 members	1 FTE physician/ 1,200 members

Open Practice Ratios

Percent of open PCP practices accepting new patients	DMHC standard	60% of PCPs in the network are accepting new patients or at least 75% of PCP locations in the network are a PCP location accepting new patients
Percent of open specialist practices accepting referrals	Internal standard	85%

DHCS Standards

Provider Type	Time and Distance Standard by County Size [1]			
	Rural	Small	Medium	Dense
Core Specialists (Adult and Pediatric) and Non-Specialty Mental Health Providers	60 miles or 90 minutes	45 miles or 75 minutes	30 miles or 60 minutes	15 miles or 30 minutes

DHCS County Size Categories by Population

Size Category	HNCS
Rural	Calaveras, Inyo, Mono and Tuolumne
Small	Amador and Tulare
Medium	San Joaquin and Stanislaus
Dense	Los Angeles and Sacramento

DHCS Core Specialists (Adult and Pediatric)

Provider type	Provider type
Cardiology/Interventional Cardiology*	Neurology*

Provider type	Provider type
Dermatology*	Obstetrics/ Gynecology (Adult Only)*
Endocrinology*	Oncology*
ENT/Otolaryngology*	Ophthalmology*
Gastroenterology*	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology*	Psychiatry*
HIV/AIDS Specialists/Infectious Diseases*	Pulmonology*
Nephrology*	Non-Physicians/Mental Health Providers*

*Can be covered by Telehealth providers.

Mandatory Provider Type	Contract Obligations
Federally Qualified Health Center (FQHC)	Must offer to contract with each provider type in the service area where available. Must contract with at least one (1) in service area, where available.
Rural Health Clinic (RHC)	
Freestanding Birthing Center (FBC)	
Indian Health Facility (IHF)	Must offer to contract with each IHF in service area, where available.
Certified Nurse Midwife (CNM)	Must contract with at least one (1) provider type each in service area, where available.
Licensed Midwife (LM)	

Additional Ratios

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
Full Time Equivalent (FTE) PCP ratio for each type of PCP to member: • Family	100% of PCPs	1 : 2,500

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
• General Practice • Internal Medicine • Pediatrics		
• High volume SCP (Obstetrics/Gynecology) • High impact SCP (Hematology/Oncology)	100% of SCPs	• 1 : 3,000 • 1 : 8,000
Behavior Health • MD's/DO (psychiatrists) • Psychologist • Masters Level practitioner	100%	• 1 : 5,000 • 1 : 2,300 • 1 : 1,150
Autism • Qualified Autism Service Provider (BCBA) • Qualified Autism Service Professionals (BCaBA) or Paraprofessionals	100%	• 1 : 5,000 • 1 : 5,000

Availability Corrective Action

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment.

These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through Health Net's Quality Improvement Committee or through the activities of Provider Network Management.

Threshold Languages

Any non-English language that meets the following criteria for Medi-Cal eligibles within a county is designated as a threshold language. As Medi-Cal is an entitlement program, the criteria is based on those that may be eligible for services not those that are enrolled in the plan. Currently, Health Net has a total of 11 non-English languages that are required for translation.

- 3,000 within one county or five percent (5%), whichever is lower

- 1,000 within one ZIP Code
- 1,500 within two contiguous ZIP Codes

Per DHCS, “Threshold Standard Languages ≥3,000 per language or ≥5% of the Medi-Cal Population that speak the language per county. Concentration Standard Languages ≥1,000 per ZIP Code or ≥1,500 per two contiguous.”

All members whose primary language has been identified as a threshold language by the Department of Health Care Services (DHCS) and Health Net receive written and oral information in that language. Health Net monitors member access to information and services in threshold languages through a variety of ways, including primary care site certification.

Amador

In Amador County, there are no non-English threshold languages.

Calaveras

In Calaveras County, there are no non-English threshold languages.

Inyo

In Inyo County, the threshold language is Spanish.

Los Angeles

In Los Angeles County, the threshold languages are Arabic, Armenian, Cambodian (Khmer), Chinese[1], Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

Mono

In Mono County, the threshold language is Spanish.

Sacramento

In Sacramento County, the threshold languages are Arabic, Chinese[1], Farsi, Hmong, Russian, Spanish, and Vietnamese.

San Joaquin

In San Joaquin County, the threshold languages are Chinese[1], Cambodian (Khmer), Spanish and Vietnamese.

Stanislaus

In Stanislaus County, the threshold language is Spanish.

Tulare

In Tulare County, the threshold language is Spanish.

Tuolumne

In Tuolumne County, there are no non-English threshold languages.

[1]Where Chinese has been identified as a threshold or concentration language and the Member has requested to receive translated written information in either traditional or simplified Chinese characters, the MCP must provide written information in the Member's preferred characters. However, if the Member has not indicated a preference for simplified or traditional Chinese characters, and the MCP does not yet have a process in place to provide written translations in Chinese, the MCP must provide translations in Simplified Chinese characters. Only upon Member request will the MCP be required to provide translated written information in Traditional Chinese characters. MCPs must comply with the updated threshold and concentration language dataset and, if applicable, provide translated written information in Chinese.

Access to care and availability standards (CalViva Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Fresno, Kings, Madera (CalViva Health)

CalViva Health's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), behavioral health care, urgent care, ancillary services, and emergency care are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards.

These access standards are regulated by the California Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS). The National Committee for Quality Assurance (NCQA) monitors medical standards for access to, and availability of, care and sets behavioral health time-elapsed appointment access standards.

Note: Behavioral health and chemical dependency services are administered by the Plan.

The Plan and its participating providers are required to demonstrate that, throughout the geographic regions of the Plan's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible, at reasonable times.

Additionally, the Plan and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within a reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practices. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Plan members are notified annually, via member newsletters or the Evidence of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

PCP and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physicians (PCP) and specialty care practitioners (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards.

PCP and SCP office hours must be posted in the provider's office. The Plan requires a PCP practice to be open at least 20 hours per week and an SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards.

During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be used to provide members with clear and simple instructions on after-hours access to medical care. Additionally, Medi-Cal participating providers must offer hours of operation to Medi-Cal members that are no less than the hours of operation offered to patients from other lines of business or to Medi-Cal fee-for-service (FFS) beneficiaries.

Behavioral Health Facility Access and Availability

Per their contract with Health Net, network facilities should be available and accessible to members during reasonable hours of operation. Emergency care, where applicable, should also be available and accessible 24 hours a day. Facility information regarding hours of operation is collected every two years via Health Net's facility application for recredentialing. Facilities must notify Health Net of any changes in their hours of operation or lapses in accessibility or availability as needed.

After-Hours Access Guidelines

As required by applicable statutes, the Plan's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, 7 days a week, and PCPs are required to have appropriate licensed professional back-up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instructions about after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should return telephone calls and pages within 30 minutes and be available 24 hours a day, 7 days a week. The PCP or on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room, as medically necessary.

Additionally, the Plan provides triage and/or screening services 24 hours a day, 7 days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although the Plan does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, 7 days a week.

After-Hours Script Template

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues.

Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction.

The Plan has designed an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can use as a guide for staff answering the telephone. For PPGs or physicians who use an automated answering system/answering machine, this template can be used as a script to advise members how to access care. The Plan's after-hours scripts provide easy to use messaging examples on how to direct members to emergency care services and who to talk to when they need urgent medical advice.

The Plan makes the script available in the following threshold languages:

- English (PDF)
- Spanish (PDF)
- Hmong (PDF)

After-hours scripts are available in alternative formats and in additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain a member's condition so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions about the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

The Plan encourages answering services to follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
- If language assistance is needed, offer the member interpreter services, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency

or urgent care treatment can be given. This is considered an authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact the Health Net Hospital Notification Unit within 24 hours or the next business day of the admission, including instances where prior authorization has already been obtained.
- The answering service should document all calls. Answering services frequently have a high staff turnover, so providers should monitor the answering service to ensure emergency procedures are followed.

Triage and/or Screening Services/Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), the Plan provides 24-hour-a-day, 7 days a week triage or screening services by phone. This program is a service that does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment and advice. The CalViva Health Medi-Cal Member Services Department coordinates member access to the service, if necessary.

The program allows California registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide self-care guidance, general health information, or recommend a visit to urgent care or the emergency room.

The Plan ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. The Plan provides triage or screening services for Medi-Cal members through medical advice lines as follows:

- Triage and/or screening services/nurse advice help is available to members 24 hours a day, 7 days a week through the Plan's State Health Programs (SHP) Member Service Department telephone line displayed on the back of the member's ID card. A representative connects the member to triage and/or screening services/nurse advice after verifying eligibility

Facility Access for Persons with Disabilities

The Plan and its participating providers and practitioners do not discriminate against members who have physical or mental disabilities. Participating providers are required to provide reasonable access for members with disabilities in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Minor's Consent for Services

As defined in 42 CFR 2.14 (a) the term "minor" means a person who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, age 18. Minors under age 18 may consent to medical care related to:

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent or prior authorization to access or obtain. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent.

Plan Medi-Cal members under the age of 18 may access Minor Consent Services as follows:

- Pregnancy testing (is considered to be a family planning service and may be obtained from any qualified provider in or out-of-network), counseling and family planning. Obstetrical care for pregnancy must be accessed through an in-network provider.
- Contraception services such as birth control (excludes sterilization).
- Abortion services (for children ages 12 and older without parental consent or court permission) - American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997).
- Services for rape and other sexual assault , treatment and collection of medical evidence.
- HIV/AIDS counseling, prevention, testing and treatment. Sexually transmitted infection prevention, testing, and treatment including sexually transmitted diseases such as syphilis, gonorrhea, chlamydia, and herpes simplex (for children ages 12 and older) - CFC §6926.
- Substance use disorder treatment for drug and alcohol abuse including screening, assessment, intervention, and referral services (for children ages 12 and older) treatment and counseling - FAM §6929(b). Members are entitled to confidential, timely referral to the county drug and alcohol program.
- Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill (AB) 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent or guardian consent is necessary for maintenance narcotic replacement therapy.
- Skeletal X-ray - a health care provider may take skeletal X-rays of a child without the consent of the child's parent/legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of it - Cal. Penal Code §11171.2.
- General medical, psychiatric or dental care if all of the following conditions are satisfied: (1) The minor is age 15 years or older; (2) The minor is living separate and apart from his or her parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence; (3) The minor is managing their own financial affairs, regardless of the source of the minor's income. If the minor is an emancipated minor, they may consent to medical, dental and psychiatric care - FAM § 6922(a) and § 7050(e).

Minor’s consent for services – Mental health services

Medi-Cal members under the age of 18 receive timely access to these services (except substance abuse and specialty mental health services which are carved-out from the Plan’s contract responsibility) from any qualified in or out-of-network providers. To access substance abuse treatment services, Plan Medi-Cal members ages 12 or older receive timely, confidential referral to these services through local county alcohol and other drug programs. To receive timely, confidential referral to carved-out specialty mental health care, Plan Medi-Cal members ages 12 or older must be mature enough to participate intelligently and where either:

1. A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the following requirement is satisfied:
    - The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.
2. A professional person offering residential shelter services, whether as an individual or as a representative of an entity, shall make their best efforts to notify the parent or guardian of the provision of services.

3. The mental health treatment or counseling of a minor shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person shall consult with the minor before determining if parent/guardian involvement is appropriate. The professional person who is treating or counseling the minor shall state in the patient record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.
4. The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian. The minor's parents or guardian are not liable for payment for any residential shelter services provided unless the parent or guardian consented to those services.
5. Minors are not authorized to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

Facility Site Review

The Plan provides PCPs with office policies and procedures to use as templates for the facility site reviews (FSRs). Refer to the Medi-Cal FSR PCP office management policy and procedure templates for more information. During the Plan's facility review process, a finding of any obvious physical barrier to accessibility for disabled members is noted. If any obvious physical barrier is found, the Plan discusses potential resolution with the provider or PPG administrator. The provider indicates the resolutions on the facility site review (FSR) corrective action plan.

Appointments and Referrals

Members are instructed to call their PCP directly to schedule appointments for routine care, except in the case of a life-threatening emergency. Plan members must seek most care through their PCP. If a member has not selected a PCP, the Plan assigns one. The PCP is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care (including emergency behavioral health care).
- Urgent care sought outside the service area, and under unusual or extraordinary circumstances provided in the service area when the participating medical provider is unavailable or inaccessible.
- Obstetrics and gynecology (OB/GYN) for preventive care, pregnancy care or gynecological complaints
    - Female members have the option to directly access a participating women's health specialist (such as an OB/GYN or certified nurse midwife) for routine and preventive covered health care services for women (such as breast exams, mammograms and Pap tests).
- Out-of-area renal dialysis services.
- Members with chronic life-threatening, degenerative or disabling conditions or diseases that require continuing specialized medical or behavioral health care, which qualify for a standing referral to a specialist under the Plan's national policy requirements. For example, a member with HIV/AIDS, renal failure, or acute leukemia may seek a standing referral to a qualified, credentialed specialist.
- Behavioral health care is not covered by the Plan under its Medi-Cal managed care program. Accordingly, members may be eligible to self-refer to a behavioral health practitioner out-of-network through the mental health departments of members' counties of residence, depending on their Medi-Cal benefit coverage.

- Medi-Cal members may seek sensitive services, such as minor consent services, and family planning, sexually transmitted diseases and HIV testing and counseling services from qualified participating or out-of-network family planning providers, the local health department (LHD) and/or family planning clinics. Sensitive services for minors include sexual assault (including rape), drug or alcohol abuse, pregnancy, family planning, sexually transmitted diseases, and behavioral health care.
- Medi-Cal members may access LHD clinics for immunizations.

Missed Appointments

According to the Plan's Medical Records Documentation Standards policies and procedures (KK47-121230), missed appointment follow-up and outreach efforts to reschedule must be documented in the member's record. When an appointment is missed, providers are required to attempt to contact the member a minimum of three times, via mail or phone.

Appointment Rescheduling

According to the DMHC timely access regulations (28 CCR 1300.67.2.2) and to the Plan's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care; and be consistent with good professional practice and with the objectives of the Plan's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice.

If the licensed applicable health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered. The provider will notify the member of this decision, including an explanation of their right to file a grievance with the Plan. The record must be available to the DHCS upon request.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow-up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider

acting within the scope of his or her practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers (including seldom used or unusual specialty services) in a Plan service area, the Plan and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
- Member costs for medically necessary referrals for out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

Providing members with a list of potentially available out-of-network providers does not meet the requirement to arrange for medically necessary services from an out-of-network provider. To ensure members have access to services within geographic and timely access standards, the Plan and its participating providers are responsible for doing the following:

- Contact the out-of-network provider on behalf of the member to find out when appointments are available for medically necessary services.
- Schedule any initial and follow-up appointments for the member with an out-of-network provider.

These requirements do not prohibit the Plan or its delegated PPGs from accommodating a member's preference to wait for a later appointment from a specific participating provider. If a member prefers to wait for a later appointment, document it in the relevant record.

Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within the Plan's service area 24 hours a day, 7 days a week.

Providing Emergency and Urgent Care Services in the PCP's Office

The physician, registered nurse (RN), or physician assistant (PA) on duty is responsible for evaluating emergency and urgent care members in the office and making the decision to further evaluate and treat, summon an ambulance for transport to the nearest emergency room, directly admit to the hospital, or refer to a same-day visit at another provider or urgent care facility.

Provider Telephone Assessment

Telephone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs, and nurse practitioners (NPs)) and only in accordance with established standards of practice.

Telehealth

Telehealth services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between the Plan and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the originating site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member.

The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

Interpreter Services

In order to comply with applicable federal and state laws and regulations, the Plan requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services. Refer to Interpreter Services for more information.

Cultural Considerations

The Plan and its participating providers, including long-term support services (LTSS) providers, must ensure that services are provided in a culturally competent manner to all members, including those who have limited-English proficiency (LEP), have limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Prior Authorization Processes

The Plan requires prior authorizations to be processed and completed in a manner that ensures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered.

For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [CCR T28 §1300.67.2.2(c)(5)(B)], more commonly known as urgent pre-service requests, must be conducted concurrently, or the prior authorization turnaround timeline must be shortened to allow sufficient time to communicate the outcome to the member and/or the referring provider and ensure an appointment is offered to the member within 96 hours of the request. Refer to the Prior Authorization section for further information. For detailed information refer to Authorization and Referral Timelines.

Note: Requests Received after business hours:

NCQA counts the time from the date when Health Net receives the request, whether or not it is during business hours. Non-urgent requests may be processed during the next business day.

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Quality Assurance

The Plan has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, the Plan monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, the Plan reviews and evaluates the information available to the Plan regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service telephone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Plan members.

The Plan's participating providers (including delegated providers) are contractually required to participate in all timely access surveys or accreditation surveys administered and studied by or on behalf of regulatory agencies such as DHCS, DMHC and the Centers for Medicare & Medicaid Services (CMS).

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible for monitoring data provided by the Plan regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

The Plan's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Medi-Cal Plans Medical Appointment Access Standards

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments for primary care - regular and routine care (PCP)	Appointment within 10 business days of request	70%
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%
Urgent care services (SCP & Other) that require prior authorization	Appointment within 96 hours of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
First prenatal visit (both PCP and SCP)	Appointment within 2 weeks of request	70%
Well-child visit	Appointment within 2 weeks of request	70%
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request	70%
After-hours care (PCP)	Ability to contact on-call physician after-hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%
Provider office telephone callback during normal business hours	Provider callback within 1 business day	90%
Phone answer time at provider's office	Within 60 seconds	90%
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Fresno, Kings and Madera Counties: Within 14 calendar days of request	80%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Availability Survey (PAHAS) conducted via telephone by the Plan and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CalViva Health Medi-Cal Plans Appointment Access Standards - Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care[1]	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life-threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

The Plan investigates and implements corrective action when timely access to care as required by the Plan's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.05) are not met.

The Plan uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one of or more metrics are noted as being non-compliant:

- Appointment Access - PPGs that do not meet the Plan's 90% rate of compliance/performance goal in one or more of the appointment access metrics.
- After-Hours Access - PPGs that do not meet the Plan's 90% rate of compliance with one or more of the after-hours metrics.

PPG Notification of a CAP

The Plan provides the following:

- PPGs receive a description of the identified deficiencies, the rationale for the corrective action and the contact information of the person authorized to respond to provider concerns regarding the corrective action.
- Feedback to the PPGs regarding the accessibility of primary care, specialty care and telephone services, as necessary.

CAP Minimum Requirements

- Each PPG is required to send in a written improvement plan (IP) to include what interventions will be implemented to improve access availability. The IP must include:
  - Date of implementation of the IP.
  - Department/person responsible for the implementation and follow-up of the IP.
  - Anticipated date that the IP is expected to produce outcomes that result in the standard meeting regulatory agency time frame compliance.
- The PPG is to return the IP within 30 calendar days.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to the PNM and Contracting departments for further action.

Availability Standards

The Plan provides established availability standards and performance goals for providers. At least annually, the Plan measures, evaluates and reports geo-access and provider availability.

Listed below are the Plan's performance goals for geo-access and provider availability-related criteria:

Geo Access and Provider Availability Standards*

DMHC Standards

Provider Type	DMHC
PCP	15 miles/30 minutes*
Hospital	15 miles/30 minutes*
Ancillary	reasonable distance from PCP

*Time or distance standards are from the members' residence.

There are no DMHC regulatory standards for Ancillary, other than reasonable distance. Health Net has set the following standards for Ancillary to be reviewed at 90 percent within 15 miles or 30 minutes from the PCP locations.

DMHC County Size Categories by Population

Size Category	HNCS
Large Metro	Los Angeles and Sacramento
Metro	San Joaquin, Stanislaus, and Tulare

Size Category	HNCS
Micro	Amador and Tuolumne
Rural	Calaveras
CEAC	Inyo

Specialist 90% Threshold - Standard in Miles

County Designation	Specialist Group 1	Specialist Group 2
Large Metro	15^	15^^
Metro	20*	25*
Micro	55	65
Rural	55	65
CEAC	100	125

Specialist Group 1: cardiovascular disease, dermatology, gastroenterology, neurology, obstetrics/gynecology, oncology, ophthalmology, podiatry, pulmonology, surgery-general, and surgery-orthopedic.

Specialist Group 2: allergy/immunology, endocrinology, hematology, nephrology, otolaryngology, pain medicine, physical medicine and rehabilitation, radiation oncology, rheumatology, and urology.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- Large Metro County – ^20 and ^^35 miles
- Metro County – *35 and **45 miles

Mental Health 90% Threshold - Standard in Miles

County Designation	Psychiatrist	MHP
Large Metro	15*	15
Metro	20*	15~
Micro	55	35
Rural	55	35

County Designation	Psychiatrist	MHP
CEAC	100	65

Psychiatrist means a physician reported as one of the following specialist physician types: psychiatry, child and adolescent psychiatry, consultation-liaison psychiatry, geriatric psychiatry or addiction psychiatry.

MHP (Mental Health Professionals) means a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, or Psychologist.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- * for Large Metro Psychiatry – 20 miles
- ** for Metro Psychiatry – 35 miles
- ~ for Metro MHPs- 20 miles

Physician/Practitioner to member Ratios

CA DMHC: COMMERCIAL/HEALTH BENEFIT EXCHANGE:	
PCP	PHYSICIAN
1 FTE PCP/ 2,000 members	1 FTE physician/ 1,200 members

Open Practice Ratios

Percent of open PCP practices accepting new patients	DMHC standard	60% of PCPs in the network are accepting new patients or at least 75% of PCP locations in the network are a PCP location accepting new patients
Percent of open specialist practices accepting referrals	Internal standard	85%

DHCS Standards

Provider Type	Time and Distance Standard by County Size [1]			
	Rural	Small	Medium	Dense
Core Specialists	60 miles or 90 minutes	45 miles or 75 minutes	30 miles or 60 minutes	15 miles or 30 minutes

Provider Type	Time and Distance Standard by County Size [1]			
(Adult and Pediatric) and Non-Specialty Mental Health Providers				

DHCS County Size Categories by Population

Size Category	HNCS
Rural	Calaveras, Inyo, Mono and Tuolumne
Small	Amador and Tulare
Medium	San Joaquin and Stanislaus
Dense	Los Angeles and Sacramento

DHCS Core Specialists (Adult and Pediatric)

Provider type	Provider type
Cardiology/Interventional Cardiology*	Neurology*
Dermatology*	Obstetrics/ Gynecology (Adult Only)*
Endocrinology*	Oncology*
ENT/Otolaryngology*	Ophthalmology*
Gastroenterology*	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology*	Psychiatry*
HIV/AIDS Specialists/Infectious Diseases*	Pulmonology*
Nephrology*	Non-Physicians/Mental Health Providers*

*Can be covered by Telehealth providers.

Mandatory Provider Type	Contract Obligations
Federally Qualified Health Center (FQHC)	Must offer to contract with each provider type in the service area where available. Must contract with at least one (1) in service area, where available.
Rural Health Clinic (RHC)	
Freestanding Birthing Center (FBC)	
Indian Health Facility (IHF)	Must offer to contract with each IHF in service area, where available.
Certified Nurse Midwife (CNM)	Must contract with at least one (1) provider type each in service area, where available.
Licensed Midwife (LM)	

Additional Ratios

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
Full Time Equivalent (FTE) PCP ratio for each type of PCP to member: • Family • General Practice • Internal Medicine • Pediatrics	100% of PCPs	1 : 2,500
• High volume SCP (Obstetrics/Gynecology) • High impact SCP (Hematology/Oncology)	100% of SCPs	• 1 : 3,000 • 1 : 8,000
Behavior Health • MD's/DO (psychiatrists) • Psychologist • Masters Level practitioner	100%	• 1 : 5,000 • 1 : 2,300 • 1 : 1,150

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
Autism • Qualified Autism Service Provider (BCBA) • Qualified Autism Service Professionals (BCaBA) or Paraprofessionals	100%	• 1 : 5,000 • 1 : 5,000

Availability Corrective Action

The Plan collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. The Plan implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through the Plan's Quality Improvement Committee or through the activities of Provider Network Management.

Threshold Languages

Any non-English language that meets the following criteria for Medi-Cal eligibles within a county is designated as a threshold language. As Medi-Cal is an entitlement program, the criteria is based on those that may be eligible for services not those that are enrolled in the plan. Currently, the Plan has a total of 3 non-English languages that are required for translation.

- 3,000 within one county or five percent (5%), whichever is lower
- 1,000 within one ZIP Code
- 1,500 within two contiguous ZIP Code

Per DHCS, “Threshold Standard Languages ≥3,000 per language or ≥5% of the Medi-Cal Population that speak the language per county. Concentration Standard Languages ≥1,000 per ZIP Code or ≥1,500 per two contiguous.”

All members whose primary language has been identified as a threshold language by the DHCS and the Plan receive written and oral information in that language. The Plan monitors member access to information and services in threshold languages through a variety of ways, including primary care site certification.

Fresno

In Fresno County, the threshold languages are Spanish and Hmong.

Kings and Madera

In Kings and Madera counties, the threshold language is Spanish.

Access to care and availability standards (CHPIV)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Community Health Plan of Imperial County

Community Health Plan of Imperial Valley's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), behavioral health care, urgent care, ancillary services, and emergency care are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards.

These access standards are regulated by the California Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS). The National Committee for Quality Assurance (NCQA) monitors medical standards for access to, and availability of, care and sets behavioral health time-elapsed appointment access standards.

Note: Behavioral health and chemical dependency services are administered by the Plan.

The Plan and its participating providers are required to demonstrate that, throughout the geographic regions of the Plan's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible, at reasonable times.

Additionally, the Plan and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within a reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practices. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Plan members are notified annually, via member newsletters or the Evidence of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioners' (SCP) office hours must be reasonable, convenient and sufficient to ensure that

they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office.

The Plan requires a PCP practice to be open at least 20 hours per week and an SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be used to provide members with clear and simple instructions on after-hours access to medical care.

Additionally, Medi-Cal participating providers must offer hours of operation to Medi-Cal members that are no less than the hours of operation offered to patients from other lines of business or to Medi-Cal fee-for-service (FFS) beneficiaries.

Behavioral Health Facility Access and Availability

Per their contract with Health Net, network facilities should be available and accessible to members during reasonable hours of operation. Emergency care, where applicable, should also be available and accessible 24 hours a day. Facility information regarding hours of operation is collected every two years via Health Net's facility application for recredentialing. Facilities must notify Health Net of any changes in their hours of operation or lapses in accessibility or availability as needed.

After-Hours Access Guidelines

As required by applicable statutes, the Plan's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, 7 days a week, and PCPs are required to have appropriate licensed professional back-up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instructions about after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should return telephone calls and pages within 30 minutes and be available 24 hours a day, 7 days a week. The PCP or on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room, as medically necessary.

Additionally, the Plan provides triage and/or screening services 24 hours a day, 7 days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although the Plan does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, 7 days a week.

After-Hours Script Template

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues.

Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. The Plan has designed

an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can use as a guide for staff answering the telephone.

For PPGs or physicians who use an automated answering system/answering machine, this template can be used as a script to advise members how to access care. The Plan's after-hours scripts provide easy to use messaging examples on how to direct members to emergency care services and who to talk to when they need urgent medical advice.

The Plan makes the script available in the following threshold languages:

- English (PDF)
- Spanish (PDF)

After-hours scripts are available in alternate formats and additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the provider is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain a member's condition so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional.

Unlicensed telephone staff should have clear instructions about the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

The Plan encourages answering services to follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
- If language assistance is needed, offer the member interpreter services, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered an authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact the Health Net Hospital Notification Unit within 24 hours or the next business day of the admission, including instances where prior authorization has already been obtained.

- The answering service should document all calls. Answering services frequently have a high staff turnover, so providers should monitor the answering service to ensure emergency procedures are followed.

Triage and/or Screening Services/Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), the Plan provides 24-hour-a-day, 7 days a week triage or screening services by phone. This program is a service that does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment and advice. The Community Health Plan of Imperial Valley Member Services Department coordinates member access to the service, if necessary.

The program allows California registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide self-care guidance, general health information, or recommend a visit to urgent care of the emergency room.

The Plan ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. The Plan provides triage or screening services for Medi-Cal members through medical advice lines as follows:

- Triage and/or screening services/nurse advice help is available to members 24 hours a day, 7 days a week through the Plan's State Health Programs (SHP) Member Service Department telephone line displayed on the back of the member's ID card. A representative connects the member to triage and/or screening services/nurse advice after verifying eligibility.

Facility Access for Persons with Disabilities

The Plan and its participating providers and practitioners do not discriminate against members who have physical or mental disabilities. Participating providers are required to provide reasonable access for members with disabilities in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Minor's Consent for Services

As defined in 42 CFR 2.14 (a) the term "minor" means a person who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, age 18. Minors under age 18 may consent to medical care related to:

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent or prior authorization to access or obtain. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent.

Plan Medi-Cal members under the age of 18 may access Minor Consent Services as follows:

- Pregnancy testing (is considered to be a family planning service and may be obtained from any qualified provider in or out-of-network), counseling and family planning. Obstetrical care for pregnancy must be accessed through an in-network provider.
- Contraception services such as birth control (excludes sterilization).
- Abortion services (for children ages 12 and older without parental consent or court permission) - American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997).
- Services for rape and other sexual assault, treatment and collection of medical evidence.
- HIV/AIDS counseling, prevention, testing and treatment. Sexually transmitted infection prevention, testing, and treatment including sexually transmitted diseases such as syphilis, gonorrhea, chlamydia, and herpes simplex (for children ages 12 and older) - CFC §6926.
- Substance use disorder treatment for drug and alcohol abuse including screening, assessment, intervention, and referral services (for children ages 12 and older) treatment and counseling - FAM §6929(b). Members are entitled to confidential, timely referral to the county drug and alcohol program.
- Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill (AB) 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent or guardian consent is necessary for maintenance narcotic replacement therapy.
- Skeletal X-ray - a health care provider may take skeletal X-rays of a child without the consent of the child's parent/legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of it - Cal. Penal Code §11171.2.
- General medical, psychiatric or dental care if all of the following conditions are satisfied: (1) The minor is age 15 years or older; (2) The minor is living separate and apart from his or her parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence; (3) The minor is managing their own financial affairs, regardless of the source of the minor's income. If the minor is an emancipated minor, they may consent to medical, dental and psychiatric care - FAM § 6922(a) and § 7050(e).

Minor's consent for services – Mental health services

Medi-Cal members under the age of 18 receive timely access to these services (except substance abuse and specialty mental health services which are carved-out from the Plan's contract responsibility) from any qualified in or out-of-network providers. To access substance abuse treatment services, Plan Medi-Cal members ages 12 or older receive timely, confidential referral to these services through local county alcohol and other drug programs. To receive timely, confidential referral to carved-out specialty mental health care, Plan Medi-Cal members ages 12 or older must be mature enough to participate intelligently and where either:

1. A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the following requirement is satisfied:
    - The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.
2. A professional person offering residential shelter services, whether as an individual or as a representative of an entity, shall make their best efforts to notify the parent or guardian of the provision of services.
3. The mental health treatment or counseling of a minor shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person shall consult with the minor before determining if parent/guardian involvement is appropriate. The professional person who is treating or counseling the minor shall state in the patient record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact

was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

4. The minor's parents or guardian are not liable for payment for mental health treatment or counseling services provided unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian. The minor's parents or guardian are not liable for payment for any residential shelter services provided unless the parent or guardian consented to those services.
5. Minors are not authorized to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

Facility Site Review

The Plan provides PCPs with office policies and procedures to use as templates for the facility site reviews (FSRs). Refer to the Medi-Cal FSR PCP office management policy and procedure templates for more information. During the Plan's facility review process, a finding of any obvious physical barrier to accessibility for disabled members is noted. If any obvious physical barrier is found, the Plan discusses potential resolution with the provider or PPG administrator. The provider indicates the resolutions on the facility site review (FSR) corrective action plan.

Appointments and Referrals

Members are instructed to call their PCP directly to schedule appointments for routine care, except in the case of a life-threatening emergency. Plan members must seek most care through their PCP. If a member has not selected a PCP, the Plan assigns one. The PCP is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care (including emergency behavioral health care).
- Urgent care sought outside the service area, and under unusual or extraordinary circumstances provided in the service area when the participating medical provider is unavailable or inaccessible.
- Obstetrics and gynecology (OB/GYN) for preventive care, pregnancy care or gynecological complaints
    - Female members have the option to directly access a participating women's health specialist (such as an OB/GYN or certified nurse midwife) for routine and preventive covered health care services for women (such as breast exams, mammograms and Pap tests).
- Out-of-area renal dialysis services.
- Members with chronic life-threatening, degenerative or disabling conditions or diseases that require continuing specialized medical or behavioral health care, which qualify for a standing referral to a specialist under the Plan's national policy requirements. For example, a member with HIV/AIDS, renal failure, or acute leukemia may seek a standing referral to a qualified, credentialed specialist.
- Behavioral health care is not covered by the Plan under its Medi-Cal managed care program. Accordingly, members may be eligible to self-refer to a behavioral health practitioner out-of-network through the mental health departments of members' counties of residence, depending on their Medi-Cal benefit coverage.
- Medi-Cal members may seek sensitive services, such as minor consent services, and family planning, sexually transmitted diseases and HIV testing and counseling services from qualified participating or out-of-network family planning providers, the local health department (LHD) and/or family planning clinics. Sensitive services for minors include sexual assault (including rape), drug or alcohol abuse, pregnancy, family planning, sexually transmitted infections, and behavioral health care.
- Medi-Cal members may access LHD clinics for immunizations.

Missed Appointments

According to the Plan's Medical Records Documentation Standards policies and procedures (KK47-121230), missed appointment follow-up and outreach efforts to reschedule must be documented in the member's record. When an appointment is missed, providers are required to attempt to contact the member a minimum of three times, via mail or phone.

Appointment Rescheduling

According to the DMHC timely access regulations (28 CCR 1300.67.2.2) and to the Plan's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care; and be consistent with good professional practice and with the objectives of the Plan's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice.

If the licensed applicable health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered. The provider will notify the member of this decision, including an explanation of their right to file a grievance with the Plan. The record must be available to the DHCS upon request.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow-up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers (including seldom used or unusual specialty services) in a Plan service area, the Plan and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
- Member costs for medically necessary referrals for out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

Providing members with a list of potentially available out-of-network providers does not meet the requirement to arrange for medically necessary services from an out-of-network provider. To ensure members have access to services within geographic and timely access standards, the Plan and its participating providers are responsible for doing the following:

- Contact the out-of-network provider on behalf of the member to find out when appointments are available for medically necessary services.
- Schedule any initial and follow-up appointments for the member with an out-of-network provider.

These requirements do not prohibit the Plan or its delegated PPGs from accommodating a member's preference to wait for a later appointment from a specific participating provider. If a member prefers to wait for a later appointment, document it in the relevant record.

Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within the Plan's service area 24 hours a day, 7 days a week.

Providing Emergency and Urgent Care Services in the PCP's Office

The physician, registered nurse (RN), or physician assistant (PA) on duty is responsible for evaluating emergency and urgent care members in the office and making the decision to further evaluate and treat, summon an ambulance for transport to the nearest emergency room, directly admit to the hospital, or refer to a same-day visit at another provider or urgent care facility.

Provider Telephone Assessment

Telephone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs, and nurse practitioners (NPs)) and only in accordance with established standards of practice.

Telehealth

Telehealth services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between the Plan and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the originating site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member.

The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

Interpreter Services

In order to comply with applicable federal and state laws and regulations, the Plan requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services. Refer to Interpreter Services for more information.

Cultural Considerations

The Plan and its participating providers, including long-term support services (LTSS) providers, must ensure that services are provided in a culturally competent manner to all members, including those who have limited-English proficiency(LEP),limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Prior Authorization Processes

The Plan requires prior authorizations to be processed and completed in a manner that ensures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards.

If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered. For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [CCR T28 §1300.67.2.2(c)(5)(B)], more commonly known as urgent pre-service requests, must be conducted concurrently, or the prior authorization turnaround timeline must be shortened to allow sufficient time to communicate the outcome to the member and/or the referring provider and ensure an appointment is offered to the member within 96 hours of the request. Refer to the Prior Authorization section for further information. For detailed information refer to Authorization and Referral Timelines.

Note: Requests Received after business hours:

NCQA counts the time from the date when Health Net receives the request, whether or not it is during business hours. Non-urgent requests may be processed during the next business day.

Quality Assurance

The Plan has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, the Plan monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, the Plan reviews and evaluates the information available to the Plan regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service telephone access to

measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Plan members.

The Plan’s participating providers (including delegated providers) are contractually required to participate in all timely access or accreditation surveys and studies administered by or on behalf of regulatory agencies such as DHCS, DMHC and the Centers for Medicare & Medicaid Services (CMS).

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible for monitoring data provided by the Plan regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

The Plan's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Medi-Cal Plans Medical Appointment Access Standards

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments for primary care - regular and routine care (PCP)	Appointment within 10 business days of request	70%
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%
Urgent care services (SCP & Other) that require prior authorization	Appointment within 96 hours of request	70%
First prenatal visit (both PCP and SCP)	Appointment within 2 weeks of request	70%
Well-child visit	Appointment within 2 weeks of request	70%
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
After-hours care (PCP)	Ability to contact on-call physician after-hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/ mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%
Provider office telephone callback during normal business hours	Provider callback within 1 business day	90%
Phone answer time at provider's office	Within 60 seconds	90%
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Within 14 calendar days of request	80%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Availability Survey (PAHAS) conducted via telephone by the Plan and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Community Health Plan of Imperial Valley Medi-Cal Plans Appointment Access Standards - Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care[1]	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life-threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments2	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care3	Appointment within 15 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization3	Appointment within 96 hours of request	70%
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

The Plan investigates and implements corrective action when timely access to care as required by the Plan's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.05) are not met.

The Plan uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one of or more metrics are noted as being non-compliant:

- Appointment Access - PPGs that do not meet the Plan's 90% rate of compliance/performance goal in one or more of the appointment access metrics.
- After-Hours Access - PPGs that do not meet the Plan's 90% rate of compliance with one or more of the after-hours metrics.

PPG Notification of a CAP

The Plan provides the following:

- PPGs receive a description of the identified deficiencies, the rationale for the corrective action and the contact information of the person authorized to respond to provider concerns regarding the corrective action.
- Feedback to the PPGs regarding the accessibility of primary care, specialty care and telephone services, as necessary.

CAP Minimum Requirements

- Each PPG is required to send in a written improvement plan (IP) to include what interventions will be implemented to improve access availability. The IP must include:
  - Date of implementation of the IP.
  - Department/person responsible for the implementation and follow-up of the IP.
  - Anticipated date that the IP is expected to produce outcomes that result in the standard meeting regulatory agency time frame compliance.
- The PPG is to return the IP within 30 calendar days.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to the PNM and Contracting departments for further action.

Availability Standards

The Plan provides established availability standards and performance goals for providers. At least annually, the Plan measures, evaluates and reports geo-access and provider availability. Listed below are the Plan's performance goals for geo-access and provider availability-related criteria:

Geo Access and Provider Availability Standards*

DMHC Standards

Provider Type	DMHC
PCP	15 miles/30 minutes*
Hospital	15 miles/30 minutes*
Ancillary	reasonable distance from PCP

*Time or distance standards are from the members' residence.

There are no DMHC regulatory standards for Ancillary, other than reasonable distance. Health Net has set the following standards for Ancillary to be reviewed at 90 percent within 15 miles or 30 minutes from the PCP locations.

DMHC County Size Categories by Population

Size Category	CHPIV
Large Metro	None in County
Metro	None in County
Micro	Imperial
Rural	None in County
CEAC	None in County

Specialist 90% Threshold - Standard in Miles

County Designation	Specialist Group 1	Specialist Group 2
Large Metro	15^	15^^
Metro	20*	25*
Micro	55	65
Rural	55	65
CEAC	100	125

Specialist Group 1: cardiovascular disease, dermatology, gastroenterology, neurology, obstetrics/gynecology, oncology, ophthalmology, podiatry, pulmonology, surgery-general, and surgery-orthopedic.

Specialist Group 2: allergy/immunology, endocrinology, hematology, nephrology, otolaryngology, pain medicine, physical medicine and rehabilitation, radiation oncology, rheumatology, and urology.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- Large Metro County – ^20 and ^^35 miles
- Metro County – *35 and **45 miles

Mental Health 90% Threshold - Standard in Miles

County Designation	Psychiatrist	MHP
Large Metro	15*	15
Metro	20*	15~
Micro	55	35
Rural	55	35
CEAC	100	65

Psychiatrist means a physician reported as one of the following specialist physician types: psychiatry, child and adolescent psychiatry, consultation-liaison psychiatry, geriatric psychiatry or addiction psychiatry.

MHP (Mental Health Professionals) means a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, or Psychologist.

DMHC has options for Alternative Low Density Zip Standard – when applicable

- * for Large Metro Psychiatry – 20 miles
- ** for Metro Psychiatry – 35 miles
- ~ for Metro MHPs- 20 miles

Physician/Practitioner to member Ratios

CA DMHC: COMMERCIAL/HEALTH BENEFIT EXCHANGE:	
PCP	PHYSICIAN
1 FTE PCP/ 2,000 members	1 FTE physician/ 1,200 members

Open Practice Ratios

Percent of open PCP practices accepting new patients	DMHC standard	60% of PCPs in the network are accepting new patients or at least 75% of PCP locations in the network are a PCP location accepting new patients
Percent of open specialist practices accepting referrals	Internal standard	85%

DHCS Standards

Provider Type	Time and Distance Standard by County Size [1]			
	Rural	Small	Medium	Dense
Core Specialists (Adult and Pediatric) and Non-Specialty Mental Health Providers	60 miles or 90 minutes	45 miles or 75 minutes	30 miles or 60 minutes	15 miles or 30 minutes

DHCS County Size Categories by Population

Size Category	HNCS
Rural	Calaveras, Inyo, Mono and Tuolumne
Small	Amador and Tulare
Medium	San Joaquin and Stanislaus
Dense	Los Angeles and Sacramento

DHCS Core Specialists (Adult and Pediatric)

Provider type	Provider type
Cardiology/Interventional Cardiology*	Neurology*
Dermatology*	Obstetrics/ Gynecology (Adult Only)*
Endocrinology*	Oncology*
ENT/Otolaryngology*	Ophthalmology*
Gastroenterology*	Orthopedic Surgery
General Surgery	Physical Medicine and Rehabilitation
Hematology*	Psychiatry*

Provider type	Provider type
HIV/AIDS Specialists/Infectious Diseases*	Pulmonology*
Nephrology*	Non-Physicians/Mental Health Providers*

*Can be covered by Telehealth providers.

Mandatory Provider Type	Contract Obligations
Federally Qualified Health Center (FQHC)	Must offer to contract with each provider type in the service area where available. Must contract with at least one (1) in service area, where available.
Rural Health Clinic (RHC)	
Freestanding Birthing Center (FBC)	
Indian Health Facility (IHF)	Must offer to contract with each IHF in service area, where available.
Certified Nurse Midwife (CNM)	Must contract with at least one (1) provider type each in service area, where available.
Licensed Midwife (LM)	

Additional Ratios

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
Full Time Equivalent (FTE) PCP ratio for each type of PCP to member: • Family • General Practice • Internal Medicine • Pediatrics	100% of PCPs	1 : 2,500
• High volume SCP (Obstetrics/Gynecology) • High impact SCP (Hematology/Oncology)	100% of SCPs	• 1 : 3,000 • 1 : 8,000

NCQA ratios, internal standards, not a regulatory standard	Rate of compliance	Standard
Behavior Health • MD's/DO (psychiatrists) • Psychologist • Masters Level practitioner	100%	• 1 : 5,000 • 1 : 2,300 • 1 : 1,150
Autism • Qualified Autism Service Provider (BCBA) • Qualified Autism Service Professionals (BCaBA) or Paraprofessionals	100%	• 1 : 5,000 • 1 : 5,000

Availability Corrective Action

The Plan collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. The Plan implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through the Plan's Quality Improvement Committee or through the activities of Provider Network Management.

Threshold Languages

Any non-English language that meets the following criteria for Medi-Cal eligibles within a county is designated as a threshold language. As Medi-Cal is an entitlement program, the criteria are based on those that may be eligible for services not those that are enrolled in the plan. Currently, the Plan has a total of 1 non-English language that is required for translation.

- 3,000 within one county or five percent (5%), whichever is lower
- 1,000 within one zip code
- 1,500 within two contiguous zip codes

Per DHCS, "Threshold Standard Languages ≥3,000 per language or ≥5% of the Medi-Cal Population that speak the language per county. Concentration Standard Languages ≥1,000 per zip code or ≥1,500 per two contiguous."

All members whose primary language has been identified as a threshold language by the Department of Health Care Services (DHCS) and the Plan receive written and oral information in that language. The Plan monitors member access to information and services in threshold languages through a variety of ways, including primary care site certification.

Imperial

In Imperial County, the threshold language is Spanish

Open Clinical Dialogue

Participating Physician Groups (PPG) | Hospitals

The Provider Participation Agreements (PPAs) include a statement that providers can communicate freely with members regarding their medical conditions and treatment alternatives, including medication treatment options, regardless of coverage limitations. Providers' contracts and subcontracts are required to include this provision.

Additionally, Health Net may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under a Health Net plan.

Claims Denials

Participating Physician Groups (PPG) | Hospitals

The Delegation Oversight auditors review claim denials by delegated entities to ensure that notification letters to providers comply with accuracy and timeliness requirements. Providers may not send a denial notice to a member as they are provider denials only.

Claims Payment Requirements

Participating Physician Groups (PPG)

Timeliness of payment of claims is monitored via the participating physician group's (PPG's) and capitated hospital's monthly claims timeliness report and is verified by routine and targeted audits conducted by the Third Party Risk Management staff.

Claims Payment

Claims must reimbursed fully or partially within 30 calendar days of receipt. If a claim is incomplete, the physician or other provider must be notified as soon as possible, and no later than 30 calendar days after receiving the claim.

Interest and Penalty Payments for Late Claims

For claims received prior to January 1, 2026, PPGs and capitated hospitals are required to:

- Pay 90 percent of Medi-Cal clean claims within 30 calendar days of receipt.
- Pay 99 percent of Medi-Cal clean claims within 90 calendar days of receipt.
- Process 95 percent of all claims within 45 business days of receipt.
- Pay 15 percent interest or $15 per annum, whichever is greater, on late paid claims for emergency services rendered in the United States.
- Pay 15 percent interest on late paid claims for all other claims.
- Pay an additional $10 if the interest is not automatically included in the claim payment.

For claims received after January 1, 2026,

- Late paid claims must include interest at the rate of 15% per annum beginning with the first calendar day after the 30-calendar day period.
- Failure to automatically include all interest that has accrued on a late payment of a claim requires a penalty payment to the claimant the greater of either an additional $15 or 10% of the accrued interest on the claim.

Member notices about incomplete claims

PPGs and capitated hospitals must notify the member and provider in writing within 30 calendar days from receipt of the claim of an incomplete claim. Notices must specify:

- Date of denial notice.
- Member name.
- Provider name.
- Specific service.
- Date of service.
- Denied amount.
- Member responsibility amount.
- Reason for the denial - Claim denials for members must include a claim denial message.
- Provider and member appeals process and information, including plan name, address and telephone number for appeals.

Timely Claims Processing Requirements

When a member seeks medical attention from a provider, it is important that the provider attempts to determine eligibility with Health Net and enrollment in the PPG before providing care. If the provider or PPG does not follow the required steps for verification of eligibility and enrollment, Health Net does not accept financial responsibility for any services performed.

All Medi-Cal claims must be processed in accordance with these requirements:

- Process 95 percent of Medi-Cal clean claims within 30 calendar days of receipt.
- The payer is required to notify the provider in writing of contested claims.
- The payer is required to notify the provider in writing of contested claims within 30 calendar days.

PPGs and Hospitals are asked to produce an action plan if the volume of claims not processed within 30 calendar days without satisfactory notification to the provider is not in compliance with Health Net's standards. PPGs and Hospitals may be sanctioned if continued non-compliance is demonstrated. Sanctions can include freezing new enrollment and can ultimately result in termination of the provider's contract.

Health Net is required to submit encounter information to the Department of Health Care Services (DHCS) within 90 days following the month in which the service was provided. To meet this requirement, providers need to submit this information to Health Net within 60 days of the date of service. This allows Health Net 30 days to process the information prior to submission to DHCS.

Claims must be submitted within six months of the last date of the month during which services were rendered. Health Net denies claims submitted beyond this period.

If providers accidentally bill Electronic Data System (EDS), EDS denies the claim and sends the claim back to the provider with a notice instructing the provider to bill the correct carrier. EDS does not forward the claim to Health Net. It is the provider's responsibility to bill the correct payer.

Claims Universe Report

PPGs are required to report all family planning and sensitive service claims that were paid or denied to non-participating providers during the regular scheduled claims audit. To ensure Health Net PPGs comply with this requirement, PPGs must submit a Claims Universe Report for the month and include:

- Member name
- Member identification (ID) number
- Provider name
- Check date
- Check mail date
- Check number and amount paid
- Claim number
- Date of service
- CPT and ICD-10 codes
- Service(s) billed amount
- Place of service

- Signed informed consent form (if required for specific service)

Authorization and Referral Timelines

Participating Physician Groups (PPG)

According to utilization management (UM) standards, all participating physician groups (PPGs) are required to:

- Approve, modify or deny and process all routine authorization requests within seven calendar days of the date of receipt of all information necessary to render a decision.
- Approve, modify or deny and process all urgent/expedited requests for authorization within 72 hours after the receipt of the request for service.
- Make a determination within 24 hours of receipt of an urgent-concurrent authorization request provided that the request is made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments. In the cases of urgent-concurrent review, care will not be discontinued until the treating provider has agreed to a care plan appropriate for the medical needs of the enrollee.

If additional clinical information is required, an initial decision may be deferred (extension) for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee, in accordance with Section 1367.03(a)(5)(H), and:

- Additional clinical information is required.
- Requires consultation by an expert reviewer.
- Additional examination or tests are to be performed.
- The member and practitioner must be notified in writing within the applicable regulatory time frame of the extension.
- Additionally, advise the requesting provider that in accordance with Health and Safety Code Section 1367.03(a)(h)(5):
    - If this delay to obtain additional information and resulting delay *will* have a detrimental impact on the health of the member, you *must* contact the Plan.
    - If this delay will *not* have a detrimental impact on the health of the member, you *must* document this in the member record.

Deferral/extension timeliness standards

- Routine (pre-service) requests:
    - If the provider has not complied with the request for additional information by the anticipated decision date, the PPG reviews the request with the information available and makes a determination by the 14th calendar day from receipt of the original request.
    - If the requested information is received, a decision must be made within seven calendar days of receipt of complete information.
- Urgent/expedited (pre-service) requests:
    - If the provider has not complied with the request for additional information by the anticipated decision date, the PPG reviews the request with the information available and makes a determination by the 14th calendar day from receipt of the original request.

- If the provider has not complied with the request for additional information by the anticipated decision date, the PPG reviews the request with the information available and makes a determination by the 14th calendar day from receipt of the original request.

- Urgent-concurrent requests:
  - Extensions are allowed only under the following conditions:
    - If the review request for extension of services was not made at least 24 hours prior to the expiration of the previously approved prescribed period of time or number of treatments, the PPG may treat the review request as an urgent pre-service review request determination and make the decision within the regulatory timeline of 72 hours from receipt of request.
    - If additional information is required, the PPG must adhere to the extension process for extending time frames for urgent/expedited requests. An additional 48 hours is afforded to the facility to provide the additional information. However, the PPG's determination must be made within 24 hours of receipt of information or end of expiration of extension, not to exceed 72 hours from receipt of original request.
- Communicate the decision to the member and practitioner within the applicable regulatory time frame from the date of the original receipt of the request.
- For cases where expert consultation is required to make initial decision

Type of request	Notification
Non-urgent pre-service	If a consultation is required by an expert reviewer, upon the expiration of the seven calendar days or as soon as Health Net becomes aware that the seven calendar day time frame will not be met, whichever occurs first, practitioner and member will be notified of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 15 calendar days from the date of the delay notice to the practitioner and member).
Post-service	If a consultation is required by an expert reviewer, upon the expiration of the 30 calendar days or as soon as Health Net becomes aware that we will not meet the 30 calendar day time frame, whichever occurs first, practitioner and member will be notified of the type of expert reviewer and the anticipated date on which a decision will be rendered (no more than 15 calendar days from the date of the delay notice to the practitioner and member).

The regulatory time frames begin when the delegated PPG receives a request for prior authorization. If the PPG's UM department receives a request for prior authorization of services and it is determined to be the Plan's responsibility, the PPG must immediately forward the request to the Plan as the regulatory time frames begin at the time of the original request. The Medicare Advantage Informational Letter to Member or Provider/ Physician carve-out letter (PDF) serves to advise the member that the PPG's utilization management entity received a prior authorization request but the PPG is not delegated to conduct a prior authorization review and the PPG notifies the member that the request has been forwarded to the Plan (no Medi-Cal carve-out letter is available at this time). The regulatory time frame for the prior authorization review does not reset or stop when this letter is issued.

The National Committee for Quality Assurance (NCQA) counts the time from the date when Health Net receives the request, regardless of whether it is during business hours. Non-urgent requests may be processed on the next business day.

Continued Access to Non-Participating Providers for SPD Members

Participating Physician Groups (PPG) | Hospitals

Health Net requires all subcontracting health plans, delegated participating physician groups (PPGs) and capitated hospitals to adhere to the Procedures for SPD Members Requesting Services from Non-Participating Providers (see section below). Health Net subcontractors must arrange for medically necessary services for newly enrolled Seniors and Persons with Disabilities (SPD) members to be provided by non-participating providers when the SPD member requests such services. This applies to Medi-Cal members enrolled in Health Net's Medi-Cal plan directly from the Medi-Cal FFS program beginning June 1, 2011, and who are in one of the following aid codes:

- Disabled (Medi-Cal only - Not Medicare eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V
- Aged (Medi-Cal only - Not Medicare eligible): 10, 14, 16, 1E, 1H

SPD members who request continued access to existing non-participating providers may be treated by the non-participating provider for medically necessary services for up to 12 months from the date of the member's enrollment in Health Net, if there are no quality-of-care issues involving the provider. If an SPD member agrees to transition to a participating provider earlier than the 12-month transition period, the PPG is encouraged to work with the member and transition him or her to a participating provider.

Health Net's subcontractors - a Medi-Cal capitated PPG, a Medi-Cal capitated hospital or Molina Healthcare, must pay non-participating providers providing covered services for SPD members under the terms and conditions of the guidelines and requirements in the above procedure at the higher of the subcontractor's Medi-Cal contracting rate, or the Medi-Cal fee-for-service (FFS) provider rate. Health Net's subcontractors may require non-participating providers to agree in writing to contractual terms and conditions, including, but not limited to, prior authorization, hospital privileging, utilization review, case management, and quality performance requirements.

Additional Terms and Conditions of Coverage

The following are additional terms and conditions of coverage for continuation of care by a non-participating provider:

- A newly enrolled SPD member has an ongoing relationship with the requested provider
  - The requested provider was not terminated from participation with Health Net or its subcontractor for a medical discipline reason, fraud or crime
  - The requested provider is not excluded, suspended or terminated from participation in the Medicare or Medi-Cal and Medicaid programs

- Services to be rendered by the provider are covered services

Procedures for SPD Members Requesting Services from Non-Participating Providers

Health Net Responsibilities

Health Net follows these steps to notify subcontractors of newly enrolled Seniors and Persons with Disabilities (SPD) members who request to continue to obtain medically necessary care and services from a non-participating provider during their 12-month transition period following enrollment with Health Net:

- The SPD member or the member's representative calls or writes Health Net's Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health's Member Services to request that the SPD member continue to be treated by a non-participating provider.
- Health Net's Medi-Cal Member Services Department verifies, to the extent possible, with the SPD member that the member has an ongoing relationship with the requested provider and forwards the completed Transition of Care/Continuation of Care Request Form for response to either:
  - Health Net's Medi-Cal Health Care Services Department
  - Molina Healthcare's medical director when the SPD member is assigned to Molina

For the purposes of these guidelines and requirements, references to medical director are meant to include the member's designated case manager

- The Health Net Medi-Cal Utilization Management Department representative reviews the fee-for-service (FFS) utilization data provided by the Department of Health Care Services (DHCS) to verify claims were paid under the FFS Medi-Cal program to the requested non-participating provider. If the requested non-participating provider does not appear in the FFS utilization data, the representative contacts the requested provider to obtain visit history for the SPD member. The representative then forwards the completed form to the member's assigned PPG medical director

Subcontractor Responsibilities

- Upon receipt of the Continuity of Care request or the completed Continuity of Care Request Form, the applicable PPG or Molina medical director or designee determines whether the SPD member qualifies for coverage of continuation of care by the non-participating provider. This includes confirming that there are no quality-of-care issues involving the non-participating provider and whether the non-participating provider is willing to provide the continuation of care at the higher of the subcontractor's Medi-Cal contracting rate or the Medi-Cal FFS provider rates. If the non-participating provider does not agree to these or other permissible terms, then the subcontractor is not required to provide the new SPD member with continued access to covered services offered by the non-participating provider
- If the applicable PPG or Molina medical director or designee determines that the SPD member does not qualify for continued access to a non-participating provider in accordance with this policy, the medical director or designee:
  - Arranges for a participating provider to provide for the SPD member's care
  - Informs the SPD member of the determination in a timely manner appropriate for the SPD member's clinical condition, not to exceed seven business days of the member's request

- If the applicable PPG or Molina medical director or designee determines that the SPD member qualifies for continued access to a non-participating provider in accordance with this policy, and the non-participating provider agrees on a rate and to comply with any of the subcontractor's other contractual requirements, the medical director or designee:
  - Authorizes coverage for continuation of care by the non-participating provider
  - Informs the SPD member of the determination in a timely manner appropriate for the SPD member's clinical condition, not to exceed seven business days of the member's request
- Subcontractors are required to track the number of continuation of care requests that are approved and the number that are denied, along with the reason that they are denied

Eligibility and Data Entry Requirements

Participating Physician Groups (PPG) | Hospitals

All participating physician groups (PPGs) and hospitals are required to enter the following into the PPG's or hospital's system:

- Eligibility and primary care physician (PCP) assignment information within two business days after receipt.
- New member information that is not yet on eligibility or capitation reports upon verification of eligibility.
- PCP changes requested by the member within two business days of receipt of requested change.

Quality Improvement Problem Resolution

Participating Physician Groups (PPG) | Hospitals

Under the plan's quality improvement (QI) standards, all participating physician groups (PPGs) and hospitals are required to:

- Initiate research, on quality-of-care problems identified by clinical staff.
- Provide feedback and information on the issue so that a determination can be made.
- Participate in the QI corrective action process, as applicable.

Participating Physician Group (PPG) Performance Management

As the health care industry in California continues to demand increased performance and value, Health Net has improved our delegation program tools to include an enhanced PPG Performance Scorecard to evaluate PPGs in seven performance areas (PDF). Delegated PPGs are reviewed for performance measures including grievances, contractual financial requirements, delegated medical management, service and quality (see Provider Oversight). The PPG scorecard brings these together in a 360-degree view of performance through an executive dashboard format, with the goal of helping ensure that delegated PPGs are meeting or exceeding standards. The resulting performance management process is governed by the Health Net Delegation Oversight Committee.

The PPG Performance Scorecard is used to:

- Ensure transparency in performance.
- Jointly identify opportunities to improve performance and commit to developing performance improvement plans that are regularly reviewed at joint operation meetings (JOMs) and regular meetings.
- Ensure performance exceeds minimum performance standards.
- Serve as a catalyst for corrective action and improvement plans.
- Align performance to performance standards, penalties and rewards outlined in PPG contracts.

Dissemination of scorecard results

PPGs will receive individualized scorecard results electronically on a quarterly basis via JOMs. Results, opportunities and actions are reviewed in JOMs and workgroups for PPGs with minimum membership thresholds.

Performance scoring

PPG performance is measured in seven key performance areas (PDF) including quality, delegation oversight utilization management (UM), delegation oversight claims, risk adjustment, financial solvency, network and encounters. Multiple measures are compiled and calculated by performance area. Findings are weighted by membership to form the performance score, defined through the following scale:

- 80% or greater: Performing – meeting/exceeding performance targets.
- 50-79%: Monitoring – inconsistently meeting performance targets.
- Less than 50%: Below standard – consistently below performance targets.

Sample Scorecard and Performance Improvement Resources

Sample Scorecard (PDF)

The PPG Performance Scorecard highlights performance improvement opportunities across seven domains. To learn more about how PPGs can improve their performance scores, explore the following helpful resources:

Quality Improvement and HEDIS Information

- HEDIS Measures & Billing Codes
- Provider Quality Improvement Tools

CAHPS Provider Resources

- Improve CAHPS® Results and Patient Experience – Health Net (PDF)
- Improve CAHPS® Results and Patient Experience – CalViva Health (PDF)

Provider Appointment Availability Survey (PAAS):

- Access to Care and Availability Standards – Medi-Cal
- Access to Care and Availability Standards – Commercial
- Access to Care and Availability Standards – Medicare
- Timely Access to Care Training

Encounter Improvement: Integrated Healthcare Association Encounter Data Resource Hub

Performance Management

Continued low performance may result in a corrective action plan (CAP), with expectation of improvement within a specified time-period. If performance does not improve as expected and/or as agreed, an escalation process may be activated. If necessary, formal action may be taken, which may include, but is not limited to, the following:

- Request for formal corrective action.
- A reduction in capitation.
- A freeze on enrollment.
- Revocation of delegation.
- Contract termination.

All actions taken are subject to the terms of the PPG contract.

Webinar and Training

2023 PPG Performance Scorecard Training (PDF) – A self-guided, on demand training that:

- Explains why the PPG Scorecard is being rolled out, and how it will benefit PPGs.
- Shows how the PPG Scorecard will look, how it will be distributed, and how it will be used in addition to existing performance reporting.
- Describes the seven PPG Scorecard Performance Measure areas: what's being measured, how scores are determined, and how PPGs can use this information to make focused improvements.

Public Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Select any subject below:

- AIDS Waiver Program
- California Children's Services
- DDS-Administered Home and Community Based Services (HCBS) Waiver
- Definitions
- Early Start Program
- EPSDT / Medi-Cal for Kids & Teens Services
- Home and Community Based Waiver
- Local Education Agency Services
- Long-Term Services and Supports
- Mental Health
- Regional Center Coordination
- Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
- Sexually Transmitted Infections (STIs)
- Tuberculosis Detection and Treatment
- WIC

Medi-Cal Waiver Program (formerly AIDS Waiver Program)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Medi-Cal Waiver Program (MCWP), formerly known as the AIDS Waiver, provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their primary care provider, family, caregivers, and other service providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution. The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care;
- Increase coordination among service providers and eliminate duplication of services;
- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and,
- Enhance utilization of the program by underserved populations.

Clients eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an “Aid Code" with full benefits and not enrolled in the Program of All-Inclusive

Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Care Management

The California Department of Public Health's (CDPH's) Medi-Cal Waiver Program agencies provide services only in non-institutional settings. The home is the most common place of service. The CDPH contracting agencies are responsible for administering the program, providing nurse care management, and authorizing payment to Medi-Cal Waiver Program services subcontractors.

The CDPH's Office of AIDS contracts with agencies throughout California to administer the Medi-Cal Waiver Program and provide nurse care management services. These agencies subcontract with licensed providers for program services.

CDPH's Medi-Cal Waiver Program care management team locates, coordinates and monitors services for enrollees. This includes developing a written service plan and assessing the service requirements and medical condition of the enrollee. Medi-Cal Waiver Program care management is performed by a team that includes a program nurse care manager, social worker or foster-child case-worker (if needed), attending physician, and member.

The CDPH's Medi-Cal Waiver Program care manager may authorize Medi-Cal FFS in-home skilled nursing care, attendant care, homemaker care, psychosocial counseling, equipment and minor physical adaptations to the home, Medi-Cal supplement for infants and children in foster care, non-emergency medical transportation, non-medical transportation, nutrition counseling, nutritional supplements, and home-delivered meals.

Eligibility

Members must meet the California Department of Public Health's (CDPH's) Medi-Cal Waiver Program eligibility requirements to participate through Health Net. Managed care members are not required to disenroll from Health Net in order to enroll in the Medi-Cal fee-for-service (FFS) Medi-Cal Waiver Program. To qualify, members with AIDS or symptomatic HIV disease must meet the California Department of Public Health's CDPH's criteria:

1. be Medi-Cal enrolled
2. have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disability related to the HIV disease or treatment
3. adults who are certified by the CDPH nurse case manager to be at the nursing facility level of care and score 60 or less on the cognitive and functional ability scale assessment tool
4. children under age13 who are identified by the CDPH nurse case manager as HIV/AIDS symptomatic (Note: Children who are HIV-positive must be referred to the California Children's Services (CCS) program.)
5. individuals with health status consistent with in-home services and who have home settings safe for both members and service providers

6. have exhausted other coverage, such as private health insurance for health care benefits similar to those available under the Medi-Cal Waiver Program prior to use of Medi-Cal Waiver Program services
7. must not be simultaneously enrolled in Medi-Cal hospice, but may be simultaneously enrolled in Medicare hospice
8. must not be simultaneously enrolled in the AIDS Case Management program
9. must not simultaneously receive case management services or use State Targeted Case Management Services program funds to supplement the Medi-Cal Waiver Program (MCWP)
10. must have an attending primary care physician (PCP) willing to accept full professional responsibility for the recipient's medical care

Members eligible for the CDPH Medi-Cal Waiver Program may remain enrolled in both Health Net's Two-Plan Model and Geographic Model managed care plans. Members accepted into the CDPH Medi-Cal Waiver Program are not required to disenroll from their Heath Net managed care Medi-Cal plans.

Excluded Managed-care Medications for HIV and AIDS

These medications are covered through the Medi-Cal Rx program. Providers bill the state directly for these medications under Medi-Cal Rx.

Problem Resolution

Disputes that arise between the Medi-Cal Waiver Program and Health Net or a participating provider are resolved by Health Net's Public Programs Specialists. During a dispute, the provider and the Health Net Health Services staff continue to manage the member's medical care.

Referral and Coordination of Care

The primary care physician (PCP), Health Net Health Care Services staff or both inform eligible members about the California Department of Public Health's Medi-Cal Waiver Program.

If the member believes he or she is eligible and requests program referral, the type of supportive care needed is identified and the Health Net Health Care Services or Public Program's staff initiates a referral.

The California Department of Public Health's Office of AIDS conducts the assessment of the member based on the CDPH's Medi-Cal Waiver Program criteria for enrollment eligibility.

With the member's consent, the PCP or the Health Net Health Care Services staff, if requested, forwards any available relevant medical documentation to the program, including the member's medical history, lab results and an outline of the therapeutic regimen, if a copy is in the plan's possession.

For members who elect to remain enrolled in both the plan and Medi-Cal Waiver Program, the Health Net Health Care Services staff concurrently institutes a care management plan and coordinates with the member's PCP.

The member's PCP and Health Net Health Care Services staff are responsible for developing a primary care management plan that covers all medically necessary treatment and meets the health care needs of the member diagnosed with AIDS. They are responsible for coordinating and authorizing pharmacy, inpatient services, outpatient services, infusion services, laboratory services, specialty referrals, durable medical equipment (DME), preventive care services, and respiratory care services.

If the member elects to disenroll from the plan, the Health Net Health Care Services staff contacts the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) to initiate the disenrollment. The Health Net Health Care Services staff is responsible for authorization of services and coordination of the member's medical care until the member enters the Medi-Cal Waiver program.

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

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal covers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) to members ages 11 years and older, including pregnant women. These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists, and licensed marriage and family therapists.

Screening and Behavioral Counseling

Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- 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
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referrals to Treatment

For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services.

Brief interventions must include the following:

- Providing feedback to the patient regarding screening and assessment results;
- Discussing negative consequences that have occurred and the overall severity of the problem;
- Supporting the patient in making behavioral changes; and
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

The USPSTF recommends that clinicians screen adults ages 18 or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

The following HCPCS codes may be used to bill for these services:

- G0442 - annual alcohol misuse screening, 15 minutes
- G0443 - brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Code G0442 is limited to one screening per year, any provider, unless otherwise medically necessary. Code G0443 may be billed on the same day as code G0442. Code G0443 is limited to three sessions per recipient per year, any provider, unless otherwise medically necessary.

Treatment Referral

Providers are responsible for referring members who meet criteria for alcohol and drug disorders to a county drug program for services. These services are not covered by Health Net. A list of county contacts for local substance use disorder treatment information and referrals is available on the DHCS website, under Referral to Treatment.

Documentation Requirements

Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);
- 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
- If and to where a referral to an AUD or SUD program was made.

PCPs must maintain documentation of SABIRT services provided to members. 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.

Continuous Care

Participating providers are responsible for providing services in a manner that ensures coordinated and continuous care to all members needing alcohol and drug treatment services, including timely referrals.

On receipt of a specific written request from the member, the primary care physician (PCP) must transfer requested summaries of the member's records to the substance abuse practitioner or program and to any organization where future care will be rendered. Any transfer of member medical records and other information must be done in a manner consistent with appropriate confidentiality standards.

A member receiving services under the Health Net Alcohol and Drug Treatment program remains enrolled with Health Net. The PCP and Health Net Health staff retain the responsibility for maintaining coordinated and continuous care for the member. The PCP monitors the member to ensure that follow-up care is provided as necessary.

Criteria for Referral

A number of screening instruments are available to the primary care physician (PCP) to assist in detecting substance use. Refer to samples of the Drug Use Questionnaire (PDF), Red Flags for Alcohol or Drug Abuse (PDF), T-Ace (PDF), and TWEAK Test (PDF).

Criteria for Admission to a Partial Hospital Program

A member is a candidate for admission in a partial hospital program for treatment of substance use if all the following criteria are met:

- A clearly documented pattern of substance use or dependence that meets current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in activities of daily living.

- The member is medically stable enough that the criteria for inpatient detoxification services are not met.
- The member requires up to eight hours of structured treatment per day in order to obtain the most benefit from coordinated services, such as individual, group or family therapy, education, or medical supervision.
- The member's living situation and social support system are sufficiently stable to allow for treatment in this care setting.
- There is evidence of sufficient motivation for successful participation in treatment in this care setting.
- The member has demonstrated, or there is reason to believe, that he or shee can avoid the use of substances between treatment sessions based on an assessment of such factors as intensity of cravings, impulse control, judgment, and pattern of use.

Criteria for Admission to a Residential Facility

A member is a candidate for referral for admission to a residential facility for the treatment of substance use if all the following are present:

- A clearly documented pattern of substance use or dependence that meets the current DSM criteria and is severe enough to interfere markedly with social and occupational functioning and cause significant impairment in activities of daily living.
- The member is medically stable enough that the criteria for inpatient detoxification services are not met.
- There is clearly documented evidence of the failure of partial hospital or structured outpatient treatment for substance use or dependence meeting the current DSM criteria.
- The member's living situation is severely impaired as a result of inadequate or unstable support systems, including the work environment, that may jeopardize successful outpatient treatment.
- There is significant risk of relapse if the member is treated in a less restrictive care setting related to severely impaired impulse control or a co-morbid disorder.
- Pregnant and postpartum women are eligible to receive substance use services through certified perinatal programs. Women are eligible during the term of pregnancy and for a period of up to 60 days after delivery.

Criteria for Admission to a Structured Outpatient Program

A member is a candidate for referral for admission to a structured outpatient program for the treatment of substance use if all the following are present:

- A clearly documented pattern of substance use or dependence that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and cause significant impairment in activities of daily living.
- The member is medically stable enough that the criteria for inpatient detoxification services are not met.
- The member requires up to four hours of structured treatment per day in order to obtain the most benefit from coordinated services, such as individual, group or family therapy, education, or medical supervision.

- The member's living situation and social support system are sufficiently stable to allow for structured outpatient treatment at this level of care.
- There is evidence of sufficient motivation for successful participation in treatment at this level of care.
- The member has demonstrated, or there is reason to believe, that he or she can avoid the use of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment, and pattern of use.

Criteria for Inpatient Detoxification

A member is a candidate for acute inpatient detoxification if symptoms are present that suggest that the failure to use this level of treatment would be life threatening or cause permanent impairment once substance use has stopped. All of the following must be present:

- Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions
- 24-hour nursing care with close and frequent observation and monitoring of vital signs
- Medical therapy, which is supervised and re-evaluated daily by the attending physician in order to stabilize the member's physical condition
- At least two of the following symptoms of substance withdrawal:
    - tachycardia
    - hypertension
    - diaphoresis
    - significant increase or decrease in psychomotor activity
    - tremor
    - significantly disturbed sleep patterns
    - nausea or vomiting
    - clouding of consciousness with reduced capacity to shift, focus and sustain attention

Referral Documentation

Participating providers are responsible for performing all preliminary testing and procedures necessary to develop a diagnosis. Referrals to Drug Medi-Cal (D/MC) or Fee-for-Service Medi-Cal (FFS/MC) programs must include the appropriate medical records supporting the diagnosis and additional documentation. The referring provider must obtain a signed release from the member prior to making the referral.

The final decision on the acceptance of a member for FFS/MC or D/MC services (authorization of the referral) rests solely with the county alcohol and drug program.

Treatment Services

The alcohol and drug treatment services covered by the Drug Medi-Cal (D/MC) program include:

- Outpatient heroin detoxification services.
- Outpatient methadone maintenance services.
- Outpatient drug-free treatment services.
- Day care habilitative services.

- Perinatal residential substance use services.

Voluntary Inpatient Detoxification

Voluntary inpatient detoxification (VID) is a Medi-Cal fee-for-service (FFS) benefit. VID services are excluded from Health Net's coverage responsibilities and are the responsibility of the Medi-Cal FFS program. Health Net members receiving VID services remain enrolled with Health Net and primary care physicians (PCPs) remain responsible for coordinating ongoing care and services unrelated to VID.

Participating providers must refer members to a VID provider in a general acute care hospital. VID services require authorization. It is the VID provider's responsibility to submit the Treatment Authorization Request (TAR) to the local Medi-Cal field office for approval.

Health Net Medi-Cal members who meet medical necessity criteria may receive VID services in a general acute care hospital. To receive VID services, a member must have one or more of the following:

- Delirium tremens with any combination of the below clinical manifestations with cessation or reduced intake of alcohol or sedative:
  - hallucinations
  - disorientation
  - tachycardia
  - hypertension
  - fever
  - agitation
  - diaphoresis
- A score greater than 15 on the Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) form.
- Alcohol or sedative withdrawal with CIWA score greater than 8 and one or more of the following high-risk factors:
  - multiple substance abuse
  - history of delirium tremens
  - unable to receive the necessary medical assessment, monitoring and treatment in a setting with a lower level of care
  - medical comorbidities that make detoxification in an outpatient setting unsafe
  - history of failed outpatient treatment
  - psychiatric comorbidities
  - pregnancy
  - history of seizure disorder or withdrawal seizures
- Complication of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following:
  - persistent vomiting and diarrhea from opioid withdrawal
  - dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care

California Children's Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The California Children's Services (CCS) program provides specialized medical care, rehabilitation services, and case management to children with medical or surgical conditions who meet program eligibility requirements. CCS services are delivered by paneled providers and approved tertiary medical centers in local communities who meet CCS program requirements.

CCS services are carved-out under the Medi-Cal managed care program, but the member remains enrolled with Health Net or its subcontracting health plans for the purpose of receiving primary care and services unrelated to the CCS condition. The responsibility for paying for treatment services for the CCS-eligible condition of the child enrolled in managed care rests with the CCS program rather than the health plan.

It is essential that physicians identify children with CCS-eligible conditions and arrange for their timely referral to the county CCS program. The primary care physician (PCP) provides a complete baseline health assessment and diagnostic evaluations sufficient to ascertain evidence or suspicion of a CCS-eligible condition. The PCP remains responsible for the complete health care of the member until CCS program eligibility is determined.

Once CCS eligibility has been established, the CCS program assumes case management responsibilities, including prior authorization of, and payment for, all services related to the CCS-eligible condition. The PCP remains responsible for providing primary care services to the member, including coordination with CCS and specialists to ensure continuity of care.

CCS does not pay for services provided before the date of referral, even though the child may have a CCS-eligible condition, except for children with full-scope Medi-Cal and emergency services or services rendered after hours. For Medi-Cal retroactive payment, services must have been provided by a CCS-paneled provider in a CCS-approved facility. Referrals for emergency or after-hours care must be made to the county CCS program on the next business day and must include documentation substantiating necessity for emergency or urgent care.

For more information, select any subject below:

- Billing Inpatient Services for Members with CCS-Eligible Conditions
- CCS Application and Service Agreement Forms
- CCS Eligibility Determination
- CCS Eligible Conditions
- CCS Program Agreement
- CCS Program Eligibility
- CCS Service Authorization Request (SAR) established client
- CCS Service Authorization Request (SAR) - New client
- Definitions
- Problem Resolution
- Program Components
- Referral to CCS
- Request for Services
- Tracking and Coordination of Care

Billing Inpatient Services for Members with CCS-Eligible Conditions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Inpatient services at private hospitals and non-designated public hospitals for Medi-Cal members who have California Children's Services (CCS)-eligible conditions are reimbursed using diagnosis-related group (DRG) methodology, which reimburses hospitals for the member's entire stay, with payments based on acuity and not length of stay.

Inpatient services at designated public hospitals (DPHs) are reimbursed based on the applicable DPH Medi-Cal inpatient interim per diem rate.

Billing policies

1. For days of service during an inpatient hospital stay, the following benefits apply for services provided to Plan Medi-Cal members with a CCS-eligible condition: If the member is admitted to the hospital for a CCS-eligible condition, the entire stay will require a CCS SAR from the date of admission and is to be billed by the hospital to Medi-Cal Fee For Service (FFS), regardless of whether any services provided during that stay are Medi-Cal covered services. NOTE: The hospital will receive one payment for the entire stay based on Medi-Cal's FFS DRG for that stay. Hospitals are disallowed from billing the Plan (APL16-008).
2. If the member is admitted to the hospital for a non-CCS-eligible condition, and subsequently receives services during the stay for a CCS-eligible condition, the entire stay will require a CCS SAR from the date of admission and is to be billed to Medi-Cal FFS. The full stay is to be billed to Medi-Cal FFS. NOTE: DHCS advises that a SAR will be authorized back to the day of admission. The hospital will receive one payment for the entire stay based on the Medi-Cal FFS DRG for that stay. Hospitals are disallowed from billing the Plan (APL 16-008).
3. When a member's stay includes delivery and well-baby coverage, the entire claim is the responsibility of the Plan. If, during the stay, a CCS-eligible condition is identified, the entire stay for the baby will require a CCS SAR from the date of admission and is to be billed to Medi-Cal FFS. The Plan is not to be billed for the baby's CCS-eligible condition stay. In this case, the hospital will receive two payments: one (1) for the delivery and well-baby stay from the Plan, and one (1) for the baby under the Medi-Cal FFS DRG.

CCS Application and Service Agreement Forms

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A signed Application to Determine CCS Program Eligibility (PDF) on file with the California Children's Services (CCS) program provides a legal right to appeal if services are denied by the CCS program.

CCS and Health Net strongly recommend that the CCS application and service agreement be completed to ensure that the member receives CCS program benefits. If the application is on file with CCS, the member may continue to receive services through CCS even if the member loses plan eligibility.

CCS Eligibility Determination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

On referral, the California Children's Services (CCS) program determines whether there is an eligible condition, whether the family is financially eligible, and whether the child is a resident of the county in which the member has applied for services. If eligibility for the program is established, the client, parent or legal guardian signs a CCS program agreement.

Financial eligibility requirements are assumed to be satisfied for Health Net's Medi-Cal members.

CCS Service Authorization Request (SAR)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

California Children's Services (CCS) sends an authorization to the CCS-paneled provider indicating that the provider may deliver the services approved for treatment of the CCS-eligible condition. The provider is reimbursed at a fee-for-service (FFS) rate. A separate service authorization request (SAR) - established client (PDF) must be obtained by the hospital and provider for each hospitalization.

For new client referrals, use the service authorization request (SAR) - new client (PDF)

CCS Program Agreement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The California Children's Services (CCS) program agreement is a consent form that indicates the family's willingness to abide by CCS program policies and procedures and offers recipients the full range of CCS program benefits.

CCS Program Eligibility

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The California Children's Services (CCS) program is open to a member who:

- Are under age 21.
- Have a physical limitation or disease that is covered by CCS.
- Are residents of California and apply in the county of residence.
- Have a family income of either:
  - Less than $40,000 reported as adjusted gross income on the state tax form.
  - More than $40,000 reported as adjusted gross income on the state tax form, but out-of-pocket costs of care for the CCS-eligible condition are expected to exceed 20 percent of the family's adjusted gross income.

Problem Resolution

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

County California Children's Services (CCS) program staff determine medical eligibility, limit authorization to CCS-paneled providers, review proposed treatment plans to determine necessity, and authorize services. Problems that arise involving the CCS program, Health Net, the participating physician group (PPG), and the primary care physician (PCP) are resolved by Health Net's public programs administrators. During any problem periods, the Health Net Health Services staff and the PCP or specialty physician continue to coordinate the medical care of the member.

The Health Net public programs administrators produce monthly CCS Reconciliation Reports to assist in tracking CCS referrals and active cases for coordination. They also meet routinely with CCS liaisons to identify and resolve areas of procedural concern on a local level and exchange client and provider listings and program and policy updates. The public programs administrators also collaborate with the local CCS programs to provide educational opportunities to participating providers.

Program Components

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Diagnosis and Treatment Program

The Diagnosis and Treatment Program provides medically necessary care and case management for infants, children and adolescents meeting program eligibility requirements. This care is delivered by California Children's Services (CCS)-paneled providers who meet program standards in tertiary care medical centers and in local communities.

High-Risk Infant Follow-Up Program

The High-Risk Infant Follow-up (HRIF) program provides outpatient services to infants who meet the CCS medical eligibility criteria for CCS-approved neonatal intensive care unit (NICU), or had a CCS-eligible medical condition during their stay in a CCS approved NICU, even if they were never CCS clients during their NICU stay. These services include comprehensive history and physical examination, including neurological and developmental assessment, ophthalmological and audiological evaluations, and family psychosocial and home assessment, including coordination of HRIF services during the first three years of life.

HIV Children's Screening Program

The Department of Health Care Services (DHCS) Office of AIDS provides funding for the California Children's Services (CCS) HIV Children's Screening Program. CCS issues authorization to a CCS-approved Infectious Disease Immunology Disease Special Care Center (IDID SCC) for outpatient diagnostic services for infants and children under age of 21 who are at risk for HIV infection. Authorizations for diagnostic services are not to exceed six months.

Medical Therapy Program

Local California Children's Services (CCS) programs deliver Medical Therapy Program (MTP) services to children with cerebral palsy and other neuromuscular conditions. MTP provides medically necessary physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services to children who are medically eligible for the program. A medical therapy unit (MTU) team performs examinations and prescribes PT, OT, durable medical equipment (DME), and any other necessary medical interventions required to treat the child's CCS-eligible diagnosis. MTUs are located at select public schools as part of an interagency agreement with the California Department of Education.

Newborn and Infant Hearing Screening Program

The Newborn and Infant Hearing Screening Program offers hearing screening to all infants delivered in California Children's Services (CCS)-approved hospitals and CCS-approved neonatal intensive care units (NICUs) prior to the infant's discharge. Infants identified through the Newborn and Infant Hearing Screening Program who need diagnostic or treatment services are referred for health care and support services. Infants eligible for the CCS program are referred to CCS-approved Communication Disorder Centers for audiological services.

Orthodontic Screening Program

Orthodontic services are a benefit of the California Children's Services (CCS) program for children with severe malocclusion if evaluated by CCS-paneled orthodontists and determined to be medically eligible for orthodontic services as defined by CCS.

Referral to CCS

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The California Children's Services (CCS) program accepts referrals for eligibility determination from any source (for example, specialist, teacher or parents). Providers may use the California Children's Services Referral form (PDF). Completed forms may be submitted via mail or fax to CCS. Los Angeles (LA) county also requires the LA County CCS Fax Cover Sheet (PDF) when submitting a CCS referral.

A new referral may be sent on a New Referral CCS/GHPP Client Service Authorization Request (SAR)form or in a letter including all of the following information:

- Member's name.
- Member's date of birth.
- Name, address and phone number of the parent or legal guardian.
- Medical condition.
- Description of services/procedures being requested.
- Name of CCS-paneled provider and phone number.
- Name, address and phone number of the referral source.

Primary care physicians (PCPs), specialists and participating physicians group (PPG) staff must refer potentially eligible children to CCS within 24 hours of identification and inform the parent or legal guardian. Hospitals must refer potentially eligible children to CCS within 24 hours of inpatient admission and inform the parent or legal guardian of the referral to the CCS program.

Referrals to CCS must include:

- Completed CCS SAR form or letter with required information.
- Medical history with sufficient medical information to ascertain the evidence or suspicion of a CCS-eligible condition.
- Recent medical records pertaining to eligible diagnosis or condition.
- Description of services being requested.
- Name of CCS-paneled provider who will perform the requested services (if known).
- Name and phone number of the referral source.
- Completed CCS Application for Service form (if available at the physician's office at the time of referral).

Providers referring a member that has an existing case with CCS should make a new referral using the Established CCS-GHPP Client SAR (PDF). If the member has a closed case, providers should make a new referral using the New Referral CCS/GHPP Client Service Authorization Request (SAR) (ca.gov)

The following are examples of the type of medical documentation that should be included with the CCS referral for some various diagnoses:

- Cerebral palsy - Detailed medical reports documenting the findings from a complete physical and neurological exam.
- HIV infection - Laboratory test results.
- Lead poisoning - Documentation confirming a blood level of 20 micrograms per deciliter or above.
- Scoliosis - X-ray reports showing a curvature of the spine greater than 20 degrees.

On receipt of a referral, the county CCS program sends a CCS program application and service agreement to the family.

Request for Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The California Children's Services (CCS) program reviews the request for services and determines medical necessity. All services, except emergency and after-hour services, require prior authorization New Referral CCS/GHPP Client Service Authorization Request (SAR). If treatment for the CCS-eligible condition or for an associated complication is found to be medically necessary, the CCS program issues an authorization.

Tracking and Coordination of Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers are required to develop a procedure for tracking California Children's Services (CCS) program referrals and submit a monthly report to the Health Net Delegation Oversight Department. Health Net is available to work with participating providers and care managers to facilitate referrals to CCS and continuity of care as needed.

CCS Eligible Conditions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medical conditions referred to California Children's Services (CCS) are subject to review under the CCS Medical Eligibility Regulations,Title 22 California Code of Regulations: Division 2, Part 2, Subdivision 7, CCS Chapter 3, Article 2, Medical Eligibility Sections 41515.2 – 41518.9. The categorical summaries of eligible conditions in these materials are merely guides for participating providers to use in identifying potential CCS-eligible conditions.

Accidents, Poisonings, Violence, and Immunization Reactions

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Injuries to organ systems or organs that, if left untreated, are likely to result in permanent physical disability, permanent loss of function, severe disfigurement, or death.
- Fractures of the spine, pelvis or femur.
- Skull fractures that, if left untreated, would result in central nervous system complications or severe disfigurement.
- All other fractures that require open reduction or internal fixation or that involve the joints or growth plates.
- Burns, when at least one of the following is present:
    - Second- and third-degree burns to more than 10 percent of the body surface area in children younger than age 10.
    - Second- and third-degree burns to more than 20 percent of the body surface area in children older than age 10.
    - Third-degree burns to more than five percent of the body surface area for any age group.
    - Burns involving signs or symptoms of inhalation injury or causing respiratory distress
    - Second- or third-degree burns to the face, ear, mouth and throat, genitalia, perineum, major joints, hands, or feet.
    - Electrical injury or burns, including burns caused by lightning.
- Presence of a foreign body when the object, if not surgically removed, would result in death or a permanent limitation or compromise of a body function.
- Ingestion of drugs or poisons that result in life-threatening events and require inpatient hospital treatment.
- Lead poisoning, defined as a confirmed blood level of 20 micrograms per deciliter or above.
- Poisonous snake bites that require complex medical management and that may result in severe disfigurement, permanent disability or death.
- Other envenomation, such spider bites, that require complex medical management and that may result in severe disfigurement, permanent disability or death.
- Severe adverse reactions to an immunization requiring extensive medical care.

Congenital Anomalies

California Children's Services (CCS) applicants with congenital anomalies are medically eligible for participation in the CCS program when the congenital anomaly is amenable to cure, correction or amelioration and one of the following:

- Anomaly limits or compromises a body function based on a combination of factors, such as its size, type and location.
- Anomaly is severely disfiguring.

The following conditions are not medically eligible for the CCS program when the application for eligibility is based solely on their presence:

- Inguinal and umbilical hernia.
- Hydrocele.
- Unilateral undescended testicle.

Diseases of Blood and Blood-Forming Organs

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Anemias due to abnormal production of red cells or hemoglobin.
- Anemias resulting solely from a nutritional deficiency, such as inadequate intake of iron, folic acid or Vitamin B-12 are eligible only when they present life-threatening complications.
- Hemolytic anemia, such as congenital spherocytosis, sickle cell disease, thalassemia, and erythroblastosis fetalis.
- Hemolytic anemias resulting from infection are eligible only when they present with life-threatening complications.
- Pancytopenia, such as congenital and acquired aplastic anemia.
- Disorders of leukocytes, such as acquired and congenital neutropenia and chronic granulomatous disease.
- Hemorrhagic diseases due to:
    - Coagulation disorders, such as hemophilia and von Willebrand disease.
    - Disorders of platelets that are life-threatening.
- Other disorders of blood and blood-forming organs that are life-threatening, such as polycythemia, hypersplenism and hypercoagulable states.

Diseases of the Circulatory System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Diseases of the endocardium, myocardium or pericardium.
- Cardiac dysrhythmias requiring medical or surgical intervention.
- Diseases of blood vessels, such as embolism, thrombosis, aneurysms, and periarteritis.
- Cerebral and subarachnoid hemorrhage.
- Chronic diseases of the lymphatic system.
- Primary hypertension that requires medication to control.
- Congenital anomalies of the circulatory system that meet the criteria of Congenital Anomalies.

Diseases of the Digestive System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Diseases of the liver, including:
    - Acute liver failure.
    - Chronic liver disease.

- Disorders of the gastrointestinal tract, including:
  - Chronic inflammatory diseases requiring complex ongoing medical management or surgical intervention, such as pancreatitis, peptic ulcer, ulcerative colitis, regional enteritis, diverticulitis, and cholecystitis.
  - Chronic intestinal failure.
- Gastroesophageal reflux when:
  - It is part of or complicates the management of a CCS-eligible condition.
  - It is an isolated condition with complications such as esophageal stricture or chronic aspiration pneumonia.
- Congenital anomalies of the digestive system that meet the criteria under Congenital Anomalies.

Diseases of the Ear and Mastoid Process

California Children's Services (CCS) applicants are eligible for participation in the CCS program for diagnostic services to determine the presence of a hearing loss when one of the following occurs:

- The applicant fails two pure tone audiometric hearing screening tests performed at least six weeks apart at levels not to exceed 25 decibels and at the minimum number of frequencies of 1,000, 2,000 and 4,000 hertz.
  - If this test is performed by an audiologist or otolaryngologist, only one exam is required for eligibility for diagnostic testing.
- The applicant fails to have normal auditory brain stem-evoked response.
- The applicant fails to have otoacoustic emission or behavioral responses to auditory stimuli as determined by two tests performed at least six weeks apart.
  - If this test is performed by an audiologist or otolaryngologist, only one exam is required for eligibility for diagnostic testing.
- The applicant fails to pass hearing screening provided through the Newborn and Infant Hearing Screening, Tracking and Intervention Program.
- The applicant exhibits symptoms that may indicate a hearing loss, such as poor speech for age or delay in age-specific behavioral milestones.
- The applicant has documentation of one of the risk factors associated with a sensorineural hearing or conductive hearing loss, such as:
  - A family history of congenital or childhood onset of hearing impairment.
  - Congenital infection known or suspected to be associated with hearing loss.
  - Craniofacial anomalies.
  - Hyperbilirubinemia at a level exceeding the indication for an exchange transfusion.
  - Ototoxic medications used for more than five days.
  - Bacterial meningitis.
- The applicant has severe depression at birth, defined as one of the following:
  - Apgar score of three or less.
  - Failure to initiate spontaneous respirations by ten minutes of age.
  - Hypotonia persisting to two hours of age.
- The applicant fails prolonged mechanical ventilation for the duration of at least 10 days.
- There is a finding of a syndrome known to be associated with hearing loss.

CCS applicants are eligible for participating in the CCS program for treatment services when one of the following is present:

- There is a hearing loss present, as defined by the following criteria:

- Children over age five, a pure tone audiometric loss of 30 decibels or greater at two or more frequencies in the same ear tested at 500,1,000, 2,000, 3,000, 4,000, 6,000, and 8,000 hertz or a loss of 40 decibels or greater at any one frequency between and including 500 through 8,000 hertz.
- Children ages three to five, a pure tone audiometric loss of 30 decibels or greater at any frequency tested at 500, 1,000, 2,000, 3,000, 4,000, 6,000, and 8,000 hertz.
- In children unable to complete a pure tone audiometric test and whose auditory brain stem evoked response, or otoacoustic emission, or behavioral responses to auditory stimuli indicate hearing loss of 30 decibels or greater.

- Perforation of the tympanic membrane that requires tympanoplasty.
- Mastoiditis.
- Cholesteatoma.
- Congenital infection known or suspected to be associated with hearing loss.
- Craniofacial anomalies.
- Congenital anomalies of the ear and mastoid process that meet the criteria for Congenital Anomalies.

Diseases of the Eye

California Children's Services (CCS) applicants with at least one of the following eye conditions are medically eligible for participation in the CCS program:

- Strabismus, when surgery is required, and either until fusion is obtained or a visibly abnormal deformity is corrected.
- Infections that produce permanent visual impairment or blindness, such as keratitis and choroditis.
- Infections that require repeated ophthalmological treatment or surgery, such as chronic dacryocystitis.
- Other diseases that can lead to permanent visual impairment, such as:
  - Cataract.
  - Glaucoma.
  - Retinal detachment.
  - Optic atrophy or hypoplasia.
  - Optic neuritis.
  - Lens dislocation.
  - Retinopathy of prematurity.
  - Persistent hyperplastic primary vitreous.
  - Ptosis.
- Congenital anomalies of the eye that meet the criteria under Congenital Anomalies.

Diseases of the Genitourinary System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Acute glomerulonephritis in the presence of acute renal failure, malignant hypertension or congestive heart failure.
- Chronic glomerulonephritis, chronic nephrosis or chronic nephrotic syndrome.
- Chronic renal insufficiency.

- Obstructive uropathies.
- Vesicoureteral reflux, grade II or higher.
- Renal calculus.
- Congenital anomalies of the genitourinary tract that meet the criteria under Congenital Anomalies.

Diseases of the Musculoskeletal System and Connective Tissue

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Acute and chronic suppurative infections of the joint.
- Chronic, progressive or recurrent inflammatory disease of the connective tissue or joints, such as rheumatoid arthritis, inflammatory polyarthropathy, lupus erythematosus, dermatomyositis, and scleroderma.
- Chronic, progressive or degenerative diseases of the muscles and fascia, such as myasthenias, myotonias, dystrophies, and atrophies that lead to atrophy, weakness, contracture and deformity, and motor disability.
- Intervertebral disc herniation.
- Scoliosis with a curvature of 20 degrees or greater.
- Other diseases of the bones and joints, except fractures, resulting in limitation of normal function and requiring surgery, complex customized bracing, or more than two castings.
- Congenital anomalies of the musculoskeletal system or connective tissue that meet the criteria under Congenital Anomalies.

Minor orthopedic conditions, such as tibial torsion, femoral anteversion, knock knees, pigeon toes, and flat feet that only require special shoes, splints or simple bracing, are not eligible.

Diseases of the Nervous System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Noninfectious diseases of the central and peripheral nervous system that produce a neurological impairment that is life threatening or disabling.
- Cerebral palsy, a non-progressive motor disorder with onset in early childhood resulting from a non-progressive lesion in the brain manifested by the presence of one or more of the following:
    - Rigidity or spasticity.
    - Hypotonia, with normal or increased deep tendon reflexes, and exaggeration of or persistence of primitive reflexes beyond the normal range.
    - Involuntary movements that are described as athetoid, choreoid or dystonic.
    - Ataxia, manifested incoordination of voluntary movement, dysdiadochokinesia, intention tremor, reeling or shaking of trunk and head, staggering or stumbling, and broad-based gait.
- Seizure disorder when either of the following occurs:
    - It is secondary to a CCS-eligible condition.
    - It is of unknown origin and one of the following exists:

- The frequency or duration of the seizures requires more than four changes in dosage or type of medications in the 12 months preceding the initial or subsequent determination of medical eligibility.
- The frequency or duration of the seizures requires three or more types of seizure medications each day.
- The frequency or duration of the seizures requires at least monthly medical office visits for assessment of the applicant's clinical status and periodic blood tests for medication levels or presence of blood dyscrasia.
- The applicant has an episode of status epilepticus, in which case medical eligibility extends for one year following that event.

- Congenital anomalies of the nervous system that meet the criteria under Congenital Anomalies.

When the eligibility criteria listed above have not been present for at least one year, eligibility ceases.

Diseases of the Respiratory System

California Children's Services (CCS) applicants with at least one of the chronic conditions of the respiratory tract, such as the following conditions, are eligible for participation in the CCS program:

- Chronic pulmonary infections, such as abscess or bronchiectasis.
- Cystic fibrosis.
- Chronic lung disease (CLD) of infancy, such as bronchopulmonary dysplasia (BPD), when one or more of the following criteria are met:
  - History of care in a neonatal intensive care unit that includes all of the following:
    - Mechanical ventilation for more than six days.
    - Concentration of oxygen greater than 60 percent for more than four of the days of ventilation.
    - Need for supplemental oxygen for more than 30 days.
  - Presence of at least one of the following in an infant:
    - Radiographic changes characteristic of CLD, such as hyperinflation, areas of radiolucency, and areas of radio density due to peribronchial thickening or patchy atelectasis.
    - Impaired pulmonary function, as manifested by one or more of the following during a stable phase: increased airway resistance, increased residual capacity, decreased dynamic compliance, arterial CO
    - Cardiovascular sequelae, such as pulmonary or systemic hypertension or right or left ventricular hypertrophy.
- Asthma, when it has produced CLD.
- Chronic disorders of the lung that are the result of chemical injury, metabolic disorders, genetic defects, or immunologic disorders other than asthma.
- Respiratory failure requiring ventilatory assistance.
- Hyaline membrane disease.
- Congenital anomalies of the respiratory system that meets the criteria under Congenital Anomalies.

Diseases of the Skin and Subcutaneous Tissues

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Persistent or progressive diseases of the skin or subcutaneous tissue, such as pemphigus and epidermolysis bullosa, which:
  - Are disabling or life-threatening.
  - Require multidisciplinary management.
- Scars when surgery is required and at least one of the following criteria is met:
  - There is limitation of or loss of mobility of a major joint, such as the ankle, knee, hip, wrist, elbow, or shoulder.
  - They are disabling or severely disfiguring.
- Congenital anomalies of the skin or subcutaneous tissue that meet the criteria under Congenital Anomalies.

Endocrine, Nutritional, and Metabolic Diseases and Immune Disorders

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Diseases of the pituitary, thyroid, parathyroid, thymus, and adrenal glands.
- Growth hormone deficiency (eligible without qualifiers).
- Diseases of the ovaries or testicles in which there is delayed onset of puberty, primary amenorrhea after the age of 15, sexual development prior to the age of eight, feminization of a male, or virilization of a female.
- Diseases of the pancreas resulting in pancreatic dysfunction.
- Diabetes mellitus (eligible without qualifiers).
- Diseases due to congenital or acquired immunologic deficiency manifested by life-threatening infections, as determined from medical information about the applicant's clinical course and laboratory studies.
- Inborn errors of metabolism, such as phenylketonuria, homocystinuria, galactosemia, glycogen storage disease, and maple syrup urine disease.
- Cystic fibrosis.

Infectious Diseases

California Children's Services (CCS) applicants diagnosed with at least one of the following are medically eligible for participation in the CCS program:

- Infections of the bone, such as osteomyelitis and periostitis.
- Infections of the eye when the infection, if left untreated, may result in permanent visual impairment or blindness.
- Infections of the central nervous system producing a neurological impairment that results in physical disability requiring surgery or rehabilitation services to regain or improve function, such as movement or speech, which was limited or lost as a result of the infection.
- Infections acquired in utero and for which medically necessary postnatal treatment is required, such as toxoplasmosis, cytomegalovirus infection, rubella, herpes simplex, and syphilis.
- HIV, when confirmed by laboratory tests.

Medical Eligibility for Care in a NICU

The following criteria are used to determine California Children's Services (CCS) medical eligibility for admission into a CCS-approved neonatal intensive care unit (NICU).

An infant is medically eligible for care in a CCS-approved NICU when one of the following conditions are met:

- There is the presence of a CCS-eligible medical condition.
- One of the following services is required (medical eligibility continues only for the duration needed to deliver the service):
    - Positive pressure ventilatory assistance that is invasive or non-invasive; the latter includes, but is not limited to, continuous positive airway pressure (CPAP) by nasal prongs, nasal cannula or face mask.
    - Supplemental oxygen concentration by hood of greater than or equal to 40 percent.
    - Maintenance of an umbilical arterial catheter or peripheral arterial catheter for medically necessary indications including, but not limited to, monitoring blood pressure, sampling of blood for monitoring blood gases, and exchange transfusions.
    - Maintenance of an umbilical venous catheter or other central venous catheter for medically necessary indications including, but not limited to, pressure monitoring, cardiovascular drug infusions, hypertonic solutions, and exchange transfusions.
    - Maintenance of a peripheral line for intravenous pharmacologic support of the cardiovascular system.
    - Central or peripheral hyperalimentation.
    - Chest tube.
- Two of the following services are required (medical eligibility continues only for the duration needed to deliver the services):
    - Supplemental inspired oxygen.
    - Maintenance of a peripheral intravenous line for administration of fluids, blood, blood products, or medications other than those agents used in support of the cardiovascular system.
    - Pharmacologic treatment for apnea or bradycardia episodes.
    - Tube feedings.

  Medical eligibility for CCS ceases when the infant does not have a CCS-eligible condition or no longer meets the criteria defined above.

Medical Therapy Program

There are two separate groups of children served in the California Children's Services (CCS) Medical Therapy Program.

CCS applicants with one of the following conditions are medically eligible for participation in the Medical Therapy Program:

- Cerebral palsy as specified in Diseases of the Nervous System section above.
- Neuromuscular conditions that produce muscle weakness and atrophy, such as poliomyelitus, myasthenias and muscular dystrophies.

- Chronic musculoskeletal and connective tissue diseases or deformities, such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, amputations, and contractures resulting from burns.
- Other conditions manifesting the findings listed in Diseases of the Nervous System, such as ataxias, degenerative neurological disease or other intracranial processes.

CCS applicants under age three are eligible when two or more of the following neurological findings are present:

- Exaggerations of or persistence of primitive reflexes beyond the normal age (corrected for prematurity).
- Increased deep tendon reflexes that are 3+ or greater.
- Abnormal posturing as characterized by the arms, legs, head, or trunk turned or twisted into abnormal position.
- Hypotonicity, with normal or increased deep tendon reflexes, in infants under one year of age (infants one year of age or older must meet criteria described in Diseases of the Nervous System).
- Asymmetry of neurological motor findings of trunk or extremities.

Mental Disorders and Mental Retardation

California Children's Services (CCS) applicants with a mental disorder, whose application is based on that disorder, are not medically eligible for the CCS program. CCS applicants with mental retardation, whose application is based on that condition, are not medically eligible for the CCS program.

CCS applicants with a mental disorder or mental retardation may be eligible only when the mental disorder is associated with or complicates an existing CCS-eligible condition.

Neoplasms

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- All malignant neoplasms, including leukemia.
- A benign neoplasm when either of the following is present:
  - The neoplasm is physically disabling or severely disfiguring.
  - The neoplasm is located contiguous to or within a vital organ or body part, and its continued growth or lack of treatment would limit or eliminate the function of the organ or body part or lead to the death of the applicant.

DDS-Administered Home and Community Based Services (HCBS) Waiver

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The primary goal of the Department of Developmental Services' (DDS)-administered Home and Community Based Services (HCBS) Waiver Program is to ensure consumer choice of waiver services and consumer satisfaction, and to provide safeguards necessary to ensure the health and safety of each consumer in the program. The DDS administered HCBS waiver program includes an array of services designed to support those with developmental disabilities in either a home or community-based setting as an alternative to care in a care facility for the developmentally disabled.

The DDS-administered HCBS waiver program is available to developmentally disabled persons regardless of their age. A developmental disability is defined as a disability that originates before an individual attains the age of 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual.

As of January 1, 2024, the Plan provides all Medically Necessary Covered Services for members residing in or obtaining care in an ICF/DD Home, including home services, professional services, ancillary services, and transportation services. The Plan ensures members in need of ICF/DD Home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. The Plan must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services.

Coordination of HCBS Services

Once Health Net determines a member may meet the requirements for participation in the Department of Development Services (DDS)-administered Home and Community-Based Services (HCBS) waiver program, Health Net initiates a referral. A regional center service coordinator is assigned to coordinate the waiver services. Receipt of DDS-administered HCBS services do not require a member to be disenrolled from the plan. The primary care physician (PCP) continues to provide all medically necessary covered services and coordinates the member's care. Health Net is responsible for coordinating with the regional center care manager and the PCP in the development of the member's individual service plan and individual education plan.

If the member is currently receiving services through the DDS program, Health Net coordinates services with the PCP and regional center service coordinator as needed.

If the member does not meet the criteria for the waiver program or if placement is unavailable, Health Net's PCP continues to manage the care and provide all covered medically necessary services to the member.

DDS-Administered HCBS Waiver Programs

The Department of Developmental Services (DDS) has administrative responsibility for the state's five developmental centers and 21 regional centers. DDS oversees the regional centers and administers the Home and Community Based Services (HCBS) waiver program. The DDS-administered HCBS waiver program provides specialized services in the member’s family home.

The regional center service coordinator is responsible for determining the DDS administered HCBS waiver setting that is best for the eligible developmentally disabled member. Although the regional centers provide overall care management, they are not responsible for direct medical services. During the member's participation in the DDS-administered HCBS waiver program, a Health Net participating primary care physician (PCP) continues to provide all primary care and other medically necessary services.

Eligibility

To be eligible for Regional Center services, an individual must have a developmental disability that originates before 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. Developmental disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (AB 8461977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes, disabling conditions found to be closely related to mental retardation intellectual disability, but does not include other handicapping conditions that are solely physical in nature.

Problem Resolution

Regional center staff determines eligibility and are responsible for overall care management. Problems that arise between the regional center and Health Net or the primary care physician (PCP) are resolved by Health Net's public programs administrators. Health Net's care manager continues to coordinate and authorize all immediate health care needs for the member in collaboration with the PCP or specialty provider until the matter is resolved.

Referrals to HCBS

Health Net coordinates referrals to the regional center when notified of a member with a potential need for supportive care and facilitates medical records from the member's primary care physician (PCP) for the Department of Developmental Services (DDS) administered Home and Community-Based Services (HCBS) waiver program.

Regional centers are nonprofit private corporations that contract with DDS to provide or coordinate the services and supports for individuals with developmental disabilities. They have offices throughout California to provide local resources to help find and access the many services available to these individuals and their families.

Definitions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

CCS liaison: California Children Services (CCS) liaison means primary point(s) of contact for the coordination of services between the contractor and county CCS program who ensure the appropriate communication and care coordination are ongoing between the contractor and county CCS program, facilitate quarterly meetings and provide updates to the county CCS program as appropriate.

The contractor must have a CCS liaison(s) that serves as the primary point(s) of contact for the coordination of services between the contractor and county CCS program to ensure the appropriate communication and care

coordination are ongoing between the contractor and county CCS program, facilitate quarterly meetings and provide updates to the county CCS program as appropriate.

CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS children.

CCS program: CCS program means a state program administered as a partnership between the county health department and the DHCS to provide medically necessary services to treat CCS-eligible conditions.

CCS provider: CCS provider means any of the following providers when used to treat members for a CCS-eligible condition:

1. A medical provider that is paneled by the CCS program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106.
2. A licensed acute care hospital approved by the CCS program.
3. A special care center approved by the CCS program.

Child/Children and Youth: Child/children and youth, regardless of whether the term is capitalized or not, means a member/members less than 21 years of age unless otherwise specified.

Children and Youth with Special Health Care Needs (CYSHCN): Children and Youth with Special Health Care Needs means children and youth who have or are at increased risk for chronic physical, developmental, behavioral or emotional condition and who also require health or related services of a type or amount beyond that required by children and youth generally. The identification, assessment, treatment and coordination of care for CYSHCN must comply with the requirements of 42 CFR Sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2)-(4).

Early Start Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

California's Department of Developmental Services' (DDS) Early Start program provides early intervention services to infants and toddlers (from birth to 36 months) who have a developmental delay or established risk or are at risk.

Developmental delay: If the child has a developmental delay of at least 25% in one or more of the following:

- Cognitive (thinking and learning)
- Expressive communication (talking and expressing self)
- Receptive communication (understanding language)
- Social and emotional (feeling, expressing, interacting)
- Adaptive (everyday living skills like eating, dressing, caring for self)
- Physical and motor development, including vision and hearing (walking, moving, seeing, and hearing)

Established Risk: If the child has an established risk condition of known cause, with a high likelihood of delayed development. Established risk conditions may include children who:

- Have genetic conditions that are associated with delays in development (e.g., Down syndrome, Fragile X syndrome, among others)
- Have fetal alcohol syndrome
- Have limited hearing, vision, or use of limbs

At risk: If the child is likely to have a developmental delay due to a number of risks that have been confirmed by a professional. At risk or high-risk conditions may include children who:

- Were born very early (less than 32 weeks gestation) and had very low birth weight
- Had extensive health problems or had long hospitalizations
- Had a prenatal exposure to drugs or alcohol
- Experienced significant birth injury Experienced neglect or abuse

Health Net identifies children under the age of 3 years who may be eligible to receive services from the DDS Early Start program and refers them accordingly.

Coordination of Care

Health Net assists primary care physicians (PCPs) and families with referrals of identified children under the age or 3 years who may be eligible to receive services from the Department of Developmental Services (DDS) Early Start program. Assistance may include contacting the local Regional Center administrative staff or the local Early Start Program by telephone or letter, or following up with the family, PCP or regional center to ensure the referral is complete and services are accessed.

Once the referral has been made, the PCP:

- Provides medically necessary covered diagnostic, preventive and treatment services identified in the individual family plan developed by the Early Start program.
- Consults and provides appropriate reports to the Early Start program intervention team
- Continues case management with assistance from the Health Net Medi-Cal Health Services Department when necessary

Identification of Conditions

Primary care physicians (PCPs) need to identify infants and toddlers (from birth to 36 months) who may benefit from services provided by the Department of Developmental Services (DDS) Early Start program.

- When determining the need to make a referral to the DDS Early Start program for intervention services, consider:

- Stability of the infant's or toddler's medical condition
- Readiness of the infant and family to benefit from services
- Need for additional assessments to document developmental delay or disability

PCP Responsibilities

Primary care physicians (PCPs) identify infants and toddlers (from birth to 36 months) who are at risk or suspected of having a developmental disability or delay through health screenings and assessments, including:

- Initial comprehensive physical evaluation for congenital abnormalities and/or treatable medical conditions.
- Developmental screening using EPSDT/Medi-Cal for Kids & Teens and/or American Academy of Pediatrics (AAP) standards. PCP also arranges for the provision of medically necessary Behavioral Health Treatment (BHT) services even without a diagnosis of Autism Spectrum Disorder (ASD). Health Net Behavioral Health Services provides the BHT services.
- Diagnosis and, if possible, etiology

PCPs are responsible for referring infants and toddlers identified as needing early intervention services to the local DDS Early Start program (administered by either the local Regional Center, education agency, or other designated agency) within two business days of determination of need. PCPs provide or arrange for all medically necessary covered services, including preventive care, referral for specialty or subspecialty consultation, and therapy services necessary to correct or ameliorate identified conditions.

Eligible infants and toddlers and their families may receive service coordination and developmental services from the local Regional Center or education agency, depending on the condition. PCPs participate or consult with staff of the local Regional Center or local education agency (LEA) in the development of the Individual Family Service Plan (IFSP).

Problem Resolution

If Health Net or a participating provider disagrees with the recommendation of the Early Start program staff, Health Net's public programs specialists are responsible for problem resolution. The Health Net Medi-Cal Health Services Department continues to coordinate and authorize all immediate covered health care needs for the member in collaboration with the primary care physician (PCP) until the matter is resolved.

Public Programs Coordination

Health Net's Public Programs Specialists, Service Coordination Liaisons and Transition of Care Representatives are available to participate in the community Local Interagency Coordination Areas (LICA). Health Net's public programs specialists and Service Coordination Liaisons work with the Regional Centers to enhance collaboration and coordination.

Referral Coordination with California Children Services

In situations where a child is eligible for both California Children's Services (CCS) and the Department of Developmental Services' (DDS) Early Start program, the primary referral is to CCS if diagnosis or treatment for a CCS-eligible condition is the primary concern. The primary care physician (PCP) must notify CCS and the local Regional Center simultaneously if both medical and DDS Early Start program intervention services are indicated.

Referrals to Early Start Programs

Referrals to the local Department of Developmental Services (DDS) Early Start program are made through the local Regional Centers.

Federal law requires that primary care physicians (PCPs) refer children under age three identified as potentially requiring developmental intervention services for evaluation within two business days of determining the need for services. Health Net may provide either written or telephone referrals to the local Regional Center, education agency, or other locally designated agency.

Providers must provide the following services and information to the DDS Early Start program with each referral:

- Initial physical evaluations
  - A comprehensive physical examination and assessment for congenital abnormalities and treatable medical conditions
  - A review of the mother's prenatal and perinatal course to identify biomedical or environmental risks
  - Follow-up of newborn screening tests to assure normal values or initiate treatment
- Developmental screening
  - Provide developmental and behavioral assessment using Early and Periodic Screening, Diagnosis, and Treatment (EPSDT/Medi-Cal for Kids & Teens; American Academy of Pediatrics (AAP) standards; or a combination). Detection of hearing or visual sensory deficits or early developmental problems are of significant interest
- Primary preventive and pediatric care, referrals for special consultations, and therapy services
  - Periodic, comprehensive physical examinations
  - Anticipatory parental guidance (for example, health education and injury prevention advice)
  - Immunizations, lead screening and hematocrit
  - Monitoring of nutrition status
- Diagnosis and, if possible, etiology
  - Complete family history, including prenatal course and genetic pedigree
  - Comprehensive medical evaluation to determine underlying causes (including genetic conditions) and any chromosome or metabolic tests performed

EPSDT / Medi-Cal for Kids & Teens Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the provision of Medically Necessary comprehensive and preventive health care services provided to members less than 21 years of age in accordance with requirements in 42 USC section 1396(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 114132(v).

Such services may also be medically necessary to correct or ameliorate defects and physical or behavioral health conditions. All EPSDT services are covered services unless they are specifically carved out from managed care (i.e., dental services, specialty mental health services, California Children's Services).

EPSDT services, without limitation, include case management and targeted case management services designed to assist children in gaining access to necessary medical, social, education and other services, such as pediatric day health center services, cochlear implant and transportation services. This could include services that are not usually a benefit for members ages 21 and up.

Annually by January 1, Health Net mails or shares electronically DHCS' Medi-Cal for Kids & Teens brochures to existing members under age 21. For new members, Medi-Cal for Kids & Teens materials will be mailed or shared electronically within seven calendar days of enrollment. Providers are encouraged to visit the Medi-Cal for Kids & Teens website for additional information regarding EPSDT services. Additionally, all network providers are required to complete the EPSDT-specific training no less than every two years. Health Net is required to report to DHCS on providers who have completed the training and providers who are not compliant with this training requirement.

Primary care physicians (PCPs), along with delegated participating physician groups (PPGs), Molina, or Health Net, are responsible for arranging for all medically necessary EPSDT services identified at a preventive screening or other visit identifying the need for treatment. Providers are required to ensure all EPSDT services are provided in a timely manner.

Health Net's Medi-Cal Health Services staff or delegated participating physician group (PPG) works with Health Net public programs specialists, Service Coordination Liaisons and Transition of Care Representatives to monitor the appropriate use of local government organizations, including regional centers, that provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services.

If EPSDT/Medi-Cal for Kids & Teens services are not available through a local government agency or organization, Health Net's Medi-Cal Health Services staff or delegated PPG issues letters of authorization and negotiated claims payment instructions to EPSDT/Medi-Cal for Kids & Teens services providers and continues to provide care coordination services, including assistance in scheduling appointments, arranging non-medical transportation and non-emergency medical transportation to and from medical appointments, and updating the care management plan.

Health Net must ensure that appropriate EPSDT/Medi-Cal for Kids & Teens services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for a follow-up. CCS is excluded from covered services.

Documentation

The member's medical record must reflect the following for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens care management services:

- Member and family education regarding EPSDT/Medi-Cal for Kids & Teens services.
- Referral to EPSDT/Medi-Cal for Kids & Teens care management services.
- Reason for referral.
- Member or family response to referral.
- Subsequent case management plan.

Problem Resolution

Health Net's public programs specialists, service coordination liaisons and transition of care representatives resolve disputes that arise regarding responsibility for necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services. The Health Net Medi-Cal Health Services staff or delegated PPG continues to coordinate and authorize all immediate health care needs in collaboration with the primary care physician (PCP) until the matter is resolved.

Referrals

In most cases, primary care physicians (PCPs) identify members in need of Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services as part of regular health screening visits.

It is also possible that the need for services is identified by the member, the member's parents or other family, or by an encounter with another health professional. Providers must direct all referrals for EPSDT/Medi-Cal for Kids & Teens services to the Health Net Medi-Cal Health Services staff or delegated PPG, and the affiliated health plans' utilization management (UM) departments for prior authorization.

The Health Net Medi-Cal Health Services staff and Health Net Medi-Cal medical directors or delegated PPG medical directors review the request and determine medical necessity for EPSDT/Medi-Cal for Kids & Teens supplemental services.

The Health Net Medi-Cal Health Services staff and Health Net's Medi-Cal medical directors or delegated PPG medical directors review requests and determine medical necessity for EPSDT/Medi-Cal for Kids & Teens services.

Referral Coordination

PCPs and delegated PPGs are responsible for referring EPSDT/Medi-Cal for Kids & Teens-eligible members identified as needing behavioral health therapy (BHT) services, regardless of diagnosis to Health Net Behavioral Health Services for assessment and referral to a mental health provider. Health Net Behavioral Health Services and delegated PPGs coordinate the management of behavioral health benefits of Medi-Cal members. BHT services may include, but are not limited to:

- Applied behavioral analysis.
- Individual or family training.
- Client/parent support behavioral intervention training.
- Adaptive skills trainer by a qualified BHT provider.

Private Duty Nursing Case Management Requirements

The following describes the health plan’s responsibilities related to case management/care coordination services for private duty nursing (PDN) services that have been approved for Medi-Cal members under age 21 pursuant to the EPSDT benefit. The health plan, with assistance from the PPGs delegated to provide utilization management for such members, is responsible for case management requirements.

Prior authorization

PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.[1]

Submit prior authorization requests for PDN services as indicated:

Providers participating through PPGs

Providers participating through a PPG must contact their PPG, follow the PPG's prior authorization process and use the PPG's forms.

Direct Network providers

Direct Network providers must request prior authorization by completing a Request for Prior Authorization form and faxing it to the health plan Prior Authorization Department at 800-743-1655. Providers must submit clinically relevant information for medical necessity review with the prior authorization request. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References.*

For CCS-eligible conditions

When PDN services support a CCS-eligible medical condition, the provider must submit a Service Authorization Request (SAR) with clinical documentation to the local CCS program office. CCS will authorize a SAR for the requested services if medical necessity criteria are met.

Requirements

- PDN services require an authorization for all members under age 21.
    - If the PPG is delegated for utilization management, the PPG is responsible for completing the authorization.
    - If the PPG's member is receiving PDN services through CCS, CCS is responsible for the authorization.
    - Whoever completes the authorization must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.
- All members under 21 receiving PDN services must be offered case management.
- Providers must submit a referral to the health plan's Case Management Department for members under 21 receiving PDN services approved by the PPG, and for their members receiving PDN services through CCS or another entity.
- Providers can submit a referral to the health plan's Case Management Department by completing and submitting the care management referral form via email to CASHP.ACM.CMA@healthnet.com or by fax to 866-581-0540. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References.*

Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012 outlines the requirements.

The health plan and PPGs delegated for utilization management are contractually obligated to provide case management/care coordination services to members. Specifically, for Medi-Cal eligible members under age 21 who have had PDN services approved, managed care health plans are required to provide case management/care coordination, as set forth in the health plan contract, and to arrange for all approved PDN services, whether or not the health plan is financially responsible for the PDN services.[2]

PDN case management/care coordination responsibilities

When an eligible member under age 21 is approved for PDN services and requests that the health plan or delegated PPG provide case management services for those PDN services, the health plan or delegated PPG's obligations include, but are not limited to:

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled home health agencies and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible home health agencies and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
- Working with enrolled home health agencies and enrolled individual nurse providers to jointly provide PDN services to the member.

Note, members approved for PDN services by delegated PPGs are identified via the delegated PPG's monthly utilization management Authorization Request (AR) source data log submission. Fifteen days post log submission, the list of approved members is provided to the health plan's Case Management Department to monitor care coordination.

Members may choose not to use all approved PDN service hours, and health plans and delegated PPGs are permitted to respect the member's choice. The member's record must document instances when a member chooses not to use approved PDN services.

Compliant policies and procedures

Delegated PPGs' policies and procedures must meet APL 20-012 requirements and either be submitted to the health plan or be made available to the health plan upon request. Such policies and procedures must be consistent with the section below about monitoring and oversight of delegated PPGs.

Monitoring and oversight of delegated PPGs

The health plan's Delegation Oversight Department will monitor and evaluate your compliance to all requirements through the health plan's annual compliance audit in the following areas:

Review of EPSDT policies and procedures including:

- Approval of services that are medically necessary for EPSDT eligible members.
- Communicating the approval duration/number of approved services/hours if applicable.
- Assisting the health plan Case Management Department with case management and care coordination services for EPSDT members regardless of financial responsibility for services approved. If the PPG was not the entity to approve the services, the PPG is still required to assist with the provision of case management services as needed or requested by the member.

- Refer members for whom PDN services have been approved or for whom the PPG is aware have been approved by another entity (such as CCS) to the health plan's Case Management Department to monitor care coordination.

Review of procedures for assisting the health plan's Case Management Department with requests for PDN services including:

- Validation that the home health agency/provider of PDN services is enrolled as a Medi-Cal provider.
- Assisting the health plan Case Management Department with contacting home health agencies and enrolled individual nurse providers on the member's behalf.
- Arranging for all PDN service hours, as needed or requested by the member.
- Documentation of all attempts to identify PDN services for the member and the member's refusal to use all PDN hours approved.

Evidence that the PPG is actively assisting the health plan to increase the network of private duty nursing services by:

- Assisting eligible home health agencies/individual providers to enroll as Medi-Cal providers.
- Assisting the health plan Case Management Department with leveraging home health agencies and individual nurse providers (in combination if needed) to meet members' needs.
- Additional activities as identified.

[1] For more information, refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012.

[2] Acceptance of available PDN services is at the member's discretion. Members are not required to use all approved PDN service hours.

Home and Community Based Waiver

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Home and Community-Based Services (HCBS) Waiver program offers an array of services designed to support an individual in his or her home as an alternative to care in a licensed health care facility. These waivers include the In-Home Medical Care Waiver and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal for Kids & Teens Services benefit. EPSDT shift nursing is a benefit for members under the age of 21. Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment and those at risk of life-threatening occurrences, requires close coordination between Health Net and the HCBS Waiver program. By providing in-home care, this program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met.

Coordination of Care

Services provided under the HCBA Waiver program are not covered under the Plan's Managed Medi-Cal Contracts (Two-Plan and Geographic Models). The Plan maintains procedures for identifying members who may be eligible for the HCBA waiver and facilitates the referrals of these members. The Plan endeavors to

monitor and ensure the coordination of services with the HCBA Waiver and to provide all medically necessary covered services to its Medi-Cal members.

Eligibility

To qualify for potential enrollment into the HCBA waiver, members must meet the following criteria:

- Must have full-scope Medi-Cal eligibility
- Physically disabled (no age limit)
- This waiver will serve Medi-Cal beneficiaries, who in the absence of this waiver, and as a matter of medical necessity, would require care in an inpatient nursing facility (NF) providing the following types of care:

1. Nursing Facility (NF) B level of care
2. NF A level of care
3. NF Level B Pediatric Services
4. NF Subacute Services
5. NF Pediatric Subacute Services

The Health Net Population Health Department monitors and reviews all inpatient stays for proper use and to identify members who may benefit from Home and Community Based Services (HCBS) Waiver programs.

HCBS Waiver Services Available

The HCBA Waiver provides care management services to persons at risk or nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team (CMT) comprised of a nurse and social worker. The CMT coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services) and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.

Requests for waiver services can come from Medi-Cal providers, associated agencies, Medi-Cal beneficiaries, families, friends, or advocates. Upon receipt of the request for HCBA Waiver services, Waiver Agency staff will mail or email an HCBA Waiver Application Packet to the individual. Assessment for the HCBA waiver services begins after the Waiver Agency receives a completed HCBA Waiver Application.

Referrals to HCBS

The primary care physician (PCP) needs to inform the member, guardian or authorized representative about the availability of in-home care alternatives.

On consent of the member, guardian or authorized representative, the Health Net Medi-Cal Population Health Department coordinates with the inpatient facility discharge planner and care manager to refer the member to a licensed and Medi-Cal-certified home health care agency for evaluation. The home health agency care managers evaluate the member's health care needs and whether they can be met in the member's home.

Local Education Agency Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Local Education Agency (LEA) provides certain health care assessment services via school programs. LEA services may include:

- Targeted case management
- Physical and mental health evaluation
- Education and psychosocial assessments
- Health and nutrition education
- Developmental assessments
- Behavioral Health screenings and treatment services
- Behavioral Health wellness programs and services

Primary care physicians (PCPs) are encouraged to inform members of these services; however, members may obtain services without a referral from their PCPs. PCPs should, whenever possible, coordinate needed medical services with LEA providers to promote continuity of care and ensure proper and timely follow-up. LEA medical services may include:

- Physical and occupational therapy
- Speech pathology and audiology
- Psychology and counseling
- Nursing services
- School health aide services
- Medical transportation
- Behavioral Health screenings and treatment
- Behavioral Health wellness programs and services

PCPs may be asked to support LEAs with the following:

- Written prescriptions for specific LEA services
- Medical evaluations or records on request
- Referrals for appropriate and necessary medical services
- Medically necessary services when school is not in session

On request, the PCP may authorize LEA providers to provide other services on a case-by-case basis.

Long-Term Services and Supports

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains member benefit and provider information on long-term services and supports (LTSS) available to Health Net Medi-Cal eligible members in California. LTSS encompasses a variety of services and supports to help members live independently.

Select any subject below:

- Community-Based Adult Services
- In-Home Supportive Services
- Multipurpose Senior Services Program (MSSP) Waiver

Community-Based Adult Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Community-Based Adult Services (CBAS) program is a community-based day care program designed to provide a variety of health, therapeutic and social services to eligible Medi-Cal members ages 18 and older. CBAS services are delivered based on need and an established care plan, offering a bundle of services during a service day. The number of days per week that members receive services is based on medical criteria and is incorporated into a Health Net-approved care plan. Services include, but are not limited to:

- skilled nursing care;
- social services;
- personal care;
- physical, occupational and speech therapy;
- family and caregiver training and support;
- meals;
- mental health services;
- transportation to and from the CBAS center.

Members who may benefit from CBAS are those with multiple complex chronic medical, cognitive or psychological conditions and functional limitations. These members require regular health monitoring, skilled nursing and therapeutic intervention, and social supports to maintain function in the community. This helps prevent avoidable emergency department or hospital admissions, or short-or long-term nursing facility admission.

CBAS is a Medi-Cal managed care benefit, and covered services are Health Net's financial responsibility. CBAS program eligibility does not affect dual-eligible (Medicare and Medi-Cal) members' Medicare coverage, Social Security benefits or the Medicare physicians they visit outside a CBAS center.

Coordination of Care

The Health Net Health Services staff and subcontractors are available to coordinate care with the member's primary care physician (PCP), the CBAS center and the multidisciplinary team. PCPs continue to provide medically necessary care and must be available to consult with the CBAS center's staff as needed.

Eligibility

Within 30 calendar days from the initial eligibility inquiry request, Health Net must conduct the CBAS-eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations shall include a face-to-face review with the member by a registered nurse with level of care determination experience for members who have not previously received CBAS through Health Net.

Medi-Cal members who have a physical, mental or social impairment occurring after age 18, and who may benefit from community-based adult services (CBAS), may be eligible. Eligible members must meet one of the following criteria:

- Needs are significant enough to meet nursing facility level of care A (NF-A) or above.
- A moderate to severe cognitive disability, including moderate to severe Alzheimer's or other dementia.
- A developmental disability.
- A mild to moderate cognitive disability, including Alzheimer's or dementia and needs assistance or supervision with two of the following:
    - bathing.
    - dressing.
    - self-feeding.
    - toileting.
    - ambulation.
    - transferring.
    - medication management.
    - hygiene.
- A chronic mental illness or brain injury and needs assistance or supervision with two of the following:
    - bathing.
    - dressing.
    - self-feeding.
    - toileting.
    - ambulation.
    - transferring.
    - medication management, or needs assistance or supervision with one from the above list and one of the following:
        - hygiene.
        - money management.
        - accessing resources.
        - meal preparation.
        - transportation.
- A reasonable expectation that preventive services will maintain or improve the present level of function (for example, in cases of brain injury due to trauma or infection).
- A high potential for further deterioration and probable institutionalization if CBAS is not available (for example, in cases of brain tumors or HIV-related dementia).

Problem Resolution

If a participating provider disagrees with the CBAS center staff's recommendation concerning provision of services, Health Net's provider engagement team can assist with dispute resolution. Refer to the Provider Appeals, Grievances and Dispute overview topic for more information about the provider appeals and dispute resolution process.

Referral Process

Participating providers, case managers, registered nurses, and licensed social workers who believe a member may benefit from the CBAS program must request a face-to-face assessment by submitting the request on the Health Net provider portal or by submitting the CBAS Treatment Request Form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF)). Health Net may forgo a face-to-face review if it is determined **that the member is clinically eligible for CBAS and needs an expedited start date.**

To submit a request for an assessment, go to the enrollee's profile and select *Assessments* . Click *Fill Out Now!* next to CBAS Treatment Request to initiate a face-to-face assessment and arrange for transportation to and from the center for assessment.

Health Net's contracted vendor completes an initial face-to-face assessment using the CBAS Eligibility Determination Tool (CEDT) to determine eligibility for CBAS. Once eligibility is validated, Health Net notifies the CBAS center to complete the evaluation of service needs and develop an Individual Plan of Care (IPC).

The CBAS center submits the evaluation and IPC, signed by all appropriate team members, to Health Net for authorization or notification of services and number of days per week. Refer to the Eligibility section above for more information about CBAS eligibility.

Prior authorization or notification is required for CBAS. Refer to Prior Authorization Requirements for additional information. For more information on how to submit a prior authorization request or notification, refer to Prior Authorization Requirements.

In-Home Supportive Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The In-Home Supportive Services (IHSS) program provides in-home care to seniors and persons with disabilities (SPD) allowing them to remain safely in their homes with as much independence as possible. IHSS include, but are not limited to:

- domestic and related services (housecleaning, meal preparation and clean up, laundry, and grocery shopping)
- personal care services (bathing, dressing, grooming)
- paramedical services (wound care, catheter care, injections)
- family and caregiver training
- accompaniment to medical appointments
- protective supervision for the mentally impaired

Members who may benefit from IHSS are those with complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short- or long-term nursing facility admission.

Members have the right to hire, fire and supervise the work of IHSS personnel rendering services to them.

IHSS, is not a managed care benefit, and services are carved out to county Departments of Social Services.

Eligibility

To qualify for enrollment in the In-Home Supportive Services (IHSS) program, Medi-Cal members must meet all of the following criteria:

- Be a resident of California.
- Have a Medi-Cal eligibility determination.
- Be age 65 or older, legally blind or disabled.
- Live at home or an abode of your own choosing (acute care hospital, long-term care facilities, and licensed community care facilities are not considered “own home”).
- Current Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient or be eligible to receive SSI/SSP.
- Be able to obtain a Health Care Certification form (SOC 873) from a licensed health care professional that indicates inability to independently perform some activity of daily living, and without IHSS, would be at risk of placement in out-of-home care.

Referral Process

Participating providers, case managers, community-based organizations, and family members who believe a member may benefit from in-home supportive services (IHSS) can contact the Health Net Member Services Department to coordinate referrals for members needing IHSS assessments.

Members potentially eligible for IHSS may also be identified through emergency room/urgent care usage, inpatient admissions, authorizations, claims, and encounter data. For additional assistance or to obtain county-specific information, providers can also contact the California Department of Social Services.

Providers must supply the completed health care certification form (SOC 873) required by the IHSS program in order to have a referral processed. If the referral comes from a source other than the member's provider, the IHSS social worker mails the SOC 873 to the member to have his or her PCP complete and return the form in order to complete the referral.

Health Net PCPs and other providers continue to render medically necessary care while the member participates in the IHSS program.

Multipurpose Senior Services Program (MSSP) Waiver

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Multipurpose Senior Services Program (MSSP) provides social and health care case management services for members ages 65 and older who wish to remain in their homes and communities. The goal of the program is to use available community services to prevent or delay institutionalization. The services must be

provided at a cost lower than that of a skilled nursing facility (SNF). MSSP services include, but are not limited to:

- environmental accessibility adaptations
- personal emergency response systems (PERSs) and communication devices
- care management
- personal care services (bathing, dressing, grooming)
- respite care (in- and out-of-home)
- adult day care, support center and health care
- housing assistance and minor home repair
- chore services
- income maintenance counseling
- mental health services
- transportation services
- protective supervision
- meal services
- communication services (translation or interpreter)

MSSP is provided by licensed MSSP sites. MSSP is not a managed care benefit.

Eligibility

To qualify for the Multipurpose Senior Services Program (MSSP), Medi-Cal members must meet all of the following criteria:

- Be age 65 or older.
- Certifiable for placement in a skilled nursing facility (SNF).
- Live in a county with an MSSP site and be within the site's service area.
- Be appropriate for care management services.
- Able to be served within MSSP's cost limitations.

MSSP is provided by licensed MSSP sites. MSSP is not a managed care benefit.

Problem Resolution

If a participating provider disagrees with the Multipurpose Senior Services Program (MSSP) decision or recommendation concerning the provision of MSSP services, Health Net's public programs specialist can assist with resolution.

Referral Process

Members who are potentially eligible for the Multipurpose Senior Services Program (MSSP) may be identified through a variety of sources, including the member's primary care physician (PCP) or specialist, community-based organizations, inpatient admissions (concurrent review), or claims and encounter data. Members may also apply for MSSP directly by calling the MSSP site directly or the Health Net Public Programs Department.

With the member's consent, Health Net provides case management information required by the MSSP. A team of health and social service professionals determine the member's eligibility for MSSP participation. The team's assessment determines the member's medical diagnosis, physical disabilities, functional abilities, psychological status, and social and physical environment. Health Net case managers continue to provide needed care coordination with the member's PCP and other community agencies pending MSSP waitlist activity.

Health Net's PCPs and other providers continue to render medically necessary care while the member participates in the MSSP.

Mental Health

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net Medi-Cal members obtain the following mental health services through Health Net:

- Non-specialty mental health services (NSMHS):
  - Mental health evaluation and treatment, including individual, group and family psychotherapy.
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
  - Outpatient services for purposes of monitoring drug therapy.
  - Psychiatric consultation.
  - Outpatient laboratory, drugs, supplies and supplements.
- Medications for Addiction Treatment (MAT), also known as medication-assisted treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

Members do not need to contact their primary care physician (PCP), participating physician group (PPG) or attending physician to request a referral for mental health care services. Health Net members may obtain these services directly through Health Net's extensive behavioral health network by calling the member services telephone number listed on their identification card (ID). Participating providers may also contact Behavioral Health Provider Services for assistance with mental health services referrals.

Prior authorization is not required for initial assessment for outpatient behavioral health services.

PCPs may refer members to marriage and family therapists, social workers, professional counselors, psychologists, and psychiatrists for services, as follows:

- Marriage and family therapists, social workers, professional counselors, and psychologists can:
  - Diagnose, treat and consult for the management of mild to moderate emotional problems for which the PCP or member feels the need for consultation.
  - Evaluate cases for which a member would benefit from psychotherapy in addition to psychotherapeutic medication.
  - Conduct psychological testing for clarification of diagnosis to establish a treatment plan (psychologists).
- Psychiatrists can:
  - Diagnose, treat and recommend a medication regimen in difficult or complex cases, including cases of depression that do not respond to a 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants.

- Evaluate cases in which members report feeling suicidal or homicidal, severe anxiety states, clear somatoform disorders, schizophrenic disorders where Clozaril® or risperidone is being considered, and bipolar disorder where lithium, carbamazepine or valproic acid may be needed.

PCPs are responsible for coordinating referrals for members requiring specialty or inpatient mental health services to county mental health plans (CMHPs) in Amador, Calaveras, Fresno, Kings, Imperial, Inyo, Los Angeles, Madera, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne. PCPs retain responsibility for coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications.

The Mental Health Services Division (MHSD) oversees CMHPs and each county is required to provide access to specialty mental health services for Medi-Cal members. Refer to the MHSD Medical Necessity Criteria document for additional information about criteria for specialty mental health services.

Excluded Psychotherapeutic Medications

Refer to the Medi-Cal Rx program for psychotherapeutic medications excluded. These medications are covered through the Medi-Cal fee-for-service (FFS) or Medi-Cal Rx program. Providers must bill the state directly for these medications.

Health Net Responsibilities

Health Net is responsible for the following:

- Monitor appropriate referral of members by primary care physicians (PCPs) through audits (specific services may be considered Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services for members under age 21).
- Monitor the availability of coordination of care services when indicated and requested by the PCP or mental health care provider.
- Provide medically necessary emergency room (ER) professional services and medical transportation services for emergency medical conditions. This includes facility charges for ER visits that do not result in a psychiatric admission and all laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a member's mental health condition.
  - Transportation for non-emergency conditions is not covered unless prior authorized. ER services for non-emergency medical conditions, services after stabilization, or an emergency medical condition require authorization.

MHSD Medical Necessity Criteria

The following Mental Health Services Division (MHSD) medical necessity criteria for specialty mental health services are the responsibility of the county mental health plan (CMHP).

Diagnosis - The member must have one of the following DSM 5-TR included diagnoses, which indicates the focus of the intervention provided:

Medical Necessary Criteria

Included diagnosis	Excluded diagnosis*
• Pervasive developmental disorders (autistic disorder excluded) • Attention deficit and disruptive behavior disorders • Feeding and eating disorders of infancy or early childhood • Elimination disorders • Other disorders of infancy, early childhood or adolescence • Schizophrenia and other psychotic disorders • Mood disorders • Anxiety disorders • Somatoform disorders • Factitious disorders • Dissociative disorders • Paraphilias • Gender identity disorder • Eating disorders • Impulse-control disorders not classified elsewhere • Adjustment disorders • Personality disorders (antisocial personality disorder excluded) • Medication-induced movement disorders	• Intellectual Disability • Learning disorders • Motor skills disorders • Communication disorders • Autistic disorders (other pervasive developmental disorders included) • Tic disorders • Delirium, dementia and amnestic and other cognitive disorders • Mental disorders due to a general medical condition • Substance-related disorders** • Sexual dysfunctions • Sleep disorders • Antisocial personality disorders • Other conditions that may be a focus of clinical attention (medication-induced movement disorders included)

*A beneficiary may receive services for an included diagnosis even if an excluded diagnosis is present.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries with an included diagnosis and a substance-related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty mental health treatment goals.

Impairment - Member must have one of the following as a result of an included mental disorder:

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning

Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

Intervention related - All three of the following must apply:

- The focus of proposed intervention is to address the condition identified in the impairment criteria identified above.
- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, or for children, it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated).
- The condition would not be responsive to physical health care-based treatment.

PCP Responsibilities and Referrals to Behavioral Health Providers

Primary care physicians (PCPs) provide outpatient mental health services within the scope of their practice. The PCP is responsible for identifying and treating, or making a specialty medical referral for, the member's general medical conditions that cause or exacerbate psychological symptoms.

If members require mental health services for mild to moderate conditions, PCPs may refer members to Health Net for assessment and referral to a mental health provider. PCPs must continue to:

- Make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition that resulted in a referral.
- Ensure the appropriate documentation is included in the member's medical record.
- Respond to requests to coordinate non-specialty mental health conditions and services with specialists.

Examples of mental health services generally considered appropriate to be provided by the PCP are:

- Complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, overeating, headaches, pains, digestive problems, altered sleep problems, and acquired sexual problems).
- Diagnosis of physical disorders with behavioral manifestation.
- Maintenance medication management after stabilization by a psychiatrist or, if longer-term psychotherapy continues, with a non-physician therapist.
- Diagnosis and case management of child, elder and dependent adult abuse and domestic violence victims.
- Coordination of psychological assessments to rule out:
    - General medical conditions as a cause of psychological symptoms.
    - Mental or substance-related disorders caused by a general medical condition.

PPG Responsibilities

Participating physician groups (PPGs) are responsible for providing the initial health history and physical assessment of members admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital.

Problem Resolution

Health Net's Service Coordination Liaisons resolve disputes that arise between the county mental health plan (CMHP) and Health Net or the primary care physician (PCP). During the dispute period, the Health Net Medi-Cal Health Services Department and the PCP or specialty provider continue to coordinate the care of the member until the matter is resolved.

Referral Process to Specialty Mental Health

The need for referral for specialty mental health services is determined by the primary care physician's (PCP's) evaluation of the member's medical history, psychosocial history, current state of health, and any request for such services from either the member or the member's family. Once the determination has been made to refer the member for specialty mental health services, PCPs may do one of the following based on the member's level of mental health impairment:

- For members with mild to moderate impairment, providers may contact Behavioral Health Provider Services for assistance.
- For Health Net members assigned to Molina with mild to moderate impairment, refer to the Molina Behavioral Health Services Line.
- For all Medi-Cal members with a severe level of impairment, refer to the county mental health plan (CMHP) for specialty mental health services (SMHS). Providers may also refer directly to the CMHP.

Refer to the Mental Health Services Division (MHSD) Medical Necessity Criteria in the section above for included and excluded diagnoses and information on when to refer to the CMHP.

Members may self-refer for behavioral health services by calling the member services phone number listed on their identification card (ID). Health Net members assigned to Molina may also self-refer by calling the member services phone number listed on their ID card.

Specialty Mental Health Services

Specialty mental health services covered by county mental health plans (CMHPs) include:

- Outpatient services
  - Mental health services, including assessments, plan development, therapy and rehabilitation
  - Medication support
  - Day treatment services and day rehabilitation
  - Crisis intervention and stabilization
  - Targeted case management
  - Therapeutic behavior services
- Residential services
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

Refer to the Mental Health Services Division (MHSD) Medical Necessity Criteria discussion above for additional information.

No Wrong Door Policy for Mental Health Services

This policy allows members who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the member is transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, members may receive coordinated, non-duplicative services in multiple delivery systems, such as when a member has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

Health Net provides or arranges for the provision of the following:

- Non-specialty mental health services (NSMHS):
  - Mental health evaluation and treatment, including individual, group and family psychotherapy.
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
  - Outpatient services for purposes of monitoring drug therapy.
  - Psychiatric consultation.
  - Outpatient laboratory, drugs, supplies and supplements.
- Medications for Addiction Treatment (MAT), also known as medication-assisted treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

NSMHS listed above applies to the following populations:

- Members ages 21 and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders.
- Members under age 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis.
- Members of any age with potential mental health disorders not yet diagnosed.

Consistent with W&I Code section 14184.402(f), clinically appropriate NSMHS are covered by Health Net even when:

1. **Services provided during the assessment period prior to a determination of a diagnosis, during the assessment period or prior to determination of whether NSMHS criteria are met.** Health Net and county mental health plan (MHPs) will not deny or disallow reimbursement for NSMHS provided during the assessment process described above if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS.
2. **Services not included in an individual treatment plan.**
3. **The member has a co-occurring mental health condition and substance use disorder (SUD)**. Health Net and CMHP will not deny or disallow reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, Health Net covers clinically appropriate SUD

services delivered by Health Net providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) whether or not the member has a co-occurring mental health condition. Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties cover clinically appropriate DMC/DMC-ODS services delivered by DMC/DMC-ODS providers, respectively, whether or not the member has a co-occurring mental health condition.

4. **Concurrent NSMHS and SMHS.** Members may concurrently receive NSMHS from a Health Net provider and SMHS via a CMHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. Health Net and CMHP will not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services.

Any concurrent NSMHS and SMHS for adults and children under ages 21, will be coordinated between Health Net and the local CMHP to ensure member choice. Health Net will coordinate with local CMHP to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process.

- Members with established therapeutic relationships with a Health Net provider may continue receiving NSMHS from the Health Net provider (billed to Health Net), even if the member simultaneously receives SMHS from a CMHP provider (billed to the CMHP), as long as the services are coordinated between the delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).
- Members with established therapeutic relationships with a CMHP provider may continue receiving SMHS from the CMHP provider (billed to the CMHP), even if the member simultaneously receives NSMHS from a Health Net provider (billed to Health Net), as long as the services are coordinated between these delivery systems and are non-duplicative.

Screening and transition of care tools

Per APL 22-028, DHCS developed the following standardized adult and youth (under age 21) screening and transition of care tools for Medi-Cal managed care plans (MCPs) and county mental health plans to use:

- Screening tools to determine the most appropriate Medi-Cal mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or county mental health plan seeking mental health services.
- Transition of care tool to ensure Medi-Cal members receive timely and coordinated care when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment.

Regional Center Coordination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Regional centers are private, non-profit corporations under contract with the California Department of Developmental Services (DDS). Their purpose is to provide or coordinate services and support for individuals with developmental disabilities. They provide a local resource to help find, plan, access, coordinate, and monitor the services and support to individuals and their families.

Primary care physicians (PCPs) must provide eligible Medi-Cal members identified with, or suspected of having, developmental disabilities with all medically necessary screenings, primary preventive care and diagnostic and treatment services. For members at risk of parenting a child with a developmental disability, Health Net covers genetic counseling and other prenatal genetic services. PCP also arranges for the provision of medically necessary Behavioral Health Treatment (BHT) services even without a diagnosis of Autism Spectrum Disorder (ASD). Managed Health Network (MHN Inc.) provides the BHT services.

Eligibility Determination

Prior to receiving services from a regional center, a member must be eligible under one the following categories:

- Developmental disability - A developmental disability originates before an individual reaches age 18, continues, or can be expected to continue, indefinitely, and is a substantial disability. Developmental disabilities include intellectual disabilities, cerebral palsy, epilepsy, autism, and disabling conditions closely related to intellectual disabilities or requiring treatment similar to that required by people with intellectual disabilities.
- Infants and toddlers (ages 0-36 months) who are at risk of having developmental disabilities or who have a developmental delay may also qualify for the prevention program.
- Individuals at risk of parenting a child with a developmental disability may be eligible for genetic diagnosis, counseling and other preventive services.

There is no financial eligibility requirement for regional center services; however, parents are required to pay based on a sliding fee scale for out-of-home placement for children under age 18. Families are responsible for primary medical and health care for their children as well as those services normally provided to a child without disabilities. All members receiving services must be California residents and must apply to the regional center in whose catchment area they reside.

Intake and Assessment

The regional center must accept for evaluation and eligibility assessment members believed to have a developmental disability. The initial intake must be performed within 15 business days following a request for assistance. Assessment must be performed within 120 business days, or within 60 days if a delay in initiating services would have a serious, negative effect on behavioral or physical development.

Determination of regional center eligibility is the responsibility of the regional center interdisciplinary team. The interdisciplinary team must include the service coordinator, a physician and a psychologist. The assessment includes collection and review of available medical history, diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental, intellectual and adaptive levels of functioning, as well as service needs.

Primary care physicians (PCPs) must assist the regional centers in obtaining medical records, diagnostic tests and specialty consultations needed to form a complete diagnosis.

If a member is not accepted by the regional center, Health Net's Medi-Cal Health Services Department confers with the referring physician and the family and coordinates referral to the Health Net public programs administrator for resolution.

PCP Responsibilities

Primary care physicians (PCPs) provide the following services to members who are clients of a regional center:

- Refer members to specialists and sub-specialists for treatment of complex medical problems.
- Refer members to mental health care providers for diagnosis and treatment of mental health disorders outside the scope of the PCP's practice.
- Identify members under age 21, with potential or confirmed ASD and refer to contracted MHN autism service provider for evaluation or treatment.
- Refer members in need of prenatal genetic diagnostic services to state-approved prenatal diagnostic services.
- Document all activities related to the referral in the member's medical record.

Problem Resolution

Regional center staff determine eligibility and provide care management services to clients. Health Net public programs specialists and Service Coordination Liaisons resolve disputes that arise between the regional centers, Health Net and primary care physicians (PCPs). During the resolution period, Health Net's Medi-Cal Health Services Department and the PCP or specialty physician continue to manage the member's medical care.

Health Net's public programs administrators maintain routine interaction with the regional centers.

Referral Coordination with CCS

In situations where the child is eligible for both California Children's Services (CCS) and regional center services, the first referral is to CCS if diagnosis or treatment for CCS-eligible conditions is the major concern. The provider may want to notify CCS and the regional center simultaneously if both medical and early intervention services are necessary.

Referral Process

Individuals having, or suspected of having, a developmental disability may be referred to the regional center nearest the applicant's residence. Referrals from the primary care physician (PCP) are directed to the intake coordinator at the regional center and must include the reason for referral, complete medical history and physical examination, including developmental screens, the results of developmental assessments and psychological evaluations, and other diagnostic tests.

When the Health Net Medi-Cal Health Services Department or health assessment coordinators identify a member as eligible for regional center services, they contact the PCP or specialist to determine whether the member and his or her family have been informed of the available regional center services.

If a member was previously referred to or accepted by the regional center, the care manager assesses the case to determine whether further coordination services are needed. If services are no longer required, the Health Net Medi-Cal Health Services Department contacts the parent or guardian for approval to discuss the member's case with the regional center. At the request of the parent or guardian, the Health Net Medi-Cal Health Services Department may coordinate the family service plan with the regional center's case manager or service coordinator.

Regional Center Responsibilities

Regional centers are not responsible for providing direct medical or health care services, but do provide care management or service coordination for their clients, assuring health, developmental, social, and educational services throughout the lifetime of members who have a developmental disability. The following are some of the services and support provided by the regional centers:

- Information and referral
- Assessment and diagnosis
- Counseling
- Lifelong individualized planning and service coordination
- Purchase of necessary services included in the individual program plan
- Resource development
- Outreach
- Assistance in finding and using community and other resources
- Advocacy for the protection of legal, civil and service rights
- Early start program
- Genetic counseling
- Family support
- Planning, placement and monitoring for 24-hour out-of-home care
- Training and educational opportunities for individuals and families
- Community education about developmental disabilities

Sexually Transmitted Infections (STIs)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Diagnosis and treatment of sexually transmitted infections (STIs) is available to Health Net Medi-Cal members without prior authorization under Health Net's contract with the Department of Health Care Services (DHCS). Members may choose any qualified provider, in- or out of network, including local health departments (LHDs) and family planning clinics, for care of an STI episode without prior authorization. STI services include education, prevention, screening, counseling, diagnosis, and treatment.

Out-of-network services provided by LHDs and family planning providers are limited to the following:

- One office visit per disease episode for the purpose of:
    1. Diagnosis and treatment of vaginal discharge and urethral discharge

2. Those STIs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and
3. Evaluation and treatment of pelvic inflammatory disease.

Additional visits may require that the member be referred back to his or her primary care physician (PCP) for any additional medically necessary follow-up or treatment.

For community providers other than LHD and family planning providers, out-of-network services are limited to one office visit per disease episode (follow-up care must be obtained by an in-network provider).

Member Education

Member education on sexually transmitted infections (STIs) includes disease-specific material, the right to out-of-network treatment, health assessment for risk factors, and the method for obtaining preventive services. Members are advised of these services in the Evidence of Coverage (EOC).

The Health Net Health Education Department sends STI health education information to providers on request.

Nonparticipating Providers

Health Net requests that nonparticipating providers contact the Health Net Medi-Cal Member Services Department to verify eligibility and benefits and to obtain billing instructions for Medi-Cal members. The nonparticipating provider is given the name of the member's primary care physician (PCP) to arrange for follow-up services. Nonparticipating providers may also use either an EDS Point of Service (POS) device or the Automated Eligibility Verification System (AEVS) by telephone to confirm eligibility. If the nonparticipating provider contacts the PCP directly, the PCP is responsible for coordinating the member's care with the non-participating provider.

If the nonparticipating provider requests care management services, the request is forwarded to the Health Net Medi-Cal Health Services Department. The Health Net Medi-Cal Health Services Department arranges for any necessary follow-up care and coordinates the care with the member's PCP.

PCP Responsibilities

Primary care physicians (PCPs) are responsible for primary treatment of sexually transmitted infections (STIs). The PCP may perform the service or may refer members to local health department (LHD) clinics, participating specialists, or on request of the member, out-of-network providers.

PCPs are responsible for reporting incidences of STIs to the LHD within specific time frames. Refer to the Communicable Diseases Reporting discussion under the Compliance and Regulations topic for a list of reportable STIs, reporting requirements and the Confidentiality Morbidity Report form (PDF).

When reporting to the LHD, the following information must be included:

- Member demographics (name, age, address, home telephone, date of birth, gender, ethnicity, and marital status)
- Locating information (employer, work address and telephone number)

- Disease information (diagnosed date of onset, symptoms, laboratory results, and prescribed medications)

Plan PCPs shall screen for chlamydia in all sexually active women 24 years or younger and women 25 years or older who are at increased risk for infection, in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations. Follow up for positive results must be documented in the medical record.

If the member refuses to have the chlamydia screening performed, unsuccessful attempts and refusals to screen must be documented in the member's medical record by the PCP.

PCPs should document any preventive care and health education counseling provided at the time of a routine exam for all members with high-risk behaviors for STIs.

Access to STI services by minors, including confidentiality and monitoring of STI services, is a covered benefit. Refer to the Access to Sensitive Services discussion under the Benefits topic for additional information.

Reimbursement

Participating providers must bill Health Net, or the capitated participating physician group (PPG), in accordance with their *Provider Participation Agreement (PPA)* .

Individually participating providers who provide sexually transmitted infection (STI) services are reimbursed at the allowable Medi-Cal fee-for-service (FFS) rate determined by the Department of Health Care Services (DHCS), if a specific rate has not been included in the *PPA* .

Denials of STI services (for example, member ineligibility under the Medi-Cal program) are sent to the provider of service to protect the member's privacy.

Plan Medi-Cal providers may submit appeals to the Provider Disputes Department for any unresolved claims issue. The procedure is outlined for providers in the Plan’s Medi-Cal Provider Manual.

Members may submit appeals to the Plan’s Medi-Cal Member Appeals and Grievance Department for any unresolved claims issue. The procedure is outlined for Members in the Evidence of Coverage document. Any questions or issues should be referred to the Plan’s Medi-Cal Customer Contact Center.

Refer to AIDS section under Benefits for more information.

Tuberculosis Detection and Treatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Tuberculosis (TB) screening, diagnosis, treatment, and follow-up are covered services for Medi-Cal members. Health Net and its participating providers, provide TB care and treatment in compliance with the guidelines recommended by the American Thoracic Society and the Centers for Disease Control and Prevention.

Health Net coordinates with local health departments (LHDs) in the provision of LHD's Direct Observation Therapy (DOT) program.

Early diagnosis, immediate reporting to LHDs and effective TB treatment are critical to interrupting continued transmission of TB. Physicians must report known or suspected cases to the LHD TB Control program office within one working day of identification (17 CCR 2505).

Care Management

Primary care physicians (PCPs) are instructed to notify the Health Net Medi-Cal Health Services Department of all suspected or active tuberculosis (TB) cases to ensure coordination of care, correct utilization and timely delivery of medical care. Health Net's Medi-Cal Health Services staff communicates with the Medi-Cal TB Control Program nurse manager and the PCP concerning these cases. When necessary, Health Net's Service Coordination Liaisons obtain referral information from Health Net's Medi-Cal Health Services staff, affiliated health plans and local health departments to ensure accurate tracking of TB cases.

PCPs need to contact the Local Health Department (LHD) TB nurse manager and the Health Net Medi-Cal Health Services Department for care management services for members who are repeated no-shows for appointments. The Health Net Medi-Cal Health Services staff attempts to contact the member. If no contact is made, the Health Net Medi-Cal Health Services staff notifies the PCP and coordinates with the LHD. The Health Net Medi-Cal Health Services staff updates the LHD TB nurse manager when members change providers.

The local TB Control Program reports to the PCP when the member does not respond to treatment or when the member experiences an adverse reaction to medication.

The LHD TB nurse manager is responsible for providing follow-up information concerning contact investigations, verifying and collecting additional information, and communicating with PCPs and Health Net's care managers.

Classification System for Tuberculosis

Class	Type	Description
0	No TB exposure Not infected	No history of exposure. Negative reaction to tuberculin skin test.
1	TB exposure No evidence of infection	History of exposure. Negative reaction to tuberculin skin test.
2	TB infection No TB disease	Positive reaction to tuberculin skin test. Negative bacteriologic studies (if done). No clinical, bacteriological, or radiological evidence of active TB.

Class	Type	Description
3	Current TB disease	Meets current laboratory criteria (for example, a positive culture) or criteria for current clinical case definition.
4	Previous TB disease (not current)	Medical history of TB disease or abnormal but stable. X-ray findings for a person who has a positive reaction to the tuberculin skin test, negative bacteriologic examination (if done), and no clinical or X-ray evidence of current TB disease.
5	TB suspected	Signs and symptoms of TB disease, but evaluation not complete (diagnosis pending).

Direct Observation Therapy for Tuberculosis

Direct observation therapy (DOT) services are offered by local health departments (LHDs) to monitor members with clinically active tuberculosis (TB) who have been identified by their primary care physician (PCP) as at risk for potential noncompliance with the treatment regimen. DOT is a measure to ensure adherence to tuberculosis treatment for members at risk for noncompliance in taking medications or who are unable to follow the treatment regimen and to protect the public health. DOT is a process by which a health care worker observes the patient swallowing anti-TB medications. The purpose of DOT is to assure that the entire course of medication is taken in the correct dose, at the correct time and for the complete period of therapy.

DOT services are carved-out under the Health Net Medi-Cal managed care program, but the member remains enrolled with Health Net for the purpose of receiving primary care and services unrelated to DOT.

The responsibility for paying for DOT services for a member enrolled in managed care rests with the LHD rather than the health plan.

Dosage Recommendations

Refer to the CDHS/CTCA Joint Guidelines for the Treatment of Active Tuberculosis Disease (PDF) for appropriate dosage recommendations for the detection and treatment of tuberculosis.

DOT Referrals to Local Health Departments

When a primary care physician (PCP) identifies a member with tuberculosis (TB) who is at risk for nonadherence with the treatment regimen, the PCP must fax a copy of the DOT referral form (PDF) to the local health department (LHD) TB control officer. A copy of the referral form must also be faxed to Health Net's Service Coordination Liaisons and the participating physician group (PPG) case manager.

The LHD must be notified when the PCP has reasonable grounds to believe that a member has ceased treatment, failed to keep an appointment, has adverse drug reactions, or has relocated without transferring or discontinuing care.

The following members must be referred for direct observation therapy (DOT) services:

- members having multiple drug resistance (defined as resistance to Isoniazid and Rifampin)
- members whose treatment has failed
- members who have relapsed after completing a prior regimen
- children
- adolescents
- noncompliant individuals

Members with the following conditions should be considered for referral:

- substance abuse
- major psychiatric, memory or cognitive disorders
- elderly
- homeless
- formerly incarcerated
- slow sputum conversion
- slow or questionable clinical adherence
- adverse reaction to TB medications
- poor understanding of their disease process and management
- language or cultural barriers

Follow-Up Care

Primary care physicians (PCPs) are required to coordinate with the local health department (LHD) tuberculosis (TB) control officer and provide follow-up care to all members receiving direct observation therapy (DOT) services. PCPs need to inform the LHD TB Control Program of any changes in the member's response to the treatment or drug therapy.

PCPs receive a periodic report from the LHD TB Control Program to advise them of members' treatment status. On completion of the DOT services, the LHD TB Control Program faxes a copy of the member's medical record and final status report to the PCP.

The PCP then arranges an appointment to develop a follow-up treatment plan for the member. The PCP's staff calls or mails the appointment schedule slip to the member. If the member does not show up for the scheduled appointment, a follow-up telephone call or letter should be initiated. If there is no response, the PCP notifies the LHD TB Control Program.

Health Education

The Health Net Medi-Cal Health Services Department makes a referral to the Health Net Health Education Department when a member is identified with tuberculosis (TB). Members are then thoroughly educated regarding TB. Effective health education programs and materials are available to members in a variety of languages. These services are provided through participating physician groups (PPGs), providers, participating hospitals, the LHD TB Control program, and Health Net.

Hospital Transfer or Discharge

Health Net requires participating primary care physicians (PCPs) to obtain the LHD TB Control Program office's approval prior to hospital transfer or discharge of any member with known or suspected tuberculosis (TB). The LHD TB Control Program office reviews requests for hospital transfer or discharge within 24 hours of receipt. Coordination of the treatment plan and discharge planning include the acute care facility, the Health Net Medi-Cal Health Services Department and the LHD TB Control program.

Initial Health Appointment

All Medi-Cal members must receive an initial health appointment (IHA) (complete history and physical examination) within 120 days of the date of enrollment, unless the member's primary care physician (PCP) determines that the member's medical record contains complete and current information consistent with the assessment requirements within periodicity time requirements. Tuberculosis (TB) testing must be included if members are identified in specific targeted or at-risk groups.

Investigation of Contacts

It is the responsibility of the local health department (LHD) to investigate tuberculosis (TB) contacts. When contacts with positive TB members are identified, the primary care physician (PCP) notifies the TB Control Program or the Health Net Medi-Cal Health Services Department of the actual or potential contact with a TB-diagnosed Health Net member. PCPs are required to provide examinations within seven days to their assigned members identified by TB Control Program as contacts. Examination results must also be reported in a timely manner back to the local TB Control Program office.

Laboratory Services

Health Net uses laboratories that conform to legal and Centers for Disease Control and Prevention (CDC) guidelines.

Medical Director Responsibilities

The Health Net Medi-Cal medical directors confer, as needed, with the local Tuberculosis (TB) Control Program nurse manager to ensure coordination of care and to correct identified deficiencies. Health Net's Medi-Cal medical directors, Health Services staff, Service Coordination Liaisons, and the local TB Control Program collaborate in monitoring and evaluating care and services provided to potential and active TB cases.

PCP Responsibilities

Primary care physicians (PCPs) are responsible for acting as the primary caregiver for the member and submitting the required tuberculosis (TB) reporting to the local TB Control Program office within one working day of identifying a TB case. Upon receipt by the local TB Control Program office, co-management of treatment is discussed. TB-diagnosed members are identified by PCPs during the normal course of practice and by specialists during consultation and treatment. The Health Net Medi-Cal Health Services Department is also notified for care management needs and tracking.

Problem Resolution

Conflicts that arise between LHD TB Control Programs and Health Net or a participating provider are resolved by Health Net's Service Coordination Liaisons.

Referrals

Primary care physicians (PCPs) who identify Class 3 and Class 5 TB cases refer them to the LHD TB Control Program for treatment.

The local health department (LHD) must be notified when the PCP has reasonable grounds to believe that a member has ceased treatment, failed to keep an appointment, had adverse medication reactions, relocated without transferring care, or discontinued care.

PCPs who elect not to refer the member identified with Class 3 or 5 TB to the LHD TB Control Program for treatment are bound by the requirements of California law in the identification, reporting, treatment, and coordination of care for these members.

Screening for Tuberculosis Infection

Screening is performed to identify infected people at high risk for disease who would benefit from treatment for latent tuberculosis infection (LTBI). It is also done to identify people with clinically active tuberculosis (TB) who need treatment. The following are at high risk for TB and need to be screened with a tuberculin skin test:

- those with HIV infection
- those in close contact with someone having an infectious TB case
- those with medical conditions that increase the risk of TB
- foreign-born people from high TB-prevalence countries
- low-income people
- high-risk minorities
- persons with alcohol or substance use disorders

- residents and employees of long-term care facilities (including prisons)
- populations identified locally as being at increased risk for TB (for example, health care workers in some areas)

Health Net collaborates with local refugee health programs to identify refugees who are possible candidates for local refugee health clinic services. Guidelines for this referral coordination may be found in the discussion of Refugee Health Programs.

TB screening, testing, interpretation of testing and coordination of referral, treatment and follow-up for children through age 20, are to be provided in accordance with the American Academy of Pediatrics (AAP) Bright Futures Recommendations for Periodic Preventive Health Care and the California Department of Public Health Tuberculosis Control Branch. A TB exposure risk assessment is required during preventive well-child screening exams at the ages recommended by the most current (AAP) Recommendations for Periodic Preventive Health Care and testing should be performed on recognition of high-risk factors.

Screening for members ages 18 and older

Members ages 18 and older can be offered TB screening assessments if risk factors are identified using the following criteria:

- Adult members who receive primary care services in a facility, clinic, center, office, or other setting where primary care services are provided, **shall be offered a TB risk assessment and TB screening test**, if TB risk factors are identified, based on the latest screening indications recommended by the U.S. Preventive Services Task Force, unless the provider reasonably believes that one of the following conditions applies:
  - The member is being treated for a life-threatening emergency.
  - The member has previously been offered or has been the subject of a TB risk assessment, TB screening test, or both, and has no new TB risk factors since the last TB risk assessment or TB screening test, unless the provider determines that they should be offered again.
  - The member has a documented, previously positive Interferon-Gamma Release Assays test or has previously tested positive for a latent tuberculosis infection (LTBI).
  - The member lacks capacity to consent to the assessment or test and/or consent cannot be obtained from a person legally authorized to make medical decisions on the patient's behalf.
  - The member is being treated in the emergency department of a general acute care hospital.
- If a member accepts the offer of the TB screening test and the test is positive, providers are required to offer the member follow-up care or refer the member to a provider who can provide follow-up care.

Skin Test Interpretation

Classification of the tuberculin skin test reaction:

AN INDURATION OF 0 TO 4 MILLIMETERS	AN INDURATION OF 5 TO 9 MILLIMETERS	AN INDURATION OF 10 OR MORE MILLIMETERS
Considered negative (insignificant reaction)	Considered positive for one or more of the following: • HIV-infected persons • close contacts of a person with infectious TB • persons who have abnormal chest radiographs • persons who inject drugs and whose HIV status is unknown	Considered positive (significant reaction)

Tuberculosis Reporting Requirements

Primary care physicians (PCPs) are responsible for reporting to the LHD TB Control Program all confirmed or suspected tuberculosis (TB) cases within one working day of diagnosis. Information reportable to the local health department (LHD) includes:

- member information (name, age, address, home phone number, date of birth, gender, ethnicity, and marital status)
- locating information (employer, work address and phone number)
- disease information (disease diagnosed, date of onset, symptoms, laboratory results, and prescribed medications)

Reports to the local TB Control Program must be made using the Tuberculosis Suspect Case Report form.

In addition, suspected and confirmed cases of TB must also be reported as a communicable disease within one day of diagnosis to the Communicable Disease Report Division of the Local Health Department. This report must be made using the Confidential Morbidity Report form (PDF). Refer to Tuberculosis Reporting and Cases Management in the Communicable Disease Reporting discussion in Compliance and Regulations for specific information.

Documentation of the report to the LHD must be included in the member's medical record. Any necessary medical information must be provided to the LHD for members receiving direct observation therapy (DOT) services.

PCPs are required to collaborate with the local TB Control Program on treatment plans for members and promptly submit treatment plans to the local TB Control Program office with updates. Until treatment is completed, requests for updates may be monthly, unless otherwise determined by the local TB Control program office. The local TB Control Program office obtains monthly sputum smears and cultures and then reports the results to the PCP until the results become negative. Radiographs may be requested after several months of treatment.

Tuberculosis Skin Testing Protocols

Mantoux tuberculin skin testing is the standard method of identifying persons infected with M. tuberculosis. The Mantoux test must be administered and read by qualified staff. Steps of tuberculin skin testing are as follows:

1. Inject intradermal Mantoux test (i.e., 0.1 ml of 5 TU purified protein derivative [PPD] tuberculin) into the volar or dorsal surface of the forearm.
2. Read the reaction to the test 48 to 72 hours after injection.
3. Measure the area of induration (palpable swelling) around the site of injection.
4. Record the diameter of the indurated area (measured across the forearm) in millimeters.

If the test is positive, a chest radiography must be done. If the chest radiography is negative, consider the person infected. As a positive tuberculosis (TB) test does not necessarily indicate the presence of active TB disease, an individual showing a positive TB test requires further screening with other diagnostic procedures.

Therapy Compliance

Noncompliance is a major problem in tuberculosis (TB) control. A health care professional aware of a nonadherent TB member needs to contact the local TB Control Program office for intervention. The local TB Control Program official then meets with the member to determine why the member is nonadherent and takes necessary action.

Members not receiving direct observation therapy (DOT) should be asked about adherence at routine follow-up visits. Routine pill counts should be taken and urine tests should be used to check for the presence of drug metabolites. If the member's sputum remains positive after two months of treatment, DOT should be considered.

Tracking and Coordination of Care

Health Net's Medi-Cal medical directors confer, as needed, with the local Tuberculosis (TB) Control Program to provide coordination of care and to correct any identified deficiencies. They are available to care managers to assist with proper member management and member compliance problems.

When requested by the primary care physician (PCP) or the Health Net public programs administrator, the Health Net Medi-Cal Health Services Department is available to provide assistance with the coordination of the member's care.

Treatment of Latent Tuberculosis Infection

The following classes of people may be eligible for the treatment of latent tuberculosis infection (LTBI) if they have not received a prior course of antituberculosis (TB) treatment. Before starting treatment for LTBI, clinically active TB must first be excluded. It is essential to obtain a chest radiograph when evaluating a person for TB. Bacteriological studies need to be obtained for all persons with an abnormal chest radiograph.

- TB Class 3 (clinically active TB) - M. tuberculosis cultured (if done), or positive reaction to TB skin test, and clinical or radiographic evidence of current disease

- TB Class 5 (TB suspected) - Diagnosis pending

The definition of a positive tuberculin skin test is as follows:

- induration between 5 mm and 10 mm
  - people known or suspected to have HIV infection
  - contact with someone having an infectious case of TB
  - person with an abnormal chest radiograph, but no evidence of active TB (TB Class IV)
- induration between 10 mm and 15 mm
  - all except those listed above
- induration of 15 mm or more
  - in California, this cutoff is not recognized by public health departments. Tuberculin skin tests are not recommended for those at low risk for TB infection

  Tuberculin skin test conversion is defined as an increase of at least 10 mm of induration from less than 10 mm to 10 mm or more within 24 months from a documented negative to a positive tuberculin skin test.

People in the following categories are to be considered for treatment for LTBI if their tuberculin skin test is positive and they have not previously completed a course of anti-TB treatment:

- those known or suspected to have HIV infection, regardless of age
- those with an abnormal chest radiograph suggestive of TB and classified into ATS Class IV, regardless of age
- close contact with a person having an infectious TB case, regardless of age
- all tuberculin skin test converters, regardless of age

People with the following conditions that have been associated with an increased risk of TB must be started on a treatment for LTBI, regardless of age:

- drug abuse (especially with injecting drug use)
- diabetes mellitus (especially insulin-dependent)
- silicosis
- prolonged corticosteroid therapy
- other immunosuppressive therapy
- cancer of the head and neck
- hematological and reticuloendothelial disease
- end-stage renal disease (ESRD)
- intestinal bypass or gastrectomy
- chronic malabsorption
- low body weight (10% or more under ideal body weight)
- malnutrition and clinical situations associated with rapid weight loss
- persons with positive tuberculin skin test

Close contacts with a tuberculin skin test under 5 mm should receive a chest radiograph and, once clinically active TB is excluded, should start the treatment for LTBI if:

- Circumstances suggest a high probability of infection.
- Evaluation of other contacts with a similar degree of exposure demonstrates a high prevalence of infection.
- The contact is a child (especially if under age four), is infected with HIV or is otherwise immunocompromised.

- For those who are started on a treatment for LTBI with a PPD less than 5 mm, a repeat tuberculin skin test should be performed 8 to 12 weeks after contact with the infectious person has been broken to determine if skin test conversion has occurred. A decision on continuing treatment for LTBI can be made once the result of the repeat skin test is available.

Tuberculosis Control Strategy

Health Net collaborates, communicates and contracts with local health departments (LHDs) in public health coordination, education, referrals, screening, treatment, direct observation therapy (DOT), care management, and related services.

Classification System for TB

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Class	Type	Description
0	No TB exposure Not infected	No history of exposure. Negative reaction to tuberculin skin test.
1	TB exposure No evidence of infection	History of exposure. Negative reaction to tuberculin skin test.
2	TB infection No TB disease	Positive reaction to tuberculin skin test. Negative bacteriologic studies (if done). No clinical, bacteriological, or radiological evidence of active TB.
3	Current TB disease	Meets current laboratory criteria (for example, a positive culture) or criteria for current clinical case definition.
4	Previous TB disease (not current)	Medical history of TB disease or abnormal but stable. X-ray findings for a person who has a

Class	Type	Description
		positive reaction to the tuberculin skin test, negative bacteriologic examination (if done), and no clinical or X-ray evidence of current TB disease.
5	TB suspected	Signs and symptoms of TB disease, but evaluation not complete (diagnosis pending).

Direct Observation Therapy for Tuberculosis

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Direct observation therapy (DOT) services are offered by local health departments (LHDs) to monitor members with clinically active tuberculosis (TB) who have been identified by their primary care physician (PCP) as at risk for potential noncompliance with the treatment regimen. DOT is a measure to ensure adherence to tuberculosis treatment for members at risk for noncompliance in taking medications or who are unable to follow the treatment regimen and to protect the public health. DOT is a process by which a health care worker observes the patient swallowing anti-TB medications. The purpose of DOT is to assure that the entire course of medication is taken in the correct dose, at the correct time and for the complete period of therapy.

DOT services are carved-out under the Health Net Medi-Cal managed care program, but the member remains enrolled with Health Net for the purpose of receiving primary care and services unrelated to DOT.

The responsibility for paying for DOT services for a member enrolled in managed care rests with the LHD rather than the health plan.

WIC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a 100% federally funded program that provides nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low-to-moderate income (up to 185% of the federal poverty level) women and children up to age 5. The purpose of WIC is to prevent infant mortality, low birth weight and other poor birth outcomes, and to improve the nutrition and health of participants. Primary care physicians (PCPs) inform eligible members of the availability of WIC

services during office visits. Refer to the Contacts section in the Provider Library for a listing of WIC office telephone numbers and addresses.

Biochemical Data Collection

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) applicants and participants are required to provide the following information when applying for WIC services:

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
Women • prenatal • breastfeeding • postpartum (non-breastfeeding)	Enrollment and subsequent certification	• Height/length and weight are required. • Data must be current within 60 days of certification. • Measures are taken in clinic only if not doing so presents a barrier to services. Whenever possible, WIC appointments are rescheduled to allow clients more time to get medical referrals completed by the health care provider.	• Blood work must be provided within 90 days of certification. Blood work must be specific to category (for example, a postpartum woman provides results of a blood test taken after delivery).
Infants under age 9 months	Enrollment	• Height/length and weight are required. • Birth data recorded on birth certificate or medical	• Hgb or Hct test is not required.

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
		record may be used for enrollment in the first 60 days after birth. Orally declared birth data is not acceptable. • Measurements are taken at WIC if not otherwise provided.	
Infants 9 months and older and children ages 1 to 5	Enrollment	• Height/length and weight are required. • Data must be current within 60 days of enrollment. • Certification period may not be shortened based on the date of anthropometric data. • Measurements are taken in clinic if not otherwise obtainable.	• Hgb or Hct testing is required. • Blood work must be provided within 90 days of enrollment. • Certification periods may not be shortened based on the date of biochemical data.
Children ages 1 to 5	Subsequent certification	• Height/length and weight are required. • Data used for recertification must be current within 60 days	• Hgb or Hct is required once every 12 months, at a minimum, if Hgb was equal to or greater than

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
		of recertification appointment. • Measures are taken in clinic only if not doing so presents a barrier to services. Whenever possible, WIC appointments are rescheduled to allow clients more time to get medical referrals completed by the health care provider.	11g/dl or Hct was equal to or greater than 33% at the previous certification. • Data must be presented within 90 days of certification. • Hgb or Hct is required once every six months, if the Hgb was less than 11 g/dl or Hct was less than 33%. • Data used for recertification must be taken during the certification period. If the child's blood values were abnormal at the initial certification, and a follow-up blood test was done during the initial certification period, the follow-up blood test may be used for the following recertification.

Identifying Eligible Members

Medi-Cal members are eligible for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services if they are:

- pregnant
- breastfeeding (up to one year after childbirth)
- non-breastfeeding women up to six months after termination of pregnancy (live birth, still birth, fetal death, or miscarriage)
- children under age 5
- determined by a WIC nutritionist to be at nutritional risk

Medi-Cal members must also:

- Receive regular medical check-ups.
- Meet income guidelines.
- Reside in a local agency's service area.

Medical Documentation

Providers must document Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) referrals in the member's medical record. The documentation can be a copy of the referral in the member's file or notes in the member's file documenting the visit and subsequent referral.

WIC considers findings and recommendations of WIC referrals to be confidential and declines to share information regarding individual referral findings. WIC has agreed to share aggregate data pending clarification regarding confidentiality from the Department of Agriculture. Until clarification is made, primary care physicians (PCPs) should encourage members to inform PCPs of the outcome of their WIC visits, thereby allowing PCPs to provide appropriate and consistent follow-up and documentation of the outcome of the referral.

County Relations/Service Coordination

The Health Net Medi-Cal County Relations/Service Coordination Department negotiates a memorandum of understanding (MOU) with local Special Supplemental Nutrition Program for Women, Infants and Children (WIC) agencies to ensure coordination and communication between Health Net and the WIC agency. Health Net's County Relations/Service Coordination administrators also work with WIC agency liaisons to resolve any conflicts that might arise between the WIC agency and a Health Net provider or Health Net.

Referrals to WIC

Primary care physicians (PCPs) are responsible for referring eligible members to Special Supplemental Nutrition Program for Women, Infants and Children (WIC) programs, providing required documentation with each referral and coordinating follow-up care. On request, Health Net or the subcontractor assists in coordinating the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals for WIC services must be made on one of the following forms:

- Pregnant Women Referral Form (PDF)
- Postpartum Women Referral Form (PDF)
- Pediatric Referral Form (PDF)

To be eligible for WIC services, some WIC applicants must provide proof of pregnancy (if applicable), height and weight measurements and blood work.

Learn more at the webpages listed below:

- Information on Medical Documentation
- Information on WIC Blood Work Requirement

WIC Program Services

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participants receive a packet of food vouchers each month that they can redeem at the local retail market of their choice. They can be redeemed for fresh produce at select farmer's markets, as well as for supplemental foods, such as milk, eggs, cheese, cereal, and juice, which provide nutrients essential for healthy pregnancies and children. WIC participants attend monthly nutrition and health education classes and receive nutrition counseling from registered dietitians and nutrition program assistants. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breastfeeding.

WIC does not provide medical nutrition therapy. This is the primary care physician's (PCP's) responsibility. WIC does, however, provide nutrition counseling consistent with the physician's plan of care.

WIC does not provide medically necessary or medically indicated formulas to participants enrolled in Medi-Cal managed care plans. Such formulas, which are referred to as therapeutic formulas by WIC, are a benefit under the Medi-Cal managed care program. When prescribing a medically necessary/therapeutic formula, providers must request authorization from their participating physician group (PPG) or Health Net.

WIC provides standard contract formulas as part of a federally mandated cost containment system. More information on WIC formulas and how to request medical formula and nutritionals can be found below:

- Health Care Provider Training Video (five minutes) on WIC Formula Process
- Letter to Health Care Providers (PDF)
- Referring Patients to WIC for Medical Formula and Nutritionals Flyer (PDF)
- WIC Formula Information
- WIC Formulas and Nutritionals List (PDF)
- WIC Medical Formula and Nutritionals Request Form (PDF)

Refer members to WIC for more information about services available in their preferred language.

Quality Improvement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's quality improvement (QI) programs, procedures and policies.

Select any subject below:

- Disease Management Programs

- Facility Site Review
- Language Assistance Program and Cultural Competency
- Medi-Cal Quality Improvement Programs
- Health Education
- Quality Improvement Program

Disease Management Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's disease management programs.

Select any subject below:

- Disease Management *Be In Charge* Program

Disease Management *Be In Charge* Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Disease Management/Health Coaching *Be In Charge!*[SM] program addresses lifestyle management needs such as exercise*, nutrition, stress*, and weight management**; tobacco cessation** and puff free pregnancy**. Disease Management also provides health coaching for members with asthma, COPD*, diabetes, and cardiac conditions* such as coronary artery disease*, heart failure*, hypertension* or hyperlipidemia*.

The goals of the program are to:

- Improve member knowledge and self-management of these diseases leading to improved quality of life, better functional status and reduced disease complications
- Enhance the effectiveness of care provided to members by:
  - Promoting participation in cardiac program guidelines to prevent subsequent cardiac events and optimize functional status.
  - Minimizing the development and/or progression of diabetic complications; optimizing nutrition, healthy-eating options, and self-care behaviors; improving self-management skills.
  - Supporting members in changing unhealthy behaviors and motivating individuals on risk reduction and achievement of health goals.
  - Promoting adherence to treatment guidelines for asthma and COPD to prevent acute exacerbations.
  - Improving physician knowledge of their assigned members with the identified diagnoses.
  - Facilitating physician and member compliance with evidence-based screening and treatment guidelines.

- Decrease preventable hospitalization and inappropriate emergency room utilization
- Meet the contractual requirements with the Department of Health Care Services

*Adult programs only.

** Pediatric weight management program is ages 2 years and above; tobacco cessation programs are ages 12 years and above.

Eligibility Criteria:

Eligible members are identified for enrollment in a variety of ways including the DMPR (Disease Management Prioritization Report), health appraisal results, referrals from the health plan (i.e., Case/Care Management), physician referral or a current or previous program participant.

How Members receive Health Coaching:

Member receive health coaching via telephonic outreach, education, and support services to assist them in addressing their health care needs as outlined in program goals. During the initial coaching session members are also screened for depression and referred to case management if applicable.

Health Net's Disease Management - *Be In Charge!* program follows the NCQA best practice four step model of population identification, stratification, education, and intensive coaching for high-risk members. Several attempts are made to contact candidates by telephone at varying times of the day. Once contact is made, the program is explained to members, eligibility is confirmed, and an enrollment assessment is initiated to collect information and establish a communication preference. A health coaching call is then scheduled (or can be completed at that time) with a health coach specializing in the applicable focus area(s).

Disenrollment

Members may be disenrolled or excluded from the program under the following circumstances:

- Member dies.
- Members with serious or life-threatening medical conditions including mental health will be referred to case management.
- Member’s health care coverage with the health plan terminates or the health plan no longer provides the member’s primary coverage.
- Member is no longer capable of participation in the program in the reasonable determination of the health coach or the provider.

Exclusions

Services are excluded for members with certain conditions and diagnosis and conditions such as:

- Gestational Diabetes
- High Risk Pregnancy
- Hospice and/or no longer receiving curative care

Identification and Stratification

Data from multiple sources is integrated to identify members who may benefit from disease management. The report used to identify members for disease management includes, but is not limited to:

- Member prioritization report -- member screening information and other existing data is included in the Disease Management Prioritization Report, which leverages seven core Disease Management Conditions in combination with the CM implacability model.
- These seven conditions include diabetes, asthma, COPD, heart failure, coronary artery disease (including hypertension and ischemic heart disease), lifestyle (obesity and tobacco use).
- Screening for depression is part of the Disease Management/Health Coaching initial screening assessment, and the member is referred to a specialist if an intervention is indicated.

Member and Practitioner Outreach and Resources

Members enrolled in the Disease Management - *Be In Charge!* Program receive Health Net mails educational materials, an action plan, information about the program, and contact numbers for the Health Net Nurse Advice Line and Member Services.

Materials are tailored to the diverse clinical, cultural and linguistic needs of Medi-Cal members. Health Net conducts outbound telephonic interventions and referrals to complex case management for members identified as being at high risk for hospitalizations or poor outcomes.

Members also have access to the Health Net Health Education Department. Providers can also refer a member for complex case management by using the Care Management Referral Fax Form – Medi-Cal (PDF), Care Management Referral Fax Form – Community Health Plan of Imperial Valley (PDF) or Care Management Referral Fax Form – CalViva Health (PDF) members.

Coordination with California Children's Services

For Medi-Cal members under age 21 with diabetes, all related diabetes care, including medications and case management services, is arranged by California Children's Services (CCS). Health Net's health assessment coordinators and utilization management nursing staff work with providers and members to make sure that appropriate CCS referrals are made for all type 1 and type 2 diabetic members. CCS has its own network of providers. To access case management services and obtain authorization for services, providers must submit a Service Authorization Request (SAR) to the county CCS program. Diabetic members under age 21 are not included in Health Net's disease management program.

Medi-Cal members under age 21 with a chronic pulmonary condition that causes significant reduction of lung volume or anatomical morphology, such as bilateral pulmonary dysplasia, receive care arranged by CCS. The care includes medications and case management services through CCS' network of providers. Members with asthma under age five are not included in the Disease Management - *Be In Charge!* program.

Facility Site Review

Provider Type: Physicians | Participating Physician Groups (PPG)

Prior to enrolling Medi-Cal beneficiaries with a primary care physician (PCP), the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) require Health Net to perform a facility site review (FSR) as part of the initial credentialing process. Re-audits are conducted at least every three years as part of the recredentialing process. DHCS reviews the results of Health Net's site reviews and may also audit a random sample of provider offices to ensure they meet DHCS standards.

In an effort to decrease duplicative FSRs and minimize the disruption of member care at provider offices, Health Net and all other managed care health plans are required to collaborate in conducting FSRs. On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a PCP and administering a corrective action plan (CAP) when necessary. The responsible plan shares the audit results and CAP with the other participating health plans.

Scope of the Review

Health Net conducts PCP office facility site reviews and medical record reviews using the DHCS Managed Care Quality and Monitoring Division (MCQMD) tools and standards and other Health Net resource materials. Refer to the following samples:

- Facility Site Review Tool (PDF)
- Facility Site Review (FSR) Standards (PDF).
- Medical Record Review Tool (PDF).
- Medical Record Review (MRR) Standards (PDF).
- Facility Site & Medical Record Review Preparation List – Health Net Northern California (PDF).
- Facility Site & Medical Record Review Preparation List – Health Net Southern California (PDF).
- Facility Site & Medical Record Review Preparation List – CalViva Health (PDF).
- Facility Site & Medical Record Review Preparation List – Community Health Plan of Imperial Valley (PDF).

Refer to definition of facility site review for more information.

Reference and Training Materials

Health Net offers the following reference and training materials to help PCPs and their office staff prepare for office site visits:

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Provider Policy Adoption Form
		Access/Safety (Section 1)
1.		**Site Accessibility by Individuals with Physical Disabilities Policy & Procedure (PDF)**
2.		**Clean and Sanitary Environment Policy & Procedure (PDF)**
	2a.	Office Cleaning Schedule (PDF)
	2b.	Office Cleaning Log/Schedule Year (PDF)
3.		**Fire Safety and Prevention and Emergency Non-Medical Procedures Policy & Procedure (PDF)**
	3a.	Workplace Violence Protocol (PDF)
	3b.	Emergency Earthquake Plan (PDF)
	3c.	Emergency Fire Plan (PDF)
	3d.	Sample Site Evacuation Plan (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
4.		**Medical and Lab Equipment Maintenance Policy & Procedure (PDF)**
5.		**Emergency Health Care Services Policy & Procedure (PDF)**
	5a.	Emergency Medication Dosage Chart (Sample A) (PDF) Emergency Medications Dosage Chart (Sample B) (PDF)
	5b.	Emergency Protocol (PDF)
	5c.	Emergency Equipment and Medication Replacement Log (Sample) (PDF)
	5d.	Emergency Supplies Inventory Checklist (PDF)
	5e.	Emergency Medication and Laboratory Supplies Inventory Checklist (PDF)
		Personnel (Section 2)
6.		**Staff Qualifications Policy & Procedure (PDF)**
	6a.	Medical Board of California Notice to Consumers re: Medical Doctors (English) (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Medical Board of California Notice to Consumers re: Medical Doctors (Spanish) (PDF) Medical Board of California Notice to Consumers re: Medical Doctors (Chinese) (PDF)
	6b.	Notice to Consumers re: Physician Assistants Licensure (PDF)
7.	7a.	Delegation of Services Agreement - Physician Assistants (PDF)
	7b.	Supervising PA PAC Document (PDF)
	7c.	Standardized Procedures Requirements for Nurse Practitioners Practice (PDF)
8.		**Unlicensed Personnel Policy & Procedure (PDF)**
	8a.	Medical Assistant Training Letter (PDF)
	8b.	Medical Assistant Certification (PDF)
	8c.	Medical Assistant Venipuncture Certification (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
9.		**Staff Education Training Policy & Procedure (PDF)**
	9a.	Staff Education Checklist (PDF)
	9b.	Health Net Provider Library Resource – Health Net (PDF) Health Net Provider Library Resource – CalViva Health (PDF) Health Net Provider Library Resource – Community Health Plan of Imperial Valley (PDF)
	9c.	Medi-Cal Member Rights & Responsibilities
	9d.	Disability Rights and Provider Obligations (PDF)
	9e.	How to Provide Culturally Competent Care for Patients with Disabilities – Health Net (PDF) How to Provide Culturally Competent Care for Patients with Disabilities – CalViva Health (PDF) How to Provide Culturally Competent Care for Patients with Disabilities – Community Health Plan of Imperial Valley (PDF)
	9f.	Achieve Health Equity Through Culturally Competent Care for BIPOC Patients – Health Net (PDF) Achieve Health Equity Through Culturally Competent Care for

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		BIPOC Patients – CalViva Health (PDF) Achieve Health Equity Through Culturally Competent Care for BIPOC Patients – Community Health Plan of Imperial Valley (PDF)
	9g.	Improve Quality and Inclusive Care for LGBTQ+ Patients – Health Net (PDF) Improve Quality and Inclusive Care for LGBTQ+ Patients – CalViva Health (PDF) Improve Quality and Inclusive Care for LGBTQ+ Patients – Community Health Plan of Imperial Valley (PDF)
10.		**Child Abuse Reporting Policy & Procedure (PDF)**
	10a.	Suspected Child Abuse Report (PDF)
11.		**Elder Abuse Reporting Policy & Procedure (PDF)**
	11a.	Report of Suspected Dependent Adult/Elder Abuse General Instructions and Form (PDF)
12.		**Intimate Partner/Domestic Violence Reporting Policy & Procedure (PDF)**
	12a.	Report of Suspicious Injury Form (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	12b.	Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings (PDF)
	12c.	Hurt, Insulted, Threatened with Harm and Screamed (HITS) Domestic Violence Screening Tool (PDF)
13.		**Informed Consent and Human Sterilization Consent Policy & Procedure (PDF)**
14.		**Minor's Rights Policy & Procedure (PDF)**
	14a.	Consent to Treatment of Minor (PDF)
15.		**Prior Authorizations/ Referrals Policy & Procedure (PDF)**
	15a.	Referral Tracking Log (PDF)
		Office Management and Medical Records (Section 3)
16.		**Member Grievances/ Complaints Policy & Procedure (PDF)**
	16a.	Complaint Log (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
.	16b-r.	Member Grievances/ Complaints Forms (Threshold languages): 16b. Member Appeal or Grievance Form - English (PDF) 16b. Member Grievance/ Complaint Form – English – CalViva Health (PDF) 16b. Member Appeal or Grievance Form – English – Community Health Plan of Imperial Valley (PDF) 16n. Member Appeal or Grievance Form – Spanish (PDF) 16n. Member Grievance/ Complaint Form – Spanish – CalViva Health (PDF) 16n. Member Appeal or Grievance Form – Spanish – Community Health Plan of Imperial Valley (PDF) 16c. Member Appeal or Grievance Form – Hmong (PDF) 16c. Member Grievance/ Complaint Form – Hmong – CalViva Health (PDF) 16q. Member Appeal or Grievance Form – Tranditional Chinese (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		16s Member Appeal or Grievance Form – Simplified Chinese (PDF) 16e. Member Appeal or Grievance Form – Arabic (PDF) 16f. Member Appeal or Grievance Form – Armenian (PDF) 16g. Member Appeal or Grievance Form – Farsi (PDF) 16h. Member Grievance/ Complaint Form – Hindi (PDF) 16i. Member Grievance/ Complaint Form – Japanese (PDF) 16j. Member Appeal or Grievance Form – Khmer (PDF) 16k. Member Appeal or Grievance Form – Korean (PDF) 16l. Member Grievance/ Complaint Form – Laotian (PDF) 16m. Member Grievance/ Complaint Form – Punjabi (PDF) 16m. Member Grievance/ Complaint Form – Punjabi – CalViva Health (PDF) 16d. Member Appeal or Grievance Form – Russian (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		16o. Member Appeal or Grievance Form – Tagalog (PDF) 16p. Member Grievance/ Complaint Form – Thai (PDF) 16r. Member Appeal or Grievance Form – Vietnamese (PDF)
17.		**Interpreter Services Policy & Procedure (PDF)**
	17a.	No-Cost Interpreter Services Available 24/7 for Your Patients– Health Net (PDF) No-Cost Interpreter Services Available 24/7 for Your Patients– CalViva Health (PDF) No-Cost Interpreter Services Available 24/7 for Your Patients– Community Health Plan of Imperial Valley (PDF)
	17b.	Health Plan Interpreter Phone Numbers (PDF)
	17c.	Interpreter Services Language Poster– Health Net (PDF) Interpreter Services Language Poster– CalViva Health (PDF) Interpreter Services Language Poster– Community Health Plan of Imperial Valley (PDF)
	17d.	Interpreter Quality Standards Guidance (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	17e.	Language Proficiency Assessment Resources (PDF)
18.		**Medical Records Policy & Procedure (PDF)**
	18a.	Advance Health Care Directives Info Sheet for English/Spanish (PDF)
	18b.	Staff Signature Document (PDF)
	18c.	Initial Health Appointment Tip Sheet – Health Net (PDF) Initial Health Appointment Tip Sheet – CalViva Health (PDF) Initial Health Appointment Tip Sheet – Community Health Plan of Imperial Valley (PDF)
	18d.	Pediatric Health Maintenance Checklist (PDF)
	18e.	Pediatric Immunization Schedule (PDF)
	18f.	Pediatric Health Maintenance Periodicity Schedule (PDF)
	18g.	Adult Health Maintenance Checklist (PDF)
	18h.	Adult Immunization Schedule

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	18i.	Adult Vaccine Administration Record (PDF)
	18j.	Adult Health Maintenance Periodicity Schedule (PDF)
	18k	CAIR California's Immunization Registry (PDF)
19.		**Appointments and Patient Recall Policy & Procedure (PDF)**
	19a.	Timely Access to Office Requirements – Health Net (PDF) Timely Access to Office Requirements – CalViva Health (PDF) Timely Access to Office Requirements – Community Health Plan of Imperial Valley (PDF)
20.		**Provision of Services 24 Hours a Day Policy & Procedure (PDF)**
21.		**Triage Policy & Procedure (PDF)**
		Clinical Services (Section 4)
22.		**Laboratory Services Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
23.		**Pharmaceutical Services Policy & Procedure (PDF)**
23a.		Sample Medication Policy, Procedure, and Logs (PDF)
	23b.	CDC - Questions about Multi-dose Vials
	23c.	Controlled Substance Log - Sample Form (PDF)
	23d.	VFC Refrigerator Management Plan (PDF)
	23e.	Refrigerator Temperature Log (Fahrenheit) (PDF)
	23f.	Refrigerator Temperature Log (Celsius) (PDF)
	23g.	Freezer Temperature Log (Fahrenheit) (PDF)
	23h.	Freezer Temperature Log (Celsius) (PDF)
	23i.	Checklist for Safe Vaccine Storage and Handling (PDF)
	23j.	Emergency Response Worksheet (PDF)
24.		**Radiology Services Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	24a.	CDPH Notice to Employees (PDF)
	24b.	Dexa Scanner (PDF)
	24c.	Radiologic Health Branch Contact Info (PDF)
		Preventive Services (Section 5)
25.		**Screening and Equipment Policy & Procedure (PDF)**
	25a.	Visual Acuity Screening Tips (PDF)
	25b.	Audiology Form (PDF)
26.		**Health Education Materials Policy & Procedure (PDF)**
	26a.	Health Education Printed Materials Online Order Form
		Infection Control (Section 6)
27.		**Bloodborne Pathogens and Waste Management Policy & Procedure (PDF)**
	27a.	Blood and Body Fluid Exposure Report Form (PDF)
	27b.	Sharps Injury Log (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	27c.	Spill Kit Information (PDF)
	27d.	Medical Waste Log Sheet (PDF)
	27e.	Medical Waste Collection Tracking Log (PDF)
28.		**Decontamination of Surfaces Policy & Procedure (PDF)**
	28a-c.	28a. Clorox Product Information (FORM A): Understanding Bleach (PDF) 28b. Clorox Product Information (FORM B): Clorox Regular Bleach (PDF) 28c. Clorox Product Information (FORM C): Ultra Clorox Germicidal Bleach (PDF)
	28d.	FDA Cleared Sterilants and High-Level Disinfection
29.		**Standard and Universal Precautions Policy & Procedure (PDF)**
30.		**Instrument Sterilization Policy & Procedure (PDF)**
	30a.	Autoclave Maintenance and Run Log (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	30b.	Equipment Transfer Log for Sterilization (PDF)
	30c.	Cold Sterilization or High Level Disinfection Log (PDF)
		Miscellaneous Resources and Sample Forms (Section 7)
31.		**Autism Screening Tool M-CHAT**
31a.		Standard of Care Guidelines for Childhood Lead Screening (PDF)
31b.		Oral Assessment Documentation and Referral (PDF)
31c.		Oral Health Risk Assessment Tool (PDF)
31d.		Fluoride Varnish (PDF)
31e.		Patient Health Questionnaire for Adolescents (PHQ-A) (PDF)
31f.		Suicide Risk Screening Tools (English/Spanish) (PDF)
31g.		Improve Postpartum Care – Health Net (PDF) Improve Postpartum Care – CalViva Health (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Improve Postpartum Care – Community Health Plan of Imperial Valley (PDF)
31h.		Edinburgh Perinatal/Postnatal Depression Scale (EPDS) Questionnaire (PDF)
31i.		Cardiac Risk Assessment (English/Spanish) (PDF)
31j.		Pediatric Sudden Cardiac Death Risk Assessment Form (PDF)
31k.		Childhood Immunizations – Health Net (PDF) Childhood Immunizations – CalViva Health (PDF) Childhood Immunizations – Community Health Plan of Imperial Valley (PDF)
31l.		Adverse Childhood Experiences – Health Net (PDF) Adverse Childhood Experiences – CalViva Health (PDF) Adverse Childhood Experiences – Community Health Plan of Imperial Valley (PDF)
32.		Breast Cancer Screening Tip Sheet – Health Net(PDF) Breast Cancer Screening Tip Sheet – CalViva Health (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Breast Cancer Screening Tip Sheet – Community Health Plan of Imperial Valley (PDF)
32a.		Patient Health Questionnaire-9 (PHQ-9) with scoring (PDF)
32b.		Improve Diabetes Management – Health Net (PDF) Improve Diabetes Management – CalViva Health (PDF) Improve Diabetes Management – Community Health Plan of Imperial Valley (PDF)
32c.		Women's Folic Acid (PDF)
32d.		Hepatitis Risk Assessment Tool (PDF)
33e.		Skin Cancer Screening Form (PDF)
32f.		TB Risk Assessment Tool (English/Spanish) (PDF)
33.		**Psychosocial Assessment (PDF)**
33a.		Social Needs Screening Tool (PDF)
		Preventive Care Sample Physical Exam Forms (Section 8)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Under 1 month (PDF)
		1 – 2 months (PDF)
		3 – 4 months (PDF)
		5 – 6 months (PDF)
		7 – 9 months (PDF)
		12 – 15 months (PDF)
		16 – 23 months (PDF)
		2 years (PDF)
		2 ½ years (30 months) (PDF)
		3 years (PDF)
		4 – 5 years (PDF)
		6 – 8 years (PDF)
		9 – 12 years (PDF)
		13 – 16 years (PDF)
		17 – 20 years (PDF)
		21 – 39 years female (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		21 – 39 years male (PDF)
		40 – 49 years female (PDF)
		40 – 49 years male (PDF)
		50+ years female (PDF)
		50+ years male (PDF)

Additional resources are in the provider library under Topics located in the left navigation bar. Search under Education, Training and Other Materials to support better health outcomes, or find provider notices under Updates and Letters.

Health Net's FSR Compliance Department promotes immunization services that meet the DHCS requirements. Refer to Administration of Immunizations for more resources.

Facility Site Review Scheduling, Frequency, Scoring, and Compliance

Health Net and all other Medi-Cal managed care health plans are required to collaborate in conducting facility site reviews (FSRs). On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a primary care physician (PCP) site. Copies of the FSR and related regulatory requirements are available online at the DHCS website and the All Plan Letter (APL) 22-017 (PDF)or the most current APL.

Representatives from the responsible plan contact the provider office prior to the FSR to discuss audit policies and procedures. A packet containing educational materials to help the office prepare, is provided to the office prior to the site review to enable the provider office to prepare for the site visit. Preliminary office site review findings are communicated at the time of the review. In addition, written results are sent to the provider by the responsible health plan. The Health Net Medi-Cal Facility Site Review Compliance Department is responsible for conducting collaborative review process for Health Net.

An FSR is conducted as part of the credentialing process for new providers. New providers must receive a passing score of at least 80 percent prior to being admitted into the plan's provider network. Facility site review audit results are shared among Medi-Cal managed care plans. Sites receiving a non-passing score on any audit from one plan are considered to have a non-passing score by all other Medi-Cal managed care plans. A medical record review (MRR) is also conducted on new provider offices three to six months following inclusion

in the network and assignment of members. The minimum passing score for the MRR is also 80 percent. Like the FSR results, MRR results are also shared and handled uniformly among participating plans.

Cap Submission and Implementation

Providers must correct deficiencies in critical elements within 10 business days following the date of the review. Providers scoring 90 percent or greater on the facility site review are not required to submit a corrective action plan (CAP) unless deficiencies are found in critical elements, including pharmaceutical services or infection control. Providers scoring 89 percent or less are required to submit a CAP. CAPs must be submitted to the plan administering the review within 30 calendar days from the date of the review.

Providers may be re-reviewed in 12 months or sooner, if deemed appropriate to assess compliance with the CAP. New members are not assigned to a PCP who receives a non-passing score until corrections are verified and the CAP is closed.

After the initial audit, participating providers are re-audited at least every three years. A full-scope site audit, which includes both the FSR and MRR, is conducted at this time. Providers must receive a passing score of at least 80 percent on both reviews. Sites receiving a non-passing score from one plan are considered to have a non-passing score by all other Medi-Cal managed care plans. New members are not assigned to a PCP who receives a non-passing score until corrections are verified and the CAP is closed. Providers who do not comply with the CAP within the established time frames are required to be removed from the network per current APL.

Practitioners who do not comply with a CAP or fail to meet threshold scores on a FSR or MRR are forwarded to Health Net's Credentialing Committee for administrative termination. The termination is applicable to the Medi-Cal contracting lines of business and practice locations and remains in effect for three years from the date of the committee's final decision. The provider must undergo an initial site review at the time of reapplication.

Provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent during the next site review in both the FSR and MRR, including sites with open CAPs in place. Sites that do not score a minimum of 80 percent in the FSR and MRR, despite ongoing monitoring, are removed from the network and members are appropriately reassigned to other providers. Health Net must notify affected members in writing 30 calendar days in advance of any provider terminations.

Health Net re-audits the provider within 12 months if the provider scores below 80 percent on FSR or MRR on a full scope audit.

Sterilization of Instruments

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information and instruction for the sterilization of instruments.

Autoclaves Maintenance and Spore Testing

Autoclaves must be maintained according to the manufacturer's written instructions. The periodic maintenance schedule must be followed by a competent technician to check gauges, steam lines and seals. Reports of these inspections must be maintained by the person responsible for the autoclave.

A log must be maintained for each autoclave load and contain the following (a sample autoclave log (PDF) is available):

- Date, time, steam pressure, and duration of each run
- Dates and results of autoclave calibration
- Results of routine spore testing, at least monthly

Biological control spore ampules must be used to check the effectiveness of sterilization. Biological testing of steam sterilization loads must be conducted monthly. Following the sterilization cycle, the control spore must be incubated according to the manufacturer's recommendations. The results of these tests must be maintained as a permanent record. If a positive result is obtained, the sterilizer must be taken out of service until it is inspected and repaired and the results of retesting are negative.

Cold and Liquid Chemical Sterilization

Instruments must be thoroughly cleaned and dried prior to immersion in the cold sterilization solution. Any organic matter creates a barrier on the instrument against the solution. Wet items dilute the solution.

The cold sterilization solution used must be able to kill HIV, hepatitis B virus and tuberculosis (TB) according to the standards set forth by the Department of Health Care Services (DHCS).

The cold sterilization solution must be used, tested and discarded according to manufacturer's written recommendations. Most cold sterilizing solutions are effective for a specific period of time; therefore, the manufacturer's instructions must be followed when preparing the solution and calculating the expiration date. Testing should be conducted regularly following the manufacturer's recommended frequency.

Use sterile gloves or forceps to remove items from cold sterilization solutions. Instruments must be rinsed thoroughly with sterile distilled water to avoid tissue damage prior to use on a member (refer to sample Cold Sterilization Log (PDF)).

Instrument Sterilization, Preparation and Handling

Instruments must be thoroughly cleaned and dried before they can be wrapped for sterilization. Soiled instruments must be cleaned as soon as possible after use to prevent blood and other substances from drying on the surfaces or in the crevices.

Complete removal of all soil from the serrations and crevices of instruments is required prior to autoclaving

Wrappers and Packaging

Instrument packaging must resist tearing or puncture and should be free of pinholes. It must also be moisture resistant. A wrapper must be flexible and memory free to allow easy aseptic presentation with assurance of no particulate contamination when the package is opened. It must establish a barrier to microorganisms and their vehicles.

If textile wrappers are used, they must be laundered between sterilization exposures to ensure sufficient moisture content in the fibers. All wrappers must be checked for tears and holes before they are used. Wrappers with defects may not be used in the sterilization process.

A chemical indicator strip must be inserted into each package prior to autoclaving (these darken to indicate that the package has been exposed to the physical conditions of an autoclave cycle).

Pressure-sensitive autoclave tape must be used to hold wrappers in place on packages and to indicate that the packages have been exposed to an autoclave cycle.

Every package intended for sterile use should be printed or labeled with the date autoclaved, run number and the contents.

Sterile Package Handling

Sterile packages must be handled with care and as little as possible.

Sterile packages must be stored in clean, dry, dustproof, and vermin-proof areas that are well ventilated. Closed cabinets and drawers are the preferable storage places.

Sterile packages are considered sterile for any length of time unless the packing shows any signs of damage, including, but not limited to, yellowing, brittle packaging, water damage, pin holes, cracks, tears, or any break in the packaging integrity.

If packaging is found to be compromised upon inspection, materials may be repackaged and sterilized for continued storage and use.

Medical Waste Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section provides guidelines for segregating medical waste from other waste products and establishing proper handling and disposal procedures in accordance with the Medical Waste Management Act, California Health and Safety Code, Division 20, Chapter 6.1.

Health Net recommends segregating medical waste at the point of generation and handling the waste properly using trained staff, protective equipment and good work practices.

Refer to definition of medical waste management materials for additional information.

Administration and Record Keeping

Offices with on-site waste treatment must keep an informational document that states how waste is contained, stored, treated, and disposed. Treatment facility operating records must be kept on-site for three years.

Offices using a hazardous waste hauler for off-site waste treatment must have an informational document that states how waste is contained, stored, treated, and disposed. Records of the quantity and type of waste

transported, date transported, and the name of the registered hazardous waste hauler must also be maintained. These tracking documents must be maintained on-site for three years.

A small quantity medical waste generator or parent organization that employs health care professionals who generate medical waste may transport medical waste generated in limited quantities up to 35.2 pounds to the central location of accumulation, provided that all of the following are met:

1. The principal business of the generator is not to transport or treat regulated medical waste.
2. The generator shall adhere to the conditions and requirements set forth in the materials of trade exception, as specified in Section 173.6 of Title 49 of the Code of Federal Regulations.
3. A person transporting medical waste pursuant to this section shall provide a form or log to the receiving facility, and the receiving facility shall maintain the form or log for a period of two years, containing all of the following information:
    - The name of the person transporting the medical waste.
    - The number of containers of medical waste transported.
    - The date the medical waste was transported.

A generator transporting medical waste pursuant to this section must not be regulated as a hazardous waste hauler pursuant to Section 117660.

Containment and Storage of Medical Waste

When storing medical waste, the following guidelines must be observed:

1. Contain medical waste separately from other waste at the point of origin.
2. Contain biohazardous waste in a biohazard bag conspicuously labeled with the words "BIOHAZARDOUS WASTE" or with the international biohazard symbol and the word "BIOHAZARD."
3. Sharps containers must be rigid and puncture and leak resistant when sealed, cannot be reopened without great difficulty, and properly labeled.
4. No bagged medical waste is to be removed from the bags.

When containing biohazardous waste in a biohazard bag, the following steps must be taken:

1. Tie bags to prevent leakage or expulsion of contents during all future storage, handling or transport.
2. Place biohazardous bags in a rigid or disposable container for storage, handling or transport. The containers must be:
    1. leak-resistant and fitted with tight covers
    2. sanitary and in good repair
    3. labeled with the words "BIOHAZARDOUS WASTE" or with the international biohazard symbol and the word "BIOHAZARD" on the lid and sides so as to be visible from any lateral direction
    4. washed and decontaminated each time they are emptied. Approved methods of decontamination include:
        1. exposure to hot water at 180 degrees F for a minimum of 15 seconds
        2. rinsing or immersing in Hypochlorite solution (500 ppm available chlorine), phenolic solution (500 ppm active agent), iodoform solution (100 ppm available iodine), or quaternary ammonium solution (400 ppm active agent) for a minimum of three minutes

    When containerizing sharps, take the following steps:

1. Place all sharps into a Sharps container.
2. Tape closed or tighten the lid of the full sharps containers to prevent spills and prepare for disposal.
3. Label sharps containers with the words "SHARPS WASTE," the international biohazard symbol and the word "BIOHAZARD."

Storage enclosures must be clean and orderly, secured to deny access to unauthorized persons and posted with a warning sign stating "CAUTION - BIOHAZARDOUS WASTE STORAGE AREA - UNAUTHORIZED PERSONS KEEP OUT," and, "CUIDADO - ZONA DE RESIDUOS - BIOLOGICOS PELIGROSOS - PROHIBIDA LA ENTRADA A PERSONAS NO AUTORIZADAS."

Handling and Treatment

Staff handling medical waste must wear the correct type of personal protective equipment (for example, gloves, goggles and lab coats).

Trash chutes, laundry chutes, compactors, and grinders must not be used to transfer or process untreated medical waste.

Recognizable human anatomical remains must be incinerated or buried (teeth are exempt).

Medical Waste Hauling

In accordance with the Department of Health Care Services (DHCS) facility site inspection requirements, providers must have a medical waste management hauler contract.

On-Site Waste Treatment Operating Procedures

Any facility planning to treat medical waste on-site using an autoclave, incinerator or microwave technology must obtain a permit from the local enforcement agency prior to commencing operations. Treated medical waste becomes solid waste and is no longer hazardous. An emergency action plan must be in place at locations where medical waste is being treated.

Any facility treating medical waste on-site using autoclaves or similar forms of sterilization must adhere to the following guidelines:

1. Follow standard written operating procedures for each steam sterilizer, including time, temperature, pressure, type of waste, type of container, pattern of loading, water content, closure on containers, and maximum leak quantity.
2. Check recording or indicating thermometers during each complete cycle to ensure 250 degrees F (121 degrees C) for 30 minutes or longer. Check thermometers for calibration at least annually. Operating parameters for each autoclave load must be documented.
3. Use heat-sensitive tape or other device for each container that is processed to indicate attainment of adequate sterilization conditions.
4. Use bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least once a month to check adequate sterilization.
5. Maintain records of procedures specified in one, two and four for a period of not less than three years.

Storage Time

Biohazardous waste less than 20 pounds may be stored on-site for up to 30 days above 0 degrees C or up to 90 days below 0 degrees C in a non-member secured area. Full Sharps containers ready for disposal and any biohazardous waste of 20 pounds or more may be stored on-site for up to seven days (longer storage times may be requested from the local enforcement agency). Biohazardous waste stored inside an office must be picked up by a licensed waste hauler every seven days.

Licensing Requirements for Equipment, Facility and Staff

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Equipment

Equipment must be licensed or registered as required by law. X-ray equipment must be registered must have a current physicist's report. Equipment must be maintained as recommended by the manufacturer and receive maintenance as the manufacturer requires. Equipment must be calibrated according to manufacturing guidelines. All maintenance activities must be documented (refer to Equipment Calibration Log (PDF)).

Facility

Facilities must be licensed in accordance with all applicable codes and regulations. X-ray and laboratory licenses are included in this requirement. If X-rays are performed in the office, there must be a supervising physician's certificate.

Safety procedures must be available in the provider's office. Refer to the Safety discussion for more information.

Staff

The following are licensing requirements for office staff:

1. Staff for whom licensure is required must have a valid, current license verified by the employer or facility. The facility must maintain a method of tracking expiration of staff licenses.
2. All individuals delivering emergency care need to be skilled in use of the equipment and knowledgeable about the treatment procedures employed. Documentation should be maintained regarding training in emergency procedures and equipment use.

3. Nurse practitioners (NPs) are to practice under standard procedures signed by the supervising physician.
4. Physician assistants (PAs) should practice under written guidelines signed by the PA and the supervising physician.
5. Registered nurses (RNs), certified medical assistants (CMAs) and licensed vocational nurses (LVNs), must provide a copy of their license, certification or training certificate.
6. Medical assistants must be trained and certified in accordance with California Business and Professions Code sections 2069-2070 (16 CCR, 1366-1366.1).

Providers must have job descriptions for their staff that include qualifications and duties for each licensed and non-licensed category.

Health Net makes template policies and procedures, including Staff Qualifications (PDF), Non-Physician Medical Practitioners (PDF), and Notice to Consumers (physicians assistance (PDF), physicians (PDF)) available for practitioners' use.

Safety

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net requires that all facilities serving Medi-Cal members strictly adhere to all regulatory agency rules and regulations regarding fire and safety. Each facility must have evidence of being fire safe as evidenced by the fire department and state fire marshal's office.

Facility Responsibilities

Supervisors or designated staff are responsible for ensuring that emergency and fire protection policies and procedures are adhered to within their areas of responsibility and that fire hazards are reported and eliminated. Evacuation routes must be clearly posted and all telephones should be marked with emergency numbers.

Monthly inspections of fire extinguishers must be performed by supervisors or designated staff and a log documenting the inspections maintained. Records of fire inspections must also be maintained.

Fire Safety Training

All new employees must be trained in facility-specific fire safety measures. A set of fire safety procedures must be issued to, read and signed by the employees, indicating their understanding of the procedures. A log documenting this training is to be kept.

Employee Responsibilities

Employees are responsible for reporting the following potential fire hazards:

1. defective or inoperable emergency equipment (for example, fire extinguishers and blocked emergency exits)
2. housekeeping hazards (over-accumulation of trash, rags and other combustibles)
3. defective heat-producing equipment (for example, malfunctioning heaters, furnaces or ovens)
4. misuse or mishandling of biohazardous materials
5. electrical hazards (for example, exposed wires on appliances)

Outside Agency Responsibilities

Local fire department representatives perform periodic inspections to ensure compliance with codes and regulations. Copies of deficiency and hazard reports are forwarded to the facility manager. Maintenance of portable fire extinguishers is performed by contractors licensed by the California state fire marshal.

Fire Emergency Procedures

Whenever a fire occurs that could result in a threat to life or property, immediately call the fire department (911) and notify the designated department in the facility.

Consult the provider facility's building management staff and follow the prescribed reporting sequence:

- Remove yourself and others in any immediate danger.
- Call the fire department or facility response team or pull alarm as specified in the facility.
- Close doors in the fire area.
- Evacuate in accordance with the facility evacuation plan.

General Fire Safety Regulations

The following safety regulations must be followed at all times:

1. Smoking is prohibited in work and common areas as designated by California and local laws, wherever an area is posted as a non-smoking area, and within 25 feet of any flammable materials storage area.
2. Corridors, passageways, roadways, stairways, and any walkways leading to and from an exit must remain clear and free of any obstructions.
3. The minimum width of an exit aisle is 28 inches.
4. A minimum clear space of 36 inches and clear access must be maintained around sprinkler system control valves, fire alarm devices, fire ladders, fire hose stations, extinguishers, and electrical switch boxes and panels.
5. Fire doors must be kept closed at all times.
6. Combustible waste or refuse must be properly stored or disposed of to prevent unsafe conditions.
7. Use of sawdust or similar combustible materials to soak up combustible or flammable liquids spilled or dropped from machinery or processes on any floor is prohibited.
8. A minimum clearance of 18 inches must be maintained between the top of stored materials and sprinkler deflectors.

Storage of Flammable and Combustible Liquids

Flammable and combustible liquids must be stored in accordance with the following:

1. Flammable and combustible liquids must be contained in Underwriter's Laboratory (UL) approved containers and properly labeled, and the date of purchase must be indicated on the container face.
2. Flammable and combustible liquids must be kept in approved storage cabinets marked "FLAMMABLE - KEEP FIRE AWAY." Up to 60 gallons of Class I and Class II flammable or combustible liquids may be stored in storage cabinets UL approved for flammable liquids.
3. Containers of flammable liquids must not be stored near steam coils or any other source of heat.
4. Stored liquids must not physically obstruct an exit.
5. Minimum aisle width of three feet must be maintained wherever flammable materials are stored.

Flammable and combustible liquids must not be stored with incompatible materials, such as acids and alkalis or with any material that reacts violently with water.

Electrical Appliances

All electrical appliances must bear the Underwriter's Laboratory (UL) or Factory Mutual (FM) approval. Further, all electrical equipment must be turned off or disconnected at the end of shift unless directed otherwise by the manufacturer.

Language Assistance Program and Cultural Competency

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's cultural and linguistic services.

Select any subject below:

- Language Assistance Program and Cultural Competency
- Language Assistance Program and Cultural Competency (Hospitals only)

Language Assistance Program and Cultural Competency

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

The Health Care Language Assistance Regulations require all health plans to provide language assistance and culturally responsive services to members or member companions with limited English proficiency (LEP), limited reading skills, who are deaf or have a hearing impairment, or who have diverse cultural and ethnic backgrounds.

To comply with this requirement, Health Net created the Language Assistance Program (LAP). Health Net's LAP offers interpreter services to members to ensure that Health Net members with LEP are able to obtain language assistance while accessing health care services. Health Net's LAP supports Health Net members' linguistic and cultural needs.

Additionally, Health Net offers interpreter support and requires all participating providers to take evidence-based cultural competency courses. Providers are encouraged to take courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Health Net's cultural competency trainings offer evidence-based practices in providing responsive, accessible care across culturally diverse populations (i.e., older adults, persons with disabilities, children with special health care needs, LGBTQIA+ communities, refugees and migrants, people experiencing homelessness (unhoused), justice involved populations). Health Net participating providers must comply with Health Net's LAP as defined in this section.

Compliance Requirements

Health Net participating providers, including providers and PPGs delegated for case management and utilization management (UM), are required to comply with Health Net's LAP by using the following:

Interpreter services - Use qualified interpreters for members with LEP. Interpreter services are provided by Health Net at no cost to providers or members. Interpretation services include face-to-face (in-person), telephone, video remote, sign language (including American Sign Language and tactile), and closed captioning interpretation. Please request interpretation services at least 5-10 days before the scheduled appointment.

- Telephone interpreters are available in more than 150 languages. Advance notice for telephone interpreters is not required.
- Translation services - Provide Health Net, upon request and in a timely manner, with the documents sent to members. If a Health Net member requests translation or an alternative format of an English document that was produced by a delegated PPG on Health Net's behalf, the provider must refer the member to the Health Net Member Services phone number listed on the member's identification (ID) card. When Member Services receives the request from the member, Health Net contacts the provider requesting a copy of the specific English document for translation or alternative format. The provider must submit an editable version of the document within 48 hours of Health Net's request. Translation is only available in threshold languages. Alternative formats are required in all languages.
- Tagline (also known as the Notice of Availability) and non-discrimination notice - Include a Health Net-specific tagline and non-discrimination notice with all member informing materials going to Health Net members.

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
Commercial Non-discrimination Notice (PDF)	Non-discrimination Notice CalViva Health (English) (PDF)	Non-discrimination Notice Community Health Plan of	Non-discrimination Notice Medi-Cal (English) (PDF)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
		Imperial Valley (English) (PDF)	
	Non-discrimination Notice CalViva Health (Hmong) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (Spanish) (PDF)	Non-discrimination Notice Medi-Cal (Arabic) (PDF)
	Non-discrimination Notice CalViva Health (Spanish) (PDF)		Non-discrimination Notice Medi-Cal (Armenian) (PDF)
			Non-discrimination Notice Medi-Cal (Khmer) (PDF)
			Non-discrimination Notice Medi-Cal (Chinese - Traditional) (PDF)
			Non-discrimination Notice Medi-Cal (Chinese - Simplified) (PDF)
			Non-discrimination Notice Medi-Cal (Farsi) (PDF)
			Non-discrimination Notice Medi-Cal (Hmong) (PDF)
			Non-discrimination Notice Medi-Cal (Korean) (PDF)
			Non-discrimination Notice Medi-Cal (Russian) (PDF)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
			Non-discrimination Notice Medi-Cal (Spanish) (PDF)
			Non-discrimination Notice Medi-Cal Tagalog) (PDF)
			Non-discrimination Notice Medi-Cal (Vietnamese) (PDF)

- Member complaint/grievance forms - Provide translated member grievance forms (provided under the Forms section of the provider library) to members upon request.
- Independent Medical Review (IMR) Application - Locate translated IMR applications on the Department of Managed Health Care (DMHC) website at www.dmhc.ca.gov and make them available to members upon request.
- Medical record documentation - Document the member's language preference (including English) and the refusal or use of interpreter services in the member's medical record.

Interpreter Services

Health Net offers 24-hour access to interpreter services at no cost. To obtain interpreter services, members and providers can contact Health Net Member Services at the phone number located on the member's ID card. Telephone interpreters are available at the time of the appointment without pre-scheduling through Member Services. Allow adequate time before the appointment to get the telephone interpreter on the line.

Language assistance services include:

- Qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics.
- Telephone interpreters available in more than 150 languages and on short notice in support of last-minute appointments to meet the revised access and availability standards.
- Face-to-face (in person), telephone, video remote, and sign language interpreter services, and closed captioning interpretation services are available when requested a minimum of 5-10 business days in advance of the appointment.
- Support to address common communication challenges across cultures.
- Oral translations of member materials in more than 150 languages.

Provider Responsibilities

Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that interpreters are available at the time of the appointment.

- Ensure that members with LEP are not subject to unreasonable delays in the delivery of services, including accessing providers after hours.
- Provide interpreter services at no cost to members.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to members with LEP that are as effective as those provided to members without LEP.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in their medical record. Providers are strongly encouraged to document the use of any interpreter in the member's record.
- Provide translated member grievance forms to members upon request.

Providers are prohibited from:

- Requesting or requiring an individual with LEP to provide their own interpreter.
- Relying on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Relying on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
- Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

Providers are responsible for providing translated care plans in threshold languages to members with LEP and/or their companions/caretakers. Care plans must be written at a 6th grade reading level for Medi-Cal and 8th grade reading level for Commercial members. Health Net provides the translations in threshold languages upon request with documentation that the content is at the applicable reading level. Refer to the provider Interpreter Services Quick Reference Guide for assistance.

- Interpreter Services Flyer (PDF) (Commercial and Medi-Cal)
- Interpreter Services Flyer (PDF) (CalViva Health)
- Interpreter Services Flyer (PDF) (Community Health Plan of Imperial Valley)

A Language Identification Poster is available to print and post in providers' offices.

- Medi-Cal Language Identification Poster (PDF)
- CalViva Health Language Identification Poster (PDF)
- Community Health Plan of Imperial Valley Language Identification Poster (PDF)

For more information about how to work with an interpreter, refer to the Health Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations – Health Net (PDF), Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – Community Health Plan of Imperial Valley (PDF) or Health

Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – CalViva Health Industry Collaboration Effort (PDF).

Cultural Competency Training

All Health Net participating providers must take cultural competency training. Training is required upon hire and every two years afterward. The trainings are computer-based training for health care providers. OMH developed these no-cost trainings to give providers competencies to better treat an increasingly diverse population. The general training is available at Think Cultural Health. OMH also has a no-cost, accredited maternal health care training available at Think Cultural Health Education. Health Net does not sponsor these trainings or materials.

The Institute for Healthcare Improvement has free downloads to improve plain language communication with patients under the Ask Me 3® program.

You can also access Health Net's cultural competency training for providers and PPG staff or contact Health Net's Health Equity Department for customized training to meet your needs.

Medi-Cal providers may have the completion of cultural competency training listed in the provider directory. The provider directory indicates a "Y" if the provider has completed two hours of cultural training within the last 24 months. Failure to complete training will result in the removal of cultural training indicator on the provider directory. PPG and delegated provider audits may result in Corrective Action Plans.

Providers who would like information about interpreter services, cross-cultural communication, health literacy or to schedule a training, can contact Health Net's Health Equity Department.

Language Assistance Program and Cultural Competency

Provider Type: Hospitals

Health Net maintains an ongoing Language Assistance Program (LAP) to ensure members with limited English proficiency (LEP), limited reading skills, who are deaf or have hearing impairment, or who have diverse cultural and ethnic backgrounds have appropriate access to language assistance while accessing health care services. Health Net provides evidence-based trainings to support culturally responsive quality care for our diverse California populations, as well as our transgender and gender diverse members. Health Net encourages providers to consider evidence-based cultural competency courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Hospital Requirements

Health Net's participating hospitals are subject to requirements to provide language interpreter services for their patients pursuant to federal and state law. Health Net expects its participating hospitals to fully meet these obligations, notwithstanding Health Net's separate obligations to meet all requirements under the Health Care Language Assistance Regulations to provide language interpreter services for its members at all points of contact.

Interpreter Services Requirements

Section 1557 of the Affordable Care Act (published as 45 CFR 92) provides guidance on interpreter services, including the use of bilingual staff that act as interpreters. The guidance is summarized below.

- Provide services to individuals with LEP and individuals with a hearing incapacity that are as effective as those provided to members without LEP.
- Providers may not request or require an individual with LEP to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not rely on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances.
    - Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
    - Health Net members have the right to file a grievance with Health Net if their language needs are not met. Members can also file a discrimination complaint with the Office of Civil Rights if their language needs are not met.

Health Net has processes in place to ensure that members with LEP can obtain Health Net's assistance in arranging for the provision of timely interpreter services to the extent its participating hospitals are not required under state and federal law to provide a particular Health Care Language Assistance Regulations-required interpreter service.

Health Net monitors its participating hospitals for deficiencies in interpreter services and takes appropriate corrective action to address these deficiencies in the delivery of interpreter services to Health Net members.

Providers who would like to schedule trainings on topics such as cross-cultural communication, health literacy or accessing interpreter services should contact Health Net's Health Equity Department.

For additional information, refer to Health Net's Interpreter Services or the Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF).

Health Education

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information about health education services.

Health Education Materials

Information for Medi-Cal members must be provided at a 6th-grade (or lower) reading level and must be in an easy-to-read format. Health Net health education brochures and fact sheets for Medi-Cal members are written at this level. Diverse cultural backgrounds are taken into consideration when these materials are created and translated. The Health Net Health Equity Department reviews these materials for accuracy of translation, cultural content and reading level.

Providers are required to have educational materials available in approved threshold languages. Health Net evaluates member materials with the assistance of experts, community advisory committees, focus groups, and individual and group interviews. For information on threshold language requirements, refer to Access to Care requirements under Compliance and Regulations.

Health Net health education printed materials may be ordered by completing the online order form.

Health Education Program and Requirements

Some participating physician groups (PPGs) provide additional health education services for members.

Medi-Cal providers must provide health education materials, services and resources in approved threshold languages and at no cost to Health Net members. Subject matter should address the needs of the general membership population. Information on the following subjects must be available:

- Age-specific anticipatory guidance (Medi-Cal only) - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Alcohol and drug use
- Appropriate use of health care services
- Asthma
- Complementary and alternative care
- Dental health
- Diabetes
- Exercise
- Family planning
- Health education services
- HIV and sexually transmitted infection (STI) prevention
- Hypertension
- Immunizations
- Injury prevention
- Managed health care
- Nutrition, weight control and physical activity

- Obstetrical care
- Parenting
- Perinatal health
- Preventive and primary health care
- Risk reduction and healthy lifestyles
- Substance abuse
- Tobacco prevention and cessation
- Tuberculosis (TB)
- Unintended pregnancy prevention

The Health Net Health Education Department offers no-cost informational materials, programs and other services on a variety of topics to promote healthy lifestyles and health improvement to Health Net members.

Health Net members and providers may call the Member Services Department (Health Net Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley) to request educational materials in different languages, information about health education programs available through Health Net, community and national health education programs and services, and to obtain toll-free health information phone numbers.

Program Monitoring

Providers are responsible for documenting health education referrals and provision of health education materials in the member's medical record. Health Net uses the following methods to monitor and assess the quality of preventive care and health education services offered by providers and participating physician groups (PPGs):

- Primary care facility site reviews conducted for new providers applying to Health Net to become Medi-Cal managed care providers and recertification reviews conducted for continuing providers.
- Health education program evaluations conducted through member satisfaction surveys as a follow-up to health education material requests and program and class referrals and participation.
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures and focused review studies.

Resources Available to Providers

Health Net provides education to primary care physicians (PCPs) and participating physician groups (PPGs) on Health Net's health education programs and services through the following methods:

- On-site provider education visits - Conducted by Health Net health promotion consultants and the Health Net Facility Site Review (FSR) Compliance Department nurses, these visits focus on the health education resources available to PCPs and are an opportunity for Health Net to distribute the health education resource material and promote preventive care screenings and education.
- Provider Updates - Used to inform providers of new health education policies, programs and services.

Health Net Quality Improvement Department

The Health Net Quality Improvement Department establishes programs to meet the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site certification, and medical record audits, along with any necessary follow-up quality action plans. This department monitors the results of quality improvement (QI) activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also responsible for preparation and implementation of any identified corrective actions based on findings of the CMS, DHCS and DMHC audits and findings identified through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by quality improvement specialists (QIS) who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. The QIS are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, a QI program manager is responsible for ensuring compliance with all CMS, DHCS and DMHC access to care standards, monitoring processes and access to care action plans.

For more information, select any subject below:

- Health Education Program, Services and Resources
- CalViva Health Education Program, Services and Resources
- Molina
- Tobacco Cessation Program

Health Education Program, Services and Resources

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following interventions and resources are available at no cost to Medi-Cal members. Members and providers may obtain more information by contacting the Medi-Cal Member Services Department (Health Net, Community Health Plan of Imperial Valley or CalViva Health) or by following the links below. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7. Printed educational resources are sent to members within four weeks of request.

- Healthy Pregnancy – Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement, and handbooks on planning a healthy pregnancy, caring for your baby, and teen parenting. High risk pregnancies receive additional case management services.
- Tobacco cessation program – Kick It California (formerly California Smokers' Helpline) is a no-cost, state-wide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers:

a telephonic quit coach:

- Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).

- Quit plan tailored to member's unique circumstances.

- Available Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.
- To enroll, members may use an online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

Automated texting program

- Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within one business day.
- Text "Quit Smoking" or "Quit Vaping" to 66819.
- Texto "Dejar de Fumar" o "No Vapear" al 66819.

Chat with a quit coach:

- Kickitca.org/chat.
- Health care providers may use the chat to find answers to cessation-related questions. Available in English only, Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.

Mobile app:

- Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
- Features tools such as personal log of smoking triggers, motivational reminders and links to helpful resources.
- Available for download in the App Store® and Google Play®.
- Visit Kick It California for more details.

Diabetes Prevention Program – Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.

- Digital Health Education: Members have access to online and digital resources for health education through our Krames Staywell Health Library – Resource library to help you learn about your health and how to stay healthy.
    - Health and Medications – Easy access to more than 4,000 health sheets.
    - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.

- Teladoc Mental Health Digital Program – Available in English and Spanish, members have access to an evidence-based, self-help resource to improve their mental health. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, sleep problems and many other mental health conditions. Members can enroll in this program at Teladoc. After completing the sign up process members can access the program using the Teladoc website or though the Teladoc mobile app.
- Health Promotion Incentive Programs – Health Education partners with the Quality Improvement department to develop, implement and evaluate incentive programs to encourage members to receive health education and to access preventive health care services.
- Community Health Education Classes – Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs – The Plan participates in health fairs and community events to promote health awareness to members and the community. Plan representatives provide screenings, presentations and/or health education materials at these events.

The following resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, dental care, prenatal care, exercise and more. These materials are available in several threshold languages.
- Health Education Material Order Form – Members can request health education resources by contacting the Medi-Cal Member Services Department (Health Net, Community Health Plan of Imperial Valley or CalViva Health). They can also get Plan printed resources at contracted provider offices and health education classes.
- Health Education Programs and Services Flyer – This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in all 12 threshold languages. They are mailed to new members and are also available online.
- Member Newsletter – Plan news is mailed to members regularly and covers various health topics with the most up-to-date information on health education interventions.

The following resources are available to providers:

- Pediatric and Adolescent Overweight Assessment and Management Guidelines – Adapted from the Child and Adolescent Obesity Provider Toolkit produced by the California Medical Association (CMA) Foundation, the downloadable Pediatric and Adolescent Overweight Management Guidelines (PDF) flip chart gives providers practical, point-of-care guidance on the prevention and treatment of being overweight, and obesity. Additionally, it outlines new requirements related to the use of World Health Organization (WHO) growth charts for children under age 2.
- Body Mass Index (BMI) Training – Commonly used as a refresher course, Health Net's BMI in-person training provides participants with an in-depth review on calculating height, weight and BMI percentile. A cultural awareness segment is also included to introduce staff to communication practices within diverse populations.
- Health Education Material Order Form – Providers can request printed health education materials by using the Health Education Material Order Form found online.

A number of resources are available via the Internet to help physicians calculate BMI, determine percentiles and obtain additional information and tools regarding obesity in children and adults:

- The Centers for Disease Control and Prevention's (CDC's) National Center for Chronic Disease Prevention and Health Promotion BMI web page includes a BMI calculator, information on BMI specific for children and teens and links to the CDC's growth charts and training modules.
- The CDC's website provides the downloadable BMI-for-age clinical growth charts.
- The National Heart, Lung, and Blood Institute offers healthy weight assessment tools and health professional resources.
- The online training modules developed by the CDC and the U.S. Health and Human Services Maternal and Child Health Bureau (MCHB) teach how to use and interpret the CDC growth charts.

CalViva Health Education Program, Services and Resources

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information applies to Fresno, Kings and Madera counties only.

The following interventions and resources are available at no cost to CalViva Health Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting the toll-free CalViva Health Member Services Department. Members are directed to the appropriate service or resource based on their needs. Telephonic and web-based services are available 24/7.

- Pregnancy Program - A supportive program for pregnant members and new parents that offers personalized care from pregnancy through after your baby is born.
- The program provides education, care coordination, and helpful resources—such as breastfeeding support, mental health support, help with basic needs, and assistance for high-risk pregnancies—to support a healthy pregnancy and baby.
- Tobacco Cessation Program – Kick It California (formerly known as the California Smokers' Helpline) is a no-cost, stop smoking and vaping program for members ages 13 years and older. This program can double one's chance of quitting for good. Kick It California offers:

Telephonic quit coach

- Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
- Tailored quit plan to member's unique circumstances.
- Available Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.
- To enroll, members may use an online web form or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

Automated Texting Program

- Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within one business day.
- Text "Quit Smoking" or "Quit Vaping" to 66819.
- Texto "Dejar de Fumar" o "No Vapear" al 66819.

Chat with a quit coach:

- Kickitca.org/chat
- Health care providers may use the chat to find answers to cessation-related questions.
- Available in English only, Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.

Mobile apps

- Kick It Quit Smoking/Vaping apps designed to help people quit smoking and vaping.

- Features tools such as personal log of smoking triggers, motivational reminders and links to helpful resources.
- Available for download in the App Store® and Google Play®.
- Visit Kick It California for more details.

- Diabetes Prevention Program - Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.
- High Blood Pressure and Heart Health – Members have access to resources to guide them in lowering their blood pressure and having better heart health.

- Digital Health Education – Members have access to online and digital resources for health education through our Krames Online Health Library – Resource Library to help them learn about their health and how to stay healthy.
    - Health and Medications– Easy access to more than 4,000 health sheets.

- Teladoc Mental Health Digital Program: Available in English and Spanish, members have access to an evidence-based, self-help resource to improve their mental health. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, sleep problems, and many other mental health conditions. Members can enroll in this program at Teladoc. After completing the sign up process members can access the program using Teladoc or through the Teladoc Health mobile app.

- Health Promotion Incentive Programs - Health Education partners with the Quality Improvement department to develop, implement and evaluate incentive programs to encourage members to receive health education and to access preventive health care services.
- Community Health Education Classes - Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs - CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide presentations and/or health education materials at these events.

The following resources are available to members:

- Health Education Resources - Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Programs and Services Flyer - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines - The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages. They are mailed to new members and are also available on www.CalvivaHealth.org.
- Member Newsletter - CalViva Health News is mailed to members regularly and covers various health topics and the most up-to-date information on health education interventions.

The following resources are available to providers:

- Pediatric and Adolescent Overweight Assessment and Management Guidelines - Adapted from the Child and Adolescent Obesity Provider Toolkit produced by the California Medical Association

(CMA) Foundation, CalViva Health's Pediatric and Adolescent Overweight Management Guidelines (PDF) flip chart gives providers practical, point-of-care guidance on the prevention and treatment of being overweight, and obesity. Additionally, it outlines new requirements related to the use of World Health Organization (WHO) growth charts for children under age 2

A number of resources are available via the Internet to help physicians calculate body mass index (BMI), determine percentiles and obtain additional information and tools regarding obesity in children and adults:

- The Centers for Disease Control and Prevention's (CDC's) National Center for Chronic Disease Prevention and Health Promotion BMI Web page includes an adult BMI calculator, information on BMI specific for children and teens and links to the CDC's growth charts and training modules
- The CDC's website provides the downloadable BMI-for-age clinical growth charts
- The National Heart, Lung, and Blood Institute offers healthy weight assessment tools and health professional resources.
- The online training modules developed by the CDC and the U.S. Health and Human Services Maternal and Child Health Bureau (MCHB) teach how to use and interpret the CDC growth charts.

Molina

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information applies to Los Angeles County only.

Health Net and its subcontracting health plan, Molina Healthcare (in Los Angeles County only), offer health education programs, services and information sources for members.

Providers participating through Molina must use the health education resources offered through their affiliated plan.

Health Education Services

Molina Healthcare (MHC) delegates the provision of health education services to independent practices association (IPA)-affiliated medical groups under the Medi-Cal managed care contract. Molina also supports all participating providers, by offering the following:

- Health education member information materials written in many languages that are culturally appropriate for various target populations in key subject areas. The most appropriate setting for a member to receive written literature is from their primary care physician (PCP) with a brief discussion.
    - Participating physicians may download or print health education materials from the Molina provider website.
- For more information, contact MHC Health Education. Materials in alternate formats, including large font of at least 18-point print, Braille or audio, should be offered for MHC Seniors and Persons with Disabilities (SPD) members with low vision or who are blind. Participating providers may request materials in alternative formats, by contacting the MHC Member Services Department.

Interpreter Services

Molina Healthcare offers members with limited English proficiency 24-hour access to qualified interpreter services at no cost. Molina also provides sign language interpreters for members who are deaf or hard of hearing.

- For interpreter services, providers or members can contact Molina Interpreter Services directly.
- For after hours and weekends, contact Molina's Nurse Advice Line (English or Spanish available).
- To speak to members who are deaf, hard of hearing, or have a speech difficulty on the telephone, providers may use the California Relay Service, dial 711 and give the relay operator (RO)/ communication assistant (CA) the member's area code and phone number. The RO/CA will connect and communicate via the member's preferred type of communication (TTY, VCO, Internet, or ASCII).

Tobacco Cessation Program

Provider Type: Physicians | Participating Physician Groups (PPG)

Kick It California (formerly California Smokers' Helpline) is a tobacco cessation program available to Health Net, Community Health Plan of Imperial Valley and CalViva Health members. The program offers specialized services for teens, pregnant smokers, individuals who chew tobacco, and e-cigarette users, and provides information on how to help a friend or family member quit tobacco use.

Health Net will cover tobacco cessation counseling for at least two separate quit attempts per year, without prior authorization, and with no mandatory break between quit attempts. Non-pregnant adult members are eligible for a 90-day regimen of any Food and Drug Administration- (FDA-) approved tobacco cessation medication. This includes over-the-counter medications with a prescription from the provider. At least one FDA-approved medication will be made available without prior authorization.

Telephonic quit coaching

- Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
- Quit plan tailored to member’s unique circumstances.
- Available Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.
- To enroll, members may use an online web form, or call 800-300-8086 (English) or 800-600-8191 (Spanish).

Texting program

- Texting program for smoking or vaping in English and Spanish.
- Designed to give extra support to quit cigarettes or vapes during the six months after enrollment.
- Messages deal with motivation, planning, getting support, self-talk, recovering from slips and more.
- Incorporate both automated messaging and personalized support. Quit coaches respond to questions within two business days.

Chat coaching

- Health care providers may use the chat to find answers to cessation-related questions.
- Available in English only, Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.

Mobile apps

- Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
- Features tools such as personal log of smoking triggers, motivational reminders and links to helpful resources.
- Available for download on the App Store® and Google Play®.

Visit Kick It California for more details.

Medi-Cal Quality Improvement Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement Department establishes programs to meet the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site certification, and medical record audits, along with any necessary follow-up quality action plans.

This department monitors the results of quality improvement (QI) activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also responsible for preparation and implementation of any identified, quality-related corrective actions based on findings of the CMS, DHCS and DMHC audits and findings identified through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by individuals who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. Assigned team members are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, they are responsible for ensuring compliance with all CMS, DHCS and DMHC access to care standards, monitoring processes and access-to-care action plans.

For more information, select any subject below:

- Community Advisory Committee
- Facility Site Review Compliance Department

Community Advisory Committee

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net has established local and regional Community Advisory Committees (CACs) for each County in which we participate as a Medi-Cal plan. The Committees' purpose is to help Health Net understand the communities' needs.

Some of the duties of a CAC include but are not limited to:

- Accessing health care and services, including preventive care services
- The Cultural and Linguistic Services Program
- Population health
- Children's services
- Discuss improvement opportunities with an emphasis on health equity and social drivers of health in order to support people living with disabilities, justice involved persons, foster youth, LGBTQIA, and other populations
- Health equity and health gaps
- Important Health Net projects

A CAC is a forum for the community to directly connect with Health Net and share their ideas and concerns. Feedback from the Committee will inform future planning for the Medi-Cal program.

A CAC comprises Medi-Cal Members, County Department representatives, Community Providers, Community Based Organizations (CBOs), Community Advocates, and Health Net staff. The Committees meet quarterly and new members are welcome.

If you're interested in joining one of our advisory committees, please register here and a Health Net representative will contact you.

Facility Site Review Compliance Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Facility Site Review (FSR) Compliance Department is responsible for conducting facility site and medical record reviews of participating primary care physicians (PCPs), and for educating and helping providers so that they may be compliant with all regulatory agency requirements and standards of practice, including preventive care, continuity of care and health education.

The Health Net FSR Compliance Department continually develops and offers materials to simplify the documentation process. Refer to Facility Site Review to obtain materials about legal and regulatory requirements on providers' responsibilities.

Health Net's FSR Compliance nurses support and educate PCPs and their staff to meet the legal and contractual requirements for Medi-Cal members. They are designated by the Department of Health Care Services (DHCS) as certified FSR reviewers. They develop tools, forms and training packets for the providers' use in documentation of medical record criteria, preventive care services, continuity of care, health education, and other clinical interventions. On request, they offer educational material for disease management and public health programs.

The FSR Compliance nurses coordinate and conduct on-site visits for individual providers, clinics and participating physician groups (PPGs) who provide primary care services. Reasons for on-site visits include:

- Requests from providers and PPGs.
- Referral from the Health Net Quality Improvement Department following facility site and medical record audits.
- Referrals from Health Net medical directors.
- Efforts to facilitate coordination of care between primary care physicians (PCPs) and state health programs.
- DHCS contractual requirements.
- Promotion of health education programs.
- Grievance visits.

The Health Net FSR Compliance Department provides the following services and resources:

- Office system consultation and assistance with quality action plans (following facility and medical record audits).
- Individualized in-service and educational programs for providers and PPGs.
- Adult and pediatric (Medi-Cal only) medical record documentation tools - A comprehensive compilation of sample forms and tools designed to help PCPs comply with DHCS documentation requirements.
- Provider education resource packets - These packets contain copies of member handouts, references to additional resources, and sample medical management documentation tools. Topic examples available include asthma, diabetes and healthy lifestyles.
- Quick Tips for Medi-Cal managed care state health programs- Customized by county, these cards contain key concepts of many public health programs with which Medi-Cal managed care providers interact. Reference numbers and focus points assist office staff in coordinating services with these agencies.

Medi-Cal Quality Improvement Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement Department establishes programs to meet the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site certification, and medical record audits, along with any necessary follow-up quality action plans.

This department monitors the results of quality improvement (QI) activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also responsible for preparation and implementation of any identified, quality-related corrective actions based on findings of the CMS, DHCS and DMHC audits and findings identified through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by individuals who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. Assigned team members are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, they are responsible for ensuring compliance with all CMS, DHCS and DMHC access to care standards, monitoring processes and access-to-care action plans.

For more information, select any subject below:

- Community Advisory Committee
- Facility Site Review Compliance Department

Quality Improvement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on the Health Net Quality Improvement (QI) program.

Select any subject below:

- Overview
- Community Supports Data Sharing and Access
- Enhanced Care Management Data Sharing and Access
- Health Net Quality Improvement and Health Equity Committees
- Medi-Cal Member Survey
- Medi-Cal Quality Improvement Projects
- Monitoring Access Standards Compliance
- Quality Improvement Program
- Quality Improvement and Health Equity Transformation Program
- Quality Improvement Program and Compliance and HEDIS
- Quality of Care Issues

Overview – Quality Improvement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement (QI) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals.

Health Net’s Population Health Management strategy leverages utilization and risk stratification data from multiple sources to support data-driven decision-making. This approach enables care teams to proactively identify and engage members with appropriate resources to address medical needs and social determinants of health. The QI program impacts the following areas:

1. **Members** in all demographic groups and in all service areas in which Health Net is licensed.
2. **Network Providers,** including physicians, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
3. **Aspects of Care**, including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.
4. **Health Disparities** by supporting targeted activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities across member populations.
5. **Communication** to meet the cultural and linguistic needs of all members.
6. **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
7. **Provider/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
8. **Services Covered by Health Net**, including preventive care; primary care; specialty care; telehealth; ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing care; home health care; long term care (LTC), Long-Term Services and Supports (LTSS); and Community Based Adult Services (CBAS), which meet the special, cultural and linguistic, complex or chronic needs of all members.
9. **Internal Administrative Processes** which are related to service and quality of care, including customer service, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

Except for Molina, Health Net does not delegate its QI program or oversight responsibilities to PPGs, participating providers, hospitals, or ancillary providers. All contracted entities are required to comply with Health Net's QI standards and requirements as outlined in this operations manual.

Health Net routinely communicates QI program goals, processes and outcomes related to member care through provider updates, committee meetings and other forums. QI program information is also available to providers by request through Health Net's Provider Services Center (Commercial, Medicare Advantage, Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley).

Community Supports Data Sharing and Access

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Bidirectional data sharing between Health Net and Community Supports (CS) providers is an important component for effective member interaction in the California Advancing and Innovating Medi-Cal (CalAIM) program. In addition to data confidentiality provisions under the *Participating Provider Agreement* (*PPA*) and requirements in relevant state and federal laws, the following establishes the terms and conditions for sharing data bidirectionally between the two parties. The manner in which data are shared and accessed by both Health Net and the CS provider includes the following information:

1) **Terminology and Common Language –** In order to ensure clarity and effective communication, this program establishes the use of common language and terminology between Health Net and the CS provider. Both parties shall make reasonable efforts to use consistent terminology and eliminate any ambiguity while referring to shared data and related concepts.

2) **Types of data include, but are not limited to**:

Data to be shared will vary depending on the criteria set by the Department of Health Care Services (DHCS) policy for each of the CS services:

1. Asthma Remediation
2. Housing Transition Navigation Services
3. Housing Deposit
4. Housing Tenancy and Sustaining Services
5. Short-Term Post-Hospitalization Housing
6. Recuperative Care (Medical Respite)
7. Respite Services
8. Day Habilitation Services
9. Nursing Facility Transition/Diversion to Assisted Living Facilities
10. Community Transition Services/Nursing Facility Transition to Home
11. Personal Care and Homemaker Services
12. Environmental Accessibility Adaptation (Home Modification)
13. Medically Supportive Food/Meals/Medically Tailored Meals

Parties de-identify data when applicable. Health Net prioritizes the data based on the criteria in the DHCS Community Supports Policy Guide. Additionally, data elements defined by DHCS encounter data reporting standards will be shared with CS providers.

3) **Specific circumstances, when Health Net grants the CS provider access to the shared data, include, but are not limited to**:

Based on the new DHCS CalAIM Data Guidance for CS member information sharing, Health Net is required to grant access and share member-level data with CS providers through a Community Supports Authorization Status File (CSASF), which will list members who have been assigned to that provider for service delivery and members the CS provider referred to Health Net for authorization consideration (as applicable).

4) **Specific circumstances, when the CS provider grants Health Net access to the shared data, include, but are not limited to**:

The CS provider is required to share timely updates about service delivery to Health Net through the Community Supports Provider Return Transmission File (CSPRTF).

5) **Individuals or staff roles within Health Net and the CS provider who will have authorized access to the shared data**.

a) Health Net individuals or staff roles who will have authorized access to CS provider's shared data include, but are not limited to:

- Director, Reporting & Business Analytics
- Supervisor, Reporting & Data Analysis

b) CS provider individuals or staff roles who will have authorized access to Health Net's shared data include, but are not limited to:

- Chief Executive Officer/Executive Director
- Chief Operating officer/Director of Operations
- CS Program Director
- CS Program Manager

6) **Tracking Referral Status –** The methods and/or tools to be used for tracking referral status (i.e., shared database or software system, etc.), the responsibilities of each party in updating and maintaining the referral status information, and the frequency of sharing updates with each party.

a) Methods and/or tools used to track the status of referrals by Health Net include but are not limited to:

Health Net expanded its partnership with findhelp, formerly known as Aunt Bertha, to support CS providers to access a closed-loop referral process. Findhelp is a network of social programs across the United States and is the largest online platform used to identify local resources, support staff, and community partners when searching for local services. Through our partnership, Health Net developed program cards for contracted CS providers and their services for visibility, referral and tracking. The platform helps create an efficiency for providers and members to search directly for no-cost or low-cost CS programs to support members with social determinants of health needs.

b) Methods and/or tools used to track the status of referrals by CS Provider include but are not limited to:

The CS provider can track all of its referrals through findhelp which is the primary referral tools for providers. Health Net encourages providers who receive referrals through phone, fax or email, to log their referrals in findhelp for tracking and reporting purposes.

c) Health Net's updating and maintaining referral status information include:

Findhelp has built-in data analytics that is updated daily where Health Net has the ability to monitor referrals and statuses on a regular basis. Health Net and findhelp provide technical assistance and support to help providers update and maintain their referral statueses.

d) CS provider's updating and maintaining referral status information include:

Within the findhelp platform, CS providers are required to and have the ability to update the statuses of the member which notifies the referring entity. There are several status that are available to use on the platform. A few examples below:

- **Eligible** – The member is eligible to receive services but has not received them yet.
- **Pending** – This status is usually made by a program and often means that the referral is being processed.
- **No longer interested** – The member has indicated they no longer need or are interested in this program. The next step is to follow up with the member and make sure their underlying need has been met.
- **Got help** – The member received services and got the help they needed.

e) The frequency at which Health Net will update and share referral status updates:

As part of the findhelp functionality, if statuses of a referral haven't been updated in a week, the provider and member would receive a referral reminder email, if email was the preferred and/or best way to reach them. Health Net also references the data on a regular basis to track referral status and follow up as needed. Additionally, Health Net developed a utilization report monthly to share with points of contact for CS providers as another way to educate and provide technical assistance.

f) The frequency at which the CS provider will update and share referral status updates:

CS providers are trained and encouraged to update the status as soon as a status needs to be updated or changed to inform the referring entity of the member's status. Health Net has the ability to pull that data directly from findhelp through the site's analytic feature.

7) Collaborative Evaluation

Both Health Net and the CS provider will engage in a yearly bidirectional evaluation process aimed at supporting joint quality improvement objectives. The partnership evaluation process will provide an opportunity for both organizations to assess and improve the effectiveness of the partnership for both staff and the individuals who Health Net and the CS provider serve. Collaborative improvement will involve both Health Net and the CS provider organizations in the evaluation process.

a) Health Net and the CS provider will collaborate to evaluate the effectiveness of its partnership:

There are several ways Health Net partners with CS providers to evaluate necessary improvements to the program.

- Each CS provider is assigned a point of contact where they meet regularly to discuss referrals, authorization, claims/billing, etc. This provides an opportunity for CS providers to bring up challenges and potential solutions or recommendations to improve processes.
- Health Net has hosted monthly office hours on several topics (i.e., findhelp, authorization and claims) for CS providers, which allowed providers to ask questions, get clarification and make recommendations for improvements.
- Health Net engages CS providers through an anonymous survey to capture where we are effective in supporting providers and where we can improve.

b) Upon completion of the collaborative evaluation on the effectiveness of the partnership, Health Net and the CS provider may use findings to inform any necessary improvements of the partnership to drive continuous quality improvement. Improvements may include but are not limited to:

Improvements focused on the infrastructure of the program specifically around IT infrastructure, including but not limited to authorization and billing as well as improvements and interoperability with findhelp. Additional improvements to the CS infrastructure includes adequate staffing and training to support providers.

Enhanced Care Management Data Sharing and Access

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Bidirectional data sharing between Health Net and Enhanced Care Management (ECM) providers is an important component for effective member interaction in the California Advancing and Innovating Medi-Cal (CalAIM) program. In addition to data confidentiality provisions under the *Participating Provider Agreement* (*PPA*) and requirements in relevant state and federal laws, the following establishes the terms and conditions for sharing data bidirectionally between the two parties. The manner in which data is shared and accessed by both Health Net and the ECM provider includes the following information:

1) Terminology and Common Language – In order to ensure clarity and effective communication, this program establishes the use of common language and terminology between Health Net and the ECM provider. Both parties shall make reasonable efforts to use consistent terminology and eliminate any ambiguity while referring to shared data and related concepts.

2) Types of data include, but are not limited to:

Data to be shared will vary depending on the criteria set by the Department of Health Care Services (DHCS) policy for each of the ECM Populations of Focus:

ECM Populations of Focus		Adults	Children & Youth
1a	• Individuals Experiencing Homelessness: • Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	X	
1b	• Individuals Experiencing Homelessness: • Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	X	X
2	• Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)	X	X

3	• Individuals with Serious Mental Health and/or SUD Needs	X	X
4	• Individuals Transitioning from Incarceration	X	X
5	• Adults Living in the Community and At Risk for LTC Institutionalization	X	
6	• Adult Nursing Facility Residents Transitioning to the Community	X	
7	• Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		X
8	• Children and Youth Involved in Child Welfare		X

9	• Birth Equity Population of Focus	X	X

Parties de-identify data when applicable. Health Net prioritizes the data based on the criteria in the Enhanced Care Management Policy Guide and DHCS CalAIM Data Guidance on Member-Level Information Sharing Between MCPs and ECM Providers. Admit, Discharge and Transfer (ADT) data will be shared with the ECM provider for the purpose of identifying best contact information and better servicing members per their need. Certain data, including diagnosis, will be shared only after member consent.

3) Specific circumstances when Health Net grants the ECM provider access to the shared data is granted include, but are not limited to:

Based on the DHCS CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers for ECM member information sharing, Health Net is required to grant access and share member level data with ECM providers through a Member Information File (MIF), which will list members who have been assigned to that provider for service delivery.

4) Specific circumstances when the ECM provider grants Health Net access to the shared data is granted include, but are not limited to:

The ECM provider is required to share timely updates about service delivery to Health Net through the Return Transmission File (RTF) and Outreach Transition File (OTF).

5) The individuals or staff roles within Health Net and the ECM provider who will have authorized access to the shared data.

a) Health Net individuals or staff roles who will have authorized access to the ECM provider's shared data include, but are not limited to:

- Director, Reporting & Business Analytics
- Supervisor, Reporting & Data Analysis
- Data analyst II

b) ECM provider individuals or staff roles who will have authorized access to Health Net's shared data include, but are not limited to:

- Chief Executive Officer/Executive Director
- Chief Operating officer/Director of Operations
- ECM Program Director
- ECM Program Manager
- ECM Lead Care Managers (LCM)

6) Tracking Referral Status - The methods and/or tools to be used for tracking referral status (i.e., shared database or software system, etc.), the responsibilities of each party in updating and maintaining the referral status information, and the frequency of sharing updates with each party.

a) Methods and/or tools used to track the status of referrals by Health Net include, but are not limited to:

- Health Net provider portal

The status for members who were referred for the ECM program can be found in the Health Net secure provider portal ECM tab. Once in the portal, select the *Eligibility* tab, then select *Enhanced Care Management* on the left navigation. This includes the members status and assigned ECM provider, if applicable (see data dictionary statuses below for member status definitions).

- Health Member Information File (MIF) and Mini-MIF (Referral File).

b) Methods and/or tools used to track the status of referrals by the ECM provider include, but are not limited to:

- Health Net provider portal

The status for members who were referred for the ECM program can be found in the Health Net secure provider portal ECM tab. Once in the portal, select the *Eligibility* tab, then select *Enhanced Care Management* on the left navigation. This includes the member's status and assigned ECM provider, if applicable (see data dictionary statuses below for member status definitions).

c) Health Net's updating and maintaining referral status information include:

Based on information received from ECM providers, Health Net updates the member status to maintain up to date information and share this with providers. This information is shared with providers through the provider portal, mini-MIF (referral file), and monthly MIF file as noted above. See data dictionary definitions below for additional details.

d) ECM provider's updating and maintaining referral status information include:

Through the Return Transmission File (RTF) submitted monthly to Health Net, ECM providers are required to update the status of the member which will notify Health Net of the status change.

e) The frequency at which Health Net will update and share referral status updates:

On a monthly basis, Health Net shares the Member Information File (MIF) with the ECM provider as an update on the status of all members. Additionally, as members are enrolled in ECM, the Health Net provider portal is updated to reflect member enrollment status.

f) The frequency at which the ECM provider will update and share referral status updates:

ECM providers are required to submit their monthly RTF file which should be updated to reflect the current status of the member. For potential ECM members who were identified in the community for referral to the plan, ECM providers are encouraged to report the member's interest in the program via the provider portal or fax.

7) Collaborative Evaluation

Both Health Net and the ECM provider will engage in a yearly bidirectional evaluation process aimed at supporting joint quality improvement objectives. The partnership evaluation process will provide an opportunity for both organizations to assess and improve the effectiveness of the partnership for both staff and the individuals who Health Net and the ECM provider serve. Collaborative improvement will involve both Health Net and ECM provider organizations in the evaluation process.

a) Health Net and the ECM provider will collaborate to evaluate the effectiveness of its partnership:

There are several ways Health Net partners with ECM providers to evaluate necessary improvements to the program.

- Each ECM provider is assigned a point of contact where they meet regularly to discuss referrals, authorization, claims/billing, etc. This provides an opportunity for ECM providers to bring up challenges and potential solutions or recommendations to improve processes.
- Health Net has hosted monthly office hours on several topics (i.e., findhelp, authorization and claims, data sharing) for ECM providers, which allowed providers to ask questions, get clarification and make recommendations for improvements.
- Health Net engages ECM providers through surveys to capture where we are effective in supporting providers and where we can improve.

b) Upon completion of the collaborative evaluation on the effectiveness of the partnership, Health Net and the ECM provider may use findings to inform any necessary improvements of the partnership to drive continuous quality improvement.

Health Net Quality Improvement and Health Equity Committees

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Quality Improvement and Health Equity Committee (QIHEC) is responsible for ensuring quality and safety of care and services rendered to Health Net members.

The QIHEC is led by Health Net's Chief Medical Director and Chief Health Equity Officer and is overseen by Health Net's Governing Board. The QIHEC meets quarterly. External practitioners (network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors) must be representative of the composition of Health Net Community Solutions' provider network.

The committee must include, at a minimum, network providers who deliver health care services to members affected by health disparities, limited English proficiency (LEP), children and youth with special health care needs (CYSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions in order to participate on this committee.

The committee must also include Health Net representatives from Behavioral Health, the Pharmacy Department, Network Management, Medical Affairs, Customer Service Operations, Credentialing, Peer Review, and Population Health & Clinical Operations (PHCO), which includes Utilization Management (UM) and Care Management. QIHEC does the following as part of its functions:

- Annually assess UM, QI, and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program at the regional and/or county level. Conduct a quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities.
    - Address activities and priorities related to the Quality Improvement and Health Equity Transformation Program (QIHETP).
    - Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
    - Institute actions to address performance deficiencies, including policy recommendations.
    - Ensure follow-up of identified performance deficiencies or gaps in care.

- Support efforts to align resources, strategies, and partners by place in order to reduce identified inequities (e.g., via use of Health Equity Improvement Zones).
- Identify differences in quality of care and utilization of physical and behavioral health care services for members directly managed and delegated to providers.
- Ensure that all interventions to address differences in quality of care and utilization have an equity focus, including addressing underlying factors such as social determinants of health (SDoH).
- Review performance measure results and address deficiencies, including results and deficiencies of all fully delegated subcontractors.
- Review progress summaries from Joint Operating Meetings.
- Ensure connectedness to the findings, recommendations and actions from the Quality Improvement Committee, Community Advisory Committees (CAC) and Public Policy Committee to drive universal decisions and programming.
- Ensure member confidentiality is maintained in QI discussions and avoid conflict of interest among the QIHEC members.
- The QIHEC shall provide input and advice on the following non-exclusive list of topics:
    - Population Health Management.
    - Health Delivery Systems Reforms to improve health outcomes.
    - Coordination of Care.
    - Clinical quality of physical and behavioral health care.
    - Access to primary and specialty health care providers and services.
    - Member experience with respect to clinical quality, access, and availability, culturally and linguistically competent health care and services, and continuity and coordination of care.
    - Non-Specialty Mental Health Services (NSMHS) member and PCP outreach & education plan.
- QIHEC is responsible for adequately addressing recommendations put forth by the CAC and providing feedback through a dashboard that outlines progress and decisions on recommendations.
    - For recommendations that the QIHEC is unable to reasonably address, a CAC may opt to escalate their recommendation to the Health Net Community Solutions (HNCS) Board of Directors for further review and consideration.
- Form and delegate authority to subcommittees when appropriate; and
- Review and reassess the adequacy of the charter annually and recommend any proposed changes to the Board for approval. The Committee shall annually review its own performance.

Subcommittees

Community Advisory Committee

Refer to Community Advisory Committee section.

Utilization Management

- Review and approve the annual Medi-Cal and dual-eligible Utilization and Care Management (CM) Programs, including the UM and CM Program Description, Work Plan and Work Plan Evaluation.
- Monitor and support the activities for UM and CM programs, review the effectiveness of the programs, and make recommendations for improvement; and
- Oversee UM activities performed by delegated subcontractors and the shared services teams.

Quality Management

- Review and approve the annual Medi-Cal, dual-eligible QI Program Description, Work Plan and Work Plan Evaluation.
- Monitor and support the activities for the QI program, evaluate the effectiveness of the Work Plan and make recommendations for improvement; and
- Review and approve the annual Health Education Program Description, Work Plan and Work Plan Evaluation.

Health Equity

- Review HNCS QI and QIHETP findings and required actions at the regional and/or county level;
- Review and approve the annual Health Equity Description, Work Plan, and Work Plan Evaluation;
- Monitor, support, and evaluate the activities for the QI and QIHETP programs, and make recommendations for improvements;
- Conduct an annual evaluation of the effectiveness of the language assistance services offered to support members with limited English proficiency and to mitigate potential cultural or linguistic barriers to accessing care in compliance with requirements from Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC);
- Concentrate on eliminating identified health disparities including, structural racism and social risk, SDoH, and community needs; make recommendations to improve individual and community health outcomes.
- Monitor, review, evaluate, and improve coordination and continuity of care services to all members, including:
    - Seniors and Persons with Disabilities (SPDs).
    - Children and Youth with Special Health Care Needs (CYSHCNs).
    - Members with chronic conditions (including behavioral health, homelessness, recently released from incarceration, use of Long-Term Services & Supports (LTSS), and children receiving child welfare services).
- Review and provide status on formal recommendations presented by the HNCS CAC.

Credentialing/Peer Review Committee

The Credentialing/Peer Review Committee verifies and reviews practitioners and organizational providers who contract to render professional services to Health Net members for training, licensure, competency, and qualifications that meet established standards for credentialing and recredentialing.

The Credentialing Committee ensures Health Net's credentialing and recredentialing criteria for participation in the Health Net network are met and maintained for all lines of business, as defined by the regional health plans. The QIHEC delegates authority and responsibility for credentialing and recredentialing peer reviews to this committee. This committee is also responsible for peer review activities and decisions regarding quality improvement follow-up on service and clinical matters, including quality of care cases. The committee provides a forum for instituting corrective action as necessary and assesses the effectiveness of these interventions through systematic follow-up for all lines of business for both inpatient and outpatient care and services.

This committee reports quarterly to the QIHEC and provides a summary of activities to the Health Net board of directors and DHCS. Membership includes practicing medical directors or practitioners (representing primary and specialty disciplines) from PPGs representing each region (northern, central and southern California).

Pharmacy and Therapeutics Committee

The Pharmacy & Therapeutics (P&T) Committee ensures appropriate and cost-effective delivery of pharmaceutical agents to Health Net membership. Committee responsibilities include the review and approval of policies that outline pharmaceutical restrictions, preferences, management procedures, explanation of limits or quotas, the delineation of Recommended Drug List (RDL) exceptions, substitution and interchange, step-therapy protocols, and the adoption of prescription safety procedures.

The P&T Committee includes a Health Net medical director, practitioners from PPGs that represent primary care and specialty disciplines, and clinical pharmacists.

A Pharmacy and Therapeutics (P&T) Committee comprises actively practicing physicians, medical directors and clinical pharmacists who review the efficacy and safety data of medications using an evidence-based process in order to make clinically appropriate utilization management recommendations to health plans and pharmacy benefit managers.

P&T Committee members also consider the potential for medication misuse or abuse, experimental or off-label use, and required level of laboratory or safety monitoring. P&T Committee utilization management tools include prior authorization criteria, quantity limits and step therapy.

Delegation Oversight Committee

Health Net may delegate responsibility for activities associated with utilization management (UM) and administrative services to its PPGs.

The Health Net Delegation Oversight Committee (DOC):

- Provides systematic oversight and regularly evaluates Health Net's PPGs or contracting vendors to assure compliance with delegated duties.
- Oversees PPG compliance with health plan and regulatory requirements pertaining to the delivery of care and services to members.
- Assesses and determines delegation for each component of the delegated responsibilities, including UM, claims, credentialing, and administrative services.
- Communicates in writing all delegation decisions, recommendations and requests for corrective action plans (CAPs) to the PPGs.
- Reports quarterly to the QIHEC.

Specialty Network Committee

The Specialty Network Committee sets standards for the Health Net participating transplant performance centers and bariatric performance centers, guiding members to specialty network providers, monitoring performance, issuing requests for CAPs, and reporting to HNQIC. This committee meets at least six times per year and reports annually to HNQIC.

Behavioral health level of care criteria and clinical position papers

Behavioral Health Medical Directors consider a number of resources in this process, including our own research on the effectiveness of elements of the guidelines in our own system, reviewing the literature about treatment of disorders, and reviewing guidelines from professional organizations. Guidelines are drafted and then reviewed by Medical Directors. The Medical Directors then submit the guidelines to the Medical Affairs

Committee (MAC) with a recommendation that it approve the guidelines. The MAC makes the final decision to approve and adopt the guidelines.

Current clinical position papers

- Medication Assisted Treatment Guidelines for Substance Use Disorders
- Criteria and Guidelines for Authorization of Psychological and Neuropsychological Testing
- Criteria and Standards for Utilizing Single Case Agreements
- Harm Reduction in Substance Use Disorder Treatment
- Ketamine Use for Treatment Resistant Depression or Post-Traumatic Stress Disorder
- Treatment of Highly Specialized Populations
- Utilization of Intranasal Spray of Spravato (esketamine) for Treatment of Treatment- Resistant Depression
- Wilderness Program Treatment

Current treatment guidelines

- Medical necessity
- When a therapist is seeing more than one family member at a time in outpatient treatment
- When a therapist is seeing a member more than once weekly in outpatient treatment
- Dual/multiple relationships with patients
- CMS national and local coverage determinations

A hard copy of these documents may be obtained by calling Behavioral Health Provider Services or accessing the Health Net website.

Medi-Cal Member Experience Survey

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net participates in the annual HEDIS® Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medi-Cal Member Experience Survey, which is required for NCQA Health Plan Accreditation. In addition, for Medi-Cal, the California Department of Health Care Services (DHCS) requires the CAHPS survey and contracts with the Health Services Advisory Group (HSAG) to administer it.

The CAHPS survey gathers member feedback on the quality, availability, and accessibility of care, satisfaction with services, and reasons for using out-of-network providers. Results are used to identify opportunities for improvement and to develop corrective action plans that enhance the member experience and overall quality of care.

Member experience is a key measure in health care, as positive patient experiences are associated with improved clinical outcomes, including prevention and disease management. Health Net uses CAHPS results to evaluate the effectiveness of improvement efforts and guide ongoing quality improvement initiatives.

Any necessary improvement plans are developed based on the results of these surveys. For additional information on CAHPS improvement refer to Improve CAHPS Result (PDF).

Medi-Cal Quality Improvement Projects

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal Performance Improvement Projects

Health Net conducts performance improvement projects (PIPs) in accordance with Department of Health Care Services (DHCS) contractual requirements as part of its ongoing efforts to improve the health outcomes of Medi-Cal members. PIPs focus on specific health issues identified as areas of concern or opportunity and may also address underutilized services where targeted interventions have the potential to increase utilization and significantly enhance health outcomes.

For each DHCS initiated PIP cycle, DHCS defines the project topic, scope, requirements, and duration of the cycle.

PIPs are developed and implemented by the Health Net Quality Improvement division in collaboration with Health Net's Medi-Cal medical directors.

Projects may be implemented on a regional basis and may target both members and providers. PIPs are designed to identify barriers to improved health outcomes through the application of quality improvement methodologies and to test and evaluate interventions aimed at addressing those barriers.

Progress, findings, and outcomes of all PIPs are reported to the Department of Health Care Services (DHCS), Health Net Quality Improvement Health Equity Committee, and Health Services Advisory Group (HSAG), which serves as Health Net's External Quality Review Organization (EQRO), for Health Net senior leadership, medical directors, and the Health Net Board of Directors.

For additional information regarding current Performance Improvement Projects, contact the QI Department.

Monitoring Access Standards Compliance

Provider Type: Participating Physician Groups (PPG)

Health Net measures participating physician group (PPG) performance with timely access standards through the Provider Appointment Access survey and the Provider After-Hours Access survey. Overall member satisfaction is measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey process.

Providers not meeting these standards are required to submit and follow a corrective action plan (CAP), which the Provider Network Management Department monitors. Refer to the Service and Quality Requirements discussion under the Provider Oversight topic for detailed information on access standards.

Health Net analyzes results in order to identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency room services, appropriate and timely access to care, and Americans with Disabilities Act (ADA) and language assistance program compliance. Health Net reports results as required to the Centers for Medicare and Medicaid Services (CMS) and DHCS.

Quality Improvement Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's Quality Improvement (QI) program provides the infrastructure for all managed care products. The QI program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes and member and provider satisfaction. The purpose and goals of the QI program are to:

- Establish standards for both the quality and safety of clinical care and service, as well as monitor and evaluate the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.
- Support Health Net's strategic business plan to promote safe, high-quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and

analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

Health Net utilizes several methods to measure access to care, including telephone-based surveys and member experience surveys. Provider satisfaction with the timeliness and usefulness of information received from other physicians and various care settings is also assessed on a regular basis to measure the coordination of care in the network. Opportunities for improvement are identified by examining provider ratings of key elements in the following functional areas: access and availability, case management, prior authorization, cultural and linguistic services, concurrent review, and discharge planning.

The Health Net QI program includes a written program description and an annually revised QI work plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net of California Quality Improvement Health Equity Committee (HNCA QIHEC), Health Net Community Solutions Quality Improvement/ Health Equity Committee (HN CS QIHEC), and the Health Net board of directors approves and monitors the annual Health Net QI program and the QI work plan. The board of directors receives quarterly reports regarding medical affairs, QI, utilization management (UM), and pharmacy.

Quality Improvement and Health Equity Transformation Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to monitor, evaluate, and take effective action to address any needed improvements in the quality and equity of care.The program applies to all covered services delivered to Health Net members, regardless of whether those services were delegated to a subcontractor, downstream subcontractor, or network provider. The QIHETP is continuous.

As a part of the QIHETP, Health Net is responsible for delivering quality care that enables all members to seek and maintain optimal health and improve or manage chronic illnesses or disabilities. Health Net must ensure quality care in the following areas:

1) clinical quality of physical health care;

2) clinical quality of behavioral health care focusing on prevention, recovery, resiliency and rehabilitation;

3) access to primary and specialty health care providers and services;

4) availability and regular engagement with PCP;

5) continuity of care and care coordination across settings and at all levels of care, and

6) member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care and care coordination.

Health Net must apply the principles of continuous quality improvement (CQI) to all aspects of its service delivery system through analysis, evaluation, and systematic enhancements of the quantitative and qualitative data collection and data-driven decision-making, up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources, feedback from members, community partners, network providers, and any other identified issues.

The purposes and goals of the QIHETP are to:

- Support Health Net's strategic business plan to promote safe, equitable and high-quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement a Quality Improvement and Health Equity Annual Plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

Health Net utilizes several methods to measure access to care, including telephone-based surveys and member experience surveys. Provider satisfaction with the timeliness and usefulness of information received from other physicians and various care settings is also assessed on a regular basis to measure the coordination of care in the network. Opportunities for improvement are identified by examining provider ratings

of key elements in the following functional areas: access and availability, case management, prior authorization, cultural and linguistic services, concurrent review, and discharge planning.

The QIHETP includes a written program description and a Quality Improvement and Health Equity Annual Plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement and Health Equity Committees (QIHECs) and the Health Net board of directors (BOD) approve and monitor the annual Health Net QI and HE programs and the QI and HE work plans. A written summary of QIHEC activities, findings, recommendations, and actions are prepared after every meeting and are submitted to the board of directors.

Quality Improvement Program and Compliance and HEDIS

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net tracks and monitors quality of care and service in a number of ways, including through the Healthcare Effectiveness Data and Information Set (HEDIS®). The National Committee for Quality Assurance (NCQA), a not-for-profit organization, created and maintains HEDIS to assess, report on and improve the quality of care and service provided by organized health care delivery systems. HEDIS is the most widely used set of performance measures in the managed care industry. Participation in this effort allows health care purchasers and providers to compare Health Net's performance relative to other health plans and to identify opportunities for improvement.

In addition, Health Net participates in multiple quality improvement organizations, including:

- California Quality Collaborative (CQC): a healthcare collaborative that seeks to improve clinical care and service for all Californians by providing strategies at the point of care. CQC programs are available to providers to improve chronic disease care, patient satisfaction, and care efficiency. For a listing of educational programs and patient satisfaction and condition management resources visit www.calquality.org.
- The Leapfrog Group: a nonprofit organization dedicated to promoting transparency, safety, and quality in healthcare. Health Net purchases The Leapfrog Group data, and promotes their ratings and standards to network hospitals, members, and the community.
- Cal Hospital Compare: a nonprofit organization providing public performance ratings for a multitude of California hospitals. Health Net contracts with Cal Hospital Compare to obtain Poor Performer and Honor Roll reports and data files to help inform hospital quality initiatives.

Quality of Care Issues

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Potential quality of care issues are reviewed by a Health Net medical director and, based on findings, are given a severity level and, if indicated, are submitted to the peer review committee (PRC) for appropriate resolution. At a minimum annually, the number, severity, actions taken, and trends noted are aggregated and reported to the Quality Improvement & Health Equity Committee (QIHEC).

Providers use the Potential Quality Issue (PQI) Referral form Health Net Referral Form (PDF), Potential Quality Issue (PQI) Referral form – Community Health Plan of Imperial Valley (PDF) or CalViva Health Referral Form (PDF) to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation.

Referrals

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on referrals.

Select any subject below:

- Investigational and Experimental Treatment
- Molina Healthcare Lab Referrals
- Molina Healthcare Service Request Form
- Primary Care Services
- Receipt of Specialist's Report
- Referral Tracking
- Referrals for Specialty Consultation
- Referrals to Specialists
- Standing Referrals to a Specialist

Investigational and Experimental Treatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal regulations indicate:

1. Experimental services are not covered.
2. Investigational services are not covered except when it is clearly documented that all of the following apply:
    1. Conventional therapy will not adequately treat the intended patient's condition.
    2. Conventional therapy will not prevent progressive disability or premature death.
    3. The provider of the proposed service has a record of safety and success with the investigational service equivalent or superior to that of other providers of the service.
    4. The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives.
    5. The service is not being performed as a part of a research study protocol.

6. There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.

All investigational services require prior authorization. Payment is not authorized for investigational services that do not meet the above criteria, or for associated inpatient care when a member needs to be in the hospital primarily because she or he is receiving such non-approved investigational services.

PPG Responsibilities

PPGs must immediately forward all pertinent documentation for investigational or experimental treatment service requests via fax to the Health Net Medi-Cal Health Services Department. Health Net's Medi-Cal Health Services Department has a dedicated fax number to receive and process prior authorization requests.

Molina Healthcare Lab Referrals

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information applies to Los Angeles County only.

For Health Net Members assigned to Molina Healthcare, consult Molina Healthcare's operations manual.

Molina Healthcare Service Request Form

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information applies to Los Angeles County only.

Molina Healthcare requires that its directly contracting primary care physicians (PCPs), staff model physicians and directly contracting medical groups adhere to the requirements in the Molina Healthcare operations manual.

Primary Care Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The primary care physician (PCP) is responsible for the management and coordination of a member's medical care, including initial and primary care, maintaining continuity of care, and initiating specialist referral. The PCP refers the member to a specialist when additional knowledge or skills are required.

Health Net has delegated the referral process to some participating physician groups (PPGs). Referrals to participating and non-participating specialists for capitated members are subject to any additional rules imposed by the PPG. PPGs may not impose referral or authorization requirements that conflict with the member's right to self-refer for services.

Listed below are examples of services that are considered primary care services. A PCP is expected to have the expertise necessary to perform most of these services. The PCP must have received relevant training within the limitations of scope of practice that is consistent with state and federal rules and regulations. These guidelines are based on routine, uncomplicated cases where care is provided by a PCP. This list provides guidelines, is not intended to be all-inclusive, and should be used with discretion.

Allergy

- Treat seasonal allergies
- Treat hives
- Treat chronic rhinitis
- Allergy history
- Environmental counseling
- Minor insect bites and stings
- Asthma, active with or without co-existing infection
- Allergy testing and institute immunotherapy (if trained)
- Administer immunotherapy

Adult Cardiology

- Perform electrocardiograms
- Interpret electrocardiograms
- Evaluate chest pain
- Evaluate and treat coronary risk factors, including smoking, hyperlipidemias, diabetes, and hypertension
- Evaluate and treat uncomplicated hypertension, CHF, stable angina, non-life-threatening arrhythmias
- Evaluate single episode syncope (cardiac)
- Evaluate benign murmurs and palpitations

Dermatology

- Treat acne - acute and recurrent
- Treat painful or disabling warts with topical preparations, electrocautery and liquid nitrogen
- Diagnose and treat common rashes, including contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor

- Screen for basal or squamous cell carcinomas
- Biopsy suspicious lesions; if trained, may do biopsy of suspicious lesions for cancer or others, such as actinic keratoses
- Punch biopsy
- Incisional biopsy
- Diagnose and treat common hair and nail problems and dermal injuries
- Common hair problems include fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects
- Common nail problems include trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails
- Dermal injuries include minor burns, lacerations, and treatment of bites and stings
- Counsel members regarding removal of cosmetic (non-covered) lesions
- Identify suspicious moles

Endocrinology

- Diabetic management, including type 1 and type 2 for most members
- Member education
- Supervision of home (SBGM) testing
- Medication management
- Manage DKA
- Manage thyroid nodules (order testing, scans, ultrasound)
- Diagnose and treat thyroid disorders
- Identify and treat hyperlipidemia
- Diet instruction
- Exercise instruction
- Provide member education for osteoporosis risk factors
- Identify and treat lipid disorders with diet and/or at least two medications for a minimum of six months

Gastroenterology

- Diagnose and treat lower abdominal pain
- Diagnose and treat acute diarrhea
- Occult blood testing
- Perform flexible sigmoidoscopy
- Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease
- Evaluate acute abdominal pain
- Diagnose and treat uncomplicated inflammatory bowel disease
- Diagnose jaundice
- Diagnose and treat ascites
- Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids
- Manage functional bowel disease
- Manage diagnosed malabsorption syndrome
- Manage mild hepatitis A

General Surgery

- Evaluate and follow small breast lumps in teenagers
- Order screening mammograms
- Aspirate cysts
- Foreign body removal
- Laceration repairs (minor)
- Local minor surgery for hemorrhoids
- Minor surgical procedures
- Diagnose gallbladder disease
- Manage inguinal hernia

Geriatrics

- Diagnose and treat impaired cognition (dementia)
- Be familiar with effects of aging on medication distribution, metabolism and interaction
- Management of advanced illness including the use of alternative levels of care
- Recognition of elder abuse

Gynecology/Obstetrics

- Perform routine pelvic exams and Pap smears
- Perform lab testing for sexually transmitted infections
- Wet mounts
- Diagnose and treat vaginitis and sexually transmitted infections
- Contraceptive counseling and management
- Normal pregnancy (if physician privileged to deliver)
- Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes
- Diagnose irregular vaginal bleeding
- Diagnose and treat endometriosis with hormone therapy
- Manage premenstrual syndrome with non-steroidal anti-inflammatory hormones and other symptomatic treatment

Neurology

- Diagnose and treat all psychophysiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, radiculopathies, and central nervous system disorders
- Diagnose and treat tension and migraine headaches
- Order advanced imaging procedures (MRI or CT scan for an appropriate anatomic area after an appropriate clinical evaluation and trial of conservative therapy
- Diagnose and manage syncope
- Treat seizure disorders
- Manage degenerative neurological disorders with respect to general medical care (for example, Parkinson's)

- Manage stroke and uncomplicated TIA members
- Lumbar puncture
- Treat myofacial pain syndromes

Ophthalmology

- Perform thorough ophthalmologic history including symptoms and subjective visual acuity
- Perform common eye-related services
  - Distant/near vision testing
  - Color vision testing
  - Gross visual field testing by confrontation
  - Alternate cover testing
  - Direct fundoscopy without dilation
  - Extraocular muscle function evaluation
  - Red reflex testing in pediatric members
- Remove corneal foreign bodies (except metallic)
- Treat corneal abrasions
- Perform tonometry
- Diagnose and treat common eye conditions:
  - Viral, bacterial and allergic conjunctivitis
  - Blepharitis
  - Hordeolum
  - Chalazion
  - Subconjunctival hemorrhage
  - Dacryocystitis

Orthopedics

- Treat low back pain and sciatica without neurological deficit
- Treat sprains, strains, pulled muscles, overuse symptoms
- Treat acute inflammatory conditions
- Chronic knee problems
- Manage chronic pain problems
- Diagnose and treat common foot problems: ingrown nails, corns, callouses, bunions
- Closed emergency reduction of dislocation: digit, patella, shoulder
- Treatment of minor fractures
- Arthrocentesis

Otolaryngology

- Treat tonsillitis and streptococcal infections
- Perform throat cultures
- Evaluate and treat oropharyngeal infections
  - Stomatitis
  - Herpangina
  - Herpes simplex

- Treat acute otitis media
- Treat effusion
- Evaluate tympanograms/audiograms
- Treat acute and chronic sinusitis
- Treat allergic or vasomotor rhinitis
- Remove ear wax
- Treat nasal polyps
- Diagnose and treat acute parotitis and acute salivary gland infections
- Treat nasal obstruction (including foreign body)
- Treat simple epistaxis

Physical Medicine and Rehabilitation

- Coordinate care for members recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist
- Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA and AFO for foot drop

Psychiatry

- Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, overeating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)
- Diagnose physical disorders with behavioral manifestations
- Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist
- Diagnose and care manage child, elder, dependent adult abuse, and domestic violence victims

Pulmonology

- Diagnose and treat asthma, acute bronchitis, pneumonia
- Diagnose and treat chronic bronchitis
- Diagnose and treat chronic obstructive pulmonary disease (COPD)
- Manage home aerosol medications and oxygen
- Work up possible tuberculosis or fungal infections
- Treat opportunistic infections
- Order chest X-rays, special views and advanced imaging

Rheumatology

- Diagnose and treat non-articular musculoskeletal problems:
    - Overuse syndromes
    - Injuries and trauma

    - Soft tissue syndromes
    - Bursitis or tendonitis
- Provide steroid injections
- Manage osteoarthritis unless there is a significant functional impairment despite treatment
- Diagnose crystal diseases
- Perform arthrocentesis
- Diagnose and treat rheumatoid arthritis
- Diagnose and treat inflammatory arthritic diseases
- Diagnose and treat uncomplicated collagen diseases

Urology/Nephrology

- Diagnose and treat initial and recurrent urinary tract infections
- Provide long term chemoprophylaxis
- Diagnose and treat urethritis
- Explain hematospermia
- Initiate evaluation of hematuria
- Evaluate incontinence
- Evaluate male factor infertility and impotence and treat readily correctable factors
- Diagnose and treat epididymitis and prostatitis
- Differentiate scrotal or peritesticular masses from testicular masses
- Evaluate prostatism and prostatic nodules
- Manage urinary stones
- Evaluate and treat renal failure
- Placement of urinary catheters
- Evaluate impotence
- Evaluate male infertility

Vascular Surgery

- Diagnose abdominal aortic aneurysm
- Diagnose and treat venous diseases
- Treat stasis ulcers
- Manage intermittent claudication
- Manage transient ischemic attacks
- Manage asymptomatic bruits

Other

- Basic life support
- Advanced life support
- Heimlich maneuver
- Endotracheal intubation
- Tracheostomy (emergency)

Hospital Procedures

- Hospital admissions and daily care
- Hospital consultations
- Pre-operative history
- Newborn evaluation and nursery care

Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Receipt of Specialist's Report

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The primary care physician (PCP) must ensure timely receipt of the specialist's report. For Medi-Cal members, reports from specialty services for consultations or procedures must be in the member's chart within 15 days. If the PCP does not receive the specialist's report within 15 days, the PCP must contact the specialist to obtain the report. For urgent and emergency cases, the specialist must initiate a telephone report to the PCP as soon as possible, and a written report must be received within 15 days.

Referral Tracking

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's participating providers are required to monitor referrals that have been authorized for medically appropriate care to ensure that the member accesses care and follows up with his or her primary care physician (PCP).

Participating physician groups (PPGs) delegated for utilization management (UM) functions are responsible for tracking referrals authorized for members assigned to PCPs within the PPG's network. The PPG is also responsible for following up with the member and PCP to ensure that the member receives a new referral for the previously authorized services if the services are still required. For additional information, refer to the PPG Responsibilities for Referral Tracking discussion under the Provider Delegation topic.

PCPs are responsible for maintaining continuity of care for Health Net members during the referral process. This entails the monitoring of referrals made for Health Net Medi-Cal members to ensure that appropriate services are accessed and pertinent specialty service reports are received for inclusion in the primary care medical record. Refer to the Care Coordination discussion under the Utilization Management topic for additional information.

Referrals for Specialty Consultation

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)| Ancillary

Listed below are examples of services that are referred for specialty consultation. This list provides guidelines and is not intended to be all-inclusive.

Allergy

- Chronic rhinitis if the allergic cause is indicated by IgE or nasal eosinophils or if mechanical obstruction, such as adenoids or tonsils, is obvious
- Hives if urticaria becomes chronic (six to 10 weeks or recurrent)
- Consultation if hospitalized, severe respiratory failure or member is steroid-dependent
- Asthma if difficult diagnostic dilemma, not well controlled with routine therapy, hospitalization or if severe respiratory failure has occurred or if the member has become steroid-dependent
- Significant reactions to stinging insects, chronic eczema, chronic sinusitis, and medication allergies
- Systemic allergic reactions, anaphylaxis

Cardiology - Adult

- Candidates for thrombolysis, stress testing, catheterization, angioplasty, or surgery, and life-threatening arrhythmias, or hemodynamic complications requiring invasive monitoring
- Unstable angina
- Hemodynamically complicated murmur
- Constrictive pericarditis
- Complicated hypertension (failure to respond or adverse response to conventional therapy)
- Angina despite maximal pharmacological therapy with maximally tolerated doses of nitrates, beta-blockers, and calcium channel blockers
- Intractable heart failure and arrhythmias
- Pericardial effusion
- Congenital or valvular disease for non-invasive studies and to define appropriate follow-up
- Evaluate and treat recurrent syncope (cardiac)
- Initial consultation for acute and chronic heart failure management

Cardiology - Pediatric

- Evaluate and treat any non-soft, non-systolic cardiac murmur
- Evaluate cyanosis that does not clear with crying
- Evaluate tachypnea
- Evaluate diminished pulses in any extremity
- Consultation for any member with a syndrome known to have cardiac complications (Down's, Marfan's, etc.)

Dermatology

- Acne that has not resolved or improved after three months
- Severe cystic acne
- Suspicious lesion suggesting melanoma
- Basal or squamous cell carcinomas
- Biopsy of suspicious lesions

Endocrinology

- Coma not rapidly reversible by glucose
- Instability in an established management program
- Brittle diabetes
- Diabetic complications, including retinopathy and nephropathy
- Exophthalmos, moderately severe or symptomatic
- Fine-needle aspiration of thyroid nodules
- Suspected disorders of calcium metabolism, adrenal, gonadal, or pituitary dysfunction
- Growth retardation (non-familial)
- Hyperlipidemia (no response to diet and medication, including two different medications, within one year)
- Radioactive iodine therapy

Gastroenterology

- Bowel obstruction diagnosed
- Polyps or other abnormalities
- Chronic bleeding, acute GI hemorrhage
- Undiagnosed hepatocellular disease or biliary obstruction
- Jaundice complicated by fever
- Severe acute and chronic hepatitis
- Ascites when peritoneal fluid is an exudate, chylous or intractable or if fever persists
- Severely symptomatic hemorrhoids refractory to treatment, may be referred for additional nonsurgical treatment
- Complex inflammatory bowel disease
- Chemotherapy for carcinoma

General Surgery

- Gallbladder disease, if significantly symptomatic
- Recurrent cysts, lumps or suspicious mammograms

Neurology/Neurosurgery

- Myofascial pain syndromes if there is no improvement and an uncertain diagnosis after six to eight weeks of conservative treatment or a progressive neurological deficit
- Seizures that are recurrent or refractory to treatment
- Degenerative neurological disorders
- Confirmation of diagnoses and/or intermittent consultation
- Ischemic attack that is associated with a carotid lesion
- CNS malignancies
- Persistent cervical or lumbosacral herniated nucleus pulposa resistant to conservative management

Obstetrics/Gynecology

- Ectopic pregnancy
- Uncertain clinical diagnosis
- Higher risk members (for example, over-age)
- Menometrorrhagia

Ophthalmology

- High index of suspicion for herpes
- Metallic foreign bodies
- Sudden visual change or loss
- Visual change accompanied by pain
- Sudden onset of flashing lights and floaters
- Any eye symptom not responding to treatment
- Unexplained abnormality on fundoscopic exam
- Sudden visual change or loss
- Pediatric members with dysconjugate gaze
- Lens opacification if associated with intolerable visual impairment

Orthopedics

- Fracture
- Locked knee
- Unstable knee
- Foot problems (deep abscess, gangrene, osteomyelitis)
- Any diabetic foot
- Obvious or apparent ligament tear
- Progressive disability of the knee despite conservative treatment and X-ray showing joint narrowing or gross destruction of the articular surface

Otolaryngology

- Tonsillectomy if three documented episodes within four months or six documented episodes within one year
- Tonsillar obstruction or recurrent peritonsillar abscess
- Acute otitis media, member toxic for 48 hours despite treatment
- Persistent middle ear effusion lasting more than three months with continuous treatment, or persistent infection after three courses of different antibiotics
- Persistent hearing loss or delayed speech and articulation in children under the age of 3
- Persistent retraction of tympanic membranes
- Recurrent epistaxis
- Acute and chronic sinusitis after treatment with antibiotics for 20 days or if infection not responsive in 72 hours
- Nasal obstruction after three months of treatment
- Parotid masses
- Acute or persistent hearing loss not attributable to fluid or wax
- Hoarseness that persists for more than three weeks

Psychiatry

- Diagnose, treat, and recommend medication regimen in difficult/complex cases, for example:
  - Depressions that does not respond to 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants
  - Members who report feeling suicidal or homicidal
  - Panic disorders
- For example, continued:
  - Severe anxiety states
  - Clear somatoform disorders
  - Schizophrenic disorders where clozapine or risperidone are being considered
  - Bipolar disorder where lithium, carbamazepine or chlorpromazine may be needed

Psychologist

- Diagnosis, treatment and consultation regarding management of clearly emotional issues for which the member or PCP feels the need for consultation
- Psychological testing for clarification of diagnosis to establish a treatment plan

Pulmonology

- Respiratory failure
- Percutaneous lung biopsies
- Pleural biopsies
- Supraclavicular node biopsies
- Pleural effusions not due to heart failure or acute pneumonia
- Unresolved pneumonia
- Neonatal lung disease
- Cystic fibrosis
- Lung masses

- Hemoptysis
- Interstitial disease
- Sarcoidosis
- Tuberculosis
- Unusual infections
- Dyspnea of uncertain etiology
- Sleep disorders
- Complicated asthma, advanced COPD, pulmonary vascular disease, including pulmonary hypertension vasculitis and pulmonary embolism

Rheumatology

- Osteoarthritis, if no response to treatment after three months
- Rheumatoid arthritis if manifestations are not controlled on the treatment program or treatment plan to include surgery
- Collagen vascular diseases depending on the extent and severity of manifestations or complications

Social Workers/Other Credentialed Providers

- Brief psychotherapy, including post-traumatic stress disorder (PTSD), grief, recent losses

Urology/Nephrology

- Scrotal mass, testicular, or does not transilluminate
- Undescended tests
- Prostate suspicious for malignancy or obstructive symptoms that may lead to surgical treatment
- Urinary stones that do not pass in a week (4 mm or less)
- Larger or proximal stones for consideration of removal, stenting or lithotripsy
- Male infertility
- Erectile dysfunction not obviously psychogenic
- Acute renal failure
- Obstructive uropathy
- 50 percent reduction in creatinine clearance
- Nephrotic syndrome
- Circumcision with recurrent balanitis or foreskin problems

Vascular Surgery

- Arterial problems, such as gangrene, ischemic ulcers or ischemic rest pain
- Venous insufficiency with stasis ulcers
- Abdominal aortic aneurysms that are symptomatic, enlarging, or greater than 5 cm in diameter

health net

Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Referrals to Specialists

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A referral is required for cases that are difficult to manage or when care is beyond the primary care physician's (PCP's) scope of practice. Refer to the Referral for Specialty Consultation discussion for a summary of some of the services that may be referred to a specialist.

Health Net delegates the referral process to full and shared-risk participating physician groups (PPGs). Referrals to participating and non-participating specialists for members assigned to a capitated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose referral or authorization requirements that conflict with the member's right to self-refer.

When referring a member for specialty care, the PCP must follow the guidelines outlined below as well as those dictated by the PPG:

- Choose a specialist from Health Net's Medi-Cal provider list or the PPG's participating providers. The specialist must be contracted with the member's assigned PPG; otherwise, the visit is considered out of network.
- For services with an out-of-network specialist, PCPs participating directly with Health Net must complete and fax the Inpatient California Medi-Cal Prior Authorization Form (PDF) or the Outpatient California Medi-Cal Authorization Form (PDF) to the specialist with the authorization number attached. PCPs participating through a PPG must follow the PPG's referral guidelines.
- For members assigned to Health Net Direct Network, specialty visits with participating specialists, there is no need to complete a prior authorization form or notify Health Net; however, many specialists prefer an authorization number prior to performing services. As a courtesy to the specialist, Health Net provides the PCP with an authorization number upon request from the PCP or specialist.
- For members assigned to PPGs, PCPs must follow the guidelines outlined by the PPG.
- Select procedures performed by specialists may require prior authorization.
- When scheduling an appointment:
    - The wait time for non-urgent specialty care must not exceed 15 business days and must be coordinated with the PCP based on the severity of the condition.
    - Wait time for urgent specialty care appointments is 96 hours if prior authorization is required.
    - Wait time for urgent specialty care appointments is 48 hours if prior authorization is not required.
- The specialist treats the member as indicated on the referral or Prior Authorization Request form and notifies the PCP of the findings.
- The specialist may order diagnostic tests, X-ray and laboratory services, and durable medical equipment (DME) (some services may require prior authorization from Health Net or the PPG). The

specialist must follow the PPG's referral guidelines and use the participating provider network when referring for lab, X-ray, DME, and other ancillary services.
- If the member requires treatment beyond the services requested by the PCP, the specialist must contact the PCP for an additional referral and follow PPG guidelines.
- Referrals are only valid between participating providers. Any referrals to nonparticipating providers require prior authorization from Health Net, its affiliated health plans, or the PPG, with the exception of those services for which members may self-refer without prior authorization.

Referrals between specialists are not covered. When a specialist determines that referral to another specialist is needed, the PCP must be notified and requested to make the referral.

Referrals for Specialty Consultation

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)| Ancillary

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- For example, continued:
  - Severe anxiety states
  - Clear somatoform disorders
  - Schizophrenic disorders where clozapine or risperidone are being considered
  - Bipolar disorder where lithium, carbamazepine or chlorpromazine may be needed

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Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Standing Referrals to a Specialist

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net and its participating physician groups (PPGs) are required to have procedures for members to receive a standing referral to a specialist or specialty care center, including, but not limited to, HIV or AIDS specialists.

Definitions

Standing referral is a referral by the primary care physician (PCP) to a specialist for more than one visit to the specialist, as indicated in a treatment plan, if any, without the PCP having to provide a specific referral for each visit.

Specialty care center is defined as a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing Referral to a Specialist

Health Net and its delegated PPGs provide for a standing referral to a specialist if the member's PCP determines in consultation with the specialist, if appropriate, and medical director (associated with PPG or Health Net) that the member needs continuing care from the specialist as follows:

- If a treatment plan is deemed necessary in the course of care and is approved by Health Net (or the PPG), in consultation with the PCP, specialist and member, the referral is made subject to the terms of the treatment plan.
- A treatment plan may not be necessary if Health Net (or the PPG) approved a current standing referral to a specialist.

- The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member.

Prolonged Standing Referral

Health Net and its delegated PPGs provide members with standing referrals for specialized medical care over a prolonged period of time specifically for members who have conditions or diseases that are life-threatening, degenerative or disabling. These members may receive a referral to a specialist or specialty care center with expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's health care as follows:

- If a treatment plan is deemed necessary in the course of care and is approved by Health Net (or the PPG), in consultation with the PCP, specialist, specialty care center, and member, the referral is made, subject to the terms of the treatment plan.
- A treatment plan may not be necessary if Health Net (or the PPG) approves the appropriate referral to a specialist or specialty care center.
- The referral is made if the PCP, in consultation with the member's specialist or specialty care center, and the PPG, determines specialized care is medically necessary for the member.

Time Limits

The determination of a standing referral request is made within three business days from receipt of request by the member or the member's PCP, and all appropriate medical records, and other information necessary is submitted.

Once Health Net or its delegated PPG make the determination, the referral authorization is issued within four business days of the date the proposed treatment plan, if any, is submitted.

Ordinarily PCPs or PPGs do not refer the member to a specialist that is not participating with the PPG or Health Net, unless there is no specialist within the PPG or Health Net's networks that are appropriate to provide treatment to the member, as determined by the member's PCP in consultation with PPG or Health Net's medical director, and documented in the treatment plan. If an out-of-network referral is necessary, benefits are provided at the in-network cost-share.

The PCP and PPG must track and monitor referrals requiring prior authorization. The tracking system must include authorized, denied, deferred, or modified referrals, the timeliness of the referrals, and referrals made to non-participating providers.

Third-Party Liability

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on third-party liability responsibilities.

Select any subject below:

- Overview
- Provider Responsibilities

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Under Health Net's Medi-Cal contracts, Health Net and its participating providers are prohibited from making any claim for recovery of the value of covered services rendered to a member when such recovery would result from an action involving recovery from: the tort liability of a third party; or recovery from the estates of deceased members; or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage; or involving class action claims.

Health Net and its participating providers are required to assist the Department of Health Care Services (DHCS) in pursuing the state's right to reimbursement from such recoveries. Health Net and its participating physician groups (PPGs) are required to notify DHCS within 10 calendar days of discovering a member has initiated such action, discovery of a lien or receipt of a request from attorneys, insurers, or members. Health Net and its PPGs shall use the appropriate DHCS online notification form at DHCS's Third Party Liability and Recovery Division Online Forms. On request from DHCS for information, Health Net and PPGs must provide additional information within 30 calendar days. Individual providers are obligated to assist Health Net and affiliated PPGs in providing the additional information on request.

Provider Responsibilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

How to notify and respond to a TPL request

Providers must notify Health Net or the participating physician group (PPG) in writing within five calendar days of all potential and confirmed third-party liability (TPL) cases that involve a Health Net Medi-Cal member in order for Health Net or the PPG to notify DHCS no later than 10 calendar days of the provider becoming aware of such request. If a provider has received subpoenas from attorneys, insurers, or members for copies of bills concerning a TPL case, the provider must notify Health Net with copies of the request and copies of documents released as a result of the request. The information must also include the name, address and telephone number of the requesting party. The notification must be submitted via email.

Note: In all third-party tort liability cases, providers may not seek to collect from a Medi-Cal member (or any financially responsible relative or representative(s)) for services for which a third party is liable. Providers may not refuse to furnish services to a Medi-Cal member because of a third party's potential liability for payment.

For services rendered, providers must bill Health Net or the PPG as usual and give all details regarding the injury or illness. Health Net pays usual benefits and refers the case to DHCS to pursue the recovery.

Requests from Health Net for TPL

If the Department of Health Care Services (DHCS) requests information regarding an individual TPL case, Health Net will send providers a letter to request TPL claims information and an itemized list of services for affected members. Providers are responsible for supplying Health Net with copies of the requested documents in the time frame described in the letter in order for Health Net to deliver the information to DHCS no later than 30 calendar days of the DHCS request. Providers must submit the information to the Health Net Third-Party Liability Department.

Pursuant to DHCS All Plan Letter 21-007, the claims data must meet the standard reporting requirements set forth by DHCS. DHCS requires the use of a DHCS-approved Excel worksheet to submit and receive TPL claims data. All claims data submissions must include the following data elements in the approved Excel format below.

If no services were rendered to the identified member, provider must promptly notify Health Net of that fact.

Note: An approved Excel worksheet will be provided by Health Net along with the request for TPL claims data. The PPG must follow the instructions in the TPL claims data request.

Field	Description
MCP/IPA	Name of the PPG or independent physician association (IPA) (the name of the business entity owned by a network of independent physicians)
Member name	The name of the Medi-Cal member
Date of birth	The Medi-Cal member's date of birth
CIN	The Client Index Number (CIN) 9-digit character on the Medi-Cal Benefits Identification Card. It starts with the number “9” and ends with an alpha (A-Z).
Date of injury	The Medi-Cal member's date of injury
CCN	A Claim Control Number (CCN) uniquely identifies any processed claims within a specific plan code.

Field	Description
Claim line number	The last two characters of the CCN are the claim line number and they are unique for each service.
Claim type	Identifies the general type of service that was rendered
Service from date	Identifies the start date of the service on a claim
Service to date	Identifies the end date of the service on a claim
Provider legal name	Indicates the provider's legal name
NPI	The National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare & Medicaid Services.
Diagnosis code 1	Identifies the diagnosis code for the principal condition requiring medical attention
Diagnosis code 2	Identifies the secondary diagnosis code which requires supplementary medical treatment
Drug label name	Label name of the drug (if claim is for drug)
Billed amount	Identifies amount billed to the plan from the provider
Paid amount	Identifies the actual amount paid to the provider for services
Reasonable value	Identifies the reasonable/customary value of the service provided. Absent the “Amount paid, due to capitated or other service type, the “Reasonable value” of the service must be

Field	Description
	provided, pursuant to Title 28, California Code of Regulations (CCR), section 1300.71(a)(3).
CPT code	Official CPT code used to report medical, surgical, and diagnostic procedures and services. CPT is a registered trademark of the American Medical Association.
CPT type	There are three types of CPT codes: Category 1 (procedures and contemporary medical practices), Category 2 (clinical laboratory services) and Category 3 (emerging technologies, services and procedures). CPT is a registered trademark of the American Medical Association.
Claim deny reason code 1 & description	Primary denial code and description (if claim denied)
Claim deny reason code 2 & description	Secondary denial code and description (if claim denied)

Urgent Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Urgent care is required for those medical conditions that do not fit the definition of emergency, but require the member receive treatment within 48 hours.

Refer to the following Behavioral Health definition in the glossary for more information.

- Urgent
- Urgent Decision
- Urgent Concurrent Review Decision
- Urgent Pre-Service Decision

Utilization Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes Health Net's utilization management program and processes.

Select any subject below:

- Overview
- Nurse Advise Telephone Triage and Screening Program
- Affiliated Health Plan Delegated Utilization Management - Reporting
- Care Coordination
- Care Management
- Clinical Criteria for Medical Management Decision Making
- Clinical Criteria for Utilization and Care Management Decisions
- Concurrent and Retrospective Review
- Continuity of Care
- Hospital and Inpatient Facility Discharge Planning
- Notification of Hospital Admissions
- Out-of-Area Service
- Prescription Utilization Review
- Prior Authorization
- Separation of Medical Decisions and Financial Concerns
- Utilization Management Program Components

Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Prior authorization allows the Health Net Utilization Management Department to review a proposed admission or procedure for coverage determination, medical necessity, level of care, length of stay, and placement prior to the delivery of services. Refer to the Prior Authorization topic for an explanation of the prior authorization process and a list of services requiring prior authorization.

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's utilization management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the

program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are elements of the UM process.

Refer to definition of medical necessity or definition of investigational services for additional information.

Nurse Advice Telephone Triage and Screening Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's Nurse Advice Telephone Triage & Screening program provides 24 hours a day, 7 days a week triage or screening services by phone. The Nurse Advice Telephone Triage & Screening program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour phone service for urgent/emergent instructions, medical condition assessment, and advice. The Health Net Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) coordinates member access to the program, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, provide self-care guidance, general health information, or recommend a visit to urgent care or the emergency room (ER). Nationally recognized triage guidelines are used to determine the level of care needed by the member.

Health Net ensures that phone Nurse Advice Telephone Triage & Screening program services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

Role of the Medi-Cal Member Services Department

The Health Net Medi-Cal Member Services Department's 24-hour toll-free phone number is printed on the back of the member's identification card. While assistance via the phone is the PCP's responsibility, the Health Net Medi-Cal Member Services Department can assist members in reaching their PCPs when needed. The Health Net Medi-Cal Member Services representative can either get the member in contact with the PCP or, if the PCP is not available or at the request of the member, the call can be routed to the Health Net Nurse Advice Line.

If, for any reason, a member services representative experiences problems reaching a member's PCP, the call is routed to Health Net's Nurse Advice Telephone Triage (or Molina in Los Angeles).

Role of the Program Nurse

On receipt of a call, the nurse addresses emergencies immediately by directing the member to a hospital emergency department and assisting the member in securing an ambulance, if necessary. Members who need urgent care are referred to an urgent care center if the PCP is not available.

The nurse educates the member on the role of the PCP and gives the member care advice instructions to care for their symptoms at home until they receive care from the PCP.

Each time a member calls into the nurse advice line, the care is documented in the member's chart with a report sent to the member's health plan advising them of the care sought and the disposition offered.

Affiliated Health Plan Delegated Utilization Management - Reporting

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following information applies to Los Angeles County only.

Primary care physicians (PCPs) participating with Molina Healthcare, directly or through a participating physician group (PPG), must send utilization reports directly to Molina detailing Medi-Cal services to members in this plan. Molina then sends copies of these reports to Health Net.

Report	Frequency	Description
California Children's Services (CCS)	--	Report of Health Net members referred to CCS at time of occurrence to initiate care coordination.
Comprehensive Perinatal Services Program (CPSP)	Case-by-case at time of occurrence	Report of Health Net members referred to CPSP at time of occurrence, to initiate care management.

Care Coordination

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Care coordination refers to the system of directing and monitoring care delivery and services for a member, either within services covered by member's Medi-Cal plan or for services that are carved out to other delivery systems, including but not limited to Medi-Cal RX, waiver programs, the county mental health plan, etc. The goal is to ensure the member receives timely, medically necessary health services without interruption.

The system comprises several procedural components that are required based on the extent of the severity of the member's health condition. Basic procedures required of primary care physicians (PCPs), to maintain care coordination are:

- Documentation of member encounters, missed appointments, extensions of appointment waiting time (noted that a longer waiting time for appointment will not have a detrimental impact on the health of the member), and referrals in members' medical record
- Referrals for members needing specialty health services
- Forwarding summaries of pertinent medical findings to specialists
- Documentation of services provided by a specialist in the member's primary care medical record
- Monitoring members who have ongoing medical conditions
- Notifying Health Net of member referrals to specialists, care management or public health programs

Additional procedures are required of PCPs when members' health conditions require urgent, emergency or inpatient health services, including:

- Documentation in members' medical records of emergency and urgent medical care and follow-up
- Coordinated hospital discharge planning
- Post-discharge care

Health Net suggests that each provider develop protocols to maintain care coordination. A log system for tracking prior authorizations, referrals to specialists, follow-up for missed appointments, and acknowledgment and verification of such things as lab and X-ray findings is recommended. The system can be manual or computerized.

Care Management Notification

The following applies to participating physician groups (PPGs) and hospitals only.

Report all admissions with an expected length of stay (ELOS) greater than 10 days and all cases identified meeting provider stop loss criteria. Fax information to the Health Net Hospital Notification Unit.

Change in Member Status

The provider must develop office procedures to remain informed about changes in the member's status (for example, member changed primary care physicians (PCPs), has been hospitalized or has died) with notation in the medical record.

The provider may obtain this information from member enrollment data. Further, the provider should receive information regarding hospital admissions within 24 hours or by the next business day from the facility, the member or Health Net (or affiliated Molina Healthcare in Los Angeles County).

Documenting Specialist Services

Specialist Report

Specialists are required to submit written reports to the referring physician. These written reports must include the specialist's findings, recommended treatment, results of any studies, tests, procedures, and recommendations for continued and or follow-up care. The primary care physicians (PCPs) must receive the report within two weeks of the member's visit with the specialist. Emergency or urgent care reports or findings must be called to the PCP within 24 hours or by the next business day.

The PCP is required to review the specialist's findings to determine whether follow-up care is medically necessary. The PCP is responsible for directing all member care through the referral process.

Services Received in an Alternate Care Setting

The PCP should receive a report with findings, recommended treatment and results of treatment for services performed outside the PCP's office.

The provider may also receive emergency department reports, hospital discharge summaries and other information.

Home health care agencies submit treatment plans to the PCP after an authorized evaluation visit and every 30 days afterward for review of home health care and authorization.

The PCP should also receive reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action.

Missed Appointments and Other Procedures

The following applies to participating physician groups (PPGs) and physicians only.

Missed Appointments

Appointments may be missed due to member cancellation or no show. The Department of Health Care Services (DHCS) requires the provider to attempt to contact the member a minimum of three times when they miss an appointment. Attempts to contact must include:

1. First attempt - telephone call to member. (A written letter must be sent if the member does not have a telephone.)
2. Second attempt - if member does not respond to the first attempt, a second telephone call must be made to the member. (A written letter must be sent if the member does not have a telephone.)
3. Third attempt - if member does not respond to the second attempt, a written letter must be sent.

For members under age 21, failure to respond to the primary care physicians (PCPs) follow-up attempt must be reported to Health Net's public programs administrators.

Documentation must be noted in the member's medical record regarding any missed or canceled appointments, reschedule dates and attempts to contact. Health Net recommends the use of a rubber stamp to document this information in the chart.

Missed Procedure or Laboratory Test

Appointments for procedures or tests may be missed or canceled. The provider must contact the member by telephone or letter to reschedule. Documentation must be noted in the medical record regarding any missed or canceled procedures or tests, reschedule dates and any attempts to contact the member.

Specialist Designation as a Primary Care Physician

The following applies to participating physician groups (PPGs) and physicians only.

A specialist may serve as a primary care physician (PCP) for Medi-Cal members who are Seniors and Persons with Disabilities (SPDs). The specialist must agree to serve as a PCP and be qualified to treat the required range of conditions of the SPD member.

SPD members may request a specialist as a PCP, as follows:

1. SPD members may contact the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or the CalViva Health Medi-Cal Member Services Department for assistance with PCP selection.
2. If the SPD member requests a specialist as a PCP, the Medi-Cal Member Services Department representative obtains the necessary information from the SPD member, including the specialist's name and participating physician group (PPG) affiliation (if applicable).
3. The Medi-Cal Member Services Department representative forwards the SPD member's request for a specialist as a PCP to Health Net, Molina Healthcare, or the delegated PPG's designated intake department.
4. The Health Net, Molina Healthcare or delegated PPG's designated intake representative contacts the specialist and explains the requirements for serving as a PCP (refer to PCP Responsibilities section below), including the facility site review (FSR) requirements. The representative may also contact the member to discuss the process and reassure the member that their chosen specialist can continue to see the member as a specialist even if the provider does not choose to become a PCP. PPGs are encouraged to work with members to help them establish a medical home with their chosen PCP.
5. If the specialist agrees to serve as a PCP and is qualified to treat the required range of conditions of an SPD member, the Health Net, Molina Healthcare or delegated PPG's designated representative initiates the process to conduct a full-scope FSR. A member cannot be assigned to a specialist who is serving as a PCP until the specialist's office has passed the FSR.
6. After the specialist passes the FSR, the applicable Health Net, Molina Healthcare, or delegated PPG's designated representative submits the documentation to change the provider's status in Health Net's data management system from a specialist to a PCP.

Once the contracting specialist agrees to serve as, and is designated by Health Net to serve as a PCP, they are no longer designated as a contracting specialist in Health Net's network.

Care Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on care management.

Select any subject below:

- Overview

- Referrals
- Complex Cancer Care
- Complex Case Management
- Discharging a Member from Care Management
- Health Education and Preventive Care Programs
- Palliative Care Services
- PCP Responsibilities

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Care Management program involves identifying medical need and allocating resources. The goal of care management is to ensure that all services are medically necessary, not duplicated, safe, provided at the acceptable standard of quality as measured by the professional medical community, and at the correct level of care.

Health Net complies with applicable federal civil rights laws and ensures that all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

Care management is not episodic or restricted to a single practice setting, but occurs across the continuum of care and addresses ongoing individual needs.

There are two different levels of care management:

- Basic population health management
- Complex care management

Basic population health management

1. **Care Coordination** – Appropriate for with primarily social determinants of health (SDOH) needs, such as housing, financial, etc., with the need for referrals to community resources for assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may aid if minor health concerns arise. Services at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure follow through. In addition, this level of care management is used for continuity of care transitions and supplemental support for Members managed by the county.
2. **Care Management** – Appropriate for members needing a higher level of service, with clinical needs. Members in care management may have a complex condition or multiple co-morbidities that are generally well-managed. Members in care management typically have adequate family or other caregiver support and need moderate to minimal assistance from a care manager. Services at this

level include those provided at the level of care coordination along with identification of member agreed-upon goals, identification of actions needed to meet the goals, and necessary support to meet those goals.

Complex Care Management (CCM)

CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner.

CCM is for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life.

CCM is provided by Health Net for members who need additional support to avoid adverse outcomes, and/or those who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care.

Services at this level include all coordination and care management services described above, along with more frequent member contact to assess continued appropriateness and adherence with their treatment plan, and progress toward meeting goals.

Care managers monitor members' key indicators of disease progress, e.g., hemoglobin A1c levels and medication adherence. Care managers also evaluate members for referral to enhanced care management (ECM) services as appropriate.

Carve-Out Services

Some services, such as major organ transplant for members under 21, have been carved-out of the health plan and are not covered by Health Net under its Medi-Cal managed care contract with the California Department of Health Care Services (DHCS). Transplant cases for members under age 21 are managed by the state of California. County care management programs include California Children's Services (CCS), waiver and regional service programs. Refer to the Public Health topic for additional information on these programs. For a complete list of carve-out services refer to Member Handbook.

Problem Resolution

Disagreements that arise between Health Net's care management and public health case management are resolved by the Health Net Medical Management Department.

Referrals

Physicians | Hospitals | Participating Physician Groups (PPG)

Referrals to Health Net

The following process applies to cases that need to be referred to the Health Net Medical Management Department:

1. The referral is made to the Health Net care management intake coordinator in Medical Management. Most cases are identified through the inpatient concurrent review process, but referrals are accepted from any source. Indicators that a member may be appropriate for care management may be based on diagnosis, potential treatment, frequent hospitalizations, extended hospitalizations, location of care, and patterns of care.
2. The case is assigned to a Health Net care manager.
3. The Health Net care manager assesses the member's medical care needs by talking with the member, family (if the member is a minor or is incapable of self-representation) and the referral source.
4. The Health Net care manager requests all pertinent medical records from the primary care physician (PCP), involved hospitals, specialists, therapists, and other treatment or referral sources.
5. The Health Net care manager notifies the referral source, member or guardian, PCP, and participating physician group (PPG), if applicable, of the member's eligibility for the Health Net care management program. If the member is not eligible for the program, the Health Net care manager may offer suggestions or alternatives for the member to pursue.
6. The Health Net care manager develops a care management plan (CMP) in collaboration with family and member. The Health Net care manager shares the care plan with the PCP and other involved health care providers as appropriate.
7. The CMP is followed and the care manager follows up with the PCP on any referrals.
8. The Health Net care manager reviews the CMP and the member's progress at least once every 30 days, allowing for re-evaluation in the event of a change in medical condition. Short-term referrals, expected to last three months or less, are reviewed more frequently. Any changes in the CMP are submitted to the PCP for approval.

Referrals to State or County Care Management

When a member is identified as eligible for a county or state-supported health care program, a Health Net care manager or review nurse assists the PCP, on request, in ensuring timely referral. The PCP makes the referral and coordinates primary medical care for members who are eligible for any of the carve-out programs. Health Net's care managers also serve as liaisons between the PCP and the county carve-out services coordinator to ensure exchange of information and provision of primary health care for individual members.

Los Angeles County - Referrals to Affiliated Health Plans

PPGs to which Health Net has delegated responsibility for care management services must refer members identified as potential care management recipients to the affiliated health plan's utilization management (UM) or health care services department.

Identification of Potential Care Management Recipients

Members are referred by the primary care physician (PCP) or specialist for individual medical care management services for high-risk medical conditions. The following list of medical conditions represents the type of conditions that can be referred for care management:

- Multiple trauma with acute extended length of stay (ELOS) greater than 10 days
- Severe neurological diseases that are chronic degenerative (for example, amyotrophic lateral sclerosis (ALS))
- Complex multi-diagnostic cases

In addition, Medi-Cal managed care members with the following medical conditions should be considered for referral to the care management program:

- HIV/AIDS
- Cancer
- Asthma, with associated inpatient admission
- Sickle cell
- Diabetes
- Congestive Heart Failure
- Depression
- Anxiety
- Children with special health care needs
- Other state-mandated criteria such as members under 21 years of age receiving private duty nursing services

Additional information regarding eligibility requirements for public health programs, such as Regional Centers and CCS, is provided in the Public Health topic.

Complex Case Management Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

The Complex Case Management program identifies members as being at high risk for hospitalizations or poor outcomes and who have barriers to their health care. The program uses an evidence-based, approach, which is member-focused and goal-directed, in developing, implementing and monitoring the care plan. Trained nurse care managers, in collaboration with a multidisciplinary team, provide coordination, education and support to the member in achieving optimal health, enhancing quality of life and accessing appropriate services.

This program supports the member, family and caregivers by coordinating care and facilitating communication between health care providers. Once a member is selected to participate in the program, a case manager contacts the member's provider to coordinate care.

Outcomes for this program include:

- Completion of a comprehensive health assessment that identifies medical needs (including primary and specialty care), medication management, durable medical equipment (DME) needs, and other psychological and social needs.
- Collaboration between the case manager, member (family and caregiver), multidisciplinary team, primary care physician (PCP), and other clinical providers to develop an individual written plan of care that is communicated to the provider and medical home.
- Coordination of care, including provision of emotional and social support, for acute and chronic illness.
- Improved member knowledge of their illnesses, self-management skills, health care options, and available services.
- Avoidance of unnecessary emergency visits and hospitalizations, seamless transitions between levels of care and the appropriate use of resources.

On an ongoing basis, Health Net evaluates the efficacy of this program by reviewing and comparing specific member outcomes and utilization before and after case management intervention.

Criteria

The Plan uses the Population Health Management (PHM) report to identify members for Complex Care Management. The PHM report combines data from multiple sources to use in its population and program eligibility process. Data elements from multiple sources are stored in corporate-wide data warehouses. Data from the warehouse is extracted into a predictive modeling tool, Impact Pro. The data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from Plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information. Members are stratified into one of 10 Population Health Categories in Impact Pro: Level 01: Healthy to Level 10: End of Life. In addition to Impact Pro, a web-based customizable report-generating system, MicroStrategy, is used to produce adjunctive analytical reports for related PHM programs including Complex Care Management.

Members stratified as described below are identified as complex and are referred to care management.

Diagnostic categories typically associated with high intensity of services and/or high cost but are generally well managed in the individual. Diagnoses include, but are not limited to:

- HIV/AIDS
- Cancer.
- Asthma with associated inpatient admission.
- Sickle cell.
- Congestive heart failure.
- Depression.
- Anxiety.
- Children with special health care needs.
- Other state-mandated criteria such as members under 21 years of age receiving private duty nursing services.
- Members otherwise meeting criteria for Complex Care Management but who do not have an additional parameter such as ER likelihood: high
- Members who reach a designated score based on responses to the Screening HRA and/or who requested an ICP or individualized care team may be referred to Care Management.

- Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources.
- Need for assistance with accessing health care services related to continuity of care.
- Participation in county program requiring supplemental Plan support.

Program Components

This program helps facilitate an appropriate personalized level of care for members, which includes:

- Telephonic interactions with a trained nurse or social worker case manager.
- Comprehensive assessment of medical, psychosocial, medication adherence, and DME needs.
- Development of an individual care treatment plan reflects the member's ongoing health care needs, abilities and preferences.
- Consolidation of treatment plans from multiple providers into a single plan of care, to avoid fragmented or duplicative care.
- Coordination of treatment plans for acute or chronic illness, including emotional and social support issues.
- Coordination of resources to promote the member's optimal health or improved functionality with referrals to other team members or programs, as appropriate.
- Education and information about medical conditions and self-management skills, compliance with the medical plan of care, and other available services to reduce readmissions and inappropriate utilization of hospital services
- Communication to the provider and medical home.

Referrals

Providers may refer members for complex case management and complete the Care Management Referral Form – Health Net (PDF), Care Management Referral Form – Community Health Plan of Imperial Valley (PDF) or Care Management Referral Form –CalViva Health (PDF). Members may self-refer to the program by calling the member services telephone number on the back of their identification (ID) card.

Discharging a Member from Care Management

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

The Health Net care manager determines when a member is to be discharged from care management. Generally, the member is discharged when the highest level of functioning within the limitations of the condition has been reached. Once the member has been discharged from care management, ongoing health care is managed by the primary care physician (PCP).

Health Education and Preventive Care Programs

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health education programs are incorporated into the Health Net care management plan to address the member's health needs. Primary prevention programs may include topics such as nutrition, exercise, smoking cessation, and stress reduction.

These programs are designed to prevent health problems, such as pregnancy counseling and care management intervention to help to reduce premature labor or low-birth-weight infants. The Health Net care manager works closely with the Health Net health education staff to coordinate in-service education for care management members.

Disease Care Management

According to Department of Health Care Services (DHCS) contractual requirements, disease care management for Medi-Cal is provided for members with chronic disease conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD)*, diabetes, and cardiac conditions* (coronary artery disease*, heart failure*, hypertension* or hyperlipidemia*).

The Disease Management/Health Coaching - *Be In Charge!*[SM] program also addresses lifestyle management needs such as exercise*, nutrition, stress*, and weight management**; tobacco cessation** and puff free pregnancy**. For detailed information, see Disease Management Be In Charge Program.

Denotes adult programs only * Pediatric weight management program is ages 2 year and above; tobacco cessation programs are ages 12 years and above.

Episodic care management involves treating a specific episode of a member's care that occurs following a specific set of events or diagnoses. Episodic care management usually involves the use of specialists, discharge planners and concurrent review nurses, in addition to the primary care physician (PCP) . Episodic care management is performed by the Health Net Health Services Department, the responsible affiliated health plan's UM department or a participating physician group (PPG) with delegated utilization management functions.

Palliative Care Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Eligible members (including Dual Special Needs Plans (D-SNPs)) at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or liver disease. Life expectancy is 12

months or less, health status continues to worsen and the emergency department (ED) or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

Referrals

Palliative care services provide extra support to current benefits.

Providers can refer an eligible Medi-Cal member to palliative care. Send an Outpatient California Medi-Cal Prior Authorization Form (Medi-Cal (PDF), CalViva (PDF), CHPIV (PDF)) and related medical records by email or fax to the Prior Authorization Department.

To process the prior authorization request correctly, the following information must be included on the request:

- Diagnosis code – Z51.5
- Procedure code – S0311
- Units – 6 (equals 6 months)
- Select the contracted provider of choice from the list (Medi-Cal (PDF), CalViva (PDF), CHPIV (PDF)).

Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in section A., below, and at least one of the four requirements outlined in section B.

Members under age 21 who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in section C., below, consistent with the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
    - Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    - Participate in advance care planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive heart failure (CHF): Must meet (a) and (b)
    - The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
    - The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.
2. Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b)
    - The member has a forced expiratory volume (FEV) of one less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    - The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. Advanced cancer: Must meet (a) and (b)
    - The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    - The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver disease: Must meet (a) and (b) combined or (c) alone
    - The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    - The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    - The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

Must meet 1. and 2. listed below. Members under age 21 may be eligible for palliative care and hospice services concurrently with curative care.

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
    - Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
    - Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
    - Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
    - Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

PCP Responsibilities

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

The primary care physician (PCP) continues to be the principal person responsible for directing the member's care. The Health Net care manager provides the PCP with reports regarding the member's progression through the care management plan. The PCP is responsible for:

- Providing ongoing medical treatment
- Providing health care information, such as medical records and the treatment plan, to expedite health services for the member
- Maintaining complete documentation in the member's medical record
- Participating as a health care team member in the member's care management plan
- Attending care conferences to evaluate the member's progress and modify the care plan, if necessary, and/or reviewing the care management plan of care and providing feedback to the care manager.

Complex Cancer Care

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Medi-Cal members with a qualifying complex cancer diagnosis can request a referral from their provider to get medically needed care from a contracted cancer center (Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley), such as a:

- National Cancer Institute (NCI)-designated comprehensive cancer center,
- Site affiliated with the NCI Community Oncology Research Program (NCORP), or
- Qualifying academic cancer center.

Members also have the option to request treatment at an out-of-network cancer treatment provider.

What is a complex cancer diagnosis?

A complex cancer diagnosis includes those listed below. These diagnoses are subject to updates.

- Blood disorders/diseases, malignancies;
- Acute leukemia;
- Advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma including blastic plasmacytoid dendritic cell neoplasm (BPDCN) and T-cell leukemias and lymphomas;
- Advanced stage (stage IV metastatic cancer), relapsed solid tumors refractory to standard FDA-approved treatment options; and
- Advanced stage rare solid tumors for which there is no known effective standard treatment options.

How referrals to an out-of-network cancer center work

A member can get medically needed services from an out-of-network provider but there must be a **payment agreement** in place with Health Net (i.e., letter of agreement or LOA). This includes:

- When a member requests a referral through an out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center, or a member chooses a different type of cancer treatment provider,

or

- When an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center refers a member diagnosed with a complex cancer to an out-of-network specialist.

Clinical Criteria for Medical Management Decision Making

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to medical necessity clinical criteria for the evaluation and treatment of specific conditions and evolving medical technologies and procedures.

Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information.

Health Net uses both externally and internally developed criteria for reviewing cases. These criteria sets create consistency in decision-making by evaluating patient-specific behaviors and symptoms to help make clinically appropriate decisions.

Clinical polices do not constitute a description of plan benefits nor can they be construed as medical advice. These policies provide guidance as to whether or not certain services or supplies are cosmetic, medically necessary or appropriate, or experimental and investigational. The policies do not constitute authorization or guarantee coverage for a particular procedure, device, medication, service, or supply.

In the event a conflict of information is present between a clinical policy, member benefits, legal and regulatory mandates and requirements, Medicare or Medicaid (as applicable) and any plan document under which a member is entitled to covered services, the plan document and regulatory requirements take precedence. Plan documents include, but are not limited to, subscriber contracts, summary plan documents and other coverage documents.

Clinical policies may have either a Health Net health plan or a “Centene” heading. Health Net utilizes InterQual® criteria for those medical technologies, procedures or pharmaceutical treatments for which a specific health clinical policy does not exist. InterQual is a nationally recognized evidence-based decision

support tool. Clinical policies are reviewed annually and more frequently as new clinical information becomes available.

Behavioral Health Providers

Behavioral health decisions are based on nonprofit professional association for the relevant clinical specialty including the criteria and guidelines set forth by the Council of Autism Service Providers Criteria and Guidelines, the American Psychological Association Guidelines for Psychological and Neuropsychological Testing and World Professional Association for Transgender Health (WPATH) criteria.

Health Net has implemented the use of the Level of Care Utilization System and Child and Adolescent Level of Care Utilization System (LOCUS/CALOCUS), and the Early Childhood Service Intensity Instrument (ECSII) criteria for all non-ABA (Applied Behavioral Analysis) mental health medical necessity determinations and level of care placement decisions. For ABA decisions, the Council for Autism Services Providers ABA Professional Guidelines are used. For substance use disorder utilization management, Health Net uses the American Society of Addiction Medicine (ASAM) criteria set. When the requested service is not in scope for LOCUS/ CALOCUS, or another nonprofit professional association for the relevant clinical specialty, Health Net utilizes internal criteria that have been developed according to generally accepted standards of mental health and substance use disorder care.

By using nationally recognized and evidence-based criteria, our Utilization Managers apply objective, evidence-based standards to support their decisions regarding procedures, levels of care, and continued stay. Supporting appropriate care decisions can lead to better outcomes for our members.

Health Net evaluates each member's plan of treatment for appropriateness and timeliness. It is Health Net's policy to share specific level of care guidelines and utilization management review procedures in writing with providers, members, customers, and members of the general public who request them.

Copies of criteria can be obtained for provider and members by calling the specific number listed on the back of the member's ID card.

Clinical Criteria for Utilization and Care Management Decisions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

To determine medical appropriateness, the Health Net utilization management (UM)/care management (CM) program uses recognized guidelines and criteria sets that are clearly documented, based on sound clinical evidence, and include procedures for applying criteria based on the needs of individual members and characteristics of the local delivery systems.

For the Medi-Cal program, Health Net uses criteria set forth in applicable sections of Titles 17 and 22 of the California Code of Regulations, Department of Health Care Services (DHCS) Managed Care All Plan Letters, DHCS Medi-Cal Provider Manuals, and Hayes evidence-based resources.

These criteria are used to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying or denying requests for services. Health Net also uses InterQual® Care Planning Criteria along with other company-wide evidence-based medical policies, which are approved and updated by the Health Net Medical Advisory Council (MAC).

These UM criteria guide the assessment of medical necessity for pre-service outpatient requests, admissions and concurrent stay review in acute and skilled facilities. If conflicting criteria exist, Health Net considers Title 22 to prevail.

When applying criteria to a specific individual case, Health Net considers at least the following factors:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable
- Characteristics of the local delivery system (if clinically necessary care is not available within the local delivery system, Health Net assists the member and practitioner to determine an alternate appropriate delivery system):
    - Ability of local hospitals to provide all recommended services within the estimated length of stay
    - Availability of skilled nursing facilities or subacute care facilities
    - Availability of other care appropriate to meet the member's individual needs

  To ensure that the criteria used are consistently current, Health Net at least annually:

- Renews license agreements for the latest versions of the appropriate criteria sets, clinical practice guidelines and technology assessments
- Analyzes and updates medical criteria changes based on information collected from the previous year

Behavioral health decisions are based on nonprofit professional association for the relevant clinical specialty including the criteria and guidelines set forth by the American Psychological Association Guidelines for Psychological and Neuropsychological Testing and World Professional Association for Transgender Health (WPATH) criteria.

The Health Net MAC and Quality Improvement and Health Equity Committee (QIHEC) are responsible for the review, revision and approval of all criteria.

Health Net makes many of the clinical criteria sets, including Health Net's medical policies, available to participating providers.

Concurrent and Retrospective Review

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Concurrent Review

Concurrent review is the process of monitoring delivery of medical services at the time the care is being rendered (inpatient admissions). Concurrent review consists of pre-admission review, continued-stay review and discharge planning.

Concurrent review is initiated at the time prior authorization is requested for an inpatient admission or on notification to the Health Net Medical Management Department that a member has been admitted (in the case of an urgent or emergency admission). Concurrent review includes an evaluation of:

- Quality of care
- Plan of treatment
- Severity of illness
- Intensity of treatment
- Length of stay
- Level of care
- Discharge plan

Based on the concurrent review process, the hospital stay is approved or denied. If the stay is approved, the hospital receives a prior authorization number. The authorization number must be indicated on the hospital claim to Health Net.

All potentially non-approved services identified by the Health Net care manager (registered nurse (RN) reviewer) are reviewed with a Health Net medical director or a specialty advisor. Physicians and members have the right of appeal all un-approved services. Care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Behavioral Health Concurrent Review

- The attending physician or facility utilization review staff calls the Health Net Utilization Review Clinician on the agreed-upon review date and provides and verifies the concurrent review information.
- The Utilization Review Clinician obtains all of the following information required for concurrent review via phone with the utilization review staff or attending psychiatrist at the facility:

  Diagnosis
  - Symptom progress/change in severity
  - Risk areas
  - Treatment goals/interventions
  - Medications
  - Indicators for continued treatment
  - Discharge planning (to begin at the time of admission)
  - Target discharge date
  - Other clinical information, as needed

Providers must notify the Health Net Utilization Review Clinician via phone on the same day that the member is discharged and provide a detailed discharge summary within 24 hours. The discharge summary must include information about the member’s status at discharge, such as current symptoms and medications, details about post-discharge appointment(s) scheduled for step-down care, and the member’s updated contact information (i.e., address, phone number).

- The Utilization Review Clinician reviews clinical data and authorizes additional days if medical necessity criteria for a continued stay are met.

- If the medical director denies authorization, refer to the non-certification procedure.
- If medical necessity criteria for a continued stay are not met for the level of care requested, the Utilization Review Clinician will review the request with a Health Net medical director.
- If the medical director denies authorization, refer to the non-certification procedure.
- The Utilization Review Clinician documents clinical appropriateness.
- The Utilization Review Clinician consults with a clinical manager and/or a medical director when any aspect of the treatment plan is unclear or in question.

Behavioral Health Noncertification

For most health plans, requesting facilities are notified by phone immediately of the review decision.

1. The Health Net Utilization Review Clinician receives requests for initial authorization from the clinical contact at the facility or program by online submission, via the Availity Essentials secure provider portal, fax or phone. The Health Net Utilization Review Clinician receives any subsequent requests for continued stay from the clinical contact by phone.
2. Administrative denials (based on exhaustion of benefits, lack of pre-authorization, etc.) do not require Health Net medical director review.
3. When medical necessity criteria do not appear to be met, the Utilization Review Clinician presents the case to the medical director for review. In some clinical denials, the facility is notified by the Utilization Review Clinician that they can request a peer-to-peer discussion with the peer reviewer who originally denied the authorization. If the denial decision is not changed following peer-to-peer review discussion and the patient or facility still disagrees with the determination, the patient or patient's representative (often the facility) can request an appeal by a different peer reviewer if the patient is still in treatment.
4. Notification of denial of authorization is typically made by phone immediately, but not longer than permitted based on the type of account. For urgent concurrent requests, written confirmation is sent within 24 hours of receipt of request.
5. The original denial letter is sent to the patient and copies are sent to the facility, parent and/or guardian (if applicable) and attending physician. The denial letter will always include the rationale for the denial decision and a full description of the appeals procedure.

In case of inpatient treatment services where the member is still hospitalized, a practitioner who wishes to appeal a denial immediately on behalf of the member is verbally notified of the urgent/expedited appeals process, in which the facility representative (e.g., attending physician) can speak with another peer reviewer to present the case.

All service requests that do not meet medical necessity approval criteria as described herein, or where medical necessity is questionable or unclear, must be reviewed by a Health Net medical director.

Retrospective Review

Retrospective review is review of the quality and necessity of medical services after care has been rendered. Retrospective professional review involves an evaluation of services that fall outside Health Net's established guidelines for coverage. These claims are reviewed by Health Net's professional review specialists (RN reviewers) and a Health Net medical director or a specialty advisor where the initial reviewer recommends that a claim be denied for lack of medical necessity.

Continuity of Care

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Under Health Net's continuity of care (COC) policy, there are two types of COC, non-clinical and clinical.

Non-Clinical COC

All new Medi-Cal members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months. An existing relationship means the member has seen the non-participating provider at least once during the previous 12 months for a non-emergency condition prior to the date of their initial enrollment with Health Net.

Member must have a pre-existing relationship with the requested provider. A pre-existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once for a non-emergency visit during the 12 months prior to the date of their initial enrollment into Health Net Medi-Cal.

The health plan or the delegated entity determines if a relationship exists through use of data provided by the Department of Health Care Services (DHCS). A member or their provider may also provide information to the health plan or the delegated entity that demonstrates a pre-existing relationship with the provider.

Following identification of a pre-existing relationship, the health plan or the delegated entity determines if the provider is an in-network provider. If the provider is not an in-network provider, the health plan or the delegated entity contacts the provider and makes a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the member.

- The requested provider is willing to accept the higher of contracted rates or Medi-Cal FFS rates.
- The requested provider has no quality-of-care concerns. Health Net does not exclude the provider from its provider network unless there are documented quality-of-care concerns, or state or federal exclusion requirements.
- The requested provider is a California State Plan-approved provider.
- The requested provider supplies all relevant treatment information to determine medical necessity, as well as the current treatment plan.

COC services not covered for Medi-Cal members

- Other ancillary providers, such as radiology, laboratory, dialysis center; non-emergency medical transportation (NEMT); non-medical transportation (NMT); other ancillary services; and non-enrolled Medi-Cal providers.
- Out-of-network providers who do not agree to abide by Health Net's utilization management (UM) policies.

If the out-of-network provider does not agree to a rate, or Health Net has a documented quality-of-care issue with the provider, the member will be offered an in-network alternative and assigned to another in-network provider.

Behavioral Health

COC for mental health services is provided by Health Net. Health Net provides COC with an out-of-network specialty mental health service provider where a member's mental health condition has stabilized and the member no longer qualifies to receive specialty mental health services (SMHS) from the county mental health plan (MHP). The member then becomes eligible to receive non-specialty mental health services from Health Net. In this situation, the COC requirement only applies to psychiatrists and/or outpatient mental health providers approved to provide Medi-Cal services.

PPG Process

Health Net begins to process the non-clinical COC request within five business days of receiving the request. For delegated participating physician groups (PPGs), the Public Program Specialist’s team forwards the COC request to the PPG's utilization management (UM) department.

Staff from the PPG UM works with the out-of-network provider to secure a care plan for the member. They also issue the decision and explain the process for requesting continued services beyond the first authorization and, if warranted, how to continue out-of-network services up to the allowable timeframe of 12 consecutive months.

Necessary authorizations must be processed within 30 calendar days for regular requests and 15 calendar days for more immediate cases. As soon as possible, but no longer than three calendar days for urgent requests (i.e., there as identified risk of harm to the member).

The PPG's responsibility is:

- Notify the member about the transition to a new provider 30 calendar days prior to the end of the COC period and coordinate the transition with the out-of-network provider.
- Work with the out-of-network provider to make sure they are willing to work with the PPG and Health Net. Out-of-network providers cannot refer the member to another out-of-network provider without authorization from Health Net or a delegated PPG.
- The PPG follows up with the out-of-network provider and member to confirm they have received authorization from the PPG, and both understand the process for further authorization requests.

Clinical COC

All new Medi-Cal members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months. An existing relationship means the member has seen the non-participating provider at least once for a non-emergency condition during the previous 12 months prior to the date of their initial enrollment with Health Net or a current Medi-Cal member may also be approved to complete care with a departing Health Net provider after that provider leaves Health Net's network. Completion of covered services are provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Health Net in consultation with the member and terminated provider or non-participating provider and consistent with good professional practice and:

- The provider contract is terminated with Health Net for a reason other than medical discipline, fraud or crime.
- Had a PPG change due to provider contract termination or provider leaving assigned PPG.

- Are new members in treatment for conditions listed below.

Types of clinical criteria where a member may be eligible for COC:

- Acute conditions, which include medical conditions that involve a sudden onset of symptoms due to an illness, injury or other medical problem requiring prompt medical attention with a limited duration. Services must be provided for the duration of the acute condition.
- Services for a serious chronic condition must be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Health Net in consultation with the member and the provider and consistent with good professional practice. Coverage may not exceed 12 months from the contract termination date. Serious chronic conditions include medical conditions due to a disease, illness or other medical problem or medical disorder that is serious in nature and does either of the following:
    - Persists without full cure or worsens over an extended period of time.
    - Requires ongoing treatment to maintain remission or prevent deterioration.
- Documented pregnancies – Completion of covered pregnancy services and the immediate postpartum period.
    - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri- or post-partum, or that arises during pregnancy, in the peri- or post-partum period, up to one year after delivery.
- Terminal illness – Services are provided for the duration of the terminal illness.
- Newborn care between birth and age 36 months – Coverage may not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new member.
- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and had been recommended and documented by the provider to occur within 180 days.

Requesting Continuity of Care

Medi-Cal members, their authorized representatives on file with Medi-Cal or their providers may initiate a request for continuity of care directly from Health Net. Health Net accepts verbal or written COC requests. Refer to the Health Net Medi-Cal Member Services Department, or CalViva Health Medi-Cal Member Services Department for assistance.

Health Net completes continuity of care requests within:

- Thirty (30) calendar days from the date of receipt
- Fifteen (15) calendar days if the member's medical condition requires more immediate attention, or
- Three (3) calendar days if there is risk of harm to the member. Risk of harm is defined as an imminent and serious threat to the member’s health.

Upon completion of the COC review, the provider and the member will be notified of the decision within seven calendar days.

- If a member changes Medi-Cal managed care plans, the COC period may start over one time.

- If the member changes Medi-Cal managed care plans a second time (or more), the COC does not start over, meaning the member does not have the right to a new 12 months of COC by the non-participating provider.
- If the member returns to Medi-Cal fee-for-service (FFS) and later re-enrolls in a Medi-Cal managed care plan, the COC period does not start over.
- If a member changes managed care plans, COC assistance does not extend to participating providers the member accessed through their previous managed care plan.

A request for COC is complete when:

- The member is informed of their right to continued access.
- Health Net and the non-participating FFS provider are unable to agree to a compensation rate.
- Health Net has documented quality-of-care issues.

Discharge Notification

Provider Type: Participating Physician Groups (PPG) | Hospitals | Ancillary

Hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) must have policies and procedures in place when transitioning members from hospitals or inpatient facilities to their homes and other community-based settings to support effective care transitions.

Hospitals and inpatient facilities must notify and communicate with the member's primary care physician (PCP) and Enhanced Care Management (ECM) provider of discharge from hospitals or inpatient facilities.

Information needed for discharge summary

When notifying the member's PCP and ECM provider of a discharge, provide the information below:

- Member name
- Identification (ID) number from patient's membership ID card
- Date of birth (DOB)
- Admission and discharge dates
- Attending physician name
- Attending physician phone number
- Diagnosis
- Follow-up appointment date, if known
- Discharge destination
- Responsible party at discharge
- Level of assistance required
- Discharge planning needs including equipment, service or other special training needs
- Medications, including dosage and frequency at discharge
- Facility name and phone number

Hospital and Inpatient Facility Discharge Planning

Participating Physician Groups (PPG) | Ancillary | Hospitals

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization. For any concurrent authorization that is denied, care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The Transitional Care Services program is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Members have the right to:

- Be informed of continuing health care requirements following discharge from the hospital or inpatient facility.
- Be informed that, if the member authorizes, a friend or family member may be provided information about the member's continuing health care requirements following discharge from the hospital or inpatient facility.
- Actively participate in decisions regarding medical care. To the extent permitted by law, participation includes the right to refuse treatment.
- Appropriate pain assessment and treatment.

Electronic medical records or administrative system (Medi-Cal providers only)

In accordance with the Provider Participating Agreement (PPA) and Federal regulation 42 CFR 482.24 section (d), hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

- Los Angeles Network for Enhanced Services (LANES)
- Manifest MedEx
- SacValley MedShare

- San Diego Health Connect
- Applied Research Works, Inc.
- Health Gorilla, Inc.
- Long Health, Inc.
- Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
- Serving Communities Health Information Organization (SCHIO)

Notification of Hospital Admissions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Reporting Requirement

Hospitals are required to notify Health Net of any Health Net member inpatient admission within:

- 24 hours, or
- One business day when the admission occurs on a weekend or holiday

Notifications are required 7 days a week and must be submitted to the Hospital Notification Unit.

Failure to Notify

Failure to notify Health Net in accordance with the requirements outlined in the Provider Participation Agreement (PPA) may result in a denial of payment.

Tracking Number and Authorization

Upon receipt of an admission notification:

- Health Net creates a tracking number and provides it to the reporting party.
- The tracking number is not an authorization and does not, by itself, confirm coverage under the member's benefit plan.
- Any services authorized by Health Net at the time of notification or thereafter are documented in the Health Net notification system.
- The tracking number is also transferred electronically to the Health Net claims processing system.

How to Report an Admission

To report a Health Net member inpatient admission, contact the Health Net Hospital Notification Unit.

After-Hours Admissions

- Notifications for after-hours admissions may be submitted via fax or web.
- On the next business day, a Health Net representative:
  - Verifies member eligibility.
  - Obtains admission details.
  - Issues a tracking number, if applicable.

When reporting inpatient admissions, a hospital face sheet may be submitted. If a hospital face sheet is not submitted, the following information must be provided:

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).
- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number (if applicable).
- For obstetrical (OB) delivery admissions, include newborn sex, weight, Apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

Timely notification of Health Net member inpatient admissions assists with timely payment of claims, reduces retroactive admission reviews and enables Health Net to concurrently monitor member progress. Health Net requires hospitals to notify the Hospital Notification Unit and the PPG (if applicable) or provider of a member's inpatient admission within 24 hours (or one business day when an admission occurs on a weekend or holiday) for the following services:

- All inpatient hospitalizations.
- Skilled nursing facility (SNF) admissions.
- Inpatient rehabilitation admissions.
- Inpatient hospice services.
- Emergency room admissions.

Electronic medical records or administrative system

In accordance with the Provider Participation Agreement (PPA) and Federal regulation 42 CFR 482.24 section (d) , hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

- Los Angeles Network for Enhanced Services (LANES)
- Manifest MedEx
- SacValley MedShare
- San Diego Health Connect
- Applied Research Works, Inc.
- Health Gorilla, Inc.

- Long Health, Inc.
- Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
- Serving Communities Health Information Organization (SCHIO)

Requests for Authorization for Post-Stabilization Care at Non-Participating and Participating Hospitals

Health Net is responsible for the coverage and payment of emergency services and post-stabilization care services to the provider that furnishes the services. This can be a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Requests for Post-Stabilization Authorization

The requirement to request authorization applies to both in-network and out-of-network hospitals when treating members. Refer to Request for Authorization to Provide Post-Stabilization Services at Non- Participating and Participating Hospitals for detailed information on how to request a post-stabilization authorization.

Out-of-Area Service

Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net provides prior authorization, concurrent, retrospective utilization review, and care management assistance to members who receive care outside the service area. Health Net Utilization Management (UM) Department initiates concurrent and medical necessity review when applicable. Health Net then notifies the primary care physician (PCP) of the member's location and clinical condition. The UM Department in collaboration with the physician and the out-of-area provider determines if the member can safely be transferred. Members are encouraged to contact their PCP or participating physician group (PPG) to determine the best plan for obtaining medical care and follow-up.

Prescription Utilization Review

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Prescription utilization is examined in aggregate monthly and quarterly to determine the types of medications that primary care physicians (PCPs) and specialists prescribe to members. Review of medications for California Children's Services (CCS)-eligible conditions are conducted monthly with Health Net's pharmacy team and Health Net Medi-Cal medical directors.

Potential cases of abuse are brought to the attention of the Special Investigation Unit for investigation.

Plan-Specific Review

Prescription utilization for the health plan is analyzed quarterly by The Pharmacy and Therapeutics (P&T) Committee, the Health Net Pharmacy Advisory Committee (PAC), and the Health Net Quality Improvement Health Equity Committees (QIHEC).

Utilization is separated by geographical area to address potential differences in practice patterns and for comparison purposes.

Pharmacy representatives participate in all aspects of utilization review that pertain to medications, including input from:

- Pharmacy and Therapeutics Advisory Board
- Medical Management
- Health Net Community Solutions Quality Improvement Health Equity Committee (HNCS QIHEC)
- Specially designed studies as requested by these committees or as deemed necessary by the health plan or by Pharmacy Services
- Health Net Pharmacy Advisory Committee (PAC)

Separation of Medical Decisions and Financial Concerns

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Under California Health & Safety Code Section 1367(g), medical decisions regarding the nature and level of care to be provided to a member, including the decision of who renders the service (for example, primary care physician (PCP) instead of specialist or in-network provider instead of out-of-network provider) must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization management (UM) decisions are, therefore, made by medical staff and based solely on medical necessity. Providers may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. Health Net requires that each participating physician group (PPG) and hospital's UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions.

Utilization Management Program Components

Physicians | Participating Physician Groups (PPG)

Utilization management (UM) is provided through a comprehensive, multi-level and flexible managed care delivery system. Health Net delegates the UM function to participating physician groups (PPGs) UM vendors and Molina Health Care in Los Angeles County for Medi-Cal. Following an evaluation of the operational capabilities of their UM program, Health Net's decision to delegate UM is based on results of pre-delegation reviews and committee approval. Health Net does not delegate UM functions to individual participating providers. Health Net staff perform UM functions when operational functions are not delegated.

When Health Net delegates UM operational functions, delegates are required to establish a formal UM program that describes how the delegated UM processes are performed and monitored. Health Net evaluates the effectiveness of the delegate program via ongoing monthly performance reporting, and annual reviews. Corrective actions are issued for below standard performance and when necessary, decisions regarding continued delegation will be reviewed by the Plan Leadership.

Health Net medical directors and provider engagement account executives are the principal liaisons between Health Net medical management and PPGs. Health Net UM and quality improvement (QI) staff support these directors and account executives. They play an integral part in helping PPGs and delegates meet the expectations of Health Net and its members. They play an important role in improving provider performance, provider satisfaction and clinical outcomes for our members through monthly engagement with providers and timely issue resolution.

Contacts

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

- Access to Interpreter Services
- AIDS Waiver Program
- Alcohol and Drug Treatment Services
- American Specialty Health Plans
- Animas Diabetes Care, LLC
- Apria Healthcare, Inc
- ATG Rehab Specialists, Inc

B

- Behavioral Health Contact Information
- Byram Healthcare Centers, Inc.

C

- California Department of Social Services
- California Children's Services Program
- California Children's Services Paneling Inquiries
- California Smokers' Helpline
- CalViva Health Medi-Cal Member Services Department
- CalViva Health Medi-Cal Provider Services Center
- CalViva Health Nurse Advice Line
- Care Ride Unit
- Case Management Department
- Centene Vison services
- Children's Medical Services
- Communicable Disease Reporting
- Community-Based Adult Services Centers
- Community-Based Adult Services Face-to-Face Request Line
- Community Health Plan of Imperial Valley Medi-Cal Member Services Department
- Community Health Plan of Imperial Valley Medi-Cal Provider Services Center
- Community Health Plan of Imperial Valley Nurse Advice Line
- Comprehensive Perinatal Services Program
- Connect Hearing, Inc

- County Mental Health Plan
- County Relations/Service Coordination
- Custom Rehab Network

D

- Denti-Cal
- Department of Health Care Services
- Department of Managed Health Care
- Department of Social Services (DSS)

E

- Electronic Claims Clearinghouse Information
- EviCore Healthcare
- Evolent Specialty Services, Inc.

F

G

H

- Health Care Options (HCO)
- Health Net Credentialing Department
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Encounter Department
- Health Net Fraud Hotline
- Health Net Health Education Department
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Long-Term Care Intake Line
- Health Net Medi-Cal Claims
- Health Net Medi-Cal Facility Site Review Compliance Department
- Health Net Medi-Cal Management Department
- Health Net Medi-Cal Member Appeals and Grievances Department
- Health Net Medi-Cal Member Services Department
- Health Net Medi-Cal Provider Appeals and Grievances

- Health Net Medi-Cal Provider Services Center
- Health Net - Prior Authorization
- Health Net Provider Communications Department
- Health Net Nurse Advice Line
- Health Net Overpayment Recovery Department
- Health Net Program Accreditation Department
- Health Net Quality Improvement Department
- Health Net's Regional Medical Directors
- Health Net Third-Party Liability Department
- Health Net Transportation Vendors
- Hearing Healthcare Providers
- HNI Corporate Address
- Hoveround, Inc

I

In-Home Operations

J

J&B Medical Supply Company, Inc

K

Kick It California

L

- LabCorp
- Linkia, LLC
- Los Angeles Department of Public Social Services

M

- Managed Care Ombudsman
- March Vision Care
- Medical Board of California
- Medi-Cal Provider Contested Claims
- Medi-Cal Rx Customer Services Center
- Member Rights Information

- MiniMed Distribution Corp, Inc
- Modivcare
- Molina Behavioral Health Services
- Molina Claims Department
- Molina Credentialing and Facility Site Review Department
- Moina Encounter Department
- Molina Healthcare Education Department
- Molina Healthcare Provider Resolutions Department
- Molina Interactive Voice Response
- Molina Member Services
- Molina Nurse Advice Line
- Molina Pharmacy Department
- Molina PM160 INF Forms
- Molina Provider Services Department
- Molina Quality Improvement Department
- Molina Utilization Management Department
- Multipurpose Senior Services

N

- National Seating and Mobility

O

P

- Peer-to-Peer Review Request Line
- Pharmacy Services
- Provider Disputes and Appeals - Commercial
- Provider Network Management Department
- Provider Relations Department

Q

Quest Diagnostics

R

- Regional Centers
- River City Medical Group

- Roche

S

- San Diego County Aging and Independence Services
- San Francisco Medi-Cal Field Office
- Sonus
- Special Supplemental Nutrition Program for WIC
- State Hearing Division

T

- Third Party Risk Management Office
- Transplant Team
- Transitional Care Services
- Tuberculosis Control Program

U

V

W

- Western Drug

X

Y

Z

Contacts

This section contains general contact information for providers.

AcariaHealth

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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AcariaHealth (preferred hemophilia provider):
844-538-4661
Fax: 844-750-0827

Access2Care

Non-emergency standard transportation services are arranged through Access2Care™.

844-515-6876

Available 24 hours a day, 7 days a week. For more information, visit the Access2Care website.

Scheduling Non-Emergency Standard Transportation Services Through Access2Care

Providers should refer to the table below and contact Access2Care to arrange for medically necessary or covered transportation services.

To assist Exclusively Aligned Enrollment (EAE) D-SNP members who have exhausted their Medicare transportation benefit and need a higher mode of transportation (e.g. a wheelchair van), providers must complete a Physician Certification Statement (PCS) form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF)) to help members get transportation services through their Medi-Cal plan.

Submit the completed form to the Health Net Care Ride Unit to help members get authorizations for transportation.

Access2Care Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Routine transportation requests	Requires a 72-hour notification

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service.
Hours of operation for urgent and same-day reservations	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance and hospital discharges	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Toll-free phone numbers	Reservations: 844-515-6876

Access to Interpreter Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net offers language assistance services to its participating providers. Participating providers may request no-cost translation and interpreter support for a Health Net member to the provider or member.

Medi-Cal

Interpreter support is available 24 hours a day, seven days a week. The California Department of Managed Health Care (DMHC) requires that interpreter services, according to Section 1367.04 of the Health and Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations, are coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. To allow sufficient time for scheduling, providers or members must request interpreter services at least five business days prior to the member's appointment. For sign language requests, please request this at least 10 business days prior to the member's appointment.

If an appointment is rescheduled, it is very important to reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may also assist in identifying the member's language needs. This service is provided at no cost to Health Net participating providers.

Participating providers may request interpreter services by using the following numbers:

Medi-Cal Interpreter Services

Member Plan	Hours of Availability	Contact Number	Required Information
Medi-Cal (Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne)	24 hours a day, 7 days a week	800-675-6110	Member name and Health Net ID number, appointment date and time
Medi-Cal/CalViva (Fresno, Kings and Madera)	24 hours a day, 7 days a week	888-893-1569	Member name and the Plan ID number, appointment date and time
Medi-Cal/Community Health Plan of Imperial Valley	24 hours a day, 7 days a week	833-236-4141	Member name and the Plan ID number, appointment date and time

HMO, Medicare Advantage HMO, PPO

Health Net requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to also reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may assist in identifying the member's language need. This service is provided at no cost to Health Net participating providers.

Participating providers may request interpreter services by using the following numbers:

Commercial Interpreter Services

Line of Business	Phone Number	Hours of Availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)

Line of Business	Phone Number	Hours of Availability
Employer Group HMO, POS and PPO	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays

Medicare Interpreter Services

Line of Business	Telephone Number	Hours of Availability
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time

AIDS Waiver Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The AIDS Waiver Program provides home and community-based services as an alternative to institutionalized care for those with AIDS or symptomatic HIV.

Kern

Department of Health Services Chronic Disease Prevention Program 1800 Flower Avenue Bakersfield, CA 93306 661-321-3000 (referrals and education)

Kings

Kings County Department of Public Health, Division of Nursing and Community Services 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-589-0652

Los Angeles

AIDS Project Los Angeles 3550 Wilshire Blvd., Suite 300 Los Angeles, CA 90010-2404 213-201-1600

ALTAMED Health Services Corp HIV Services Division 5427 East Whitter Boulevard Los Angeles, CA 90022-4101 323-869-5449

Minority AIDS Project 5149 West Jefferson Boulevard Los Angeles, CA 90016 323-936-4949

St. Mary Medical Center Care Program 1045 Atlantic Avenue, Suite #1016 Long Beach, CA 90813 562-624-4900

Tarzana Treatment Center 18646 Oxnard Street Tarzana, CA 91356-1486 818-342-5897
Fax: 818-345-6256

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 559-675-7893

Riverside

1695 North Sunrise Way Palm Springs, CA 92262 760-323-4197

Sacramento

RX Staffing and Home Care, Inc. 4640 Marconi Avenue, Suite 1 Sacramento, CA 95821 916-979-7300

Sacramento County CCS Program 9616 Micron Avenue, Suite 640 Sacramento, CA 95827 916-875-9900 Fax: 916-854-9500

San Bernardino

1695 North Sunrise Way Palm Springs, CA 92262 760-323-4197

San Diego

North County Health Services AIDS Case Management 150 Valpreda Road, Suite 101B San Marcos, CA 92069 760-736-6725
Fax: 760-736-3210

San Joaquin

San Joaquin County Public Health Services - AIDS/Communicable Diseases Program 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3822
Fax (209) 468-8222

health net

Stanislaus

Stanislaus County Community Health Services 830 Scenic Drive, Bldg. 3 Modesto, CA 95350 209-558-4800 Fax 209-558-4905

Alcohol and Drug Treatment Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Drug/Medi-Cal (D/MC) Alcohol and Drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. The state of California Alcohol and Drug Programs oversee the alcohol and drug programs. Health Net, its affiliated health plans, and subcontracting providers are available to coordinate referrals for members requiring substance abuse treatment and services. Members receiving services under the D/MC program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member.

Amador

Amador County Alcohol & Drug 10877 Conductor Blvd, Sutter Creek, CA 95685 209-223-6412

Calaveras

Calaveras County Substance Abuse 891 Mountain Ranch Rd Bldg L, San Andreas, CA 95249 209-754-6555

Fresno

Fresno County Alcohol and Drug Program 559-493-2185

Inyo

Inyo County Alcohol & Drug 162 Grove St J, Bishop, CA 93514 760-873-5888

Kern

Kern County Mental Health 2151 College Avenue Bakersfield, CA 93305 661-868-8111

Kings

Kings County Department of Public Health 330 Campus Drive Hanford, CA 93230 559-584-1401

Los Angeles

Los Angeles County Office of Alcohol and Drug Programs 714 West Olympic Boulevard Los Angeles, CA 90015 323-948-0444

Madera

Madera County Behavioral Health Services 14227 Road 28 Madera, CA 93639 559-673-3508

Mono

Mono County Alcohol & Drug Services 452 Old Mammoth Rd, Mammoth Lakes, CA 93546 760-924-1740

Sacramento

Alcohol and Drug System of Care Sacramento County Department of Health and Human Services 3321 Power Inn Road, Suite #120 Sacramento, CA 95826 916-874-9754

San Diego

Office of Alcohol and Drug Programs 888-724-7240

San Joaquin

San Joaquin County Behavioral Health Services - Substance Abuse Services 620 N Aurora ST., Suite #1 Stockton, CA 95205 209-468-3800
Fax (209) 468-3723

Stanislaus

Stanislaus County Behavioral Health and Recovery Services Stanislaus Recovery Center 1904 Richland Avenue Ceres, CA 95307 888-376-6246
209-541-2121

health net

Tulare

Alcohol and Drug Treatment 559-636-4000

American Specialty Health Plans

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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HMO, Medicare Advantage HMO, and PPO

The following information does not apply to Individual Family Plan (IFP) members.

Health Net contracts with American Specialty Health Plans, Inc. (ASH Plans) to administer and arrange chiropractic, acupuncture and massage therapy services for Health Net members in accordance with the member's applicable benefit plan.

HMO members 800-972-4226
Medicare Advantage members: 800-678-9133

April–September

Monday through Friday, 5 a.m. – 8 p.m. Pacific time (PT)

October–March

7 days a week, 8 a.m. – 8 p.m. PT

For more information, visit the American Specialty Health website.

Medi-Cal

Health Net contracts with American Specialty Health Plans, Inc. (ASH Plans) to administer and arrange acupuncture services for Health Net members.

800-972-4226, option 2.

Animas Diabetes Care LLC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of insulin pumps and supplies.
877-937-7867

Apria Healthcare Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of durable medical equipment (DME) services, excluding orthotics.

800-277-4288

ATG Rehab Specialists Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of rehabilitation equipment services.

877-489-3651

Byram Healthcare Centers, Inc.

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Byram Healthcare Centers, Inc.

877-902-9726
Fax: 866-992-6331

Byram Healthcare website

Behavioral Health Contact Information

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Behavioral Health Function	Description and/or Contact
Claims inquiries or questions	Behavioral Health Provider Services **Phone**: 844-966-0298
Eligibility and benefit checks	• Availity Essentials Provider Portal ◦ Technical Support Phone: 800-282-4548 (Monday–Friday, 5 a.m.–5 p.m. Pacific time). • Health Net Provider Portal ◦ Technical Support Team Phone: 866-458-1047.
Prior authorization	Submit initial prior authorization requests for all facility-based behavioral health services as outlined below. Concurrent reviews will continue with the assigned Utilization Review Clinician. **Commercial and Medicare (Ambetter HMO/PPO, Employer Group HMO/POS, and Wellcare By Health Net members)** • **Online**: Availity Essentials secure provider portal • **Fax**: 855-663-2244 • **Phone**: 844-966-0298 For transcranial magnetic stimulation (TMS), ABA or neuropsychological testing, submit via fax at: • **TMS**: 855-661-0077 • **ABA**: 855-427-4798 • **Neuropsychological testing**: 855-703-3268 **Medi-Cal** Call 844-966-0298 for assistance.
Update provider data	Providers directly contracted with Health Net can refer to the Participating Provider Operations page for detailed

Behavioral Health Function	Description and/or Contact
	instructions. Providers contracted under a PPG can contact their PPGs to update this information.
Provider disputes	Submit using the Behavioral Health Provider Appeal/ Dispute Form (PDF).
Request a copy of your contract	Behavioral Health Provider Services **Phone**: 844-966-0298
Contract renegotiation	Send a request via email to DNBHC@healthnet.com

California Department of Health Care Services Subacute Contracting Unit

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Facilities can contact the California Department of Health Care Services (DHCS) Subacute Contracting Unit (SCU) to request an application to be contracted for subacute care and receive Medi-Cal subacute care reimbursement.

California Children's Services Paneling Inquiries

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Paneling Inquiries:

Visit the Department of Health Care Services website or contact the Integrated Systems of Care Division, Provider Enrollment Unit at 916-552-9105. Select option 5, then option 2.

California Department of Social Services State Fair Hearing

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

California Department of Social Services State Hearings Division
P.O. Box 944243, MS 19-17-37 Sacramento, California 94244-2430

Fax: 916-651-2789 Phone: 800-743-8525 (voice) and 800-952-8349 (TTY)

California Children's Services Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The California Children's Services (CCS) program provides specialized medical care, rehabilitation services, and case management to children with medical or surgical conditions who meet program eligibility requirements. It is essential that physicians identify children with CCS-eligible conditions and arrange for their timely referral to the county CCS program.

Amador

County Department of Health 10877 Conductor Blvd., Ste. 400 Sutter Creek, CA 95685

209-223-6630
Fax: 209-223-3524

Calaveras

County Department of Health Mail: 891 Mountain Ranch Road San Andreas, CA 95249-9713 700 Mountain Ranch Road, Suite C2 San Andreas, CA 95249

209-754-6460
Fax: 209-754-1710

Fresno

1221 Fulton Mall, Room #101 P.O. Box 11867 Fresno, CA 93721

209-754-6460
Fax: 559-455-4789

Imperial

935 Broadway Street El Centro, CA 92243-2396

442-265-1455
Fax: 442-265-1481

Inyo

County Department of Health 1360 N. Main Street, Suite 203-C Bishop, CA 93514 760-873-7868
Fax: 760-873-7800

Kern

1800 Mt. Vernon Avenue Bakersfield, CA 93306

661-321-3000
Fax: 661-868-0268

Kings

Kings County Department of Public Health, Division of Nursing and Community Services 330 Campus Drive Hanford, CA 93230-4375 559-852-4693
Fax: 559-582-6803

Los Angeles

9320 Telstar Avenue, Suite #226 El Monte, CA 91731-2849 800-288-4584
Fax: (855) 481-6821

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638-5715 559-675-4945
Fax: 559-675-7803

Mono

County Department of Health Mail: P.O. Box 3329, Mammoth Lakes, CA 93546 1290 Tavern Road, Suite 246 Mammoth Lakes, CA 93546 760-924-1848
Fax: 760-924-1831

Riverside

Riverside County Department of Health 10769 Hole Ave, #220 Riverside, CA 92505-2869 951-358-5401
Fax: 951-358-5198

Sacramento

9616 Micron Avenue, Suite #640 Sacramento, CA 95827 916-875-9900
TTY 800-735-2929
Fax: 916-854-9500

San Bernardino

San Bernardino County Department of Health 150 E Holt Blvd, 3rd Floor Ontario, CA 91762 909-458-1637
Fax: 909-986-2970

San Diego

Department of Health 6160 Mission Gorge Road, Suite 400 San Diego, CA 92120 619-528-4000
Fax: 619-528-4087

San Joaquin

San Joaquin County Public Health Services 420 South Wilson Way Stockton, CA 95205

209-468-3900
Fax 209-953-3632

Stanislaus

830 Scenic Drive, Bldg. 3 PO Box 3088 Modesto, CA 95353-3088 209-558-7515
Fax: 209-558-7862

Tulare

1062 South K Street Tulare, CA 93274 559-687-6915

Fax: 559-713-3740

Tuolumne

County Department of Health 20111 Cedar Road North Sonora, CA 95370-5939 209-533-7404
Fax: 209-533-7406

CalViva Health Medi-Cal Member Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To ensure appropriate coverage of medical services for Medi-Cal members, CalViva Health requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, CalViva Health directs inquiries from members to CalViva Health's Medi-Cal Member Services Department. Provider inquiries are directed to the CalViva Health liaison Provider Engagement Network Specialists when applicable.

The CalViva Health Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the CalViva Health Member Handbook and other member-informing materials are translated into the required threshold languages.

CalViva Health's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests

The CalViva Health toll-free number is printed on the back of the member’s identification card 888-893-1569 (TTY 711). CalViva Health is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the CalViva Health Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. CalViva Health's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the CalViva Health Nurse Advice Line (N24) when applicable.

CalViva Health Member Services Department; Open 24/7 phone number:888-893-1569
Fax: 844-837-5947 or 800-281-2999

CalViva Health Medi-Cal Provider Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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As a prepaid health care delivery system, CalViva Health has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, CalViva Health directs inquiries from providers to CalViva Health's Medi-Cal Provider Services Department or to CalViva Health's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

CalViva Health's Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates, and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the CalViva Health Medi-Cal Recommended Drug List (RDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/ PCP/PPG reassignment for non-compliant members

The CalViva Health Medi-Cal Provider Services Department phone number 888-893-1569, option 2.

Fax: 844-837-5947 or 800-281-2999

Eligibility and claims status available online.

Provider’s may use the Medi-Cal Claims Inquiry email box for claim status only if the provider portal is down or not working. This box is only for claim status and denial inquiries.

CalViva Health Nurse Advice Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The CalViva Health Nurse Advice Line program provides 24-hours a day, 7 days a week triage or screening services by phone. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment, and advice. The CalViva Health Medi-Cal Member Services Department coordinates member access to the CalViva Health Nurse Advice Line, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, provide self-care guidance, general health information, or recommend a visit to urgent care or the ER. Nationally recognized triage guidelines are used to determine the level of care needed by the member.

Health Net ensures that Nurse Advice Telephone Triage & Screening program services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

Role of the Program Nurse

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members who need urgent care are referred to an urgent care center if the PCP is not available.

The nurse educates the member on the role of the PCP and gives the member care advice instructions to care for their symptoms at home until they receive care from the PCP.

Each time a member calls into the nurse advice line, the care is documented in the member’s chart with a report sent to the member’s health plan advising them of the care sought and the disposition offered.

888-893-1569

Cancer Information Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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If a participating physician group (PPG), hospital, ancillary provider, or physician is not affiliated with a mammography center, a list of certified centers is available from Cancer Information Services or the Food and Drug Administration's (FDA's) website at www.fda.gov

800-422-6237

Care Ride Unit

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Phone: 833-236-9695

Fax: 833-701-0051

Case Management Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Contact the Case Management Department at:

Commercial

Email: Case.Management.Referrals@healthnet.com
Fax: 800-745-6955

Medi-Cal

Email: CASHP.ACM.CMA@healthnet.com
Fax: 866-581-0540

Case Management for Health Net, CalViva Health or Community Health Plan of Imperial Valley (CHPIV) Medi-Cal members with Adverse Childhood Experiences (ACEs):

If your patient is uncertain about next steps or would like to learn more, please refer them to the Plan's behavioral health Case Management Department by contacting Member Services at

- 800-675-6110 if the member has a Health Net Medi-Cal plan.
- 833-236-4141 if the member has a CHPIV Medi-Cal plan.
- 888-893-1569 if the member has a CalViva Health Medi-Cal plan.

Centers for Medicare & Medicaid Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the Department of Health and Human Services that governs the Medicare, Medicaid, Clinical Laboratories (under CLIA program), and

Children's Health Insurance programs to help ensure that eligible beneficiaries in these programs are able to get high-quality health care.

Health Net has entered into an agreement with CMS to administer health care services to eligible Medicare beneficiaries. Participating providers are required to adhere to all legislative and regulatory requirement issued by CMS.

To obtain additional information regarding CMS, refer to the CMS website.

Centene Vision Services

Contact Centene Vision Services to locate a participating optometrist or optician from whom Medi-Cal member may receive covered services (routine vision examination/refraction, lenses and frames) when medically necessary.

- Fresno, Kings and Madera Counties: 844-876-7123
- Amador, Calaveras, Imperial, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne counties: 844-820-8600

WELLCARE BY HEALTH NET (MEDICARE ADVANTAGE) Contact Centene Vision Services to locate a participating optometrist or optician from whom Wellcare By Health Net member may receive covered services (routine vision examination/refraction, lenses and frames) when medically necessary. Provider Services for Wellcare By Health Net: 866-392-6058

Centralized Transplant Unit

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Fax numbers for organ transplant reviews and authorizations:

- For individual Medicare plan members: 833-769-1143
- For employer group Medicare members: 833-769-1142

Children's Medical Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Children's Medical Services (CMS) Branch of the California Department of Health Services (DHS) oversees state-funded public health programs for children, including California Children's Services (CCS).

Children's Medical Services Branch Office MS 8100 P.O. Box 997413 Sacramento, CA 95899-7413

Communicable Disease Reporting

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To protect the public from the spread of infectious, contagious, and communicable disease, health care providers are required by law to report communicable diseases to the local health officer. Every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, must notify the local health department (LHD).

Reports must be made using the Confidential Morbidity Report. A completed copy of the report must be sent to the Communicable Disease Control division of the county health department.

Amador

10877 Conductor Blvd Sutter Creek, CA 95685 209-223-6407
Fax: 209-223-1562

Calaveras

700 Mountain Ranch Road, Suite C-2 San Andreas, CA 95249 209-754-6460
Fax: 209-754-1709

Fresno

Communicable Disease Control County of Fresno 1221 Fulton Mall P.O. Box 11867 Fresno, CA 93775
559-445-3324
Fax: 559-445-3535

Imperial

935 Broadway Street El Centro, CA 92243 442-265-1444
Fax: 442-265-1440

Inyo

1360 N. Main Street Bishop, California 93514 760-873-7868
Fax: 760-873-7800

Kern

Department of Public Health Services Chronic Disease Prevention Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 Fax: 661-321-3000

Kings

Kings County Department of Public Health, Communicable Disease Services 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-584-5672

Los Angeles

Acute Communicable Disease 313 North Figueroa Street, Room #117 Los Angeles, CA 90012 888-397-3993 888-397-3778 or 213-482-5508

HIV Epidemiology Program 600 South Commonwealth, Room #805 Los Angeles, CA 90005 213-351-8196

Long Beach Health Department 562-570-4000

Pasadena Health Department 626-744-6005

Pediatric HIV and AIDS Reporting Program 313 North Figueroa Street, Room #203 Los Angeles, CA 90012 213-250-8666

Sexually Transmitted Disease Program 2615 South Grand, Room #500 Los Angeles, CA 90007 213-744-3251 > Fax: 213-749-9602

Tuberculosis Control Program 2615 South Grand, Room #507 Los Angeles, CA 90007 213-744-6160
Fax: 213-749-0926

Madera

Madera County Department of Public Health, Communicable Disease Control Program 14215 Road 28 Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Mono

1290 Tavern Road, Suite 246 PO Box 3329 Mammoth Lakes, CA 93546 760-965-9897
Fax: 760-924-1831

Sacramento

Sacramento County Public Health 7001-A East Parkway, Suite 600A Sacramento, CA 95823 916-875-5881 (online reporting and set-up assistance)
Fax: 916-854-9708

San Diego

San Diego Department of Community Epidemiology Health & Human Services Agency 3851 Rosecrans Street San Diego, CA 92110 619-692-8499
Fax: 858-715-6458

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3822
Fax: 209-468-8222

Stanislaus

Stanislaus County Health Services Agency Communicable Disease Program 820 Scenic Drive Modesto, CA 95350 209-558-5678 (Reporting Line)
209-664-6032 (After hours emergency/weekend - confidential phone number for reporting purposes only)
Fax: 209-558-7531

Tulare

Tulare County Department of Health Services 115 East Tulare Avenue Tulare, CA 93274 559-685-5720
Fax: 559-685-4835

Tuolumne

20111 Cedar Road N. Sonora, CA 95370 209-533-7401
Fax: 209-533-7406

Community-Based Adult Services Centers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Community-based adult services (CBAS), formerly Adult Day Health Care (ADHC), provides an alternative to institutionalization for eligible Medi-Cal members ages 18 and older.

Licensed CBAS centers include the following:CBAS Providers - Community-Based Adult Services - Providers & Partners | California Department of Aging - State of California

Community-Based Adult Services Face-To-Face Request Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Providers must submit all Community-Based Adult Services (CBAS) requests, including requests for a face-to-face assessment, by submitting the CBAS Treatment Request Form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF). Providers can also submit request through the Health Net provider portal. Once logged in, go to the member's profile and select *Assessments* . Select *Fill Out Now!* next to CBAS Treatment Request.

Comprehensive Perinatal Services Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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All pregnant members must have access to Comprehensive Perinatal Services Program (CPSP) services, which integrate health education, nutrition and psychosocial services with obstetrical care.

Amador

Amador County Public Health 10877 Conductor Blvd. 400 Sutter Creek, CA 95642 209-223-6407
Fax: 209-223-3524

Calaveras

Calaveras Public Health Department
891 Mountain Ranch Road San Andreas, CA 95249 209-754-6464
Fax: 209-754-6459

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3234

Imperial

935 Broadway Street El Centro, CA 92243 800-675-2229

Inyo

Inyo County Health Department
207 A West South Street Bishop, CA 93514 760-873-7868
Fax: 760-873-7800

Kern

Department of Public Health Services Comprehensive Perinatal Services Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 661-868-0523

Kings

Kings County Department of Public Health 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-584-5672

Los Angeles

Los Angeles 213-639-6419

Long Beach 562-570-4060

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Mono

Mono County Health Department P.O. Box 3329 Mammoth Lakes, CA 93546 760-924-1842
Fax: 760-924-1831

Riverside

951-358-5438

Sacramento

Sacramento County Department of Health and Human Services 7001-A East Parkway, Suite 600 Sacramento, CA 95823 916-875-5437
Fax: 916-875-5888

San Bernardino

800-227-3034

San Diego

3851 Rosecrans Street San Diego, CA 92110 619-542-4053

San Joaquin

San Joaquin County Public Health Services - CPSP 1601 E. Hazelton Ave Stockton, CA 95205 209-468-3004
Fax 209-468-2072

Stanislaus

Stanislaus County Health Services Agency

Maternal and Child Health Branch 830 Scenic Drive Modesto, CA 95350 209-558-6819

Tulare

559-685-2275

Tuolumne

Tuolumne County Health Department
20111 Cedar Rd. N. Sonora, CA 95370 209-533-7401
Fax: 209-533-7406

Connect Hearing Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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888-608-7462

Connect Hearing website

County Mental Health Plan

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Services available under the Medi-Cal specialty mental health program are excluded from Health Net's coverage responsibilities. Primary care physicians (PCPs) provide outpatient mental health services, within the scope of their practice and coordinate referrals for members requiring specialty or inpatient mental health services.

County Mental Health Plan Contact Information

COUNTY	PHONE NUMBER
Amador	888-310-6555 or 209-223-6412
Calaveras	800-499-3030 or 209-754-6525
Fresno	559-253-9180
Imperial	760-482-2939

COUNTY	PHONE NUMBER
Inyo	800-841-5011
Kern	800-991-5272 or 661-868-8000
Kings	800-655-2553
Los Angeles	800-854-7771
Madera	888-275-9779
Mono	800-687-1101 or 760-924-1740
Riverside	800-706-7500
Sacramento	Sacramento County Mental Health Treatment Center 2150 Stockton Blvd. Sacramento, CA 95817 Adult Access team 916-875-1055 Fax: 916-875-1190 TTY: 916-874-8070 Child and Family Access team 916-875-9980 Fax: 916-875-9970 TTY: 916-876-8892 Psychiatric emergencies 916-732-3637 Toll-free 24-hour information line 888-881-4881
San Bernardino	888-743-1478
San Diego	888-724-7240
San Joaquin	209-468-8700 Crisis intervention line 209-468-8686
Stanislaus	888-376-6246
Tulare	559-624-7445 Emergency or crisis line: 800-320-1616
Tuolumne	800-630-1130 or 209-533-6245

County Relations/Service Coordination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Public programs specialists interact with public health departments and programs and work with participating providers and Department of Health Care Services (DHCS) in administering public programs and services.

800-526-1898
Fax: 866-208-2240

Coram

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net's preferred infusion provider

- Phone: 866-899-1661
- Fax: 866-843-3221

Custom Rehab Network

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of custom rehabilitation equipment services.

800-276-6557

Community Health Plan of Imperial Valley Member Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To ensure appropriate coverage of medical services for Medi-Cal members, Community Health Plan of Imperial Valley requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, Community Health Plan of Imperial Valley directs inquiries from members to Community Health Plan of Imperial Valley's Medi-Cal Member Services Department. Provider inquiries are directed to the Community Health Plan of Imperial Valley liaison Provider Engagement Network Specialists when applicable

The Community Health Plan of Imperial Valley Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the Community Health Plan of Imperial Valley Member Handbook and other member-informing materials are translated into the required threshold languages.

Community Health Plan of Imperial Valley's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests.
- Handling complaints about Community Health Plan of Imperial Valley programs or staff

The Community Health Plan of Imperial Valley’s toll-free number is printed on the back of the member’s identification card: 833-236-4141 (TTY 711). Community Health Plan of Imperial Valley is available 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Community Health Plan of Imperial Valley Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Community Health Plan of Imperial Valley's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Community Health Plan of Imperial Valley Nurse Advice Line (N24) when applicable.

Community Health Plan of Imperial Valley Provider Services Center Opened 24/7 Phone Number 833-236-4141

Fax: 844-837-5947 or 800-281-2999

Community Health Plan of Imperial Valley Provider Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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As a prepaid health care delivery system, Community Health Plan of Imperial Valley has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, Community Health Plan of Imperial Valley directs inquiries from providers to Community Health Plan of Imperial Valley 's Medi-Cal Provider Services Department or to CHPIV's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

Community Health Plan of Imperial Valley s Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates, and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the CHPIV Medi-Cal Recommended Drug List (RDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/ PCP/PPG reassignment for non-compliant members

The Community Health Plan of Imperial Valley Medi-Cal Provider Services Department toll-free telephone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Community Health Plan of Imperial Valley Provider Services Department Phone Number: 833-236-4141

Fax: 844-837-5947 or 800-281-2999

Eligibility and claims status available online.

Provider’s may use the Medi-Cal Claims Inquiry email box for claim status only if the provider portal is down or not working. This box is only for claim status and denial inquiries.

Community Health Plan of Imperial Valley Nurse Advice Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Community Health Plan of Imperial Valley Nurse Advice Line program provides 24-hours a day, 7 days a week triage or screening services by phone. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP.

According to Health Net's community access-to-care standards, all PCPs must provide 24-hour phone service for urgent/emergent instructions, medical condition assessment, and advice. The Community Health Plan of Imperial Valley Medi-Cal Member Services Center coordinates member access to the Community Health Plan of Imperial Valley Nurse Advice Line, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, provide self-care guidance, general health information, or recommend a visit to urgent care or the ER. Nationally recognized triage guidelines are used to determine the level of care needed by the member.

Health Net ensures that Nurse Advice Telephone Triage & Screening program services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

Role of the Program Nurse

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members who need urgent care are referred to an urgent care center if the PCP is not available.

The nurse educates the member on the role of the PCP, , and gives the member care advice instructions to care for their symptoms at home until they receive care from the PCP.

Each time a member calls into the nurse advice line, the care is documented in the member’s chart with a report sent to the member’s health plan advising them of the care sought and the disposition offered.

833-236-4141

Delta Dental

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

855-643-8515

April–September
Monday through Friday
8 a.m. – 8 p.m. Pacific time (PT)

October–March
7 days a week
8 a.m. – 8 p.m. PT

Dental Benefit Providers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

866-249-2382

April–September
Monday through Friday
5 a.m.– 8 p.m. Pacific time (PT)

October–March
7 days a week
5 a.m. – 8 p.m. PT

Denti-Cal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Medi-Cal members are entitled to annual dental screenings, as described in the periodic health exam schedules. Primary care physicians (PCPs) refer members for dental services to Medi-Cal dental providers.

800-322-6384

Department Of Health Care Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The sterilization informational brochures are available online for downloading and printing. California Department of Health Care Services (DHCS)

Department of Insurance

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Department of Insurance (DOI) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use Health Net's grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DOI. Providers, including participating physicians, may assist the member in submitting a complaint to the DOI for resolution and may advocate the member's position before the DOI. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

800-927-4357
213-897-8921

Department Of Managed Health Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use the grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DMHC. Providers, including participating physicians, may assist the member in submitting a complaint to the DMHC for resolution and may advocate the member's position before the DMHC. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

888-466-2219
800-400-0815
TTY: 877-688-9891

Contact DMHC

Department Of Social Services (DSS)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Department of Social Services (DSS) Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding fair hearings and grievances.

PO Box 944243 Mail Stop 19-37 Sacramento, CA 94244-2430

800-952-5253
TTY: 800-952-8349
Fax: 916-229-4110

Electronic Claims Clearinghouse Information

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Submit electronic claims for Health Net members to the appropriate clearinghouse:

Clearinghouse Information

CLEARINGHOUSE	PHONE NUMBER	WEBSITE	HEALTH NET PAYER ID NUMBER
Change Healthcare (fee-for-service only)	877-469-3263 or 800-792-5256	client-support.changehealthcare.com	68069 (Medicare and Individual Family Plans including Covered California) 95567 (Medi-Cal and Commercial)
Transunion (capitated encounters only)	Your account manager or 310-337-8530	www.transunion.com	95568 and 95570

The payer ID must be included with every claim.

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse.

EviCore Healthcare

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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eviCore healthcare is responsible for prior authorization for select sleep and radiation therapy services.

Sleep

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: 866-999-3510

Radiation therapy

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: Radiation Therapy: 800-540-2406

Evolent Specialty Services, Inc.

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Evolent Specialty Services, Inc. (Evolent), formerly known as National Imaging Associates, Inc. (NIA), is responsible for prior authorization for advanced imaging services and cardiac imaging.

Prior authorization requests must be submitted to Evolent online or by phone as follows. Evolent does not accept fax submissions.

www.RadMD.com (24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours)

Evolent Specialty Services Contact Information

PRODUCT	HOURS OF OPERATION	PHONE NUMBER
Commercial	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4802
Medi-Cal	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4809

EyeMed Vision Care

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Health Net is contracted with Centene Vision Services to provide vision benefits to Health Net members for some plans. Centene Vision Services sub-delegates benefit administration to EyeMed. EyeMed provides benefits for routine vision exams and eyewear through their network of optometrists, dispensing opticians and optometric laboratories.

Benefit administration for the routine vision examination varies by plan/product. Please verify coverage to determine if an appointment for a vision examination is covered through the participating physician group (PPG) or through EyeMed.

EyeMed Vision Care
Health Net Vision
4000 Luxottica Place
Mason, OH 45040

866-392-6058

Third Party Risk Management Office

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Third Party Risk Management Office (TPRMO) is responsible for tracking and monitoring the financial solvency of delegated providers. Contact them for assistance to submit quarterly financial updates or statements and for questions.

email: financeoversight-pa@healthnet.com

Health Care Options (HCO)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Care Options (HCO) contractor processes Medi-Cal managed care enrollments and disenrollments. Refer members to the appropriate toll-free number for assistance.

Arabic 800-576-6881

Armenian 800-840-5032
Cambodian 800-430-5005

Cantonese 800-430-6006

English and other languages 800-430-4263

Farsi 800-840-5034

Hmong 800-430-2022

Korean 800-576-6883

Laotian 800-430-4091

Mandarin 800-576-6885

Russian 800-430-7007

Spanish 800-430-3003

Tagalog 800-576-6890

Telephonic device for the deaf and hearing impaired 800-430-7077

Vietnamese 800-430-8008

Health Net Care Management Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net offers transition of care assistance that allows members who are receiving care to continue with their established non-participating provider. Approval decisions are based on individual review of member's care needs in relation to benefits and regulatory requirements.

- Medicare Case Management: 800-977-7915
- Commercial Case Management: 888-732-2730

Health Net Claims Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Claims address for HMO products.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Continuity and Coordination of Care Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Participating physician groups (PPGs) must immediately forward all pertinent documentation for investigational or experimental treatment for a terminal illness via fax or by overnight mail.

Fax: 866-295-4780

Health Net of California, Inc.
Continuity and Coordination of Care
Medical Management Department
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Credentialing Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Credentialing Department is responsible for credentialing and recredentialing directly contracting providers and all providers affiliated with participating physician groups (PPGs) to which credentialing responsibilities have not been delegated. The Health Net Credentialing Department also oversees delegated and subcontracting credentialing activity.

20151 Nordhoff
Chatsworth, CA 91311
Fax: 800-655-4128

Health Net's Health and Wellness Referral Fax

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To refer a Health Net member to one of the programs for disease management, case management or complex case management, fax a referral to 800-745-6955 or 678-355-4018 for pregnancy notification only.

You can also email a referral fax.

Delegation Oversight Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Delegation Oversight Department (previously Provider Oversight Department) oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies. The department conducts on-site due diligence evaluations prior to Health Net agreeing to contract with a provider and through on-site evaluations at least annually thereafter. Based on these evaluations, the Health Net Delegation Oversight Committee (DOC) determines which functions are to be delegated to the participating physician group (PPG). The Health Net DOC measures, monitors and oversees compliance of providers and requires corrective actions when deficiencies are discovered. The DOC is a multi-disciplinary committee comprised of, but not limited to, members from Health Net's Delegation Oversight, Health Care Services, Network Management, Medical Management, Finance Departments, and State Health Programs. If the prescribed three-step corrective action process with progressive sanctions does not resolve the deficiency, delegation may be revoked and the provider's contract terminated.

Coalition Reports

Program Accreditation Department
21281 Burbank Blvd., 5th Floor
Woodland Hills, CA 91367

Fax: 866-476-0311 provider.oversight@healthnet.com

Email the Delegation Oversight Group at Delegation_Oversight_Group@CENTENE.COM for any questions about access, users, or use of the Delegation Oversight Interactive Tool.

Health Net EDI Claims Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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For questions on electronic claims or electronic remittance advice for Individual Family Plan (IFP), Medicare Advantage (MA) HMO member claims, contact:

Centene EDI Department

800-225-2573, extension 6075525

Or by email at EDIBA@centene.com

The following providers can continue to contact Health Net EDI department by phone at 800-977-3568 or by email at edi.support@healthnet.com

- California, MA HMO employer group, HMO, PPO (including EnhancedCare PPO for small business group), POS, and Medi-Cal (including CalViva Health)

Health Net Elect Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Claims address for the Health Net Elect Point-of-Service (POS) product.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net Encounter Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Contact the Health Net Encounter Department via email for encounter data questions.

Enc_Group@healthnet.com

Health Net Enrollment Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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For general questions regarding eligibility and enrollment, contact the Health Net Enrollment Services Department Monday through Friday, from 7:30 a.m. to 7 p.m. at:

800-327-0502

Health Net Facility Site Review Compliance Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-on-one education and support of providers.

The Health Net FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staffs in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

21281 Burbank Blvd., Woodland Hills, CA 91367 209-943-4803
Email: Facility.site.review@healtlhnet.com

Health Net Fraud Hotline

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net is serious about finding and reporting fraud, waste or abuse (FWA). To report suspected FWA, please contact the Special Investigations Unit at one of the following:

Phone: 866-685-8664. The toll-free Fraud, Waste & Abuse Hotline is answered by an independent third party and is available 24 hours a day, 7 days a week.

Email: Special_Investigations_Unit@centene.com

Mail: Centene Special Investigations Unit7700 Forsyth Blvd 5th floor, Room 519, Clayton, MO 63105

Reports of suspected FWA may be made anonymously.

Health Net Health Education

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Medi-Cal Counties

Fresno, Kings, Madera

The Health Education System promotes resources and programs to educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

CalViva Health education programs, services and resources are available at no cost to CalViva Health Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting the Member Services at 888-893-1569. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

7625 N. Palm Suite #107 Fresno, CA 93721 888-893-1569
Fax: 800-628-2704

Amador, Calaveras, Imperial, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne

The Health Net Health Education educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

Health education programs, services and resources are available at no cost to the Plan's Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting Member Services at 800-675-6110. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

21281 Burbank Boulevard Woodland Hills, CA 91367 800-675-6110

Fax: 800-628-2704

Health Education programs and services include:

- Member Services Line. Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, and exercise. These materials are available in several threshold languages. Direct members to call their respective Member Services line.
- Tobacco Cessation Program. Kick It California is a no-cost, statewide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers:
    - **Telephonic Quit Coaching**:
        - Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
        - Tailored quit plan to member's unique circumstances.
        - Available Monday – Friday 7 a.m. – 9 p.m., Saturday 9 a.m. – 5 p.m.
        - To enroll, members may use the online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

        - **Automated Texting Program:**
            - Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within two business days.
            - Text "Quit Smoking" or "Quit Vaping" to 66819.
            - Texto "Deje de Fumar" o " No Vepear" al 66819.
        - **Chat with a Quit Coach**
            - Kickitca.org/chat
            - Alternative option for both members and health care providers.
            - Platform allows members quick responses to inquiries such as available services and free nicotine patch evaluation.
            - Health care providers may use the chat to find answers to cessation-related questions.
            - Available in English only, Monday – Friday, 7 a.m. – 9 p.m., and Saturday 9 a.m. – 5 p.m.
        - Mobile App:
            - Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
            - Features tools such as a personal log of smoking triggers, motivational reminders and links to helpful resources.
            - Available for download on the App Store® and Google Play®
            - Visit Kick It California for more details
- Digital Health Education - members have access to online and digital resources for health education through our Krames Staywell health library – Resource library to help you learn about your health and how to stay healthy.
    - Health and Medications – Easy access to more than 4,000 health sheets.
    - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.

  The Teladoc Mental Health Digital Program website and mobile application offers clinically-proven mental health resources to help members manage depression, anxiety, stress, substance use, and pain management.
- Health Education Classes. Members may access health education classes on a variety of health topics, such as diabetes, asthma, healthy eating, oral health, heart health, fitness, and prenatal

care. Members can request a schedule of upcoming health education classes by calling their respective Member Services phone line.
- Member Incentive Programs - Incentive programs for members allow eligible individuals to engage in activities aimed at promoting behavioral change, such as health screenings, preventive health appointments, and health education initiatives, in exchange for rewards. Health Net will notify members who are eligible to participate.
- Provider Resources. Physicians may order health education materials online by using the Health Education Material Order Form.

21281 Burbank Boulevard Woodland Hills, CA 91367
Fax: 800-628-2704

Health Net Health Equity Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Health Equity Department promotes access to care for members who speak a primary language other than English. The department is responsible for developing, implementing and monitoring processes to meet regulatory requirements. The department assesses the cultural and language needs of members and encourages provider, community advocate, and member input through ongoing communication and by participation in county-specific Community Advisory Committees. This helps ensure that materials and interpreter services are available in the member's language, while taking into consideration the member's cultural background in the development of member materials.

The Health Net Health Equity Department has a number of internal processes to enhance services to Health Net's non-English speaking members, including:

- Tracking the interpretation needs of members.
- Monitoring population and membership language distribution for trends.
- Monitoring the availability of materials translated into threshold languages.
- Assessment of language capabilities of the existing provider network and recommendations to the Health Net Provider Network Management staff for network development.
- Review of translations of member materials, such as the Evidence of Coverage (EOC), provider directories, marketing materials, form letters, health reminders, member surveys, newsletters, and health education materials.
- Providing in-service trainings, workshops and educational opportunities to Health Net staff on the linguistic needs and cultural background of Health Net members.
- Supporting Health Net participating providers with information and material on the cultural background, linguistic needs and health care concerns of Health Net members.
- Gathering feedback from providers, the community and members using surveys and focus group studies on cultural and linguistic needs.
- Monitoring and tracking cultural or linguistic related member grievances to gain an understanding of issues impeding member access to care.

Contact the Health Net Health Equity Department for more information at Cultural.and.Linguistic.services@healthnet.com

Commercial: 800-977-6750
Medicare: 800-546-4570

Fax: 818-543-9188

For written translation assistance services, contact the appropriate Provider Services Center:

Line of Business	Phone Number	Hours of Availability
Large Employer Group	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (off exchange)	800-361-3366	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (on exchange)	888-926-5133	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (off exchange)	877-857-0701	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (on exchange)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time
Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m. Pacific time

Line of Business	Phone Number	Hours of Availability
After hours Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110, select the member option	6 p.m. to 8 a.m. Pacific time, weekends and holidays
Medi-Cal/CalViva Health (Fresno, Kings and Madera)	888-893-1569	24 hours a day, 7 days a week
Medi-Cal/Community Health Plan of Imperial Valley	833-236-4141	24 hours a day, 7 days a week

Health Net Hospital Notification Unit

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Post-stabilization authorization request: call 800-995-7890 to provide notification.

Hospitals are required to contact the Health Net Hospital Notification Unit (HNU) within 24 hours of an admission (or one business day when an admission occurs on a weekend or holiday) for a Health Net member via phone, fax or website.

Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITES
• Employer group Medicare Advantage (MA) HMO • Employer group HMO, POS, PPO, (includes EnhancedCare PPO Small Business Group (SBG)) • Medi-Cal	Fax: 800-676-7969	provider.healthnetcalifornia.com

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITES
• Individual MA HMO and Special Needs Plan (SNP) (does not apply to MA HMO employer groups)	Fax: 844-825-8045	provider.healthnetcalifornia.com

For Individual & Family Plans (IFP) members (Ambetter HMO and Ambetter PPO), hospitals are required to contact the HNU within 24 hours or one business day, via fax or by web, when an admission occurs on a weekend.

IFP Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITE
• IFP Ambetter HMO • IFP Ambetter PPO	Fax: 844-760-8992	provider.healthnetcalifornia.com

Health Net
Attention: Hospital Notification Unit
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Long-Term Care Intake Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Providers should contact the Health Net Long-Term Care Intake line via fax to notify Health Net of its Medi-Cal members' admissions to long-term nursing facilities.

Fax: 855-851-4563

800-453-3033 - to check the status of your request

Health Net Mail Order Prescription Drug Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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HMO and PPO

For commercial [non-Individual and Family Plan (IFP)] plans, use **CVS:**

New prescription medication requests may be mailed by the member or faxed to CVS by the prescribing physician. The member's identification number, date of birth, telephone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

CVS Caremark
PO Box 94467
Palatine IL 60094-4467
Fax: 800-378-0323

For on/off-exchange Ambetter HMO/PPO plans, use **Express Scripts® Pharmacy:**

The prescribing physician can send requests for new prescriptions to Express Scripts Pharmacy via **fax to 800-837-0959** or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx.

Medicare Advantage HMO

The prescribing physician can send requests for new prescriptions to **Express Scripts Pharmacy** via **fax to 800-837-0959** or e-prescribe the request to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx. The member's identification number, date of birth, phone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

Note: For Employer Group Retiree Drug Subsidy (RDS) members, use CVS Caremark mail order service.

Health Net Marketing Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Prior to using, distributing or displaying marketing materials directed to Medicare-eligible beneficiaries, participating providers are required to send these materials for approval to the Health Net Marketing Department, Attention: Medicare Marketing Director.

MedicareMktgReview@healthnet.com

Health Net Medi-Cal Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address for written correspondence regarding claims, tracers, adjustment requests, or denial reconsideration. Health Net Community Solutions, Inc. Medi-Cal Claims PO Box 9020 Farmington, MO 63640-9020

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medi-Cal Facility Site Review Compliance Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Medi-Cal Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-to-one provider education and support.

The Health Net Medi-Cal FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staff in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

Phone: 209-403-9310

Fax: 877-779-0753

Health Net Medi-Cal Medical Management Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Medical Management Department conducts concurrent review of inpatient cases and coordinates care for members under the care management program. Contact the Health Net Prior Authorization Department to request prior authorization or assistance with referrals. Participating physician groups (PPGs) may contact the Medical Management Department for assistance with member case management. Providers affiliated with a delegated PPG must follow their PPG's instructions for referrals and requests for prior authorization. All participating providers must inform Health Net immediately when investigational or experimental treatment is requested.

Phone number for status of request: 800-421-8578
Fax: 800-743-1655

Medi-Cal Member Appeals and Grievances Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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- By phone: Contact Health Net 24 hours a day, 7 days a week by calling 800-675-6110 or 833-236-4141(Imperial County). If you cannot hear or speak well, please call TTY: 711.
- In writing: Fill out an appeal form or write a letter and send it to:

Health Net Medi-Cal Member Appeals and Grievances Department P.O. Box 10348 Van Nuys, CA 91410-0348
Fax: 877-713-6189

Your doctor’s office will have appeal forms available. Your health plan can also send a form to you.

- Electronically

OR

CalViva Health Member Appeals and Grievances Department PO Box 10348 Van Nuys, CA 91410-0348

Fax: 877-831-6019

Health Net Medi-Cal Member Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To ensure appropriate coverage of medical services for Medi-Cal members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, Health Net directs inquiries from members to Health Net's Medi-Cal Member Services Department. Provider inquiries are directed to the Provider Engagement Network Specialists when applicable.

The Health Net Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the Health Net Member Handbook and other member-informing materials are translated into the required threshold languages.

Health Net's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests.
- Handling complaints about Health Net programs or staff.

The Health Net toll-free number is printed on the back of the member’s identification card 800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Health Net Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Health Net's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Health Net Nurse Advice Line (N24) when applicable.

Health Net Member Services Department Open 24/7

Phone Number: 800-675-6110

You can also visit Member Services online at any time at www.healthnet.com.

Fax: 844-837-5947 or 800-281-2999

Medi-Cal Provider Appeals and Grievances - Health Net Medi-Cal and CalViva Health

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address for provider disputes and grievances:

Medi-Cal Provider Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

OR

CalViva Health Provider Disputes and Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

Health Net Medi-Cal Provider Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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As a State Health Program, Health Net has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, Health Net directs inquiries from providers to Health Net's Medi-Cal Provider Services Department or to Health Net's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

Health Net's Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the Plan’s Medi-Cal Rx Contract Drug List (CDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/PCP/PPG reassignment for non-compliant members

The Health Net Medi-Cal Provider Services Department toll-free phone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Health Net Provider Services Department Phone Number: 800-675-6110, option 2
Fax: 844-837-5947 or 800-281-2999 Provider website

Providers may use HNMedi-cal.ClaimsInquiry@healthnet.com for claim status only if the provider portal is down or not working. This email is only for claim status and denial inquiries.

To disenroll a non-compliant member refer to the Disenrollment section.

Fax or mail the formal letter and all supporting documents to:

Attn: Non-Compliance Unit

Fax: 844-837-5947

Address: PO BOX 10303, Van Nuys, CA 91410-0303

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medicare Advantage Claims Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address for Health Net Medicare Advantage (MA) claims.

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medicare Advantage Provider Disputes

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address for Medicare Advantage provider disputes.

Health Net Provider Appeals Unit
PO Box 9030
Farmington, MO 63640-9030

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Medicare Appeals and Grievances Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Although there is a specific post office box for submission of Health Net Medicare member appeals for denied services or other grievance correspondence, Health Net prefers to receive appeals and grievances by fax. This enables Health Net to receive, process and resolve the member's issues quickly in accordance with state and federal timeliness requirements. Member appeal requests must be submitted in writing.

Health Net Medicare Appeals and Grievances Department

Fax: 844-273-2671

PO Box 10450
Van Nuys, CA 91410-0450

800-275-4737

For non-contracted providers, submit your dispute request in writing, along with complete documentation (such as a remittance advice from a Medicare carrier), to support your payment dispute to:

Wellcare By Health Net – Appeals
P.O. Box 3060
Farmington, MO 63640-3822

Health Net Medicare Programs Provider Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To ensure appropriate coverage of medical services for Medicare members, Health Net requires the provision of timely responses and accurate information an absolute necessity. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this issue, Health Net directs inquiries from members and employer groups to the Medicare Programs Member Services Department. Inquiries from participating physician groups (PPGs), hospitals, ancillary providers, and physicians are directed to the Provider Services Department, or the provider relations and contracting specialist (previously known as regional network administrators), where available.

The Provider Services Department telephone number is to be used exclusively by PPGs, hospitals and providers and should not be given to members.

During business hours (Monday through Friday, 8 a.m. to 5 p.m.), Health Net Provider Services Department representatives are available to assist providers with:

- Member eligibility and effective dates, and eligibility research.
- Questions about the Health Net prescription drug program.
- Conflict resolution regarding benefit interpretation.
- Exceptions and administrative decisions.
- Complaints regarding health care services, delivery of health care services or PPG staff.
- Request for removal of members for disciplinary actions.
- PPG transfer requests, other than address change or open enrollment.
- Questions regarding claim status.

Claims address:

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

800-929-9224 for all Medicare individual and Medicare employer group plans

800-641-7761 for all Medicare Supplement plans

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Member Appeals and Grievances Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address and telephone numbers for member appeals for denied services or other grievance correspondence.

PO Box 10348

Van Nuys, CA 91410-0348

800-522-0088 for commercial members in Northern California

800-638-3889 for commercial members in Southern California

Fax: 877-831-6019

Health Net Member Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To ensure appropriate coverage of medical services for members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may unintentionally misuse the program, resulting in medical services not being covered. To avoid these problems, member and employer group inquiries are directed to an expert team of associates via the Health Net Member Services Department. This team is responsible for resolving member and employer group issues that have been routed to them via a telephone call, written correspondence or the Internet. The Health Net Member Services Department is responsible for resolving issues pertaining to the following:

- Health Net benefit questions and explanations.
- Education on the access of the health care delivery system.
- Professional and hospital services, bills and claims.
- ChiroNet benefits and eligibility.
- Health Net prescription drug program questions, eligibility and claims.
- EyeMed Vision Care program questions about eyewear benefits, eligibility and claims.
- Membership problems and inquiries.
- Member updates (includes adding and deleting members, address changes, PCP/PPG changes).
- Contract cancellation requests.
- Conversion.
- Identification card requests.

Health Net Member Services Department
PO Box 9103
Van Nuys, CA 91409-9103
800-522-0088

Health Net Provider Communications Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net National Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, changes in contractual, legislative and regulatory requirements through provider operations manuals, updates, letters, and newsletters. To access the most current information, log on to the provider portal.

4191 East Commerce Way
Sacramento, CA 95834
Mailstop: CA4191-04-167

provider.communications@healthnet.com

Health Net Nurse Advice Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour telephone service for instructions, medical condition assessment and advice. The Health Net Medi-Cal Member Services Department coordinates member access to the Health Net Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

800-675-6110

Health Net Overpayment Recovery Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address for overpayment refunds and applicable information.

California Medi-Cal and Commercial
Health Net
File# 56527
Los Angeles, CA 90074-6527

WellCare by Health Net (Medicare) and **Health Net Marketplace**
Attention: Claims Recovery Team
P.O. Box 886027
Los Angeles, CA 90088-6027

Health Net PPO Claims Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net – Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net accepts prior authorization requests for elective and urgent services by fax, phone and online. All participating providers must immediately inform Health Net when there is a request for investigational or experimental treatment.

Prior Auth Contacts

Lines of Business	Contact Numbers	Provider Portal Websites
• IFP Ambetter HMO	Fax: 844-694-9165 Phone: 888-926-2164 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• IFP Ambetter PPO	Fax: 844-694-9165 Phone: 844-463-8188 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Employer Group HMO, Point of Service (POS), PPO	Fax: 844-694-9165 Phone: 800-641-7761 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Health Net Medi-Cal • CalViva Health • Community Health Plan of Imperial Valley	Fax: 800-743-1655 • Health Net: 800-675-6110 • CalViva Health: 888-893-1569 • CHPIV: 833-236-4141 Transplant fax: 833-769-1141	provider.healthnetcalifornia.com
• Medicare (Individual and Employer Group) and Special Needs Plan (SNP)	Fax: 844-501-5713 Phone: 800-929-9224 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com
• Medicare Supplement	Fax: 844-501-5713 Phone: 800-641-7761	provider.healthnetcalifornia.com

Lines of Business	Contact Numbers	Provider Portal Websites
	Transplant fax: 833-769-1143	

Mailing Address

Attention: Prior Authorization Department.

Medicare Claims

21281 Burbank Blvd.

Woodland Hills, CA 91367

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Program Accreditation Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Program Accreditation Department supports and promotes activities to assess and monitor organization-wide and provider compliance with regulatory and oversight bodies, including the California Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the California Managed Risk Medical Insurance Board (MRMIB). The department is also responsible for preparation and implementation of any identified actions based on the findings of DMHC, NCQA and CMS audits.

The Program Accreditation Department collects, reviews and assesses various required submissions from delegated participating physician groups (PPGs), including financial statements and utilization management reports.

Address to submit expedited organization determination (EOD), Notice of Medicare Non-Coverage (NOMNC) tracking logs, utilization management and financial reports:

Program Accreditation Department Compliance Analyst
21281 Burbank Blvd.
Woodland Hills, CA 91367

818-676-6704

Provider Oversight efax: 877-890-4105

UMQIMR@healthnet.com

Health Net Provider Services Center

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Health Net Provider Services Center is available to physicians, participating physician groups (PPGs), hospitals, and other providers, and features live customer service representatives, an interactive voice response (IVR) system and the provider portal websites. Customer service representatives are available via telephone and online during business hours (Monday through Friday, 8 a.m. to 6 p.m. PT). Services provided include the following:

- Member eligibility and effective dates information.
- Health Net's prescription drug program information.
- Claims status information.
- Instructions on how to submit disputes and appeals.
- Instructions on how to submit a complaint regarding the provision of care by a provider or express concerns about provider office staff.
- Instructions on how to request the removal of members for disciplinary actions.
- Information about the provider portal websites.

IVR for Employer Group HMO and PPO members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member eligibility and claim information without waiting to speak with a Provider Services Center representative. For employer group HMO and PPO members, providers may contact 800-641-7761. The IVR includes:

- Current and past eligibility status.
- Benefits information.
- Single or multiple claims status.
- Claims submission addresses.
- Automated fax back of member eligibility and claim status information.

IVR for Covered California and Individual & Family Plans (IFP) members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member information. The following IVRs are available for Covered California and IFP members, which include Ambetter HMO and PPO Individuals and Families. Providers may verify or check eligibility status by member name and plan, claims status and copayment information.

IFP IVR Phone Numbers

If...	Then contact Health Net at...	And...
Covered California appears on the member identification (ID) card	888-926-2164 for Covered California Health Net members	Follow the prompts
Covered California does not appear on the member (ID) card	877-857-0701 for Health Net IFP members	Follow the prompts

Provider Services Center Contact Information

Line of Business	Phone Number	Provider Portal Website
Health Net Employer Group HMO, POS, and PPO	800-641-7761	provider.healthnetcalifornia.com
Ambetter from Health Net HMO Individual & Family Plans	888-926-2164	provider.healthnetcalifornia.com
Ambetter from Health Net PPO Individual & Family Plans	844-463-8188	provider.healthnetcalifornia.com

Claims Address

Health Net Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Email Address

provider_services@healthnet.com

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Health Net Quality Improvement Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The information provided is the most up-to-date as of the date of this publication. For the most up-to-date information, visit providerlibrary.healthnetcalifornia.com

Contact Health Net's Quality Improvement Department for questions regarding quality improvement projects (QIPs).

For commercial providers email:
cqi_dsm@healthnet.com

For Medicare providers email:
cqi_medicare@healthnet.com

Health Net's Regional Medical Directors

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To provide better service to participating physician groups (PPGs), hospitals, employer groups, and members, Health Net's regional medical directors are located in the Irvine, Oakland, Rancho Cordova, San Diego, Woodland Hills, and other regional offices. Health Net's regional medical directors are directly responsible for any clinical matters related to Health Net policies and procedures. They also serve as professional consultants to the PPGs and hospitals.

Health Net's regional medical directors work closely with PPGs and hospitals to monitor, manage and achieve greater efficiency in the following areas:

- Utilization management (UM), including care management
- Quality management
- Pharmaceutical management
- Case review or member complaints relating to quality of care and access
- Introduction of new products

Health Net Third-Party Liability Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Medi-Cal

Providers must notify Health Net or the participating physician group (PPG) in writing of all potential and confirmed third-party tort liability cases involving a Health Net Medi-Cal member. Notify Health Net if a provider receives any subpoenas from attorneys, insurers or beneficiaries for copies of bills. Supply Health Net with copies of the request and copies of documents released as a result of the request, and provide the name,

address and telephone number of the requesting party. The notification must be submitted via email to or mail notifications to:

Health Net TPL Recovery TPL Department Mailstop: CA-4191-04-108 4191 East Commerce Way Sacramento, CA 95834

Health Net Transfer/Termination Request Unit

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Participating physician groups (PPGs) considering the termination of a Health Net member must submit a Transfer/Termination (T/T) Incident Report to the Health Net Transfer/Termination Request Unit.

HMO

T/T Requests
P.O. Box 10348
Van Nuys, CA 91410
Fax: 877-831-6019

Medicare Advantage HMO

T/T Requests

Medicare Services:
Health Net Appeals and Grievances Department
P.O. Box 10344
Van Nuys, CA 91410-0344
Fax: 877-713-6189

Health Net Transplant Care Manager

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Submit transplant information to Health Net. Health Net reviews the request and may advise the participating physician group (PPG) or provider to refer the member to a transplant performance center for evaluation. Health Net's designated transplant performance centers are Medicare-certified. On completion of any evaluation, the transplant performance center must fax the evaluation directly to the Health Net transplant care manager.
888-732-2730
Fax: 866-292-5294

Health Net Transportation Vendors

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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- Medi-Cal: ModivCare – Members can call Where's My Ride? at 855-253-6863, TTY: 711.
- Medicare: Access2Care – Medicare members can call 844-515-6876.

Health Net Utilization Management Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net's Utilization Management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are the elements of the UM process.

Health Net Utilization Management Department
PO Box 10198
Van Nuys, CA 91410

Health Net Wellness and Prevention Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Contact the Health Net Wellness and Prevention Department at:

916-935-1263

Hearing Care Solutions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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866-344-7756
Monday through Friday
5 a.m.-5 p.m. PT

For more information, visit the Hearing Care Solutions website.

Hearing Healthcare Providers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Hearing Healthcare Providers (HHP)

www.hhpca.org

HNI Corporate Address

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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If a participating physician group (PPG) needs to request a change to the information currently in their Provider Participation Agreement (PPA), the request must be made in writing and sent to:

Health Net of California, Inc.
Attention: Vice President, Provider Contracting/Provider Network Management
21281 Burbank Blvd
Woodland Hills, CA 91367

Hoveround Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of custom rehabilitation equipment services.

800-701-5781

In-Home Operations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment, and those at risk of life-threatening occurrences, requires close coordination between Health Net and the Home and Community-Based Services (HCBS) Waiver program administered by In-Home Operations (IHO). This program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met by providing in-home care. 916-552-9105 in Northern California
213-897-6774 in Southern California
email: IHOwaiver@dhcs.ca.gov

J&B Medical Supply Company Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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J&B Medical Supply Company, Inc. Address: 50496 W. Pontiac Trail, Wixom, MI 48393-2088 Phone: 800-737-0045
Fax: 800-737-0012 Website: www.jandbmedicalinsurance.com

Kick It California

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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800-300-8086 (English)

800-600-8191 (Spanish)

kickitca.org

LabCorp

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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To find a LabCorp center near you or request a pick-up, visit www.LabCorp.com or call 800-244-9698.

Linkia LLC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Linkia, LLC is Health Net's preferred provider for orthotics and prosthetics.

877-754-6542

Livante (California Quality Improvement Organization (QIO)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Livante
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolise Junction, MD 20701

Phone: 877-588-1123 or TTY: 855-887-6668
Appeals fax: 855-694-2929
All other reviews fax: 844-420-6672

Los Angeles Department Of Public Social Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Providers may call the Los Angeles Department of Public Social Services (DPSS) for assistance with the In-Home Supportive Services (IHSS) program.

The IHSS program provides services to seniors and persons with disabilities allowing them to remain safely in their homes.

888-944-4477 213-744-4477

Mahmee

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Mahmee offers virtual doula services via the Mahmee mobile app that is designed to better connect new moms with health care and support. Mahmee can be contacted at the number listed below:

818-431-1118

Monday through Friday from 6 a.m. to 8 p.m. PT.

Saturday and Sunday from 8 a.m. to 6 p.m. PT.

Managed Care Ombudsman

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Department of Health Care Services (DHCS) Managed Care Ombudsman investigates and attempts to resolve complaints about managed care plans that members have been unable to resolve through their health plans. 888-452-8609

March Vision Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net members assigned to Molina Healthcare may contact March Vision Care to locate a participating optometrist and optician from whom to order and receive lenses and frames.

888-493-4070

Matria Health Care Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Matria Health Care, Inc. provides home health and infusion services to high-risk obstetric members.

800-289-7744

Medical Board Of California

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to members. For a no-cost brochure, contact the Medical Board of California, Breast Cancer Treatment Options. Breast Cancer Treatment Options 1426 Howe Avenue, Suite #54 Sacramento, CA 95825 Fax: 916-263-2479

Medi-Cal Provider Contested Claims

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Address for provider contested claims:

Health Net Medi-Cal Contested Claims Department PO Box 989736 West Sacramento, CA 95798

OR

CalViva Health Contested Claims Department PO Box 989736 West Sacramento, CA 95798

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Medi-Cal Rx CSC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Medi-Cal Rx

Phone: 800-977-2273 Fax 800-869-4325

Appeals
Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 730 Rancho Cordova, CA, 95741-0730

Prior authorization
Medi-Cal Rx Customer Service Center Attn: PA Request PO Box 730 Sacramento, CA 95741-0730 Phone: 800-977-2273

Medicare Appeals Council

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net Medicare Advantage (MA) and MA members may request that the Medicare Appeals Council (MAC) review an administrative law judge (ALJ) decision. The review request must be made within 60 days from the date Health Net receives the ALJ hearing decision or dismissal. The request for appeal may be submitted directly to the MAC.

Department of Health and Human Services
Department Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

Member Rights Information

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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This insert must be customized with the health plan and/or participating physician group (PPG)-specific phone number and applicable couty-specific phone number for the applicable legal services office.

Legal Services Offices for Assistance for Medi-Cal Managed Care Enrollees

COUNTY	LEGAL SERVICES OFFICE
Fresno	Central California Legal Services - 800-675-8001
Kern	Greater Bakersfield Legal Aid - 661-321-3982
Kings	Central California Legal Services - 800-675-8001
Los Angeles	Neighborhood Legal Services - 800-896-3203
Madera	Central California Legal Services - 800-675-8001
Orange	Legal Aid Society of Orange County - 800-834-5001
Riverside	Inland Counties Legal Services Indio Office - 800-226-4257 Riverside Office - 888-455-4257

COUNTY	LEGAL SERVICES OFFICE
Sacramento	Legal Services of Northern California - 888-354-4474
San Bernardino	Inland Counties Legal Services San Bernardino - 800-677-4257 Rancho Cucamonga - 800-977-4257
San Joaquin	Legal Services of Northern California - 888-354-4474
San Diego	Legal Aid Society of San Diego - 877-734-3258
Stanislaus	Central California Legal Assistance - 800-675-8001
Tulare	Central California Legal Services, Visalia Office - 800-350-3654

MHN Customer Service Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or his or her staff may contact the MHN Customer Service Department for a referral to an MHN provider. Customer service specialists may also assist with member eligibility, benefits and general questions about MHN.

888-935-5966

Providers treating CalViva Health members: 888-327-0010

MiniMed Distribution Corp Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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MiniMed Distribution Corp, Inc. provides insulin pumps and supplies to members with diabetes.

800-795-0618
Fax: 800-611-1716

Modivcare

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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HMO

Non-emergency transportation services are arranged through Modivcare™ 24 hours a day, 7 days a week.

For HMO:

866-842-0675
Fax: 800-762-1777

HMO

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week

Medi-Cal

Refer to the table below to arrange for transportation services through Modivcare. Modivcare uses language-line interpreter services for all interpretation needs during reservations.

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Standard days and hours of customer service center operation for routine reservations.	Monday through Friday, 7 a.m. to 7 p.m. Pacific time.
Weekend and holiday schedule	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas
Routine transportation requests	- Rideshare curb-to-curb in “real time”. (For avoidance of doubt, “real time” is defined as within 1 hour of member request.) - Non-rideshare curb-to-curb 24 hours in advance (sedan, taxi) - 48-hour notice for any mode of transportation higher than sedan (wheelchair [including ambulatory door-to-door], stretcher, non-emergent ambulance)
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for the same day of service for hospital discharges and urgent treatment types. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance (Where's my Ride? line) and hospital discharges	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week

Modivcare Contact Information

FORM OF CONTACT	CONTACT INFORMATION
Toll-free telephone numbers	**Non-Emergency Medical Transportation (NEMT) services: Submit a Physician Certification Statement (PCS) form to the Health Net Care Ride Unit to obtain authorization before contacting Modivcare for scheduling.** Reservations and ride assistance (Where's My Ride? line) for Medi-Cal members: 855-253-6863 Ride assistance (Where's My Ride? line) for CalViva Health members: 855-253-6864 Ride assistance (Where's My Ride? line) for CHPIV members: 855-251-7097 Hearing impaired (TTY) line: 866-288-3133 For providers: Facility line: 866-529-2128 Facility fax: 877-601-0535
Website	Modivcare.com Providers may use the Modivcare website to schedule only routine transports with an advance notice of 5 business days. Print an enrollment form from the Modivcare website to sign up for this HIPAA-compliant service and return it by fax to 877-601-0535.

Molina Behavioral Health Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Behavioral Health Services assists providers with mental health services for Molina members.

1-888-665-4621
Fax: 1-866-472-0596

Molina Claims Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Submit written correspondence or claims, tracers, appeals, or adjustments to the Molina Healthcare Claims Department.

Molina Healthcare Claims PO Box 22702 Long Beach, CA 90801 1-888-665-4621, press 1 for provider

Molina Credentialing And Facility Site Review Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Healthcare Credentialing Department verifies all information about each Molina provider and evaluates the applicant's qualifications to be credentialed or recredentialed. Recredentialing of providers is conducted at least every three years. Credentialing: 1-800-526-8196 ext. 120117
Fax: 1-888-665-4629

Facility Site Review 1-800-526-8196 ext. 120118
Fax: (562) 499-6185

Molina Encounter Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Encounter Department handles all claims for capitated services.

P.O. Box 22807 Long Beach, CA 90801 MHCEncounterDepartment@MolinaHealthCare.com

Molina Healthcare Education Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Healthcare Education Department improves the health outcomes of Medi-Cal members through member and provider education and facilitating provider access to member education resources and information.

1-866-472-9483

Molina Healthcare Provider Resolution Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Healthcare Provider Resolution Department handles written inquiries from providers regarding claim disputes. Written inquiries should be sent to the following address.

Molina Healthcare Attn: Provider Dispute Unit PO Box 22722 Long Beach, CA 90801 Fax: (562) 499-0633

Molina Interactive Voice Response

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Contact the Molina Interactive Voice Response system if a member arrives at a primary care physician (PCP) office to receive care and does not appear on the current month's eligibility listing. 1-800-357-0172

Molina Member Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Molina Healthcare offers telephonic services via telephone. 1-888-665-4621

Molina Nurse Advice Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Molina&s nurse advice line is staffed 24 hours a day, seven days a week by highly trained nurses for member assistance and referrals. 1-888-275-8750 (English)
1-866-648-3537 (Spanish)

Molina Pharmacy Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Healthcare Pharmacy Authorization Desk is responsible for Molina's medication prior authorization requests.

1-888-665-4621, press 1 for provider
Fax: 1-866-508-6445

Molina PM160 INF Forms

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Send completed PM160 Information Only (INF) forms to Molina Healthcare via the fax below. (562) 435-3666, ext. 127350
Fax: (562) 499-6193

Molina Provider Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. The Molina Healthcare Provider Services Department is the provider liaison to the health plan's administrative programs. This department handles telephone and written inquiries from providers regarding contracting, capitation verification, scheduling of in-service training, site audit status, and credentialing information.

200 Oceangate, Ste. 100 Long Beach, CA 90802 1-855-322-4075
Fax: 1-855-278-0312 www.molinahealthcare.com

Molina Quality Improvement Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Quality Improvement Department reviews member medical records, population-based studies on preventive care, clinical practice guidelines, focused studies, member and provider satisfaction studies, complaints and grievances, and monitors continuing quality improvement. 1-800-526-8196, ext. 126137
Fax: (562) 499-6185

Molina Utilization Management Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Molina Healthcare Utilization Management Department handles referrals and prior authorization requests, conducts concurrent review on inpatient cases, and coordinates care for members under the case management program, including California Children's Services (CCS).

Outpatient and urgent referral requests: 1-800-526-8196, option3, then option 4

Inpatient referral requests: 1-800-526-8196, option3, then option 4

CCS referral requests: 1-888-562-5442, ext. 126586

Case management referral requests: 1-800-526-8196, ext. 127604
Fax: (562) 499-6105

Outpatient and prior authorization requests: Fax: 1-800-811-4804

Notification of inpatient admissions: Fax: 1-866-553-9262

Notification of concurrent review: Fax: 1-866-553-9263

Multipurpose Senior Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Multipurpose Senior Services Program (MSSP) Waiver Program assists frail members ages 65 and older in remaining safe in their homes. The program is administered by the Department of Aging and provides a cost-effective alternative to institutionalization while assisting seniors in maintaining important ties to family, friends and the community. A Health Net member who meets the criteria for MSSP services and is approved and accepted into the waiver program is disenrolled from Health Net and becomes eligible for the Medi-Cal fee-for-service (FFS) program.

Amador, Calaveras, Tuolumne

Area 12 Agency on Aging
19074 Standard Road Sonora, CA 95370 209-532-6272
Fax: 209-532-6501

Fresno, Madera

Fresno and Madera Agency on Aging 3837 N. Clark Street Fresno, CA 93726 (559) 453-4405

Imperial

Imperial County Work Training Center, Inc. 210 Wake Avenue El Centro, CA 92243 760-352-6181
Fax: 760-352-6332

Inyo, Mono

Eastern Sierra Area Agency on Aging
1360 North Main Street, Suite 201 Bishop, CA 93514-2709 760-873-3305
Fax: 760-878-0266

Kings, Tulare

Kings and Tulare Area Agency on Aging 5957 S. Mooney Boulevard Visalia, CA 93277 (559) 737-4660 (800) 321-2462

San Joaquin

San Joaquin County Human Services Agency - Aging & Community Services Bureau 102 S. San Joaquin Street Stockton, CA 95202 (209) 468-1104
Fax (209) 932-2613

Stanislaus

Stanislaus County Community Services Agency 251 East Hackett Road Modesto, CA 95353 (209) 558-2346
Fax: (209) 558-2681

National Seating And Mobility

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of custom rehabilitation equipment services.

800-404-6676

Nurse Advice Line

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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HMO and PPO

Health Net's Nurse Advice Line is a telephonic support program that empowers members to better manage their health. The Nurse Advice Line offers support for members coping with chronic and acute illness, episodic

or injury-related events and other health care issues. Highly trained registered nurses (health information managers) are available 24 hours a day, seven days a week.

The Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Nurses provide one-on-one consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the nurse advice line by calling the member services number on the back of their identification (ID) card.

The Nurse Advice Line is available to physicians to discuss concerns or make referrals at 800-893-5597; select the physician/provider options.

Medicare Advantage HMO

Contact the Nurse Advice Line at 800-893-5597

Peer-to-Peer Review Request Line

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To request a peer-to-peer review, call the Peer-to-Peer Review Request Line at: 833-236-9715. Be sure to have the following information available:

- Member name
- Member date of birth
- Case number
- Medical director name
- Name of the nurse who worked the case
- Member identification number

If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Pharmacy Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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HMO and PPO

Providers must contact Pharmacy Services and complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) to request prior authorization for certain prescription medications before medications are dispensed.

Prior authorization type	Fax	Phone	Mail
Pharmacy and self-injectable requests	800-314-6223	800-548-5524 (Option 2)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530
Physician-administered medications	800-314-6223	800-867-6564 (Option 2)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Medi-Cal

Providers must contact Pharmacy Services and complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (Health Net (PDF), CalViva Health (PDF), Community Health Plan of Imperial Valley (PDF)) to request prior authorization for certain prescription medications before medications are dispensed. Pharmacy Services is responsible for review of requests for medical benefit medication prior authorization for Health Net Medi-Cal members.

Prior authorization type	Fax	Phone	Mail
Pharmacy and self-injectable medications	800-869-4325	800-977-2273 (Medi-Cal Rx)	N/A
Physician-administered medication requests	833-953-3436	800-867-6564 (Option 2)	MedPharm Attention: Prior Authorization 4191 East Commerce Way

			Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Medicare Advantage HMO

Providers can submit prior authorization electronically through CoverMyMeds (preferred), submit the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) or contact Pharmacy Services to request prior authorization for certain prescription medications.

Contact	Fax	Phone	Mail
Pharmacy and self-injectable medications and physician-administered medications	800-977-8226	800-867-6564 (Option 1)	MedPharm Attention: Prior Authorization 4191 East Commerce Way Sacramento, CA 95834-9679 Mailstop: CA4151-04-530

Premier Eye Care

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Premier Eye Care

833-883-2339

Monday – Friday, 8 a.m. – 8 p.m. Pacific time

Email: info@premiereyecare.net

Provider Disputes and Appeals - Commercial

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Address for provider disputes and appeals:
Health Net Commercial Provider Disputes
PO Box 9040
Farmington, MO 63640-9040

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Provider Network Management Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Provider Network Management (PNM) Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

HMO, Medicare Advantage HMO, Medicare Supplement, and PPO

If you need additional information, contact the Provider Services Department (HMO, PPO, and Medicare Advantage HMO, and Medicare Supplement) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For hospitals and PPGs, if you need further assistance you may contact your regional provider network manager or provider network administrator.

Medi-Cal

If you need additional information, contact the Provider Services Department (Health Net, CalViva Health or Community Health Plan of Imperial Valley) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Provider Network Management, Access and Availability Team

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Email: Provider Network Management, Access and Availability Team for more information.

For Behavioral Health Information, refer to Health Net Behavioral Health Contact Information page.

Provider Relations Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.

Email: The Provider Relations Department

Pumping Essentials

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net's preferred breast pump provider.

866-688-4203

Quest Diagnostics

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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For information about Quest Diagnostics laboratory testing solutions and services or to set up an account, call 866-697-8378.

To locate a Quest Diagnostics Patient Service Center (PSC), or schedule a PSC appointment for a Health Net member, log on to the Quest Diagnostics website or call 888-277-8772.

Regional Centers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Regional centers are private, non-profit corporations under contract with the California Department of Developmental Services (DDS). Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidence of developmental disabilities. Below are the regional centers as indicated for each county:

Amador, Calaveras and Tuolumne

Valley Mountain Regional Center
702 North Aurora Street Stockton, CA 95202 209-473-0951
Fax: 209-473-0256

Fresno, Kings, Madera, and Tulare

Central Valley Regional Center 4615 North Marty Ave. Fresno, CA 93722 559-276-4300
Fax: (559) 276-4360

Imperial

San Diego Regional Center 4355 Ruffin Road, Suite 200 San Diego, CA 92123-1648 858-576-2996
Fax: 858-576-2873

Inyo, Kern and Mono

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93308 661-327-8531
Fax: 661-324-5060

Kern

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93305 661-327-8531

Los Angeles

Eastern Los Angeles Regional Center 1000 South Fremont Ave., PO Box 7916, Alhambra, CA 91802-4700 626-299-4700

Frank D. Lanterman Regional Center 3303 Wilshire Blvd., Ste. 700, Los Angeles, CA 90010-2197 213-383-1300

Harbor Regional Center 21231 Hawthorne Blvd., Torrance, CA 90503 310-540-1711

North Los Angeles Regional Center 15400 Sherman Way, Ste. 170, Van Nuys, CA 91406 818-778-1900

San Gabriel/Pomona Regional Center 75 Rancho Camino Dr., Pomona, CA 91766 909-620-7722

South Central Los Angeles Regional Center 650 W. Adams Blvd., Ste. 200, Los Angeles, CA 90007 213-744-7000

Westside Regional Center 5901 Green Valley Circle, Ste. 320, Culver City, CA 90230-1024 310-258-4000

Sacramento

Alta California Regional Center 2241 Harvard St., Sacramento, CA 95815 916-978-6400
Fax: (916) 929-1036

San Diego

San Diego Regional Center for the Developmentally Disabled 4355 Ruffin Rd., Ste. 200, San Diego, CA 92123-1648 858-576-2931

San Joaquin and Stanislaus

Valley Mountain Regional Center 702 N. Aurora St., Stockton, CA 95202 209-473-0951
Fax: (209) 473-0256

Reinsurance Claims Unit

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Insured service claims should be sent to:

Reinsurance Claims Unit/LNR - C3
Attn: Mail Code - CA-100-03-02
21281 Burbank Blvd.
Woodland Hills, CA 91367

River City Medical Group

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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River City Medical Group (RCMG) members may contact RCMG to locate a participating optometrist and optician from whom to order and receive lenses and frames.

800-928-1201

Roche

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of insulin pumps and supplies to members with diabetes.

800-280-7801

San Diego County Aging and Independence Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The San Diego County Aging and Independence Services (AIS) provides services to seniors and persons with disabilities and their family members allowing them to remain safely in their homes.

Providers can call the San Diego County AIS for assistance with In-Home Supportive Services (IHSS) or the Multipurpose Senior Services Program (MSSP).

800-510-2020

San Francisco Medi-Cal Field Office

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Except for kidney transplants, major organ transplant authorization requests for Medi-Cal members age 21 and over must be sent to the San Francisco Medi-Cal Field Office. 575 Market Street, Suite 400 San Francisco, Ca 94105 415-904-9600

Mailing address: P.O. Box 193704 San Francisco, CA 94119

SilverSneakers Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net contracts with American Specialty Health Fitness, Inc. to administer and arrange a fitness service for Health Net members in accordance with the member's applicable benefits plan. Refer members to the Silver&Fit® website for more information.

Smiths Medical Inc

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Provider of insulin pumps and supplies.

800-826-9703

Solutran

Multi-Benefit Spendables Card

Wellcare By Health Net Dual Special Needs Plan (D-SNP) offer members extra benefits at no cost. Included in the plan, members have an over-the-counter (OTC) benefit where they will receive a fixed dollar monthly

allowance amount preloaded into their Wellcare Spendables Card. The monthly allowance rolls over to the following month if unused and expires at the end of the plan year.

Members may use the Wellcare Spendables Card OTC dollars to purchase everyday items like bandages, pain relievers, cold remedies, toothpaste and much more. The card can be used on any combination of the following:

- Over-the-counter items such as cold medicine, first aid supplies, and vitamins.
- Buy groceries.
- Pay for utilities such as electric, gas, trash, water, internet, cable, and phone service.
- Help with the cost of rent for their home.
- Pay for gas at the pump (cannot be used to pay in person at the cash register).

Note:

- Any unused funds will roll over to the next month and will expire at the end of the year.
- The card cannot be used to set up automated, recurring payments.
- The care can only be used up to the available allowance amount.
- The card is similar to a debit card. Members can use their card to pay for eligible items and services at participating retail location or order online that accept Visa.

For more information about this benefit, members may contact Solutran.

855-744-8550
April-September
Monday through Friday
5 a.m.-8 p.m. Pacific time (PT)

October-March
7 days a week
5 a.m.-8 p.m. PT

For more information, visit secure member website.

Sonus

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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888-383-4521

SONUS

Special Supplemental Nutrition Program For WIC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition education and specific foods for women, infants and children from families with low incomes. WIC is temporary and provides supplemental food and nutrition education for a limited time during critical periods of growth and development.

Amador

430 Sutter Hill Rd. Sutter Creek, CA 95685 209-223-7685

Calaveras

209-223-7685

Fresno

Special Supplemental Nutrition Program

Location	Phone Number
Fresno Economic Opportunity Commission	559-263-1150
Huron WIC Clinic	559-945-5090
Kerman WIC Clinic	559-846-6681
Mendota	888-638-7177
Orange Grove	888-638-7177
Parlier WIC Clinic	888-638-7177
Reedley WIC Clinic	888-638-7177

Location	Phone Number
Sanger WIC Clinic	888-638-7177
Selma WIC Clinic	888-638-7177

Imperial

2600 Thomas Dr. El Centro, CA 92243 877-686-5468
Fax: 760-353-2555

Inyo

760-872-1885

Kern

Community Action Partnership 500 E. California Bakersfield, CA 93307 661-327-3074
Fax: (661) 327-2833

Clinica Sierra Vista - WIC Administrative Office 1430 Truxtun Avenue, Suite 300 Bakersfield, CA 93301
661-862-5422
661-326-6490
800-707-4401
Fax: (661) 322-1418

Kings

Special Supplemental Nutrition Program

Location	Phone Number
Hanford, Lemoore, Avenal, Corcoran, Kettleman	559-582-0180

Los Angeles

Special Supplemental Nutrition Program

Location	Phone Number
Antelope Valley Hospital	661-949-5805
Harbor - UCLA Research and Education Institute	310-661-3080
Long Beach	562-570-4242
Northeast Valley Health	818-361-7541 800-942-9675
Orange County Health Care	714-834-8333
Pasadena	626-744-6520
Public Health Foundation Enterprises	888-942-2229 626-856-6600
Watts Health Foundation	323-568-3070

Madera

Special Supplemental Nutrition Program

Location	Phone Number
Madera	559-675-7623
Oakhurst	559-658-7456
Chowchilla	559-201-5000

Mono

760-924-4610

Sacramento

Community Resource Project WIC Program 915 Broadway Sacramento, CA 95818 916-326-5830

Sacramento County Department of Health and Human Services 2251 Florin Road, Suite 100 Sacramento, CA 95822 916-427-5500

San Diego

Special Supplemental Nutrition Program

Location	Telephone Number
American Red Cross WIC	800-500-6411
North County Health Services	Appointment line: 888-477-6333 or 760-471-2743
San Diego State University Foundation	Client Call Center: 888-999-6897
San Ysidro Health Center	Appointment line: 619-426-7966

San Joaquin

San Joaquin County Public Health Services 1145 N Hunter Street Stockton, CA 95202 209-468-3281
Fax 209-468-8573

Stanislaus

Stanislaus County Health Services WIC Program 401 Building E. Paradise Road Modesto, CA 95351
209-558-7377
Fax: 209-558-8318

Tulare

New WIC appointments and client line: 800-360-8840
559-685-2521

Porterville Clinic 1055 West Henderson, Suite 5 Porterville, CA 93257 559-788-1323

Tuolumne

209-533-7434

State Hearing Division

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members can ask for a State Hearing in the following ways:

- Online
- By phone:
  - 800-743-8525.
  - TTY/TDD 800-952-8349.
- In writing:
  - Members should fill out a State Hearing form or write a letter. Send it by mail or fax to: Mail: California Department of Social Services

State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430 Fax: 916-309-3487 or toll-free at 833-281-0903

Teladoc Health

Wellcare By Health Net (Health Net) has partnered with Teladoc Health™ (Teladoc) to give members access to telehealth care at no additional cost. Telehealth, or virtual care, allows members to interact with a doctor, nurse or therapist by phone or video without leaving the comfort and safety of their home for many healthcare services.

Teladoc Health offers convenient telehealth services for members. Through Teladoc Health, members can get confidential access to virtual visits with quality doctors and behavioral health providers. Members can schedule a visit with one of Teladoc Health's U.S. board-certified doctors and behavioral health providers, they can be diagnosed, treated and prescribed medication if medically necessary.

Members can use their telehealth benefit for:

- Non-emergency care from in-network providers using their home phone, laptop, table, or smartphone to connect for a video call.
- Speak to a Nurse 24/7: Get answers to health questions and find out if they need to see a doctor or urgent care center.
- Book a phone or video appointment.

Telehealth services with in-network providers work just like face-to-face in office appointments. Telehealth visits do not require a prior authorization. Plan copays, coinsurance and deductible costs may apply. Members may refer to their plan Summary of Benefits for coverage.

To preregister for Teladoc services, visit Teladoc Health.

800-835-2362 Available 24 hours a day, 7 days a week

Tuberculosis Control Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Tuberculosis (TB) screening and treatment services for Health Net Medi-Cal members are covered by Health Net under the Department of Health Services (DHS) contract. Health Net collaborates with local health departments (LHDs) to control the spread of TB and to help members get TB treatment. Health Net coordinates with LHDs to establish effective coordination of care. Early diagnosis, immediate reporting to LHDs, and effective TB treatment are critical to interrupting continued transmission of TB. Physicians must report known or suspected cases to the LHD TB Control program office within one day of identification.

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3434
Fax: 559-445-3598

Kern

Department of Public Health Services Chronic Disease Prevention Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 661-321-3000

Kings

Kings County Department of Public Health Communicable Disease Services 1400 West Lacey Boulevard Hanford, CA 93230 559- 584-1401 ext. 2741

Madera

Madera County Public Health Department Communicable Disease Control Program 14215 Road 28 Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Sacramento

Sacramento County DHHS, Chest Clinic Paul F Hom Primary Care Center 4600 Broadway, Room 1300 Sacramento, CA 95820 916-874-9823
Fax: 916-874-9442

San Diego

Tuberculosis (TB) Control Program 619-540-0194

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3828
Fax 209-468-8222

Stanislaus

Stanislaus County Health Services Agency 209-558-7700
Fax: 209-558-5014

Tulare

Tulare County Department of Health Services 559-685-2275
Fax: 559-685-4786

Transitional Care Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Transitional Care Services (TCS) program ensures a smooth transition from one setting to another and reduces re-hospitalization risks and other potentially adverse events.

Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post-discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner.

Knowledge of internal and external processes surrounding the inpatient and post-discharge stay is essential in navigating the health care continuum and addressing barriers to post-discharge success for the member.

Members can call the Transitional Care Services toll free line anytime during their inpatient stay or after their discharge to request TCS support 866-801-6294.

Providers are encouraged to refer members while inpatient or recently discharged from a hospital within the past 10 days to the Transitional Care Services program. Providers are still responsible for ECM and CS referrals/coordination as appropriate and required by DHCS.

If the member is beyond the 10 days post discharge, please refer to the Complex Case Management Program.

Transplant Team

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Transplant Team

Fax: 833-769-1141

TurningPoint Healthcare Solutions, LLC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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TurningPoint Healthcare Solutions, LLC is responsible for prior authorization for:

- Certain inpatient and outpatient musculoskeletal surgical procedures for HMO, POS, HSP, EPO, PPO (Commercial) and Medi-Cal lines of business.
- Cardiovascular and ear, nose and throat (ENT) for Commercial lines of business.

TurningPoint Contacts

Phone: 855-332-5898

Fax: 949-774-2254

Email: centenecaum@turningpoint-healthcare.com

Website: MyTurningPoint

Training: Email provider support or contact TurningPoint by telephone at 866-422-0800

VRI

Personal Emergency Response Systems (PERS)

Medical alert systems can provide peace of mind if or when member have a medical emergency. Medicare members are covered for one personal emergency medical response (PERS) device per lifetime and the

monthly fee at no additional cost. A PERS device provides peace of mind and 24/7 response to member's emergent and non-emergent needs. Prior authorization may be required.

VRI
800-860-4230, Option 2
Monday through Friday
5 a.m.-5 p.m. Pacific time

For more information, visit VRI.

Wellcare by Health Net Medicare Member Services Department

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net directs calls about coverage for Medicare members to the Health Net Medicare Member Services Department. If you have questions about Medicare services for these members, contact:

- 800-275-4737 (TTY: 711): Medicare Advantage (HMO) Plans (non-SNP)
- 800-431-9007; (TTY: 711): Medicare Advantage Dual Special Needs Plans (HMO D-SNP) and Medicare Advantage Chronic Special Needs Plans (HMO C-SNP)

Mail to:
Health Net Medicare Advantage for California
PO Box 10420
Van Nuys, CA 91410

Western Drug

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Western Drug

Attention Celeste Melgoza Email: celeste@westerndrug.com

Fax: 818-551-9612 or 818-956-6695

Western Drug direct phone: 818-956-6691

Send a Blood Pressure Monitor Request Form (Medi-Cal, CalViva, CHPIV) to our preferred DME provider, Western Drug.

Glossary

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- Life-Threatening Emergent (Behavioral Health)
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- Medical Waste Management Materials
- Medical Information
- Mental health application information (Behavioral Health)
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- Subcontractor
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- Urgent Decision (Behavioral Health)

- Urgent Pre-Service Decision (Behavioral Health)

Terms Glossary

This section contains general terms information for providers. Please select a term from the navigation list, or choose your line of business below.

- Medi-Cal Glossary
- Medicare Advantage Glossary
- HMO Glossary
- PPO Glossary

AIDS

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The definition of AIDS includes several diagnoses with and without HIV positivity. The services that are directly attributed to these specific diagnoses are paid for through special risk reinsurance. These diagnoses include:

- Candidiasis of esophagus, trachea, bronchi, or lungs
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis with diarrhea in indivduals older than one month
- Cytomegalovirus disease in organs other than liver, spleen or lymph nodes in individuals older than one month
- Kaposi's sarcoma in indivuduals younger that age 60
- Lymphoma of the brain (primary) in individuals younger than age 60
- Mycobacterium avium complex/M. Kansasii disease, disseminate
- Pneumocystis carinii pneumonia
- Progressive multifocal leukoencephalopathy
- Toxoplasmosis of the brain in individuals older than one month
- Herpes simplex virus with an ulcer lasting longer than one month or herpes simplex virus with bronchitis, pneumonia, or esophagitis in individuals older than one month

Additional diagnoses associated with AIDS require a positive HIV test in order to be covered under the special risk reinsurance pool. These diagnoses include:

- CD4 T-lymphocyte count less than 200
- Recurrent pneumonia, more than one episode within one year
- Invasive cervical cancer
- Coccidiomycosis, disseminated
- HIV encephalopathy
- Histoplasmosis, disseminated
- Isosporiasis with diarrhea more than one month

- Non-Hodgkin's lymphoma
- Tuberculosis
- Recurrent salmonella septicemia
- HIV wasting syndrome

Approved Clinical Trial

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net covers routine patient care costs for members participating in an approved clinical trial including items and services furnished in connection with participation by members in a qualifying clinical trial. An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veterans Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

Coverage of routine patient care costs is to be provided regardless of geographic location or if the treating provider or principal investigator of the qualifying clinical trial is a network provider. Coverage of routine patient care costs must be based on provider's and principal investigator's approval regarding the member's appropriateness for the qualifying clinical trial.

Authorizations for items and services furnished in connection with participation by members in a qualifying clinical trial are expedited and completed within 72 hours.

Health Net requires the submission of the Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for approval of the clinical trial. The attestation form must include the following information:

1. The member's name and client identification number;
2. The national clinical trial number;
3. A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
4. A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

Appeal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Member Request for Reconsideration

A verbal or written request to reconsider a previous decision or adverse determination. Requests can be from a member, the member's participating provider or the member's representative and are categorized as: pre-service, post-service, expedited, or external review.

Certificate of Insurance (COI)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Certificate of Insurance (COI) is a document issued by Health Net Life Insurance Company to employees insured under a group insurance policy, which describes the covered services, supplies and exclusions and limitations that apply to the benefits for which the employee and their insured dependents are eligible. COIs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's COI by requesting it from the Health Net Provider Services Center. COIs apply to Health Net Life, PPO, EPO and Flex Net plans.

Clean Claim

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Physician Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, physician name(s), date of service (DOS), diagnosis code(s), and billed amount among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

PPG Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, participating physician group (PPG) and physician names, date of service (DOS), diagnosis code(s), and billed amount are among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

Complaint

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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First Contact Resolution

Any verbal expression of dissatisfaction regarding quality-of-service (excluding quality-of-care) that can be resolved in an initial contact with Health Net's Member Services Department. This first contact resolution must

be to the member or participating provider's satisfaction, such that they do not ask for additional assistance or recompense.

Definition of Contracted Provider Dispute

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A contracted provider dispute is a provider's written notice to Health Net challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested, or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's Tax ID number or Health Net's provider ID number, provider's contact information, and:

If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Health Net to a contracted provider, the following must be provided:

- Original claim form number (located on the RA).
- A clear identification of the disputed item.
- The date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.

If the contracted provider dispute is not about a claim:

- A clear explanation of the issue and the provider's position on such issue.

If the contracted provider dispute involves an enrollee or group of enrollees:

- The name and identification number(s) of the enrollee or enrollees.
- A clear explanation of the disputed item, including the date of service.
- Provider's position on the disputeAn enrollee's written authorization for the provider to represent said enrollees.

Emergency

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Department of Managed Health Care's (DMHC's) definition for an emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Per the DMHC, emergency services and care means:

1. Medical screening, examination and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the emergency medical condition, within the capability of the facility; and/or
2. An additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of the facility.

The Medicare definition of an emergency medical condition and emergency services is as follows:

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Emergency Services and Care (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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1. Screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists; and
2. Treatment necessary to relieve or eliminate the psychiatric emergency medical condition. The intent is to assure that enrollees who have non-medical, mental health emergencies receive proper access to and continuity of care.

Emergency Services and Care also means additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition.

Emergency Services and Care also means additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition.

Psychiatric Emergency Medical Condition means a psychiatric medical condition for which the onset is sudden and manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the afflicted person, or others, in serious jeopardy.
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part. In cases of the provision of Emergency Services and Care, the provider agrees to notify Health Net as soon as possible, but no later than 24 hours after it could be reasonably determined that the patient is an enrollee.

Evidence of Coverage (EOC)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Evidence of Coverage (EOC) is any certificate, agreement, contract, brochure or letter of entitlement issued to a member setting forth the coverage to which the member is entitled. The EOC for each HMO, HSP and POS plan contains comprehensive terms and conditions of Health Net coverage. EOCs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's EOC by requesting it from the Health Net Provider Services Center. EOCs apply to Health Net HMO, HSP and POS plans only. Language used in these documents is reflective of current laws and regulations and meets disclosure requirements applicable to health plan documents. The text included in the EOC is wholly subject to regulatory review and approval prior to use.

Facility Site Review

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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All primary care physicians (PCPs) participating in Medi-Cal managed care are required by California statute (Title 22, CCR Section 56230) to complete an initial facility site inspection and subsequent periodic facility site inspections regardless of the status of other accreditation and/or certifications program as part of the initial credentialing process. The full scope site review includes the facility site review (FSR) and medical record review (MRR).

All PCP sites must also undergo the Physical Accessibility Review Survey (PARS). PARS is conducted for participating PCPs, high-volume specialists, ancillary providers, and hospitals. The PARS tool includes 86 criteria and highlights six specific indicators. Based on the outcome of the new PARS (Seniors and Persons with Disabilities (SPD)) evaluation, each PCP site is designated as having basic or limited access, as described below, along with the six specific accessibility indicator designations for parking, external building, interior building, restrooms, exam rooms, and medical equipment (for example, accessible weight scales and adjustable exam tables).

- Basic access - demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room, and restroom. To meet basic access requirements, all 29 critical elements must be met.
- Limited access - demonstrates facility site access for the member with a disability are missing or incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in one or more of the critical elements are encountered.

Results of the PARS assessment component of the FSR audit are made available to the Health Net Medi-Cal Member Services Department and CalViva Health Medi-Cal Member Services to assist members in selecting a PCP that can best serve the member's health care needs.

Grievance

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Grievance means any expression of dissatisfaction about any matter other than an adverse benefit determination (ABD), and may include, but is not limited to: the quality of care or services provided, aspects of interpersonal relationships with a provider or contractor’s employee, failure to respect a member’s rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by contractor to make an authorization decision. A complaint is the same as grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other contractor processes.

Hospice Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Hospice is a specialized health care program for terminally ill members who chose supportive and palliative care rather than curative measures and aggressive treatments for their terminal illness. It focuses on symptom control, pain management and psychosocial support for members with a life expectancy of one year or less to live. Hospices do not speed up or slow down the dying process. Rather, hospice programs provide state-of-the-art palliative care and supportive services to members at the end of their lives, as well as to their family and significant others, in both the home and facility-based settings. It consists of a physician-directed, nurse-coordinated interdisciplinary team consisting of social workers, counselors, clergy, physical and occupational therapists, and specially trained volunteers.

For additional information refer to Criteria for Hospice Appropriateness.

Description

A hospice care program consists of, but is not limited to, the following:

- Professional services of a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy and speech therapy
- Medical and surgical supplies and durable medical equipment (DME)
- Prescribed medications
- In-home laboratory services
- Medical social service consultations
- Inpatient hospice room, board and general nursing service
- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family or other persons caring for the member
- Family counseling related to the member's terminal condition
- Dietitian services
- Pastoral services
- Bereavement services
- Educational services

Hospice Consideration Request

To further assist providers in proper utilization of hospice care, Health Net has developed a Hospice Consideration Request letter (PDF). The letters (generic) may be used when notifying a primary care physician (PCP) or attending physician of the member's need for hospice care.

Inquiry

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Member Question

Any verbal or written question for clarification, without an expression of dissatisfaction or request for reconsideration (such as a request for information or action by a member).

Investigational Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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This definition is provided for illustrative purposes only. Consult the applicable health benefit plan contract (member's *Evidence of Coverage*) for the specific definition of *investigational or experimental.*

Investigational or experimental is used to describe a service (a medication, biological product, device, equipment, medical treatment, therapy, or procedure) that Health Net has determined is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury.

A service is considered experimental or investigational if it meets any of the following criteria:

- It is currently the subject of an active and credible evaluation (such as clinical trial or research) to determine:
  - Clinical efficacy
  - Therapeutic value of beneficial effects on health outcomes
  - Benefits beyond any established medical based alternatives
- It does not have final clearance from applicable government regulatory bodies, such as the United States Food and Drug Administration (FDA), and unrestricted market approval for use in the treatment of a specified medical condition of the condition for which authorization of the service is requested and is the subject of an active and credible evaluation.
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Life-Threatening Emergent (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Referrals for service which require immediate evaluation.

Medical Necessity

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Definitions of Medical Necessity and Investigational Services

Health Net's has provided a clarification of terms used in its medical policies for medical necessity, investigational or experimental, and not medically necessary and not investigational. This clarification should enable participating physician groups (PPGs) to more quickly determine whether a service is considered investigational and, therefore, timely submit the request for a proposed service to Health Net for utilization management (UM) review and determination based on the terms of the provider's contract.

Commercial

Except where state or federal law or regulation requires a different definition, Health Net defines “Medically Necessary” or comparable terms in each agreement with physicians, physician groups, and physician organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition. “Medically Necessary” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of mental health or substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and members or for the convenience of the patient, treating physician, or other health care provider.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Pursuant to Insurance Code, Section 10144.52, Health Net bases any medical necessity determination or the utilization review criteria that the Plan, and any entity acting on the Plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health or substance use disorders on current generally accepted standards of mental health or substance use disorder care. All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of members diagnosed with mental health or substance use disorders shall be conducted in accordance with the requirements of Section 1374.721.

Medi-Cal

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the members' current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Behavioral Health Medical Necessity or Medically Necessary Definition

Except where state or federal law or regulation requires a different definition, the behavioral health team shall apply the following definition of medically necessary (Health & Safety Code: 1374.72 (3)(A)

A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the generally accepted standards of mental health or substance use disorder care.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health or substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health or substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the U.S. Food & Drug Administration.

Medical Necessity for Non-Specialty Mental Health Services (NSMHS):

The health plan will cover medically necessary services, which are defined by the MHP as reasonable and necessary services to protect life, prevent significant illness or significant disability, alleviate severe pain through the diagnosis and treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity (Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).

These include services to: diagnose a mental health condition and determine a treatment plan for the treatment of mental health conditions that result in mild or moderate impairment (excluding couples and family counseling for relational problems); refer adults to the county MHP for specialty mental health services when a mental health diagnosis covered by the MHP results in moderately to severely significant impairment; or refer children under age 21 to the MHP for specialty mental health services when they meet the criteria for those services (regardless of severity of impairment for beneficiaries under age 21).

Medi-Cal Specialty Mental Health Services (SMHS)

The federal Section 1915(b) Medi-Cal Waiver requires Medi-Cal members needing SMHS to access these services through MHPs. For individuals under 21 years of age and in accordance with California Welfare & Institutions Code (W&I Code) sections 14059.5 and 14184.402, a service is “medically necessary” or a “medical necessity” if the service meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the United States Code (USC).

The federal EPSDT mandate requires states to furnish all services it defines as appropriate and medically necessary services that could be covered under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state’s Medicaid State Plan.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered under the EPSDT mandate.

By contrast, for members who are 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I code section 14059.5).

Medicare Advantage

The Centers for Medicare and Medicaid Services (CMS) defines medical necessity and medically necessary services as services or supplies that: are proper and needed for the diagnosis or treatment of medical conditions, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or health care provider.

Medical Waste Management Materials

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The following are definitions of medical waste management materials:

Biohazard bag - A disposable red bag that is moisture-resistant and has sufficient strength to withstand ripping, tearing or bursting under normal conditions of use. A biohazard bag must be certified by the manufacturer and constructed of material of sufficient thickness strength to pass the 165 g dropped dart impact resistant test.

Biohazardous waste - Laboratory waste, including:

- medical and pathological human specimen cultures
- cultures and stocks of infectious agents
- waste from the production of bacteria, viruses or the use of spores, discarded live and attenuated vaccines, culture dishes and contaminated devices used for above
- discarded waste from specimens sent to the laboratory
- human specimens or tissues removed during surgery or autopsy, which are suspected by the attending physician or dentist of being contaminated with infectious agents

Medical waste - Biohazardous waste, sharps waste or waste generated or produced as a result of diagnosis, treatment or immunization of human beings. Medical waste may be infectious.

Sharps waste - Any device having acute rigid corners or edges or projections capable of cutting or piercing, including:

- hypodermic needles, syringes, blades, and needles
- broken glass items, pipettes and vials that are contaminated with other medical waste

Medical Information

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

“Medical information” is any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment.

“Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient’s name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

“Mental health application information” means information related to a consumer’s inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

“Mental health digital service” means a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

- Reproductive or sexual health application information – information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
- Reproductive or sexual health digital service – a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
- "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

A business entity that offers a "sexual health digital service" is now considered a "provider" under the California Medical Information Act (CMIA, 56.06)(e).

- Any business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of this part. However, this section shall not be construed to make a business specified in this subdivision a provider of health care for purposes of any law other than this part, including, but not limited to, laws that specifically incorporate by reference the definitions of this part.

Mental Health Application Information (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Information related to a consumer's inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

Mental Health Digital Service (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Mobile-based application or internet websites that collect mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

Non-Life Threatening Emergent (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Represents a clinical risk rating assigned by a licensed clinician who has determined that a member requires services within six hours. In these cases, the clinician has determined that without services in this time frame, there is a likelihood that the member will become an imminent danger to themselves or others or become gravely disabled.

Non-Urgent, Pre-Service Decision (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Any case or service that requires prior authorization by Health Net, in whole or in part, in advance of the member obtaining medical care or services that do not meet the criteria for an urgent decision.

Not Medically Necessary and Not Investigational

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Evaluation and clinical recommendations are assessed according to the scientific quality of the supporting evidence and rationale (such as national medical associations, independent panels or technology assessment organizations).

A service is considered not medically necessary and not investigational if it meets any of the following criteria:

- There are no studies of the service described in recently published peer-reviewed medical literature
- There are no active or ongoing credible evaluations being undertaken of the service, which has previously been considered not medically necessary
- There is conclusive evidence in published peer-reviewed medical literature that the service is not effective
- There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety or efficacy of the use of the service
- It is contraindicated

Offshore

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and American Virgin Islands). Examples of countries that meet the definition of offshore include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Opt Out Provider

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A provider who has opted out of Medicare has terminated their Part B contract with Medicare by submitting a valid affidavit to the local Medicare carrier. Affidavits are valid for two years. After the two-year period has expired, the provider may elect to return to Medicare or opt out again. Services received from a provider that has opted out of Medicare are not covered.

Participating Provider

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A facility, physician, physician organization, other health care provider, supplier, or other organization, which has met applicable credentialing and/or recredentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net, or indirectly through another entity, such as, another participating provider, to provide covered services. Health care provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Post-Service Decision (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Any review for care or services that has already been received and completed but not previously reviewed and authorized.

Post-Stabilization Services (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Medically necessary services that are related to an emergency medical condition, provided after a member is stabilized, and provided to maintain the stabilized condition or, under certain circumstances, to improve or resolve the member's condition.

Primary Care Physician (PCP)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A doctor of medicine (MD), doctor of osteopathy (DO) or other health care professional who: (1) is duly licensed and qualified under the laws of the relevant jurisdiction to render contracted services; (2) is a participating provider and (3) meets the credentialing standards of Health Net for designation as a PCP and who provides for continuity of care and 24-hour-a-day, seven-day-a-week availability to beneficiaries.

Psychiatric Emergency Medical Condition

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others or immediately unable to provider for, or utilize, food, shelter, or clothing, due to the mental disorder.

Rape and Sexual Assault

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Under California law, rape and sexual assault generally involve non-consensual sexual acts. Below is a simple breakdown as derived from the California Penal Code (PC), which can be accessed in detail through the California Legislator.

- **Rape** (PC 261, 263, 263.1): Non-consensual sexual intercourse accomplished through force, threats, fraud, or when the victim is unable to give consent due to intoxication, unconsciousness, or mental incapacity.
- **Consent** (PC 261.6): A voluntary, freely given agreement to engage in sexual activity. Lack of resistance does not imply consent.
- **Sodomy and oral copulation** (PC 286, 287): Engaging in anal or oral sex without consent, using force, threats, or exploiting a victim's inability to resist.
- **Sexual acts with a child** (PC 288.7): Any sexual intercourse, sodomy, or oral copulation with a child under 10 years old is a felony.

Residential Treatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Residential treatment is available, based on medical necessity with this added benefit. Medi-Cal members seeking residential treatment are referred to their respective county Specialty Mental Health division .

A residential treatment center is defined as a 24-hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. This plan requires that all contracting residential treatment centers hold appropriate licensure by their state in order to provide residential treatment services.

This plan does not cover admission to the following residential treatment facility types as they are not considered to be medical treatment:

- Foster homes or halfway houses
- Wilderness Center training
- Therapeutic boarding schools
- Custodial care, situation or environmental change

Routine (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Referrals for services requiring evaluation by a licensed mental health professional within 10 business (14 calendar) days or a psychiatrist within 15 business days.

Telehealth

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care. Telehealth facilitates patient self-management and caregiver suppot for patients and includes synchronous interactions and asynchronous store and forward transfers.

- **Originating site** - The site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward transfer originates.
- **Distant site** - The site where a health care provider who provides health care services is located while providing these services via a telecommunications system.
- **Synchronous interaction** - A real-time interaction between a patient and a health care provider located at a distant site.

- **Asynchronous store and forward transfer** - The transmission/transfer of a patient's medical information from an originating site without the patient being present to the health care provider at a distant site.

Schedule of Benefits or Summary of Benefits (SOB)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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The Schedule of Benefits is a brief list of benefits, with applicable copayment, coinsurance and deductible information for the member's health plan. It does not list the exclusions and limitations or other important legal and contractual terms applicable to the plan; these are described in the EOC or COI.

The Schedule of Benefits is called the Summary of Benefits for certain Medicare Advantage plans, including C-SNP and D-SNP. The Summary of Benefits has the same information as the Schedule of Benefits but in a slightly different format.

The Schedule of Benefits and Summary of Benefits are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may access members' Schedule of Benefits on the provider portal. Once you log in, select *Patients* > the applicable member from the list > *Schedule of Benefits* .

Schedule of Benefits are available for all Health Net plans (except California Medi-Cal plans)

Serious Illness

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Serious illness is defined as a condition that may result in death, regardless of the estimated length of the patient's remaining period of life.

Subcontractor

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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A subcontractor is any organization with which a first-tier, downstream or related entity contracts to fulfill or help fulfill requirements in its contracts.

Note: A subcontractor means an individual or entity who has a subcontract with the plan that relates directly or indirectly to the performance of the plan's obligation under the contract with the Department of Health Care Services (DHCS).

Unclean Claim

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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An unclean claim lacks sufficient information to pay or deny, and results in an examiner requesting information from a source outside the Medicare Advantage Organizations (MAOs), such as a participating physician group (PPG) or hospital. The following are examples of claims considered to be unclean (this list is not all inclusive):

- A claim does not have the necessary fields completed to process the claim, for example, the provider identification (ID) number.
- The claim does not have a diagnosis that is immediately identifiable as an emergency, out-of-area urgently needed service, or out-of-area renal dialysis.
- The claim lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergency care.
- A claim that appears to be fraudulent or is in a foreign language or currency.

Unclean Claim Adjudication

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), MAOs and PPGs are required to pay or deny non-clean claims within 60 calendar days of receipt.

Urgent (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Referrals for service which require evaluation by a licensed mental health professional within 48 hours.

Urgent Concurrent Review Decision (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Any review for treatment that has already begun.* This determination is always considered urgent, with the following exception:

1. If the request is to extend a course of treatment beyond the period of time or the number of treatments previously approved by Health Net, and the treatment involved does not meet the definition for an Urgent Decision below, default to the Non-Urgent Pre-Service category.

** For Medicare, treatment that has begun within one (1) business day can be considered Pre-Service Urgent.*

Urgent Decision (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Any request with respect to which the application of the time periods for making non-urgent care determinations:

Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a subjective standard that focuses on the belief in the existence of an Emergency Medical Condition or Psychiatric Emergency Medical Condition that requires immediate medical and/or psychiatric treatment; or

In the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Urgent Pre-Service Decision (Behavioral Health)

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Any case or service that requires prior authorization by Health Net, in whole or in part, in advance of the member obtaining medical care or services that meet the criteria for an urgent decision listed above.

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- 30-Day Eligibility Report (PDF)
- 60-Day Eligibility Report (PDF)
- 90-Day Eligibility Report (PDF)
- 120-Day Initial Health Appointment Report (PDF)
- 837 5010 Professional and Institutional Standards
- 837 Institutional Companion Guide
- 837 Professional Companion Guide

A

- AAP Recommendations for the Preventive Pediatric Health Care (PDF)
- Add Report (PDF)
- Administration of Fluoride Varnish (PDF)
- Advance Directive Labels for Member Medical Record (PDF)
- Advance Health Care Directives Info Sheet for English/Spanish (PDF)
- Adult AIDS/HIV Confidential Case Report (PDF)
- Adult Health Maintenance (PDF)
- Adult Vaccine Administration Record (PDF)
- After-Hours Sample Script - Arabic (PDF)
- After-Hours Sample Script - Armenian (PDF)
- After-Hours Sample Script - Chinese (Traditional) (PDF)
- After-Hours Sample Script - Chinese (Simplified) (PDF)
- After-Hours Sample Script - English (PDF) (CalViva)
- After-Hours Sample Script - English (PDF)
- After-Hours Sample Script - Farsi (PDF)
- After-Hours Sample Script - Hmong (PDF)
- After-Hours Sample Script - Hmong (PDF)
- After-Hours Sample Script - Khmer (Cambodian) (PDF)
- After-Hours Sample Script - Korean (PDF)
- After-Hours Sample Script - Russian (PDF)
- After-Hours Sample Script - Spanish (PDF)
- After-Hours Sample Script - Spanish (PDF)
- After-Hours Sample Script - Tagalog (PDF)
- After-Hours Sample Script - Vietnamese (PDF)

- Applied Behavioral Analysis (ABA) Prior Authorization Request Form – Health Net (PDF)
- Applied Behavioral Analysis (ABA) Prior Authorization Request Form – CalViva Health (PDF)
- Applied Behavioral Analysis (ABA) Prior Authorization Request Form – Community Health Plan of Imperial Valley (PDF)
- Applied Behavioral Analysis (ABA) Recommendation and Referral Form – Health Net (PDF)
- Applied Behavioral Analysis (ABA) Recommendation and Referral Form – CalViva Health (PDF)
- Applied Behavioral Analysis (ABA) Recommendation and Referral Form – Community Health Plan of Imperial Valley (PDF)
- Appointments and Patient Recall (PDF)
- Asthma Action Plan (PDF)
- Audiometer Form (PDF)
- AUDIT - English (PDF)
- AUDIT - Spanish (PDF)
- AUDIT-C - English (PDF)
- AUDIT-C - Spanish (PDF)
- Autoclave Maintenance and Run Log (PDF)

B

- Blood and Body Fluid Exposure Report Form (PDF)
- Blood Pressure Monitor Request Form Medi-Cal (PDF)
- Blood Pressure Monitor Request Form CalViva (PDF)
- Blood Pressure Monitor Request Form CHPIV (PDF)
- Breast Cancer Treatment Information Sign
- Bright Futures Promoting Oral Health (PDF)

C

- Cancer Center (contracted) (PDF)
- Cancer Center (Contracted) (CalViva Health) (PDF)
- Cancer Centers Contracted (PDF) (CHPIV)
- Care Management Referral Form - (CalViva Health) (PDF)
- Care Management Referral Form (PDF) (CHPIV)
- Care Management Referral Form (PDF)
- CCS Parent Notification Letter (PDF)
- CCS Program Application (PDF)
- CCS-GHPP Discharge Planning SAR (PDF)
- Certification for Contracts Grants, loans, and Cooperative Agreements (PDF)
- CHDP - Report of Health Exam for School Entry – English (PDF)
- CHDP - Report of Health Exam for School Entry – Spanish (PDF)
- CHDP Consent Form – English (PDF)
- CHDP Consent Form – Spanish (PDF)
- CHDS-CTCA Joint Guidelines for the Treatment of Active Tuberculosis Disease (PDF)
- Checklist for Safe Vaccine Storage and Handling (PDF)
- Child Abuse Reporting (PDF)
- Clean and Sanitary Environment (PDF)

- Clorox Regular Bleach (PDF)
- Community-Based Adult Services Treatment Request Form (PDF)
- Community-Based Adult Services Treatment Request Form (PDF) (CalViva Health)
- Community-Based Adult Services Treatment Request Form (PDF) (Community Health Plan of Imperial Valley)
- Confidential Morbidity Report (PDF)
- Confidentiality and Release of Information Form (PDF)
- Confirmation Pregnancy Form (PDF)
- Confirmation of Pregnancy Form (PDF) (CalViva Health)
- Confirmation of Pregnancy Form (PDF) (Community Health Plan of Imperial Valley)
- Consent for Minors to Travel without an Escort (PDF)
- Consent Form PM 330 (English) (PDF)
- Consent Form PM 330 (Spanish) (PDF)
- Controlled Substance Log Form (PDF)

D

- Decontamination of Surface (PDF)
- Delegation of Service Agreement Supervision of Physician Assistance (PDF)
- Delineation of UM Responsibilities (PDF)
- Dexa Scanner (PDF)
- Direct Observation Therapy Referral (PDF)
- Directory Removal for At-Risk Providers Form (PDF)
- Directory Removal for At-Risk Providers Form (CalViva Health) (PDF)
- Directory Removal for At-Risk Providers Form (PDF) (CHPIV)
- Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF)
- Domestic Violence Reporting (PDF)
- Drug Use Questionnaire (DAST-20) (PDF)
- Durable Medical Equipment Prosthetics Orthotics and Supplies Coding Policies (PDF)

E

- Edinburgh Perinatal/Postnatal Depression Scale (EPDS) Questionnaire (PDF)
- Elder Abuse Reporting (PDF)
- Electronic Eligibility File 277 (PDF)
- Eligibility Listing Staff Model Roster (PDF)
- Eligibility Report Field Descriptions (PDF)
- Emergency Earthquake Plan (PDF)
- Emergency Fire Plan (PDF)
- Emergency Health Care Service (PDF)
- Emergency Medication Dosage Chart (PDF)
- Emergency Protocol (PDF)
- Emergency Response Worksheet (PDF)
- Emergency Supplies Inventory Checklist (PDF)
- Endoscopy Matrix (PDF)
- Equipment Calibration Log (PDF)

- Equipment Transfer Log for Sterilization (PDF)
- Established CCS/GHPP Client SAR (PDF)

F

- Facility Site Review Guidelines (PDF)
- Facility Site Review Tool (PDF)
- Fire Safety and Prevention and emergency Non-Medical Procedures (PDF)
- Freezer Temperature Log for Vaccines (Celsius) (PDF)
- Freezer Temperature Log for Vaccines (Fahrenheit) (PDF)

G

H

- Health Education Materials Order Form (CalViva Health) (PDF)
- Health Education Materials Order Form (PDF)
- Health Plan Interpreter Phone Numbers (PDF)
- Hearing and Vision Graph (PDF)
- Hepatitis B Vaccination Declination (PDF)
- High-Risk Pregnancy Referral Form (CalViva Health) (PDF)
- High-Risk Pregnancy Referral Form (CHPIV) (PDF)
- High-Risk Pregnancy Referral Form (PDF)
- Hospice Services Documentation Guide (PDF)
- Hospice Services Documentation Guide (PDF) (CalViva Health)
- Hospice Services Documentation Guide (PDF) (Community Health Plan of Imperial Valley)
- Hysterectomy - Informed Consent (PDF)

I

- Identification card (Medi-Cal CalViva Health) (PDF) or (Medi-Cal CalViva Health) (PDF)
- Identification card (Medi-Cal Community Health Plan of Imperial Valley) (PDF) or (Medi-Cal Community Health Plan of Imperial Valley) (PDF)
- Identification card (Medi-Cal mainstream) (PDF) or (Medi-Cal mainstream) (PDF)
- Identification card (Medi-Cal Molina Healthcare) (PDF)
- Individualized Care Plan (ICP) - Directions (PDF)
- Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations (PDF)
- Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations (PDF) (CalViva Health)
- Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations (PDF) (Community Health Plan of Imperial Valley)
- Informed Consent and Human Sterilization Consent (PDF)

- Injectable Medication HCPCS/DOFR Crosswalk (PDF)
- Inpatient California Medi-Cal Prior Authorization (CalViva Health) (PDF)
- Inpatient California Medi-Cal Prior Authorization (CHPIV) (PDF)
- Inpatient California Medi-Cal Prior Authorization (PDF)
- Instrument Sterilization (PDF)
- Interpreter Quality Standards Guidance and Requirements (PDF)
- Interpreter Services (PDF)
- Interpreter Service Quick Reference Card (PDF)
- Interpreter Service Quick Reference Card (CalViva Health) (PDF)
- Interpreter Service Quick Reference Card (PDF) (Community Health Plan of Imperial Valley)
- Interpreters Available Poster (CalViva Health) (PDF)
- Interpreters Available Poster (PDF)

J

K

L

- Laboratory Services (PDF)
- Language Assistance Notice (PDF)
- Language Assistance Notice (CalViva Health) (PDF)
- Language Assistance Notice (Community Health Plan of Imperial Valley) (PDF)
- Language Identification Poster (PDF)
- Language Identification Poster (CalViva Health) (PDF)
- Language Proficiency Assessment Resources (PDF)
- Linkage/Enrollment Tracking Log for Initial Health Appointment (PDF)
- Long-Term Care Authorization Notification Form (PDF)
- Long-Term Care Authorization Notification Form (PDF) CalViva
- Long-Term Care Authorization Notification Form (PDF) CHPIV
- Los Angeles County CCS Fax Cover Sheet (PDF)

M

- Marketing Guidelines for Providers Serving CalViva Health Medi-Cal Members (PDF)
- Marketing Guidelines for Providers Serving Medi-Cal Members (CHPIV) (PDF)
- Marketing Guidelines for Providers Serving Medi-Cal Members (PDF)
- Medical and Lab Equipment Maintenance (PDF)
- Medical Assistance Certification (PDF)
- Medical Assistance Training Letter (PDF)
- Medical Assistance Venipuncture Certification (PDF)
- Medical Records (PDF)
- Medical Record - Adult Health Maintenance Checklist With Standards (PDF)

- Medical Record - Advance Directive Labels (PDF)
- Medical Record - Audiometric Screening (PDF)
- Medical Record - History Spanish (PDF)
- Medical Record - Medication and Chronic Problem Summary (PDF)
- Medical Record - Preventive Care Forms - ages 0 - 50+ (PDF)
- Medical Record Review Tool (PDF)
- Medical Record Review Guidelines (PDF)
- Medical Record - Referral Log (PDF)
- Medical Record - Signature Page (PDF)
- Medical Waste Collection Tracking Log (PDF)
- Medical Waste Log Sheet (PDF)
- Member Complaint Log (PDF)
- Member Instructions for Post-Emergency Room Care (PDF)
- Member Appeal or Grievance Form - Arabic (PDF)
- Member Appeal or Grievance Form - Armenian (PDF)
- Member Appeal or Grievance Form - Traditional Chinese (PDF)
- Member Appeal or Grievance Form - Simplified Chinese (PDF)
- Member Appeal or Grievance Form - English (PDF)
- Member Appeal or Grievance Form - Farsi (PDF)
- Member Appeal or Grievance Form - Hmong (PDF)
- Member Appeal or Grievance Form - Khmer (PDF)
- Member Appeal or Grievance Form - Korean (PDF)
- Member Appeal or Grievance Form - Russian (PDF)
- Member Appeal or Grievance Form - Spanish (PDF)
- Member Appeal or Grievance Form - Tagalog (PDF)
- Member Appeal or Grievance Form - Vietnamese
- Member Appeal or Grievance Form - English (Community Health Plan of Imperial Valley (PDF)
- Member Appeal or Grievance Form - Spanish (Community Health Plan of Imperial Valley (PDF)
- Member Grievance/Complaint Form - Hindi (PDF)
- Member Grievance/Complaint Form - Japanese (PDF)
- Member Grievance/Complaint Form - Laotian (PDF)
- Member Grievance/Complaint Form - Panjabi PDF)
- Member Grievance/Complaint Form - Thai (PDF)
- Member Grievance/Complaint Form - English (CalViva) (PDF)
- Member Grievance/Complaint Form - Hmong (CalViva) (PDF)
- Member Grievance/Complaint Form - Spanish (CalViva) (PDF)
- Member Grievance/Complaint Form (PDF)
- Minor's Rights to Sensitive Services (PDF)
- Miscellaneous Coding Policies (PDF)
- Molina Service Request Form (PDF)
- Monthly Equipment and Medication Replacement log (PDF)
- Monthly Medication and Lab Supplies Inventory Checklist (PDF)

N

- New Referral CCS/GHPP Client SAR (PDF)
- Non-discrimination Notice and Taglines (CalViva) (PDF)
- Non-discrimination Notice and Taglines - Hmong (CalViva) (PDF)

- Non-discrimination Notice and Taglines - Spanish (CalViva) (PDF)
- Non-discrimination Notice and Taglines (Community Health Plan of Imperial Valley) (PDF)
- Non-discrimination Notice and Taglines - Spanish (Community Health Plan of Imperial Valley) (PDF)
- Non-discrimination Notice and Taglines (PDF)
- Non-discrimination Notice and Taglines - Arabic (PDF)
- Non-discrimination Notice and Taglines - Armenian (PDF)
- Non-discrimination Notice and Taglines - Cambodian (PDF)
- Non-discrimination Notice and Taglines - Chinese (Traditional) (PDF)
- Non-discrimination Notice and Taglines - Chinese (Simplified) (PDF)
- Non-discrimination Notice and Taglines - Farsi (PDF)
- Non-discrimination Notice and Taglines - Hmong (PDF)
- Non-discrimination Notice and Taglines - Korean (PDF)
- Non-discrimination Notice and Taglines - Russian (PDF)
- Non-discrimination Notice and Taglines - Spanish (PDF)
- Non-discrimination Notice and Taglines - Tagalog (PDF)
- Non-discrimination Notice and Taglines - Vietnamese (PDF)
- Notice to Consumers (Physicians Assistance) (PDF)
- Notice to Consumers (Physicians) (PDF)
- Notice of Action Letter Translations and Alternate Formats: Akorbi Plunet Portal Guide (PDF)
- Notice of Action Letter Translations and Alternate Formats: Akorbi Plunet Portal Guide (CalViva) (PDF)
- Notice of Action Letter Translations and Alternate Formats: Akorbi Plunet Portal Guide (CHPIV) (PDF)

O

- Office Cleaning Schedule (PDF)
- Office Cleaning Log/Schedule Year (PDF)
- Office Equipment and Supplies Maintenance Log (PDF)
- Oral Health Risk Assessment Tool (PDF)
- Outpatient California Medi-Cal Prior Authorization (PDF) (CalViva Health)
- Outpatient California Medi-Cal Prior Authorization (PDF) (CHPIV)
- Outpatient California Medi-Cal Prior Authorization (PDF)

P

- Palliative and Hospice Care Contracted Provider List (PDF) Medi-Cal
- Palliative and Hospice Care Contracted Provider List (PDF) CalViva
- Palliative and Hospice Care Contracted Provider List (PDF) CHPIV
- Pediatric Health Maintenance Checklist (PDF)
- Perinatal Notification and Assessment Report (Kern, San Joaquin and Stanislaus) (PDF)
- Perinatal Notification and Assessment Report (Los Angeles, San Diego, Sacramento, Riverside, San Bernardino and Tulare) (PDF)
- Perinatal Risk Screening Tool (PDF)
- Personnel and Staff Training (PDF)

- Pharmaceutical Services (PDF)
- Physical Accessibility Review Survey (FSR Attachment C) (PDF)
- Physician Certification Statement Form - Request for Transportation (PDF)
- Physician Certification Statement Form - Request for Transportation CalViva Health (PDF)
- Physician Certification Statement Form - Request for Transportation (CHPIV) (PDF)
- Policy and Procedure: Staff Qualifications (PDF)
- Policy and Procedure: Standard and Universal Precautions (PDF)
- Potential Quality Issue Referral Form (CalViva Health) (PDF)
- Potential Quality Issue Referral Form (CHPIV) (PDF)
- Potential Quality Issue Referral Form (PDF)
- Prescription Drug Prior Authorization or Step Therapy Exception Form (PDF) (Health Net)
- Prescription Drug Prior Authorization or Step Therapy Exception Form (PDF) (CalViva Health)
- Prescription Drug Prior Authorization or Step Therapy Exception Form (PDF) (CHPIV)
- Preventive Services Screening and Equipment (PDF)
- Preventive Care Physician Examination Form - 1 month: and Under Infants (PDF)
- Preventive Care Physician Examination Form - 1 - 2 months: Infants (PDF)
- Preventive Care Physician Examination Form - 3 - 4 months: Infants (PDF)
- Preventive Care Physician Examination Form - 5 - 6 months: Infants (PDF)
- Preventive Care Physician Examination Form - 7 - 9 months: Infants (PDF)
- Preventive Care Physician Examination Form - 10 - 11 months: Infants (PDF)
- Preventive Care Physician Examination Form - 12 - 15 months: Toddlers (PDF)
- Preventive Care Physician Examination Form - 16 - 23 months: Toddlers (PDF)
- Preventive Care Physician Examination Form - 2 years: Children (PDF)
- Preventive Care Physician Examination Form - 2 1/2 years (30 months): Children (PDF)
- Preventive Care Physician Examination Form - 3 years: Children (PDF)
- Preventive Care Physician Examination Form - 4 - 5 years: Children (PDF)
- Preventive Care Physician Examination Form - 6 - 8 years: Children (PDF)
- Preventive Care Physician Examination Form - 9 - 12 years: Children (PDF)
- Preventive Care Physician Examination Form - 13 -16 years: Teens (PDF)
- Preventive Care Physician Examination Form - 17 - 20 years: Teens (PDF)
- Preventive Care Physician Examination Form - 21 - 39 years female: Adults (PDF)
- Preventive Care Physician Examination Form - 21 - 39 years male: Adults (PDF)
- Preventive Care Physician Examination Form - 40 - 49 years female: Adults (PDF)
- Preventive Care Physician Examination Form - 40 - 49 years male: Adults (PDF)
- Preventive Care Physician Examination Form - 50+ years female: Adults (PDF)
- Preventive Care Physician Examination Form - 50+ years male: Adults (PDF)
- Primary Language Assessment Labels (PDF)
- Prior Authorization/Referrals (PDF)
- Participating Physician Groups (PDF)
- Prostate Cancer Treatment Information Sign (PDF)
- Provider Dispute Resolution Request - CalViva Health (PDF)
- Provider Dispute Resolution Request - (CHPIV) (PDF)
- Provider Dispute Resolution Request - Commercial and Medi-Cal (PDF)
- Provider Notification of Pregnancy (PDF)
- Provider Notification of Pregnancy - CalViva Health (PDF)
- Provider Notification of Pregnancy - CHPIV (PDF)
- Provision of Service 24 Hours a day (PDF)

Q

R

- Radiology Health Branch Contact Info (PDF)
- Radiology Services (PDF)
- Reconstructive Surgery Decision Tree (PDF)
- Red Flags for Alcohol/Drug Abuse (PDF)
- Referral Tracking Log (PDF)
- Refrigerator Temperature Log for Vaccines (Celsius) (PDF)
- Refrigerator Temperature Log for Vaccines (Fahrenheit) (PDF)
- Reportable Diseases (PDF)
- Report of Suspected Dependent Adult/Elder Abuse Form and General Instructions (PDF)
- Request for PCP-PPG Change Form (PDF)
- Request for PCP-PPG Change Form (Spanish) (PDF)
- Request for PCP-PPG Change Form (CalViva Health) (PDF)
- Request for PCP-PPG Change Form (CalViva Heath) (Spanish) (PDF)
- Request for PCP-PPG Change Form (Community Health Plan of Imperial Valley) (PDF)
- Request for PCP-PPG Change form (Community Health Plan of Imperial Valley) (Spanish) (PDF)

S

- Sample Site Evacuation Plan (PDF)
- Sharps Injury Log (PDF)
- Site Accessibility by Individuals with Physical Disabilities (PDF)
- Skin Cancer Screening Form (PDF)
- Spill Kit Information (PDF)
- Staff Education Checklist (PDF)
- Staff Qualifications (PDF)
- Staff Signature Page Form for Member Medical Records (PDF)
- Standard of Care Guidelines for Childhood Lead Screening (PDF)
- Standardized Procedures Requorements for Nurse Practitioners Practice (PDF)
- Standardized and Universal Precautions (PDF)
- State Health Programs Provider Inquiry Spreadsheet (PDF)
- Sterilization Procedures Log (PDF)
- Supervising PA PAC Document (PDF)
- Suspected Child Abuse Report (PDF)
- Suspected Injury Report Form (PDF)

T

- T-ACE (PDF)
- TB Risk Assessment - English/Spanish (PDF)

- Transplant Performance Centers (PDF)
- Triage (PDF)
- Tuberculosis Suspect Case Report (PDF)
- Tuberculosis Suspect Case Report Tulare (PDF)
- TWEAK Test (PDF)

U

- Ultra Clorox Germicidal Bleach (PDF)
- Understanding Bleach (PDF)
- Unlicensed Personnel (PDF)
- Utilization Management Timeliness Standards - Medi-Cal (PDF)

V

W

- WIC Pediatric Referral Form (PDF)
- WIC Referral for Postpartum-Breastfeeding Women (PDF)
- WIC Referral for Pregnant Women (PDF)
- Women's Folic Acid (PDF)
- Workplace Violence Protocol (PDF)

X

Y

Z

1 (1) PAGE : 4

FMMR336 (2)

H E A L T H N E T

Q/CARE PROVIDER ASSIGNMENT REGISTER - MEDI-CAL

ELIGIBILITY PERIOD : 12/01/03 - 12/31/03

(4) REPORT DATE : 12/15/03

ELIGIBILITY REPORT

MEMBERS WHO HAVE BEEN ELIG FOR 30 DAYS (3)

>>>>>>>>>>>>>> PLEASE REFER TO THE HEALTH NET MEDI-CAL MANUAL FOR KEY TO REPORTS <<<<<<<<<<<<<

TAX ID : 233456789 - THE DOCTOR'S GROUP (5)

PROVIDER : A088877 - TALLULAH BELLE (6)

PROV ADDR : 7654 CROSSROADS STREET, CITY, CA ZIP

(7) PROVIDER COUNTY : 00 COUNTY NAME

(8) MEMBER NAME / ADDRESS/PHONE	(9) HN MEMBER ID	(10) D-O-B	(11) SEX	(12) 1ST ELIG EFF DATE	(13) PCP/CLNC EFF DATE	(14) ELIG STAT	(15) PRIOR PCP ID/NAME	(16) OHC CODE	(17) ETHNIC CODE	(18) LANG CODE	(19) PUB HLTH	(20) MEDI-CAL ID CIN ID (21) / * = PSEUDO (22)
BALL, LUCILLE 4717 23RD STR, AMITYVILLE, CA 05512 (000)555-7998	63212345610	03/15/87	F	11/01/03	11/01/03	(+)	A099999 NO PRIMARY MD		1	7		532N5992266880 83283282A
BRUCE, LENNY 5621 64TH AVE, HOBOKEN, CA 05527 (000)555-4640	11122777700	09/28/73	M	11/01/03	11/01/03	(+)	A048594 PYTHON, MONTGOMERY		2	7		65454343232100 1118888QA

MCFMMR336_30_DAY_ELIG_101603.FM

SAMPLE "MEMBERS WHO HAVE BEEN ELIGIBLE FOR 30 DAYS" REPORT

1 (1) PAGE : 5

FMMR336 (2)

H E A L T H N E T

Q/CARE PROVIDER ASSIGNMENT REGISTER - MEDI-CAL

ELIGIBILITY PERIOD : 12/01/03 - 12/31/03 (4) REPORT DATE : 12/15/03

ELIGIBILITY REPORT

MEMBERS WHO HAVE BEEN ELIG FOR 60 DAYS (3)

>>>>>>>>>>>>>> PLEASE REFER TO THE HEALTH NET MEDI-CAL MANUAL FOR KEY TO REPORTS <<<<<<<<<<<<<

TAX ID : 233456789 - THE DOCTOR'S GROUP (5)

PROVIDER : A088877 - TALLULAH BELLE (6)

PROV ADDR : 7654 CROSSROADS STREET, CITY, CA ZIP

(7) PROVIDER COUNTY : 00 COUNTY NAME

(8) MEMBER NAME / ADDRESS/PHONE	(9) HN MEMBER ID	(10) D-O-B	(11) SEX	(12) 1ST ELIG EFF DATE	(13) PCP/CLNC EFF DATE	(14) ELIG STAT	(15) PRIOR PCP ID/NAME	(16) OHC CODE	(17) ETHNIC CODE	(18) LANG CODE	(19) PUB HLTH	(20) MEDI-CAL ID CIN ID (21) / * = PSEUDO (22)
CHAMBERS, DIANE 7600 BOSTON BLVD, CERES, CA 05502 (000)555-8080	88811444410	11/15/77	F	09/01/03	09/01/03	(+)	A052748 PIERCE, HAWKEYE		1	7		454N8874586600 4477660QA *
CLAVEN, CLIFF 8686 BARSTOOL WAY, BEANTOWN, CA 05526 (000)555-6968	99977555500	02/28/96	M	09/01/03	09/01/03	(+)	A037482 BURNS, FRANK		2	7		85665885665800 55555555A

MCFMMR336_60_DAY_ELIG_101603.FM

SAMPLE "MEMBERS WHO HAVE BEEN ELIGIBLE FOR 60 DAYS" REPORT

1 PAGE : 6

FMMR336 (2)

H E A L T H N E T

Q/CARE PROVIDER ASSIGNMENT REGISTER - MEDI-CAL

ELIGIBILITY PERIOD : 12/01/03 - 12/31/03

REPORT DATE : 12/15/03

ELIGIBILITY REPORT

MEMBERS WHO HAVE BEEN ELIG FOR 90 DAYS (3)

>>>>>>>>>>>>>> PLEASE REFER TO THE HEALTH NET MEDI-CAL MANUAL FOR KEY TO REPORTS <<<<<<<<<<<<<

TAX ID : 233456789 - THE DOCTOR'S GROUP (5)

PROVIDER : A088877 - TALLULAH BELLE (6)

PROV ADDR : 7654 CROSSROADS STREET, CITY, CA ZIP

(7) PROVIDER COUNTY : 00
COUNTY NAME

(8) MEMBER NAME / ADDRESS/PHONE	(9) HN MEMBER ID	(10) D-O-B	(11) SEX	(12) 1ST ELIG EFF DATE	(13) PCP/CLNC EFF DATE	(14) ELIG STAT	(15) PRIOR PCP ID/NAME	(16) OHC CODE	(17) ETHNIC CODE	(18) LANG CODE	(19) PUB HLTH	(20) MEDI-CAL ID / CIN ID (21) / * = PSEUDO (22)
DICKENS, CHARLES 9410 67TH STR, PORT CHARLES, CA 05502 (000)555-8426	12312123400	01/18/94	M	07/01/03	07/01/03	(+)	G011111 KENOBI, BEN		3	7		24680246801357 78787878A
PLATH, SYLVIA 273 21ST STR, PORT CHARLES, CA 05502 (000)555-4700	57957957910	07/14/99	F	07/01/03	07/01/03	(+)	C033333 ORGANA, LEIA		2	7		13579135792468 48648648A
WHITMAN, WALT 7745 WRITERS ROW, PORT CHARLES, CA 05502 (000)555-4700	84994849400	09/21/91	M	07/01/03	07/01/03	(+)	C099999 NO PRIMARY M.D.		2	7		88877755522212 21232123A

MCFMMR336_90_DAY_ELIG_101603.FM

SAMPLE "MEMBERS WHO HAVE BEEN ELIGIBLE FOR 90 DAYS" REPORT

1 2 H E A L T H N E T PAGE : 1
FMXR337 MEDI-CAL
ELIGIBILITY REPORT
120 DAY INITIAL HEALTH ASSESSMENT REPORT (1) REPORT DATE : 03/14/03 (3)
MEMBERS WHO HAVE BEEN ELIGIBLE OVER 120 DAYS (2)
>>>>>>>>>>>>>> PLEASE REFER TO THE HEALTH NET MEDI-CAL MANUAL FOR KEY TO REPORTS <<<<<<<<<<<<<<

TAX ID :123456789 - JOHN TRAPPER PROVIDER COUNTY : 00
PROVIDER :A123456 - JOHN TRAPPER COUNTY NAME
PROV ADDR :1234 SERIALDRAMA STREET,CITY,CA,ZIP

MEMBER NAME / ADDRESS/PHONE	HN MEMB (4)	ID AGE (5)	D-O-B (6)	SEX	1ST ELIG EFF DATE (7)	PCP/CLNC EFF DATE	PRIOR PCP ID/NAME	OHC CODE	ETHN CODE	LANG CODE	DAYS ELIG (8)	MEDI-CAL ID CIN *=PSEUDO (9) (10)
BERGMAN, INGRID	61234567810	15	07/07/88	F	09/01/01	09/01/01	L055555		2	7	560	19123456789012
1234 40TH STR, CITY, CA ZIP	(000)123-4567						SKYWALKER,LUKE		(000)555-2222			01234567C
BOGART, HUMPHREY	23456789400	17	10/21/86	M	08/01/00	05/01/01	C033333		3	7	956	19823456789012
2345 41st STR, CITY, CA ZIP	(000)555-1948						ORGANA,LEIA		(000)555-3333			98765432A
GRABLE, BETTY	54567890110	6	02/04/97	F	07/01/02	07/01/02			1	7	257	19567890123456
6789 45TH STR, CITY, CA ZIP	(000) 555-7391											4567890QA*

1 2 H E A L T H N E T PAGE : 2
FMXR337 MEDI-CAL
ELIGIBILITY REPORT
120 DAY INITIAL HEALTH ASSESSMENT REPORT REPORT DATE : 03/14/03
MEMBERS WHO HAVE BEEN ELIGIBLE 91 - 120 DAYS (11)
>>>>>>>>>>>>> PLEASE REFER TO THE HEALTH NET MEDI-CAL MANUAL FOR KEY TO REPORTS <<<<<<<<<<<<<<

TAX ID :123456789 - JOHN TRAPPER PROVIDER COUNTY : 00
PROVIDER :A123456 - JOHN TRAPPER COUNTY NAME
PROV ADDR :1234 SERIALDRAMA STREET,CITY,CA,ZIP

MEMBER NAME / ADDRESS/PHONE	HN MEMB	ID AGE	D-O-B	SEX	1ST ELIG EFF DATE	PCP/CLNC EFF DATE	PRIOR PCP ID/NAME	OHC CODE	ETHN CODE	LANG CODE	DAYS ELIG	MEDI-CAL ID CIN *=PSEUDO
CRAWFORD, JOAN	53456789210	2	04/25/00	F	12/01/02	01/01/03	G055555		1	7	104	19456789012345
4567 43RD STR, CITY, CA ZIP	(000) 555-8765						FETT,BOBA		(000)555-5555			34567890B
GRANT, CARY	55678901200	14	08/07/88	M	12/01/02	12/01/02	G011111		3	7	104	19678901234567
7890 46TH STR, CITY, CA ZIP	(000) 555-2468						KENOBI,BEN		(000)555-6666			5678901QA*

(12)
NUMBER OF ELIGIBLE MEMBERS NEEDING HEALTH ASSESSMENT: 5

SAMPLE "120-DAY INITIAL HEALTH ASSESSMENT" REPORT

Health Net/Centene

- Trading Partner guidelines for 837 5010 professional and institutional submissions.
- To be added to HN 837 companion guides.

Items covered by this document

- ✓ ST / SE Standards
- ✓ ISA / GS Standards (encounter)
- ✓ Provider Id – Mandatory Required Fields

ST / SE Standards

All ST / SE standards are applied by our Clearinghouse FinThrive at Health Net's direction.

- Health Net requires at least one ST and one SE record per Submitter ID within a submission.
- This means that Health Net requires one ST and one SE for each unique occurrence of the 1000A NM109 Submitter ID field.
- We have noted that some submitters are sending a unique instance of ST/SE records for every claim/encounter within the submission. Our Translator is able to process a unique instance ST/SE combination.

FinThrive ISA / GS Standards to Health Net only.

Our standards are shown below.

837 Inbound Transaction (Health Net is the Receiver)

X12 Data Element	Description	Values Used	Comments
Clearinghouse Rule – for receiver id			
ISA07	Receiver Qualifier	30 or ZZ	30 or ZZ
ISA08	Receiver Id	As agreed, upon	Health Net of CA Tax Id (~~———~~)
Clearinghouse Rule – for GS03 field			
GS03	Receiver's Code	As agreed, upon	Identifies HN health plan encounters submission

Professional 837

Provider ID – Professional (See tables below)

1. **Billing Provider Name, NPI** and **Taxonomy** is required in Loop 2010AA. The Billing Provider state and zip code is required when the address is in the United States.
   Medicare Atypical Only: Professional NPI (1999999984) and DME NPI (199999999)
   Medi-Cal Atypical Only: Atypical Taxonomy Code, no Billing NPI, 2010 BB REF*G2 must contains 9 digits
2. **Referring Provider Name** and **NPI** is required in loop 2310A if referred. Required on DME Services
3. **Rendering Provider Name, NPI** and **Taxonomy** is required in loop 2310B if different that Billing Provider
4. **Service Facility Name** and **NPI** is required in loop 2310 if different than the Billing Provider.

Billing Provider **REQUIRED**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2000A	PRV	PRV01	BI	Provider Code
2000A	PRV	PRV02	PXC	Reference Qualifier
2000A	PRV	PRV03		Billing Provider Taxonomy Code
2010AA	NM1	NM103		Billing Provider Last Name/Org Name
2010AA	NM1	NM104		First Name **Required** if NM102 = 1 (Person and has First Name)
2010AA	NM1	NM108	XX	Qualifier
2010AA	NM1	NM109		Billing Provider NPI
2010AA	REF	REF01	EI or SY	ID Qualifier
2010AA	REF	REF02		Tax ID No. /Social Security No.
2010AA	REF	N301		Billing Provider Address
2010AA	REF	N401		Billing Provider City
2010AA	N4	N402		Billing Provider State
2010AA	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Referring Provider (Claim Level) Entity Type 1 = Person **REQUIRED if Referred or DME**

Loop Id	Segment Id	Reference Designator			Values	Descriptions
2310A	NM1	NM108			XX	Qualifier
2310A	NM1	NM109				Referring Provider NPI
2310A	REF	REF01			G2	Provider Commercial Number
2310A	REF	REF02			9999	Referring Provider Tribal Indicator - Used to identify a Tribal Provider

Rendering Provider (Claim Level) Entity Type 1 = Person **REQUIRED if different than Billing Provider in Loop 2010AA**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310B	NM1	NM103		Rendering Provider Last Name/Org Name
2310B	NM1	NM104		First Name **Required** if NM102 = 1 (Person and has First Name)
2310B	NM1	NM108	XX	Qualifier
2310B	NM1	NM109		Rendering Provider NPI
2310B	PRV	PRV01	PE	Provider Code
2310B	PRV	PRV02	PXC	Reference Qualifier
2310B	PRV	PRV03		Rendering Provider Taxonomy Code

2310B	REF	REF01	G2	Provider Commercial Number
2310B	REF	REF02	9999	Rendering Provider Tribal Indicator - Used to identify a Tribal Provider

Service Facility (Claim Level) **REQUIRED if different than Billing Provider Loop 2010AA)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310C	NM1	NM103		Laboratory of Facility Name
2310C	NM1	NM108	XX	Qualifier
2310C	NM1	NM109		Service Facility NPI
2310C	N3	N301		Billing Provider Address
2310C	N4	N402		Billing Provider State
2310C	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Professional Requirements:

Total Claim Charge Amount, Admission Date, Patient responsibility, Allowed Amount, Anesthesia Qualifier, Co-Pay, Co-insurance, Deductible, Ambulance Transport, In and Out of Network Indicator, UD Modifier, National Drug Code (*PAD*), DRG, Newborn Submission, Duplicate logic, Twin Logic, Same Procedure Code submission and VAR (*Void/Adjustment/Replacement*)- Professional (***See requirement details below***)

1. **Total Claim Charge Amount** (Loop 2300 CLM02) Medicare encounter cannot be less than 0 or greater than 99,999.99. Medi-Cal cannot be less than 0 or any amount over 1 million.

2. **Admission Date** is required on all inpatient medical visits. Admission date must be equal to or less than from Service line From Date.

3. **Patient responsibility** amount AMT*F5 is required if Loop 2430 contains CAS PR 1, 2 or 3. If Loop 2430 does not contain CAS*PR* (1, 2 or 3) do not send.

4. **Allowed Amount** - This is a CMS requirement. The HCP*10 (loop 2400) segment at the line level is required on all capitated encounters submission. HCP02 Allowed Amount must be 0 or greater.

5. **Anesthesia Qualifier Requirement (**Loop 2400 SV103) must be **MJ** when procedure code qualifier (SV101-03, 04, 05, 06) is an anesthesia **Service Line Quantity Qualifier (**Loop 2400 SV103) must be **MJ** when procedure code qualifier (SV101-03, 04, 05, 06) is an anesthesia modifier (AA, AD, QK, QX, QY or QZ). Per CMS services that contain an **anesthesia procedure code must be submitted with the appropriate anesthesia modifier in the first position**. Additional modifiers QS, G8 and G9 are to be placed in the second position. ***Additional Modifier QS will be added to our logic third quarter of 2024.

6. **Patient coinsurance, copayment and deductible** is required on all professional (*Medicare, Commercial & ACA*) encounters in **Loop 2430** in the x12 837 **CAS*PR*1, 2 or 3** segment when patient responsibility is greater than 0. The total CAS PR values must match Loop 2300 AMT*F5 value.

7. **Ambulance Transport** is required on all professional encounters when billing for ambulance or non-emergency transportation. (**CLM05-01 is '41' or '42'**).

8. **In and Out of Network** is required in Loop 2300 HCP15 in the x12 837 when known.

9. Service lines that have a **340B physician-administered drug** should include the "**UD**" modifier in the procedure code qualifier positions (Loop 2400 SV101).

10. **National Drug Code (NDC)** (Loop 2410 LIN03) is required on all outpatient Physician-Administered Drugs (PADs). A PAD is any covered drug provided or administered to a patient which is billed by a provider other than a pharmacy. Includes any method of administration and is not limited to injectable drugs.

11. **National Drug Code (NDC) Loop 2410 CPT04** unit count quantity is required to be greater than 0 (zero).

12. **DRG Codes** are not allowed in Medi-Cal capitated encounter records. They will be rejected by DHCS if submitted.

13. **Newborn Submission**

Current Guideline to submit Newborn encounters is within 30 days of birth.

- CM = Commercial, MC = Medicare, ACA = Affordable Care Act, ** ML = MediCal

** Guideline to submit Newborn encounters month of birth plus next month. – Effective Date: 10/23/2023

- ML = MediCal

Newborn can be submitted as a subscriber in Loop 2010BA, Subscriber Name field and in ID field a father's ID or a mother's ID can be submitted depending on the product line:

- Father's ID or Mother's ID (CM, MC, ACA)
- Mother's ID (ML)

Below is the example:

Newborn can be billed as a subscriber:

If the Newborn does NOT have eligibility from the date of birth

HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1* Newborn Last Name*Newborn First Name****MI*Subscriber ID (ML- Mother's CIN ID) ~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

OR

Newborn is billed as a dependent

In loop 2000C Patient Information **PAT*19** Individual Relationship Segment (child/dependent) and in loop 2010CA **NM1*QC**, submit newborn information in this segment and Subscriber can be submitted as a father or a mother depending on the product line:

- Father's Information or Mother's Information (CM, MC, ACA)
- Mother's Information (ML)

Or in some cases the first name can be submitted under PAT*19 as a "BABY" and the last name as BOY or GIRL.

Below is the example:

HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID ~
NM1*PR*2*HEALTH NET*****PI* 954402957~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Newborn Last Name* Newborn First Name ~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~

DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

OR
Newborn is billed as a subscriber:
If the Newborn has eligibility from the date of birth
Submit the newborn as the subscriber in Loop 2010BA Subscriber Name NM1 segment.

Below is the example:
HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Subscriber DOB*Subscriber Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

14. **Duplicate logic (MediCal LOB Only)** *to align with DHCS duplicate logic guideline, bolded in **red** below are the fields added – **Effective 10/23/23***
    - Member ID
    - Date(s) of Service – 2400 DTP*472 DTP03 *(can be a range)*
    - Rendering Provider *(NM1*82)* NPI, none present then Billing provider *(NM1*85)* NPI
    - Procedure Code – 2400 SV101-2 ***First time submission, can be sent more than once (Effective 11/18/2024)***
    - Procedure Modifier(s) – 2400 SV101-3,4,5,6
    - NDC Drug code – 2410 LIN03 – *(Drug code is used when it is present).*
    - Place of service
    - Frequency code
    - Remittance/Processed date *(DTP*573)* greater
    - To appropriately represent encounters for the same service that can be performed multiple times in a day, these modifiers **59, 76, 77 and XS** can be used to override the duplicate validation logic. ***Use of these modifiers is strictly monitored by DHCS***.

Duplicate logic (Medicare LOB) - – *Effective 04/29/24*

- Member ID
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
- Rendering Provider (NM1*82) NPI, none present then Billing provider (NM1*85) NPI
- **Paid Amount** - 2320 AMT02 field, AMT01 =" D", AMT02 = Paid Amount
- Procedure Code 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- **Line Level Billed Amount**- 2400 SV102
- **Line level Paid Amount** -2430 SVD02
- NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
- Place of Service
- Frequency code
- Remittance/Processed date (DTP*573) greater

Duplicate logic (**Commercial & Dual LOB**)

- Member ID
- Date(s) of Service – 2400 DTP*472 DTP03 *(can be a range)*
- Rendering Provider *(NM1*82)* NPI, none present then Billing provider *(NM1*85)* NPI
- Procedure Code – 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- NDC Drug code – 2410 LIN03 – *(Drug code is used when it is present).*
- Place of service
- Frequency code
- Remittance/Processed date *(DTP*573)* greater

15. **Twin Logic**: Member's ID, Date of Birth (DOB) and the First name.

16. If the **same procedure code** is submitted more than once on the same date of service, than it must contain a unique modifier or NDC code.

17. **VAR** (*Void/Adjustment/Replacement*) **requirement:** A claim Frequency Code is required on all professional capitated encounters at the claim level Loop 2300 CLM05-03 segment) with a greater process date in service line loop 2430 DTP*573 than the previously accepted.
    a. Frequency code 1 indicates the original encounter
    b. Frequency code 7 indicates a replacement to a previously submitted encounter
    c. Frequency code 8 indicates a voided encounter

Claim Information (Claim Level)

Loop Id	Segment Id		Reference Designator	Values	Descriptions
2300	CLM		CLM05-03	1,7,8	Frequency Type Code 1 = Original 7 = Replacement/Adjustment 8 = Void

Patient Amount Paid (Claim Level) - REQUIRED if Loop 2430 Patient Responsibility is greater than 0)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	AMT	AMT01	F5	Qualifier
2300	AMT	AMT02	Greater than 0	Monetary Amount – Patient Responsibility Amount greater than Zero (0). *Value of 0 cannot be accepted, if zero, please remove segment.* It AMT*F5* is greater than zero (0) must send CAS*PR*(1, 2 or 3) in Loop 2430.

Payer Claim Control Number (Claim Level) REQUIRED if Frequency Code 7 or 8 is sent in CLM05-03)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	REF	REF01	F8	Original Reference ID Number
2300	REF	REF02		Payer Original Claim Control Number

Ambulance Transport Information (Claim Level) REQUIRED when CLM05-01 is '41' or '42')

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	CR1	CR101	LB	Unit or Basis for Measurement Code (Pound) – Required if known
2300	CR1	CR102		Patient Weight - Required if known

2300	CR1	CR104	(A, B, C, D, or E)	Ambulance Transport Reason
2300	CR1	CR105	DH	Unit or Basis for Measurement Code (Miles)
2300	CR1	CR106		Transport Distance

Condition Information (Claim Level) **REQUIRED when condition information applies to claim)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	HI01	BG	Qualifier
2300	HI	HI02		Condition Code

Claim Pricing Repricing Information (Claim Loop) **REQUIRED if known**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HCP	15	3, 6	In and Out of Network Indicator 1 or 3 = Out of Network 6 = In Network

Admission Date (Claim Level) **REQUIRED on Inpatient claims, = to or less than Statement From Date**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	DTP	DTP01	435	Admission Qualifier
2300	DTP	DTP02	D8 (CCYYMMDD)	Date Time Period Format Qualifier
2300	DTP	DTP03		Admission Date and Hour

Ambulance Transport Pick-Up Location (Claim Level) **REQUIRED when CLM05-01 is '41')**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310E	NM1	NM101	PW	Entity Identifier Code
2310E	NM1	NM102	2	Entity Type Qualifier (Non-Person)
2310E	N3	N301		Pick-up Address
2310E	N4	N401		Pick-up City
2310E	N4	N402		Pick-up State if in USA or Canada
2310E	N4	N403		Pick-up Zip Code if in USA or Canada
2310E	N4	N404		Pick-up Country if outside USA or Canada

Ambulance Transport Drop-Off (Claim Level) **REQUIRED when CLM05-01 is '41'**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310F	NM1	NM101	45	Entity Identifier Code
2310F	NM1	NM102	2	Entity Type Qualifier (Non-Person)
2310F	NM1	NM103		Last Name or Organization Name of Ambulance transport drop-off location (Required if known)

Other Subscriber Information (Claim Level) **REQIRED to send Patient Responsibility and Adjustment Reason Codes**

Loop Id	Segment Id	Reference Designator	Values	Descriptions

2000B	SBR	SBR01	S	S = Secondary
2000B	SBR	SBR02	18	Required if loop 2000C is NOT present
2000B	SBR	SBR09		Insurance Type Code 16 = HMO Medicare Risk CI = Commercial HM = Health Maintenance Org
2320	SBR	SBR01	P	Payer Responsibility Sequence Number Code
2320	AMT	AMT01	D	Payor Amount Paid Qualifier
2320	AMT	AMT02	0 or greater	Payer Paid Amount (0 or greater) Must balance to the sum of the SVD service line(s) amount in Loop 2340 NOTE: If Loop 2320 CAS is present Loop 2430 SVD02 minus (-) Loop 2320 CAS Monetary Amount(s) = AMT D
2320	OI	OI03	N, Y, W	Yes/No Condition or Response Crosswalk of CLM08
2320	OI	OI06	I, Y	Release of Information Code Crosswalk of CLM09
2320	MOA	MOA02		HCPCS Payable Amount Required to report Medicare 100% Allowed Amount

Other Subscriber Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2330A	NM1	NM1		Other Subscriber Name
2330A	NM1	NM108		Identification Code Qualifier
2330A	NM1	NM109		Identification Code Delegated Medical Groups Member ID / Subscriber ID
2330B	NM1	NM103		Payer Name Last or Organization Name
2330B	NM1	NM108	PI	Identification Code Qualifier
2330B	NM1	NM109		Identification Code

Line Pricing / Repricing Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2400	SV1	SV101-03,04,05,06	UD	Service lines that have a 340B physician-administered drug should include the “UD” modifier in one of the four available modifier positions.
2400	K3	K301	EHB	Essential Health Benefit Indicator
2400	HCP	HCP01	10	Other Pricing - Required on Medicare encounters
2400	HCP	HCP02	0 or greater	Service Line Allowed Amount – Required on Medicare encounters

Line Adjudication Information (Line Level) **REQUIRED when Patient Responsibility is greater than 0)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2430	SVD	SVD01		Other Payer Primary Identifier (same as Loop 2330B NM109)
2430	SVD	SVD02	0 or greater	Monetary Amount – Cannot be a negative number - Required on Medicare encounters NOTE: Loop 2400 SV103 (Prof) Line-Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary Amount(s) = SVD02
2430	SVD	SVD03		Procedure Code

2430	SVD	SVD05		Quantity
2430	CAS	CAS01	CO, CR, OA, PI, PR	Line Adjustment Group Code CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions **PR = Patient Responsibility** NOTE: When submitting **Member Cost Share** use code **PR** and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below.
2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17		Line Adjustment Reason Code CAS*PR*1,2,3 **Member Cost Share (PR qualifier), reason codes:** 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
2430	CAS	CAS03, CAS06, CAS09 CAS12, CAS15, CAS18		Monetary Amount
2430	DTP	DTP01	573	Payment Date
2430	DTP	DTP02	D8	
2430	DTP	DTP03		CCYYMMDD Payment/Remittance Date

Drug Identification (Line Level) **REQUIRED if procedure code requires a Physician-Administered Drug (PAD)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2410	LIN	LIN02	N4	Qualifier
2410	LIN	LIN03		11digit National Drug Code without hyphens
2410	CTP	CTP04	Greater than 0	National Drug Unit Count
2410	CTP	CTP05		Composite Unit of Measure
2410	CTP	CTP05-1	F2, GR, ME, ML, UN	Unit or Basis for Measurement code

Institutional 837

Provider ID scenarios – Institutional (See tables below)

1. **Billing Provider Name, NPI and Taxonomy** is required in loop 2010AA. The Billing Provider state and zip code is required when the address is in the United States.
   MEDICARE Atypical Only: Institutional NPI (1999999976) and DME NPI (1999999992 –Inst)
   Medi-Cal Atypical Only: Atypical Taxonomy Code, no Billing NPI, 2010 BB REF*G2 must contains 9 digits

2. **Attending Provider Name NPI and Taxonomy** must be provided in the loop 2310A when the encounter record contains any service other than non-scheduled transportation.

3. **Service Facility Name** and **NPI** is required in loop 2310E if different than Billing Provider.

4. **Referring Provider Name** and **NPI** is required in loop 2310F when known. Required on DME

5. **Rendering Provider Name** and **NPI** is required in Loop 2310D if different than Attending Provider.

Billing Provider (Claim Level REQUIRED)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2000A	PRV	PRV01	BI	Provider Code
2000A	PRV	PRV02	PXC	Reference Qualifier
2000A	PRV	PRV03		Billing Provider Taxonomy Code
2010AA	NM1	NM103		Billing Provider Name Last or Organization Name
2010AA	NM1	NM108	XX	Qualifier
2010AA	NM1	NM109		Billing Provider NPI
2010AA	REF	REF01	EI	Employer's ID No. Qualifier
2010AA	REF	REF02		Tax ID
2010AA	N3	N301		Billing Provider Address
2010AA	N4	N401		Billing Provider City
2010AA	N4	N402		Billing Provider State
2010AA	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Attending Physician (Claim Level) **REQUIRED when the claim contains any services other than non-scheduled transportation**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310A	NM1	NM103		Attending Provider Name Last or Organization Name
2310A	NM1	NM104		First Name REQUIRED when person has a first name
2310A	NM1	NM108	XX	Qualifier
2310A	NM1	NM109		Referring Provider NPI
2310A	PRV	PRV01	AT	Provider Code
2310A	PRV	PRV02	PXC	Reference Qualifier
2310A	PRV	PRV03		Rendering Provider Taxonomy Code

Operating Physician (Claim Level) **Entity Type 1 = Person**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310B	NM1	NM108	XX	Qualifier
2310B	NM1	NM109		Operating Provider NPI

Rendering Provider (Claim Level) **Entity Type 1 = Person REQUIRED if different than Attending**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310D	NM1	NM103		Provider Name Last or Organization Name
2310D	NM1	NM104		First Name REQUIRED when person has a first name
2310D	NM1	NM108	XX	Qualifier
2310D	NM1	NM109		Rendering Provider NPI
2310D	REF	REF01	G2	Provider Commercial Qualifier

2310D	REF	REF02	9999	Rendering Provider Tribal Indicator - Used to identify a Tribal Provider.

Service Facility (Claim Level) **REQUIRED if different than Billing Provider Loop 2010AA**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310E	NM1	NM103		Laboratory of Facility Name
2310E	NM1	NM108	XX	Qualifier
2310E	NM1	NM109		Service Facility NPI
2310E	N3	N301		Billing Provider Address
2310E	N4	N402		Billing Provider State
2310E	N4	N403	9 digits	Billing Provider Zip Code Note: Last 4 digits cannot be 0000 or 9999; the new default value is 9998.

Referring Provider (Claim Level) **Entity Type 1 = Person**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2310F	NM1	NM108	XX	Qualifier
2310F	NM1	NM109		Referring Provider NPI
2310F	REF	REF01	G2	Provider Commercial Qualifier
2310F	REF	REF02	9999	Referring Provider Tribal Indicator - Used to identify a Tribal Provider

Institutional Requirements:

Total Claim Charge Amount, Patient Responsibility, Admission Date, Discharge Hours, Admitting Diagnosis, Patient Reason for Visit Code, Present on Admission, In and Out of Network Indicator, Allowed Amount, Patient Responsibility, National Drug Code (PAD), and HIPPS Codes

1. **Total Claim Charge Amount** (Loop 2300 CLM02) Medicare encounter cannot be less than 0 or greater than 99,999,999.99. Medi-Cal cannot be less than 0 any amount over 1 million.

2. The **patient responsibility amount** AMT*F3 is required if Loop 2430 CAS PR 1, 2 or 3 is on any service line in Loop 2430. If no Loop 2430 CAS PR 1, 2 or 3 is submitted do not send.

3. **Admission Date and Admitting Diagnosis Code** is required on all inpatient visits. Patient Reason for Visit is required on certain outpatient visits. Admission date must be equal to or less than Statement from Date.

4. **Discharge Hours** is required in Loop 2300 in the X12 837 DTP*096 segment, when an inpatient service is submitted. This is a **DHCS** requirement.

5. **Present on Admission (POA)** Indicator is required on Inpatient claims Principal Diagnosis, Other Diagnosis, and External Cause of Injury Diagnosis Codes.

6. **In and Out of Network** is required in Loop 2300 HCP15 in the x12 837 when known.

7. **Allowed Amount** - This is a CMS requirement. The HCP*10 segment at the line level (Loop 2400) is required on all capitated encounters submission. HCP02 Allowed Amount must be 0 or greater.

8. **Patient coinsurance, copayment and deductible** is required in Loop 2430 in the x12 837 **CAS*PR*1, 2 or 3** segment when Patient Responsibility is greater than 0. The total CAS PR values must match AMT*F3

9. Service lines that have a **340B physician administered drug** should include the "**UD**" modifier in modifier position (Loop 2400 SV202).

10. The **National Drug Code (NDC)** Loop 2410 LIN03 is required on all outpatient Physicians-Administered Drugs (PADs). A PAD is any covered drug provided or administered to a patient which is billed by a provider other than a pharmacy. Includes any method of administration and is not limited to injectable drugs.

11. **National Drug Code (NDC) Loop 2410 CPT04** unit count quantity is required to be greater than 0 (zero).

12. **Skilled Nursing Facility and Home Health** Medicare and CMC services only must be submitted in the 837-institutional format with at least one HIPPS code on the encounter. SNFs and HHAs encounters must contain a valid (HP) HIPPS code when REV code 0022, 0023, 0024 are present. Effective **01/15/24** - Health Net will be accepting HIPPS codes on the **Medi-Medi** product line to algin with DHCS guidelines. As per DHCS a Medi-Medi/Crossover recipient is identified as eligible for both Medicare and Medi-Cal product type in which case Medicare is responsible for a portion of the encounter and Medi-Cal is responsible for any remaining coverage. 1. If a Medi-Medi/Crossover encounter is submitted, and the member is a Health Net Medicare member, then the encounter will be accepted and processed as Medicare. 2. If a Medi-Medi/Crossover encounter is submitted and the member is not a Health Net Medicare member, then the Claim Filing Indicator on the encounter must be **SBR09 = **MA, MB or 16** in either Loop 2000B, loop 2320, or both in order to accept the HIPPS Codes, otherwise the encounter will be rejected

13. **Duplicate logic process – (Commercial & Dual LOB)**
    - Member ID
    - Statement Date (Loop 2400-line level date *DTP*472 (can be a range),* if not present, then Loop 2300 claim level date *DTP*434*)
    - Attending Provider *(NM1*71)* NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider *(NM1*85)* NPI is required)
    - Procedure Code, – 2400 SV201-2
    - Procedure Modifier(s) – 2400 SV201-3,4,5,6
    - NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
    - Bill Type
    - Frequency code
    - Remittance/Processed date *(DTP*573)* greater

14. **Duplicate logic process - (MediCal lob only)** *to align with DHCS duplicate logic guideline, bolded in **red** below are the fields added – Effective 10/23/23.*
    - Member ID
    - Statement Date (Loop 2400-line level date *DTP*472 (can be a range),* if not present, then Loop 2300 claim level date *DTP*434*)
    - Attending Provider *(NM1*71)* NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider *(NM1*85)* NPI is required)
    - **Rendering Provider** *(NM1*82)*
    - **Revenue Code (Outpatient & Inpatient) – 2400 SV201**
    - **Admission Date/Hour - 2300 DTP*435/DTP03 *(can be a date or a date/time)***
    - **Discharge Hour - 2300 DTP*096 / DTP03**
    - Procedure Code, – 2400 SV201-2
    - Procedure Modifier(s) – 2400 SV201-3,4,5,6
    - NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
    - Bill Type
    - Frequency code
    - Remittance/Processed date *(DTP*573)* greater
    - **Diagnosis Code - (ICM-10 CM) Z38.30 - Z38.8 (**Diagnosis applies to multiple newborns only)**

    - To appropriately represent encounters for the same service that can be performed multiple times in a day, these modifiers **59, 76, 77 and XS** can be used to override the duplicate validation logic. *Use of these modifiers is strictly monitored by DHCS.*

Duplicate logic (Medicare LOB) - – *Effective 02/12/24*

Medicare Institutional Outpatient Duplicate logic - CHANGES

Member ID
Statement Date (2400 DTP*472 DTP03 (can be a range) if not present Loop 2300 DTP*434)
Attending Provider (NM1*71) NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider (NM1*85) NPI is required)
Paid Amount (2320 AMT02 field, AMT01 =" D", AMT02 = Paid Amount)
Revenue Code – 2400 SV201 – Outpatient ONLY
Procedure Code 2400 SV201-2
Procedure Modifier(s) – 2400 SV201-3,4,5,6
Line Level Billed Amount - 2400 SV203
Line Level Paid Amount - 2430 SVD02
NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
Bill Type
Frequency code
Remittance/Processed date (DTP*573) greater

Medicare Institutional Inpatient Duplicate Logic: NO CHANGES

Member ID
Statement Date (2400 DTP*472 DTP03 (can be a range) if not present Loop 2300 DTP*434)
Attending Provider (NM1*71) NPI (except non-scheduled transportation services submitted with the REV codes – 540-549 then Billing provider (NM1*85) NPI is required)
Procedure Code 2400 SV201-2
Procedure Modifier(s) – 2400 SV201-3,4,5,6
NDC Drug code – 2410 LIN03 – Drug code is used when it is present.
Bill Type
Frequency code
Remittance/Processed date (DTP*573) greater

****Multiple Newborn**

- To report the same service that was performed for the mother and the baby or babies, these modifiers **25, XE, XP, and XU** can be used to override the newborn duplicate validation logic.

15. **Twin Logic**: Member's ID, Date of Birth (DOB) and the First name.

16. **Newborn Submission**

Current Guideline to submit Newborn encounters is within 30 days of birth.
- CM = Commercial, MC = Medicare, ACA = Affordable Care Act, ** ML = MediCal

** Guideline to submit Newborn encounters month of birth plus next month. – Effective Date: 10/23/23
- ML = MediCal

Newborn can be submitted as a subscriber in Loop 2010BA, Subscriber Name field and in ID field a father's ID or a mother's ID can be submitted depending on the product line:

- Father's ID or Mother's ID (CM, MC, ACA)
- Mother's ID (ML)

Below is the example:
Newborn can be billed as a subscriber:
If the Newborn does NOT have eligibility from the date of birth
HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1* Newborn Last Name*Newborn First Name****MI*Subscriber ID (ML- Mother's id) ~

N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~
OR
Newborn is billed as a dependent

In loop 2000C Patient Information **PAT*19** Individual Relationship Segment (child/dependent) and in loop 2010CA **NM1*QC**, submit newborn information in this segment and Subscriber can be submitted as a father or a mother depending on the product line:

- Father's Information or Mother's Information (CM, MC, ACA)
- Mother's Information (ML)

Or in some cases the first name can be submitted under PAT*19 as a "BABY" and the last name as BOY or GIRL.

Below is the example:

HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID ~
NM1*PR*2*HEALTH NET*****PI* 954402957~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*Newborn Last Name* Newborn First Name ~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Newborn DOB*Newborn Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

OR
Newborn is billed as a subscriber:
If the Newborn has eligibility from the date of birth
Submit the newborn as the subscriber in Loop 2010BA Subscriber Name NM1 segment.

Below is the example:
HL*2*1*22*1~
SBR*S**1145A******HM~
NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID~
N3*100 DOWNTOWN RD~
N4*ELK GROVE*CA*922209999~
DMG*D8*Subscriber DOB*Subscriber Gender type~
CLM*12340*100***13>B>1*Y*A*Y*Y~
LX*1~
DTP*472*D8*Date of Service~

17. If the **same procedure code** is submitted more than once on the same date of service, than it must contain a unique modifier or NDC code.

18. **Allowed Amount** - This is a CMS requirement. The HCP*10 (Loop 2400) segment at the line level is required on all professional and institutional capitated encounters. HCP02 Allowed Amount must be 0 or greater.

19. **VAR** (*Void/Adjustment/Replacement*) **requirement:** A claim Frequency Code is required on all institutional capitated encounters at the claim level Loop 2300 CLM05-03 segment) with a greater process date in service line loop 2430 DTP*573 than the previously accepted. **DHCS** will only accept Frequency code – 1,7,8.
    a. Frequency code 1 indicates the original encounter
    b. Frequency code 6 indicates an adjustment to a previously submitted institutional encounter
    c. Frequency code 7 indicates a replacement to a previously submitted encounter
    d. Frequency code 8 indicates a voided encounter
    e. Frequency codes 1 – 9 are used in institutional encounters

Claim Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	CLM	CLM05-03	1,2,3,4,6,7,8	Frequency Type Code 1 = Original 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 6 = Adjustment 7 = Replacement 8 = Void

Admission Date (Claim Level) REQUIRED on Inpatient claims, = to or less than 24 hours from Statement From Date

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	DTP	DTP01	435	Admission Qualifier
2300	DTP	DTP02	D8 (CCYYMMDD), DT (CCYYMMDDHHMM)	Date Time Period Format Qualifier
2300	DTP	DTP03		Admission Date and Hour

Patient Estimated Amount Due (Claim Level) REQUIRED if Loop 2430 Patient Responsibility is greater than 0

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	AMT	AMT01	F3	Qualifier
2300	AMT	AMT02		Monetary Amount – Patient Responsibility Amount greater than Zero (0). *Value of 0 cannot be accepted, if zero, please remove segment.* If AMT*F3* greater than zero (0) must send CAS*PR*(1, 2 or 3) in Loop 2430.

Payer Claim Control Number (Claim Level) REQUIRED if Frequency Code 6, 7 or 8 is sent in CLM05-03

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	REF	REF01	F8	Original Reference ID Number
2300	REF	REF02		Payer Original Claim Control Number

Principle Diagnosis (Claim Level) REQUIRED on all encounters

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	ABJ or BJ	Qualifier
2300	HI	-02		Admitting Diagnosis Code

2300	HI	-09	N , Y, U, W	Present on Admission Indicator

Admitting Diagnosis (Claim Level) **REQUIRED on inpatient encounter**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	ABJ or BJ	Qualifier
2300	HI	-02		Admitting Diagnosis Code

Patient Reason for Visit (Claim Level) **REQUIRED on outpatient visits**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	APR or PR	Qualifier
2300	HI	-02		Patient Reason for Visit

External Cause of Injury (Claim Level) **Report external cause of injury, poisoning, or adverse effect – series of 3 required**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	ABN or BN	Qualifier
2300	HI	-02		External Cause of Injury Code
2300	HI	-09	N , Y, U, W	Present on Admission Indicator

Condition Code (Claim Level) **REQUIRED when condition information applies to claim**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HI	-01	BG	Condition Code Qualifier
2300	HI	-02		Condition Code

Claim Pricing Repricing Information (Claim Level) **REQUIRED if known**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2300	HCP	15	3, 6	In and Out of Network Indicator 1 or 3 = Out of Network 6 = In Network

Other Subscriber Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2000B	SBR	SBR01	S	S = Secondary
2000B	SBR	SBR02	CI or 16	Insurance Type Code 16 = HMO Medicare Risk CI = Commercial HM = Health Maintenance Org
2320	SBR	SBR01	P	Payer Responsibility Sequence Number Code
2320	AMT	AMT01	D	Payor Amount Paid Qualifier
2320	AMT	AMT02	0 or greater	Payer Paid Amount (0 or greater)

				Must balance to the sum of the SVD service line(s) amount in Loop 2340
2320	OI	OI03	N, Y, W	Yes/No Condition or Response NOTE: Crosswalk of Loop 2300 CLM08
2320	OI	OI06	I, Y	Release of Information Code NOTE: Crosswalk of Loop 2300 CLM09
2320	MOA	MOA02	0 or greater	HCPCS Payable Amount Required to report Medicare Allowed Amount

Other Subscriber Information (Claim Level)

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2330A	NM1	NM1		Other Subscriber Name
2330A	NM1	NM108		Identification Code Qualifier
2330A	NM1	NM109		Identification Code Delegated Medical Groups Member ID / Subscriber ID
2330B	NM1	NM103		Payer Name Last or Organization Name
2330B	NM1	NM108	PI	Identification Code Qualifier
2330B	NM1	NM109		Payer Identification Code
2330B	DTP	DTP01	573	Date Time Qualifier
2330B	DTP	DTP02	D8	Format Qualifier
2330B	DTP	DTP03		CCYYMMDD Payment/Process Date

Line Pricing / Repricing Information (Line Level) REQUIRED on Outpatient, Home Health or Inpatient SNF

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2400	SV2	SV201		Revenue Code
2400	SV2	SV202	**HC** - CPT/HCPCS code ER - Health Insurance Prospective Payment System **HP** - HIPPS IV - HIEC WK - DC-10	Procedure Code -- REQUIRED on outpatient HP Qualifier: Medicare/MediCal - SNFs and HHAs encounters must contain a valid (HP) HIPPS code when REV code 0022, 0023, or 0024 is present.
2400	SV2	SV202-03,04,05,06	UD	Service lines that have a 340B physician administered drug should include the “UD” modifier in one of the four available modifier positions.
2400	HCP	HCP		Other Subscriber Name
2400	HCP	HCP01	10	Other Pricing - Required on Medicare encounters
2400	HCP	HCP02	0 or greater	Service Line Allowed Amount - Required on Medicare encounters

Line Adjudication Information (Line Level) REQUIRED when Patient Responsibility is greater than 0

Loop Id	Segment Id	Reference Designator	Values	Descriptions

2430	SVD	SVD01		Payer Primary Identifier - Required on Medicare encounters NOTE: Must match Loop 2330B NM109 Payer Identification Code
2430	SVD	SVD02	0 or greater	Monetary Amount – Cannot be a negative number NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV203 (Insti) Line-Item Charge Amount
2430	SVD	SVD03		Procedure Code
2430	SVD	SVD04		Revenue Code
2430	SVD	SVD05		Quantity
2430	CAS	CAS01	CO, CR, OA, PI, PR	Line Adjustment Group Code CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions **PR = Patient Responsibility** NOTE: When submitting **Member Cost Share** use code **PR** and include the appropriate Claim Adjustment Reason Code in (CAS02) (1,2,3) as listed below.
2430	CAS	CAS02, CAS05, CAS08 CAS11, CAS14, CAS17		Line Adjustment Reason Code PR (1, 2, 3) **Member Cost Share (PR qualifier), appropriate reason codes:** 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
2430	CAS	CAS03, CAS06, CAS09 CAS12, CAS15, CAS18		Monetary Amount NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV103 (Prof) or SV203 (Inst) Line-Item Charge Amount
2430	DTP	DTP01	573	Date Time Qualifier
2430	DTP	DTP02	D8	Format Qualifier
2430	DTP	DTP03		CCYYMMDD Payment Date

Drug Identification **(Line Level)** **REQUIRED if procedure code requires a Physician-Administered Drug (PAD)**

Loop Id	Segment Id	Reference Designator	Values	Descriptions
2410	LIN	LIN02	N4	Qualifier
2410	LIN	LIN03		11 Digit National Drug Code without hyphens
2410	CTP	CTP03		Unit Price
2410	CTP	CTP04	Greater than 0	National Drug Unit Count
2410	CTP	CTP05		Composite Unit of Measure
2410	CTP	CTP05-1	F2, GR, ME, ML, UN	Unit or Basis for Measurement Code

Health Net, LLC

HIPAA 837 Institutional Transaction Standard Companion Guide

Refers to the Health Care Claim: Institutional 837 Implementation Guides Based on X12 version 005010X223A2

Companion Guide Version Number: 2.0

February 22, 2019

Disclosure Statement

This Companion Guide describes the EDI requirements for the submission of CA and Arizona Encounters to Health Net. Throughout the remainder of this document Health Net will be referred to HNT to describe the All Regions of Health Net.

Preface

This Companion Document to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Health Net, LLC HNT. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
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1 Introduction

1.1 Scope

This Companion document supports the implementation of a batch processing application.

HNT will accept inbound submissions that are formatted correctly in X12 terms. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide.

HNT EDI applications will edit for these conditions and reject files that are out of compliance.

This companion document will specify everything that is necessary to conduct EDI for this standard transaction. This includes;

- Specifications on the communications link
- Specifications on the submission methods
- Specifications on the transactions

1.2 Overview

This companion guide compliments the ASC X12N implementation guide currently adopted from HIPAA. As of 2007 this companion guide has been amended to include the National Provider Identifier requirements for the 837 X12 transaction.

This companion guide will be the vehicle that HNT uses with its trading partners to further qualify the HIPAA adopted implementation guide. This companion guide is compliant with the corresponding HIPAA implementation guide in terms of data element and code sets standards and requirements.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are;

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Trading partner profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

- 837 (005010X223A2)

1.4 Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between trading partners. The computer system generating the transactions must supply complete and accurate information while the system receiving the transactions must be capable of interpreting and utilizing the information in ASC X12N format, without human intervention.

The transactions must be sent in a specific format that will allow our computer application to translate the data. Health Net LLC (HNT)

supports the standard transactions adopted from HIPAA. HNT maintains a dedicated staff for the purpose of enabling and processing X12 EDI transmissions with its trading partners.

It is the goal of HNI to establish trading partner relationships and to conduct EDI as opposed to paper information flows whenever and wherever possible.

1.5 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.
HIPAA covered healthcare providers that choose to submit transactions electronically, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, the National Provider Identifier (NPI) is meant to be a lasting identifier, and would not change based on changes in a health care provider's name, address, ownership, membership in health plans or Healthcare Provider Taxonomy classification.
HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans (including Health Net), must use only the NPI in the primary identifier position to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

This companion guide has been updated to reflect how the NPI will be integrated in the 837 X12 transaction.

2 Getting Started

2.1 Working with Health Net, LLC

Contact HNT EDI Dept. for all EDI related customer service requests. (See contact information in section 5 below.)

There are three units within HNT that work internally to complete EDI service requests from our trading partners.

The first unit is Health Net's EDI Operations Dept. This group will serve as the trading partner's central point of contact. This group will also facilitate the implementation of trading partners through all steps of external testing.

The second unit is Health Net's Electronic File Transfer (EFT) team, an IT infrastructure group. This is a technical team that implements the communication link and ensures that trading partner to payer connectivity is established properly.

The third unit is Health Net's EDI IT Translator team. This group is responsible for our inbound and outbound X12 Translator applications.

2.2 Trading Partner Registration

To register as a trading partner with HNT the following sequence of events will take place.

1. Initial conversations are held between the trading partner and HNT.
2. Verbal agreements are reached as to the transactions that will be conducted.
3. A trading partner agreement and associated companion guides are provided and reviewed.
4. Submitter Id and Receiver Id is established for the purpose of identification.
5. Required trading partner profiling is built into our EDI translator.
6. Test files are exchanged and test runs conducted.
7. Once a brief testing phase is completed and a trading partner agreement is in place the trading partner is registered.

2.3 Certification and Testing Overview

HNT requires its trading partners to show evidence of third party certification. This is consistent with industry standard conventions that have been adopted for HIPAA Transaction and Code Sets implementation.

HNT will also show evidence of third party certification for standard transactions.

This requirement exists so that the process to test and implement a trading partner for the purpose of conducting EDI with standard transactions is a smooth and efficient process.

The complexity of X12 files when not tested and certified by a third party will cause delays in the ability to enable the X12 submissions in a production environment.

HNT wants to spend the majority of the testing period time, working with prospective trading partners on the agreed components of this companion document rather than X12 or HIPAA implementation guide syntax.

HNT will be certified from Claredi incorporating the following WEDI/SNIP levels of testing where applicable:
Level 1, Integrity Testing (X12 Syntax)
Level 2, Requirement Testing (HIPAA Implementation Guide Syntax)
Level 3, BalancingTesting (i.e. 835 claim line balancing to the claim document)
Level 4, Situation Testing (Use of Situational Segments that business relevant
Level 5, Code Sets Testing
Level 6, Product Types/Types of Service Testing (i.e. provider specialties)

3 Testing with the Payer

HNT would like to establish with the trading partner a set of scenarios that are intended for testing. This can be a high level description of the contents of the transaction. It should be a representation or cross section of the majority of conditions that will be encountered with production data from these transactions.

HNT requires testing be completed with all trading partners. The testing phase will consist of several smaller phases of testing, as appropriate.

3.1 HIPAA Compliance Testing

HNT uses an industry standard data translator, General Electric Information Systems (GEIS) now know as GXS to validate transactions meet the 6 levels of HIPAA compliance, and to translate them into an acceptable format for internal processing. The 997/999 Acknowledgement will be tested during this phase. Any issues identified during this phase of testing will have to be addressed in order for subsequent phases to continue.

3.2 Trading Partner Agreement Testing

Trading partner specific setup, as defined in either the trading partner agreement or companion guide will be verified. Generally, this will be done in conjunction with Compliance testing.

3.3 Functional and Regression Testing

Once the transactions have successfully tested through GXS and trading partner specifics, they will be processed through our internal system to ensure they are handled appropriately. Response transactions will be generated during this phase, where applicable.

3.4 Parallel Testing

Depending on the stage of the HNT implementation, a period of parallel testing may be required. This would involve sending the current proprietary transaction format, as well as, sending the same transactions in the x12 format, to our test system. This phase will allow for the comparative analysis necessary to ensure appropriate handling by our system.

4 Connectivity with the Payer / Communications

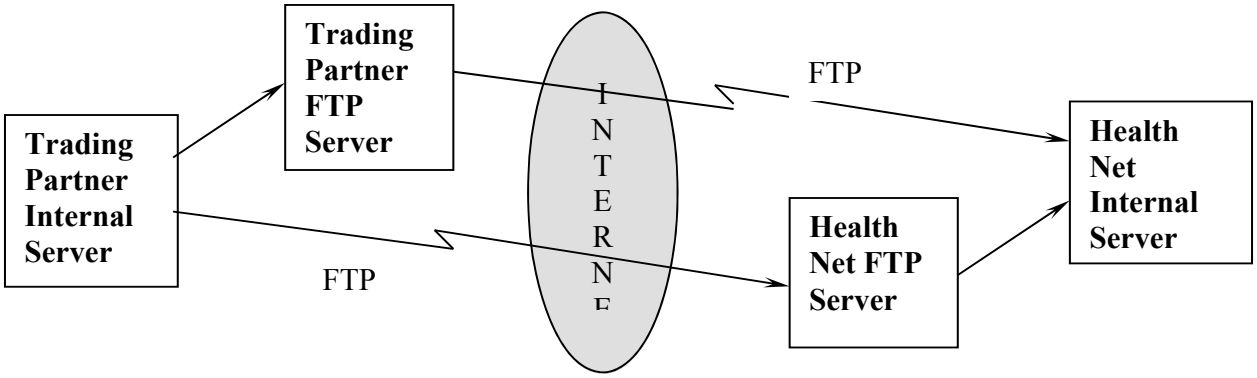
4.1 Process flows

Three file exchange methods are supported to enable batch data file transmission; (1) FTP of encrypted data over the Internet, (2) use of Connect: Direct (NDM) over the AT&T AGNS (formerly Advantis) SNA network, and (3) FTP over frame relay for trading partners with very high volumes.

4.1.1 FTP of Encrypted data over the Internet

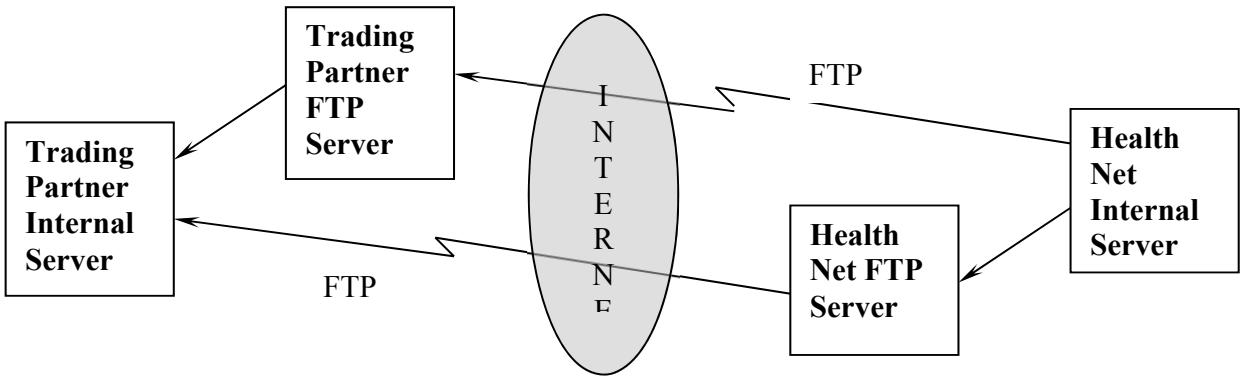
One method of exchanging data files is encrypting the file, sending it over the Internet where it is then decrypted. For data inbound to Health Net (see Figure 4.1), the trading partner would encrypted the data on an internal server and then transfer to either a trading partner owned FTP server or to Health Net's FTP server. Then, Health Net will retrieve the encrypted file from either the trading partner FTP server or from Health Net's FTP server to an internal server where the file is decrypted and processed.

Figure 4.1.1A
FTP of Encrypted Data over the Internet from Trading Partner to Health Net



For data outbound from Health Net (see Figure 4.2), Health Net will generate the X12 data file and encrypt it. Once encrypted, the file will be sent either to Health Net's FTP server or the trading partners FTP server. Then the trading partner can retrieve the file from the appropriate FTP server, transfer it to their internal system, and encrypt it and process.

Figure 4.1.1B
FTP of Encrypted Data over the Internet from Health Net to Trading Partner



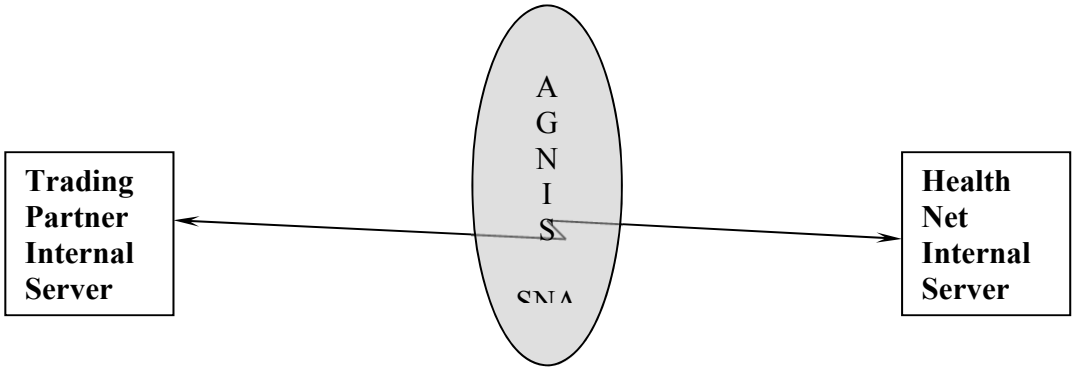
4.1.2 Use of Connect: Direct (NDM) over the AT&T AGNS (Advantis) SNA Network

Data may also be exchanged over the AT&T AGNS (formerly Advantis) SNA network (see Figure 4.3). The transmission software must Sterling Commerce Connect: Direct (formerly NDM). For data inbound to Health Net, the trading partner will make the data file available on their internal server. Health Net will retrieve the data from the trading partner server with Connect: Direct (preferred) or the trading partner my initiate the transfer and send the data to Health Net's internal server.

Data outbound from Health Net takes just the opposite path with either Health Net (preferred) or the trading partner initiating the file transfer.

Data transferred over the AGNS network may be encrypted or sent in clear text.

Figure 4.1.2
Connect: Direct Transfer over the AT&T AGNS Network

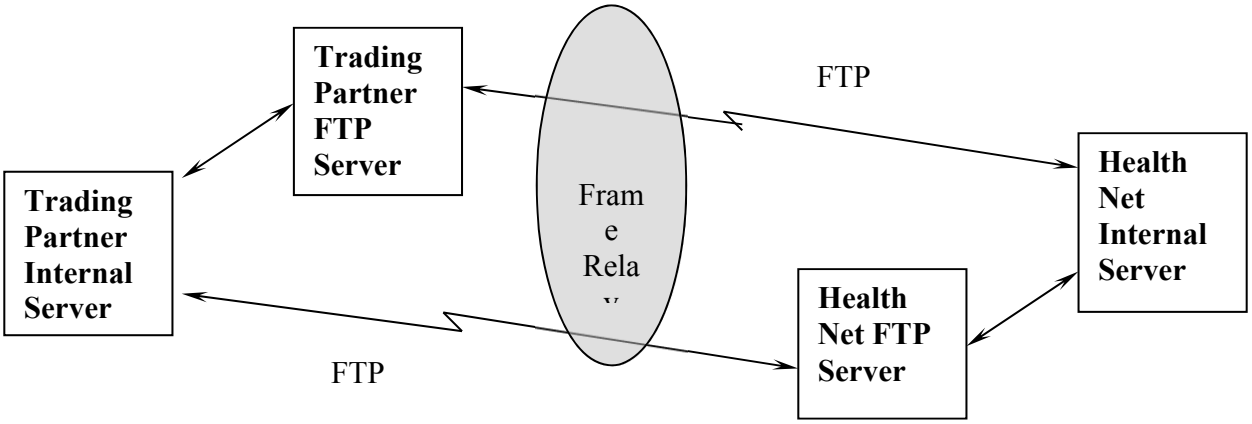


4.1.3 FTP Over Frame Relay

For trading partners with very large data volume to exchange with Health Net, a private virtual circuit may be established over a frame relay link (see Figure 4.4). Once established, data will be exchanged similarly to the FTP over the Internet approach except the data will not flow over the Internet.

Data transferred over the frame relay network may be encrypted or sent in clear text.

Figure 4.1.3
FTP Over Frame Relay



4.2 Transmission Administrative Procedures

Before establishing data communications with Health Net, a trading partner relationship must exist. As part of the process establishing the relationship, Health Net and the trading partner must exchange certain technical information. This information is needed by both parties in order to establish communications.

The information requested will include:

1. Contacts; business, data and communications
2. Dates; testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, user ID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be retransmitted, the trading partner will contact their primary contact at Health Net. At that time, procedures will be followed for Health Net to accept and re-transmit a file.

4.3 Communication protocol specifications

4.3.1 FTP over the Internet

The following items are required to exchange data with Health Net utilizing FTP over the Internet. The trading partner is responsible for the acquisition and installation of these items. This list assumes that Health Net FTP server will be used.

1. Internet Connectivity, if large files will be exchanged, then the trading partner should consider a broadband connection.
2. Computer with FTP client and connectivity to the Internet.
3. PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with Health Net via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include confirming FTP connectivity, exchanging PGP public keys and performing end-to-end communications testing.

Before sending data to Health Net, the data must be encrypted with PGP and then sent to the Health Net FTP using the FTP client over the Internet connection. When receiving data from Health Net, the FTP client will be used to get the data from the Health Net FTP server after which PGP will be used to decrypt the data.

4.3.2 Connect: Direct over the AT&T AGNS

The following items are required to exchange data with Health Net utilizing Connect: Direct (formerly NDM) over the AT&T AGNS network (formerly Advantis).

1. SNA Connectivity to the AT&T AGNS network.
2. Connect: Direct software loaded and configured on an applicable host system. Health Net runs Connect: Direct on an OpenVMS system. Not all Connect: Direct versions are compatible with Connect: Direct for OpenVMS. The trading partner must confirm that their version is compatible.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with Health Net via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Connect: Direct parameters (APPLID, LUs, etc.), submission of security requests to AT&T and end-to-end communications testing.

Using Connect: Direct, data may be “pushed” or “pulled” by either party. Health Net prefers to initiate the connection. Data is exchanged when one party initiates a Connect: Direct session with the other and either “pushes” or “pulls” a file to/from the other party.

4.3.3 FTP over Frame Relay

This method of communications is only appropriate for trading partners with a very high and frequent volume. The initial setup of this method can be lengthy.

The following items are required to exchange data with Health Net utilizing FTP over Frame Relay.

1. Connectivity to a Frame Relay network common with Health Net.
2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with Health Net via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Frame Relay PVC parameters and submission of a request to the frame relay carrier for connectivity. Once connectivity is established at the frame relay level, this method is similar to the FTP over the Internet method.

4.4 Passwords

Health Net requires the uses of UserIDs and Passwords to access it's systems and servers. If Health Net's FTP server is to be used to exchange data, Health Net will assign each trading partner a unique UserID and password. The UserID and other information will be communicated with the trading partner via e-mail. However, the password will be communicated via another method such as phone or fax.

In the event a trading partner forgets their password, Health Net will change the password after verifying the authenticity of the request.

Likely, Health Net will not utilize a trading partner owned FTP server that is not protected with a UserID and password.

4.5 Encryption

Health Net requires the encryption of data that is exchanged via the Internet or any other public network. Health Net utilizes PGP with 1024 or 2048 bit keys for file encryption.

5 Contact information

5.1 HNT EDI Department

HNT EDI Dept. is the central point of contact for all trading partner EDI activity including questions relating to file submissions. They will internally route EDI questions to one of three EDI areas for resolution.

Once resolution is reached, trading partners will receive a response from this same central EDI Dept.

The three areas within HNT EDI that work on EDI customer service issues are.

- HNT IT EDI Translator Team (EDI ITG Team)
- HNT IT Payer Connectivity and Infrastructure EFT Team
- HNT EDI Business Operations Team

Contact Phone number for EDI Dept is:
NE and AZ 1-866-334-4638
CA and OR 1-800-977-3568

6 Control Segments / Envelopes

6.1 ISA-IEA

See Section 10.

6.2 GS-GE

See Section 10.

6.3 ST-SE

See Section 10.

7 Payer Specific Business Rules and Limitations

- All monetary amounts are to include decimal points with two positions allowed to the right of the decimal point to represent cents.
- HNNE encourages the use of HNNE Group and Plan Information
- ICD-9 Procedure codes and dates are required by Health Net for all claims
- ICD-9 codes should not include the decimal point
- ICD-10 codes are not to be sent until mandated cutover date
- Condition code should be limited to a length of 5
- Treatment code and Value code should be limited to a length of 10
- Commercial Member numbers are alpha-numeric. They begin with an R or an HN. Medi-Cal members should submit the Medi-Cal ID.

8 Acknowledgements and or Reports

997/999 and 277CA Acknowledgement will be sent so the trading partner will get confirmation that we received their 837submission.

9 Trading Partner Agreements

- HNT is internally reviewing an industry standard draft for a trading partner agreement at this time.

10 Transaction Specification Information

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
C.3	Interchange Control Header	ISA01	R	Author Info Qualifier	2/2	00 – No Authorization Information Present
		ISA02	R	Author Information	10/10	Spaces
		ISA03	R	Security Info Qualifier	2/2	00 – No Security Information Present
		ISA04	R	Security Information	10/10	Spaces
		ISA05	R	Interchange Sender Qualifier	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA06	R	ISA Sender ID	15/15	(**As agreed upon**)
		ISA07	R	Interchange Receiver Qualifier	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA08	R	ISA Receiver ID	15/15	HNT Tax ID - 954402957 (**As agreed upon**)
		ISA09	R	Interchange Date	6/6	Date of Transmission (YYMMDD)
		ISA10	R	Interchange Time	4/4	Time of Transmission (HHMM)
		ISA11	R	Repetition Separator	1/1	
		ISA12	R	Interchange Control Version Number	5/5	00501
		ISA13	R	ISA Control Number	9/9	Control number assigned by the sender, Must be identical to control number in IEA02
		ISA14	R	Acknowledgement Indicator	1/1	**1** - Send TA1, **0** - Do not send TA1
		ISA15	R	Usage Indicator	1/1	**T** - Test, **P** - Production
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
C.7	Functional Group Header	GS01	R	Functional Identifier Code	2/2	**HC** - Health Care Claim (837)
		GS02	R	GS Sender's Code	2/15	(**As agreed upon**)
		GS03	R	GS Receiver's Code	2/15	HNCA-ENC (**As agreed upon**)
		GS04	R	Group GS Date	8/8	Functional group creation date (CCYYMMDD)
		GS05	R	Group GS Time	4/8	Functional group creation time (HHMM)
		GS06	R	Group Control Number	1/9	Control number assigned by the sender
		GS07	R	Responsible Agency Code		**X** Accredited Standards Committee X12

		GS08	R	Version /Release ID Code	1/12	005010X223A2
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
67	Transaction Set Header	ST01	R	Transaction Set Identifier Code	3/3	**837** Health Care Claim: Institutional
		ST02	R	Transaction Set Control Number	4/9	Unique control number assigned by sender's translator
		ST03	R	Transaction Set Version	1/35	005010X223A2
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
68	Beginning of Hierarchical Transaction	BHT01	R	Hierarchical Structure Code	4/4	**0019** Code identifying the purpose of a transaction set
		BHT02	R	Transaction Set Purpose Code	2/2	00 - Original 18 - Reissue
		BHT03	R	Originator Application Transaction Identifier	1/50	
		BHT04	R	Application Creation Date	8/8	CCYYMMDD
		BHT05	R	Application Creation Time	4/8	
		BHT06	R	Claim or Encounter Indicator	2/2	Identifies cap vs. fee for service claims RP - Reporting (**Encounters/ Capitation**)
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
71	1000A	NM101	R	Entity Identifier Code	2/3	**41 Submitter**
		NM102	R	Entity Type Qualifier	1/1	**1** person **2** non-person
		NM103	R	Submitter Name	1/60	
		NM104	S	Submitter First Name	1/35	
		NM105	S	Submitter Middle Name	1/25	
		NM106 NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	**46** Electronic Transmitter ID Number (ETIN).
		NM109	R	Submitter Identifier	2/80	9-digit HNT Submitter ID (**Assign by Health Net**)
		NM110- NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
73	1000A	PER01	R	Contact Function Code	2/2	**IC** Inbound
		PER02	S	Submitter Contact Name 1	1/60	
		PER04/06/08	R	Contact Telephone Number 1	1/256	**PER03,05,07=TE**
		PER06/08	R	Contact Telephone Extension 2	1/256	**PER05,07=EX**
		PER04/06/08	R	Contact Fax number 1	1/256	**PER03,05,07=FX**
		PER04/06/0	R	Contact Email Address 1	1/256	**PER03,05,07=EM**

		8				
		PER02	S	Submitter Contact Name 2	1/60	**IC** Used if more contact information needed.
		PER04/06/08	S	Contact Telephone Number 2	1/256	**PER03,05,07=TE**
		PER06/08	S	Contact Telephone Extension 2	1/256	**PER05,07=EX**
		PER04/06/08	S	Contact Fax number 2	1/256	**PER03,05,07=FX**
		PER04/06/08	S	Contact Email Address 2	1/256	**PER03,05,07=EM**
		PER09				Not Used by HIPAA
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
76	1000B	NM101	R	Entity Identifier Code	2/3	**40** Receiver
		NM102	R	Entity Type Qualifier	1/1	**2** Non-Person
		NM103	R	Receiver Name	1/60	
		NM104-NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	**46** Electronic Transmitter ID Number (ETIN).
		NM109	R	Receiver Identifier	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
78	2000A	HL01	R	Hierarchical ID Number	1/12	
		HL02	R	Hierarchical Parent ID Number	1/12	
		HL03		Hierarchical Level Code	1/2	20 – Information Source
		HL04		Hierarchical Child Code	1/1	1 – Additional Subordinate
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
80	2000A	PRV01	R	Provider Code	1/3	**BI** Billing
		PRV02	R	Reference Identification Qualifier	2/3	**PXC** Provider Taxonomy Code
		PRV03	R	Billing Provider Taxonomy Code	1/50	
		PRV04-PRV06		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
81	2000A	CUR01	R	Entitiy Identifier Code	2/3	**B5** currency for Billing provider
		CUR02	R	Currency Code	3/3	
		CUR03-CUR21		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
84	2010AA	NM101	R	Entitiy Identifier Code	2/3	**85** Billing Provider
		NM102	R	Entity Type Qualifier	1/1	**2** Organization
		NM103	**R**	Billing Provider Name	1/60	

		NM104-NM107		Not Used by HIPAA		
		NM108	**R**	Identification Code Qualifier	1/2	**XX** HIPAA National Provider ID
		NM109	**R**	Billing Provider Primary ID XX	2/80	**REQUIRED**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
87	2010AA	N301	R	Billing Provider Address 1	1/55	
		N302	S	Billing Provider Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
88	2010AA	N401	R	Billing Provider City	2/30	
		N402	R	Billing Provider State	2/2	
		N403	R	Billing Provider Zip Code	3/15	Nine digit Zip Code
		N404	S	Billing Provider Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Billing Provider Sub Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code** **S**	**Name**	**Length**	Notes/Comments
90	2010AA	REF01	R	Reference Identification Qualifier	2/3	**EI** Employer's identification number
		REF02	R	Billing Provider Secondary ID **EI**	1/50	**REQUIRED**
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
91	2010AA	PER01	R	Contact Function Code		**IC** Informtion Contact
		PER02	S	Billing Provider Contact Name 1	1/60	
		PER04/06/08	S	Contact Telephone Number 1	1/256	**PER03,05,07 = TE**
		PER06/08	S	Contact Telephone Extension 1	1/256	**PER05,07 = EX**
		PER04/06/08	S	Contact Fax Number 1	1/256	**PER03,05,07 = FX**
		PER04/06/08	S	Contact Email Address 1	1/256	**PER03,05,07 = EM**
		PER02	S	Billing Provider Contact Name 2	1/60	**IC** Used if more Billing Provider contact
		PER04/06/08	S	ContactTelephone Number 2	1/256	**PER03,05,07 = TE**
		PER06/08	S	ContactTelephone Extension 2	1/256	**PER05,07 = EX**
		PER04/06/08	S	Contact Fax Number 2	1/256	**PER03,05,07 = FX**
		PER04/06/08	S	Contact Email Address 2	1/256	**PER03,05,07 = EM**
		PER09		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code** **S**	**Name**	**Length**	Notes/Comments
94	2010AB	NM101	R	Entity Identifier Code	2/3	**87** Pay-to Provider

		NM102	R	Entity Type Qualifier	1/1	**2** Organization
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
107	2000B	NL01		Hierarchical ID Number	1/12	
		HL02		Hierarchical Parent ID Number	1/12	
		HL03		Hierarchical Level Code	1/2	22 – Subscriber
		HL04		Hierarchical Child Code	1/1	0 – No Subordinate 1 – Additional Subordinate
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
109	2000B	SBR01	R	Payer Responsibility Sequence Number Code	1/1	COB Payment Sequence Indicator P - Primary S - Secondary T - Tertiary A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven U - Unknown
		SBR02	S	Individual Relationship Code	2/2	Individual Relationship Code 18 - Self, if patient is subscriber. Blank otherwise
		SBR03	S	Insured Group or Policy Number	1/30	Subscriber's group number
		SBR04	S	Insured Group Name	1/60	Subscriber's group name
		SBR05-SBR08		Not Used by HIPAA		
		SBR09	S	Claim Filing Indicator Code	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity 16 - HMO Medicare Risk AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS CI - Commercial Insurance Company DS - Disability HM - HMO LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined
`Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
112	2010BA	NM101	R	Entity Identifier Code	2/3	**IL** Insured or Subscriber
		NM102	R	Entity Type Code	1/1	**1** (person) **2** (non-person)

		NM103	R	Subscriber Last Name	1/60	
		NM104	S	Subscriber First Name	1/35	
		NM105	S	Subscriber Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Subscriber Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	½	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use)*
		NM109	R	Subscriber Primary ID	2/80	HN Member ID or Medi-Cal ID
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
115	2010BA	N301	R	Subscriber Address 1	1/55	
		N302	S	Subscriber Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
116	2010BA	N401	R	Subscriber City Name	2/30	
		N402	S	Subscriber State	2/2	
		N403	S	Subscriber Zip Code	3/15	
		N404	S	Subscriber Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Subscriber Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
118	2010BA	DMG01	R	Date Time Period Format Qualifier	2/3	**D8** Date
		DMG02	R	Subscriber Birth Date	1/35	
		DMG03	R	Subscriber Gender Code	1/1	F - Female M - Male U - Unknown
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
120	2010BA	REF01	R	Reference Identification Qualifer	2/3	**SY** Social security number (cannot be used for Medicare)
		REF02	R	Subscriber Secondary ID SY	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
121	2010BA	REF01	R	Reference Identification Qualifier	2/3	**Y4** Property/Casualty Agency identification number
		REF02	R	Subscriber Secondary ID Y4	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
122	2010BB	NM101	R	Entity Identifier Code	2/3	**PR** Payer
		NM102	R	Entity Type Qualifer	1/1	**2** Non-Person Entity
		NM103	R	Payer Name	1/60	Health Net of CA, Healthnet of Arizona, (based on payer id)

		NM104-NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	R	Payer Primary ID	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
124	2010BB	N301	R	Payer Address 1	1/55	
		N301	S	Payer Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
125	2010BB	N401	R	Payer City Name	2/30	
		N402	S	Payer State	2/2	
		N403	S	Payer Zip Code	3/15	
		N404	S	Payer Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Payer Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
127	2010BB	REF01	R	Reference Identification Qualifier	2/3	**2U** Supplemental payer id number **FY** Claim office number **EI** Federal Taxpayer's ID Number
		REF02	R	Payer Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
129		REF01	R	Reference Identification Qualifier	1/50	**LU** Provider Location ID Number **G2** Provider Commercial ID Number
		REF02	R	Billing Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
131	2000C	HL01		Hierarchical ID Number	1/12	
		HL02		Hierarchical Parent ID Number	1/12	
		HL03		Hierarchical Level Code	1/2	23 - Dependent
		HL04		Hierarchical Child Code	1/1	0 – No Subordinate
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
133	2000C	PAT01	R	Dependent Relationship Code	2/2	01 - Spouse 03 - Father or Mother Stepson or Stepdaugher 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship

		PAT02-PAT09		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
135	2001CA	NM101	R	Entity Qualifier Code	2/3	**QC** Patient
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Dependent Last Name	1/60	
		NM104	R	Dependent First Name	1/35	
		NM105	S	Dependent Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Dependent Suffix Name	1/10	
		NM108-NM111		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
137	2010CA	N301	R	Dependent Address 1	1/55	
		N302	S	Dependent Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
138	2010CA	N401	R	Dependent City Name	2/30	
		N402	R	Dependent State	2/2	
		N403	R	Dependent Zip Code	3/15	
		N404	S	Dependent Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Dependent Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
140	2010CA	DMG01	R	Date Time Period Format Qualifier	2/3	**D8** Date
		DMG02	R	Dependent Birth Date	1/35	
		DMG03	R	Dependent Gender Code	1/1	F - Female M - Male U - Unknown
		DMG04-DMG11		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
142	2010CA	REF01	R	Reference Identification Qualifer	2/3	**Y4** Property/Casualty Agency identification number
		REF02	R	Dependent Secondary ID Y4	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
142	2010CA	REF01	R	Reference Identification Qualifer	2/3	**1W** Property/Casualty Patient Identifier **SY** Property/Casualty Patient Identifier
		REF02	R	Patient Identifier ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
143	2300	CLM01	R	Patient Account Number	1/38	Patient account number assigned by submitter's system

		CLM02	R	Total Claim Charge Amount	1/18	
		CLM03 CLM04		Not Used by HIPAA		
		CLM05-1	R	Facility Type Code	1/2	1st and 2nd positions of Uniform Bill Type code. CLM05-2 Always 'A'
		CLM05-3	R	Claim Frequency Code	1/1	3rd position of Uniform Bill Type code 1 = Admit thru Discharge 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 6 = Adjustment 7 = Repalcement 8 = Void **NOTE: REF*F8 is required if 3, 4, 5, 6,7, or 8**
		CLM06		Not Used by HIPAA		
		CLM07	S	Provider Accept Assignment Code	1/1	Indicates whether provider accepts assignment. A - Assigned B – Assignment Accepted on Clinical Lab Services Only C - Not Assigned
		CLM08	R	Assignment of Benefits Indicator	1/1	Indicates whether insured has authorized benefits to be assigned to the provider Y - Yes N - No W - Not Applicable
		CLM09	R	Release of Information Indicator	1/1	Indicates whether the provider has a signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim
		CLM10- CLM19		Not Used by HIPAA		
		CLM20	S	Delay Reason Code	1/2	1 - Proof of Eligibility Unknown or Unavailable 2 - Litigation, 3 - Authorization Delays 4 - Delay in Certifying Provider, 5 - Delay in Supplying Billing Forms 6 - Delay in Delivery of Custom-made Appliances 7 - Third Party Processing Delay, 8 - Delay in Eligibility Determination 9 - Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules 10 - Administration Delay in the Prior Approval Process 11 - Other 15 - Natural Disaster
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
149	2300	DTP01	R	Date/Time Qualifier	3/3	096 - Discharge
		DTP02	R	Date Time Period Format Qualifier	2/3	TM
		DTP03	R	Discharge Hour	1/35	**096** Time patient was discharged

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
150	2300	DTP01	R	Date/Time Qualifier	3/3	**434** Statement
		DTP02	R	Date Time Period Format Qualifier	2/3	**RD8** Date Range
		DTP03	S	Date Time Period	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
151	2300	DTP01	R	Date/Time Qualifier	3/3	**435** Admission
		DTP03	R	Date Time Period Format Qualifier	1/35	**D8** Date or **DT** Date + Time
		DTP03	S	Date Time Period	1/35	**Required on Inpatient**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
152	2300	DTP01	R	Date/Time Qualifier		**050** Received
		DTP02	R	Date Time Period Format Qualifier		**D8** Date
		DTP03	R	Repricer Received Date	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
153	2300	CL101	R	Priority (Type) of Admission or Visit	1/1	Addendum 223A2 changed usage from S to R and element name
		CL102	S	Point of Origin for Admission or Visit	1/1	Addendum 223A2 changed element name
		CL103	R	Patient Status Code	1/2	
		CL104		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
154	2300	PWK01	R	Attachment Report Type Code	2/2	61 possible codes. See code list on pages 183-184 of HIPAA Guidelines.
		PWK02	R	Attachment Transmission Code	1/2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only (X12 275) EM - Email FX - By Fax
		PWK03 PWK04		Not Used by HIPAA		
		PWK05		Identification Code Qualifier	1/2	**AC** Attachment Control Number
		PWK06	S	Attachment Control Number	2/80	
		PWK07- PWK09		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
158	2300	CN101	R	Contract Type Code	2/2	01 - DRG 02 - Per Diem 03 - Variable Per Diem 04 - Flat 05 - Capitated 06 - Percent 09 - Other
		CN102	S	Contract Amount	1/18	
		CN103	S	Contract Percentage	1/6	Allowance or charge percent
		CN104	S	Contract Code	1/50	
		CN105	S	Terms Discount Percentage	1/6	

		CN106	S	Contract Version Identifier	1/30	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
160	2300	AMT01		Amount qualifier Code	1/3	**F3 Patient Amount Paid/Responsibility**
		AMT02	R	Patient Responsibility Amount	1/18	Monetary Amount – Patient Amount Paid/Responsibility. **REQUIRED If Loop 2430 CAS*PR 1,2 or 3 is present. Value of all CAS*PR must match AMT*F3*Amount**
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
161-175	2300	REF01	R	Reference Identification Qualifier	2/3	**D9** VAN/Clearinghouse unique per claim ID **F8 ICN/DCN** **LX** IDE number **4N** Special Payment Reference Number **G4** PRO Approval Number **G1** Prior authorization number **9F** Referral number **EA** Medical record number **P4** Demonstration Project Identifier **LU** State of Record of Auto Accident. **9A** Repricer's claim number **9C** Repricer's claim number for a previously adjusted (resubmitted) claim
		REF02	R	Reference Identification Number	1/50	**NOTE: Required if CLM05-03 = 6,7, or 8 Payer Claim Control Number**
		REF03 REF04		Not Used by HIPAA		Ambulatory Patient Reference Numbers removed
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
181	2300	CRC02	R	Certification Condition Code Applies Indicator	1/1	**ZZ** Mutually Defined N - No, Y - Yes
		CRC03	R	Certification Condition Code 1	2/3	AV - Available - Not Used (Patient refused referral) NU - Not Used (Must be used when CRC02=N) S2 - Under Treatment (Patient currently under treatment for referred diagnostic or corrective health problem) ST - New Services Requested
		CRC04	S	Certification Condition Code 2	2/3	See CRC03 for expected codes.
		CRC05	S	Certification Condition Code3	2/3	See CRC03 for expected codes.
		CRC06 CRC07		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
184	2300	HI01-1	R	Principal Diagnosis Qualifier	1/3	BK - ICD-9 ABK - ICD-10
		HI01-2	R	Principal Diagnosis Code	1/30	
		HI01-3-HI01-8		Not Used by HIPAA		
		HI01-9	S	Principle Diagnosis POA Indicator	1/1	Y - Yes N - No U - Unknown W - Not Applicable 1 – Filler **Required on certain Inpatient**
		HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments

187	2300	HI01-1	R	Admitting Diagnosis Qualifier	1/3	BJ = ICD-9 ABJ= ICD-10
		HI01-2	R	Admitting Diagnosis	1/30	if present, next HI segment in loop. **Required on Inpatient**
		HI01-3-HI01-9 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
189	2300	HI01-1	R	Patient Reason for Visit Qualifier	1/3	PR=ICD-9 APR=ICD-10
		HI01-2	S	Patient Reason for Visit	1/30	**Required on Outpatient visits**
		HI01-3-HI01-9		Not Used by HIPAA		
		HI02-1	R	Patient Reason for Visit Qualifier	1/3	PR=ICD-9 APR=ICD-10
		HI02-2	S	Patient Reason for Visit	1/30	
		HI02-3-HI02-9		Not Used by HIPAA		
		HI03-1	R	Patient Reason for Visit Qualifier	1/3	PR=ICD-9 APR=ICD-10
		HI03-2	S	Patient Reason for Visit	1/30	
		HI03-3-HI03-9 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
193	2300	HI01-1	R	External Cause of Injury Qualifier - 1	1/3	BN=ICD-9 ABN=ICD-10
		HI01-2	S	External Cause of Injury Code - 1	1/30	Also known as E-Code.
		HI01-3-HI01-8		Not Used by HIPAA		
		HI01-9	S	Other Diagnosis 1 POA Indicator	1/1	N - No U - Unknown W - Not Applicable Y – Yes **Required on certain Inpatient**
		HI02-1	R	External Cause of Injury Qualifier - 2	1/3	BN=ICD-9 ABN=ICD-10
		HI02-2	S	External Cause of Injury Code - 2	1/30	Also known as E-Code.
		HI02-3-HI02-9		Not Used by HIPAA		
		HI03-1	R	External Cause of Injury Qualifier - 3	1/3	BN=ICD-9 ABN=ICD-10
		HI03-2	S	External Cause of Injury Code - 3	1/30	Also known as E-Code.
		HI03-3-HI03-8 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
218	2300	HI01-2	S	Diagnosis Related Group Code	1/30	**DR** Also known as DRG Group Code.
		HI03-3-HI03-9 HI02-HI12		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments **Segment Repeat 2**
220	2300	HI01-01 – HI12-01	R	Other Diagnosis Qualifier	1/3	Segment 1. BN=ICD-9 ABN=ICD-10
		HI01-02 – HI12-02	R	Other Diagnosis 1	1/30	

		HI01-09 - HI12-09	S	Other Diagnosis 1 POA Indicator	1/1	N - No U - Unknown W - Not Applicable Y – Yes **Required on certain Inpatient**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
239	2300	HI01-1	R	Principal Procedure Code Qualifier	1/3	BR=ICD-9 ABR=ICD-10 CAH=Advanced Billing Concepts
		HI01-2	R	Principal Procedure Code	1/30	
		HI01-4	R	Principal Procedure Date	1/35	**D8**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments **Segment Repeat 2**
242	2300	HI01-01 – HI12-01	R	Other Procedure Code 1-12 Qualifier	1/3	Segment 1. BQ=ICD-9 ABQ=ICD-10
		HI01-02 – HI12-02	R	Other Procedure Code 1-12	1/30	Additional procedure
		HI01-03 – HI12-03	R	Other Procedure 1-12 Date	1/35	**D8**
		HI01-04 – HI12-04	R	Date Time Period	8	**CCYYMMDD**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
258	2300	HI01 - 2	R	Occurrence Span Code - 1	1/30	Segment 1. **BI** Occurrence Span
		HI01 - 4	R	Occurrence Span From Date - 1	1/35	**RD8** Date Range
		HI01 - 4	R	Occurrence Span To Date - 1	1/35	
		HI02 - 2	S	Occurrence Span Code - 2	1/30	**BI** Occurrence Span
		HI02 - 4	S	Occurrence Span From Date - 2	1/35	**RD8** Date Range
		HI02 - 4	S	Occurrence Span To Date - 2	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
271	2300	HI01 - 2	R	Occurence Code 1	1/30	Segment 1. **BH** Occurrence
		HI01 - 4	R	Occurrence Code Date 1	1/35	**D8** Date
		HI02 - 2	S	Occurence Code 2	1/30	**BH** Occurrence
		HI02 - 4	S	Occurrence Code Date 2	1/35	**D8** Date
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
284	2300	HI01 - 2	R	Value Code-1	1/30	**BE** Value
		HI01 - 5	R	Value Code Amount-1	1/18	
		HI02 - 2	S	Value Code-2	1/30	**BE** Value
		HI02- 5	S	Value Code Amount-2	1/18	
		HI03 - 2	S	Value Code-3	1/30	**BE** Value
		HI03- 5	S	Value Code Amount-3	1/18	
		HI04 - 2	S	Value Code-4	1/30	**BE** Value
		HI04- 5	S	Value Code Amount-4	1/18	
		HI05 - 2	S	Value Code-5	1/30	**BE** Value
		HI05- 5	S	Value Code Amount-5	1/18	
		HI06 - 2	S	Value Code-6	1/30	**BE** Value
		HI06- 5	S	Value Code Amount-6	1/18	
		HI07 - 2	S	Value Code-7	1/30	**BE** Value
		HI07- 5	S	Value Code Amount-7	1/18	
		HI08 - 2	S	Value Code-8	1/30	**BE** Value
		HI08- 5	S	Value Code Amount-8	1/18	
		HI09 - 2	S	Value Code-9	1/30	**BE** Value
		HI09- 5	S	Value Code Amount-9	1/18	
		HI10 - 2	S	Value Code-10	1/30	**BE** Value
		HI10- 5	S	Value Code Amount-10	1/18	
		HI11 - 2	S	Value Code-11	1/30	**BE** Value
		HI11- 5	S	Value Code Amount-11	1/18	

		HI12 - 2	S	Value Code-12	1/30	**BE** Value
		HI12- 5	S	Value Code Amount-12	1/18	
		HIxx-3 HIxx-4 Hixx-6- HIxx-9		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
294	2300	HI01 - 2	R	Condition Code 1	1/30	Segment 1 **BG** Condition
		HI02 - 2	S	Condition Code 2	1/30	**BG** Condition
		HI03 - 2	S	Condition Code 3	1/30	**BG** Condition
		HI04 - 2	S	Condition Code 4	1/30	**BG** Condition
		HI05 - 2	S	Condition Code 5	1/30	**BG** Condition
		HI06 - 2	S	Condition Code 6	1/30	**BG** Condition
		HI07 - 2	S	Condition Code 7	1/30	**BG** Condition
		HI08 - 2	S	Condition Code 8	1/30	**BG** Condition
		HI09 - 2	S	Condition Code 9	1/30	**BG** Condition
		HI10 - 2	S	Condition Code 10	1/30	**BG** Condition
		HI11 - 2	S	Condition Code 11	1/30	**BG** Condition
		HI12 - 2	S	Condition Code 12	1/30	**BG** Condition
		HIxx-3- HIxx-9		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
304	2300	HI01 - 2	R	Treatment Code 1	1/30	Segment 1. **TC** Treatment Codes
		HI02 - 2	S	Treatment Code 2	1/30	**TC** Treatment Codes
		HI03 - 2	S	Treatment Code 3	1/30	**TC** Treatment Codes
		HI04 - 2	S	Treatment Code 4	1/30	**TC** Treatment Codes
		HI05 - 2	S	Treatment Code 5	1/30	**TC** Treatment Codes
		HI06 - 2	S	Treatment Code 6	1/30	**TC** Treatment Codes
		HI07 - 2	S	Treatment Code 7	1/30	**TC** Treatment Codes
		HI08 - 2	S	Treatment Code 8	1/30	**TC** Treatment Codes
		HI09 - 2	S	Treatment Code 9	1/30	**TC** Treatment Codes
		HI10 - 2	S	Treatment Code 10	1/30	**TC** Treatment Codes
		HI11 - 2	S	Treatment Code 11	1/30	**TC** Treatment Codes
		HI12 - 2	S	Treatment Code 12	1/30	**TC** Treatment Codes
		HIxx-3- HIxx-9		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
313	2300	HCP01	R	Claim Pricing/Repricing Methodology	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing 10 - Other Pricing 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	R	Claim Repricing Allowed Amount	1/18	

		HCP03	S	Claim Repricing Saving Amount	1/18	
		HCP04	S	Claim Level Repricing Organization ID	1/50	
		HCP05	S	Claim Repricing Per Diem or Flat Rate	1/9	
		HCP06	S	Claim Repricing Approved Ambulatory Patient Group Code	1/50	
		HCP07	S	Claim Repricing Approved Ambulatory Patient Group Amount	1/18	
		HCP08	S	Claim Repricing Approved Revenue Code	1/48	
		HCP09 HCP10		Not Used by HIPAA		
		HCP11	S	Claim Repricing Quantity Qualifier	2/2	Codes: DA - Days UN - Units Qualifies the basis for measurement represented in the HCP12 Quantity field.
		HCP12	S	Claim Repricing Approved Quantity	1/15	
		HCP13	S	Claim Repricing Reject Reason Code	2/2	T1 - Cannot identify provider as TPO participant T2 - Cannot identify payer as TPO participant T3 - Cannot identify insured as TPO participant T4 - Payer name or identifier missing T5 - Certification information missing T6 - Claim does not con
		HCP14	S	Claim Repricing Policy Compliance Code	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Net
		HCP15	S	Claim Repricing Exception Code	1/2	Exception reason for consideration of out-of-network services 1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 – Other **Required if known** **1 or 3 = Out of Network** **6 = In Network**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
319	2310A	NM101		Entity Identifier Code	2/3	**71** Attending Physician **Required when contains any service other than non-scheduled transportation**
		NM102		Entity Type Code	1/1	**1** Person
		NM103	R	Claim Attending Physician Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Attending Physician First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Attending Physician Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Attending Physician Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	**XX** National Provider **Required**
		NM109	R	Attending Physician Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110- NM112		Not Used by HIPAA		

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
322	2310A	PRV01		Provider Code	1/3	**AT** Attending physician specialty type
		PRV02	R	Reference Identification Qualifier	2/3	**PXC** Provider Taxonomy Code
		PRV03	R	Attending Physician Taxonomy Code	1/50	**REQUIRED If loop is sent**
		PRV04-PRV06		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
	REF	**S**	**Occur 4**	**Attending Provider Secondary Identification**	**Page: 324**	
324	2310A	REF01	S	Reference Identification Qualifer	2/3	**1G** UPIN number **0B** State license number **LU** Location Number **G2** Provider commercial number
		REF02	S	Attending Physician Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
326	2310B	NM101	R	Entity Identifier Code	2/3	**72** Operating Physician
		NM102	R	Entity Type Code	1/1	**1=**Person **2=**Organization
		NM103	R	Operating Physician Last Name	1/60	**REQUIRED If loop is sent**
		NM104	R	Operating Physician First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Operating Physician Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Operating Physician Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	**XX** HIPAA National Provider ID
		NM109	R	Operating Physician Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
329		REF01	S	Reference Identification Qualifer	2/3	UPIN number **=1G** State license number **=0B** (zero B) Location Number **=LU** Provider commercial number **=G2**
		REF02	S	Operating Physician Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
331	2310C	NM101	R	Entity Identifier Code	2/3	**ZZ** Mutually Defined
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Other Operating Physician Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Other Operating Physician First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Other Operating Physician Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Other Operating Physician Name Suffix	1/10	

		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID=**XX**
		NM109	R	Other Operating Physician Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
			S			
334	2310C	REF01	S	Reference Identification Qualifier	2/3	UPIN number **=1G** State license number **=0B** (Required) Location Number **=LU** Provider commercial number. **=G2**
		REF02	S	Other Operating Physician Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
336	2310D	NM101	R	Entity Identifier Code	2/3	**82** Rendering Provider **REQUIRED if different than Attending**
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Rendering Provider Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Rendering Provider First Name	1/35	**REQUIRED If loop is sent**
		NM105	S	Rendering Provider Middle Name	1/25	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX REQUIRED**
		NM109	R	Rendering Provider Primary ID XX	2/80	**REQUIRED**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
			S			
339	2310D	REF01	**S**	Reference Identification Qualifier	2/3	UPIN number **=1G** State license number = **0B** (Required) Location Number **=LU** **Provider commercial number. =G2** **G2 Required to report Tribal Provider (REF02 = 9999)**
		REF02	S	Rendering Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
341	2310E	NM101	R	Entity Identifier Code	2/3	Service facility/Lab name **=77** **Required if different than Billing to idenitiy entity where service were preformed**
		NM102	R	Entity Type Qualifier	1/1	**2** Non-Person Entity
		NM103	R	Service Facility Name	1/60	**REQUIRED If loop is sent**
		NM104-NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX REQUIRED**
		NM109	R	Service Facility Primary ID XX	2/80	**REQUIRED If loop is sent**
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
344	2310E	N301	R	Service Facility Address 1	1/55	Must not be blank if loop used.
		N302	S	Service Facility Address 2	1/55	
Page	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments

#						
345	2310E	N401	R	Service Facility City	2/30	
		N402	R	Service Facility State	2/2	
		N403	R	Service Facility Zip Code	3/15	
		N404	S	Service Facility Country Code	2/3	Required only if country not USA.
		N405 N406		Not Used by HIPAA		
		N407	S	Service Facility Sub-Country Code	1/3	Required only if country not USA.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
347	2310E	REF01	R	Reference Identification Qualifier	2/3	State license number **=0B** (zero B) Location Number **=LU** Provider commercial number. **=G2**
		REF02	R	Service Facility Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
349	2310F	NM101	R	Entity Identifier Code	2/3	**DN** Referring Provider **Required if Referred**
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103	R	Referring Provider Last Name	1/60	**REQUIRED If loop is sent**
		NM104	S	Referring Provider First Name	1/35	
		NM105	S	Referring Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Referring Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX**
		NM109	R	Referring Provider Primary ID XX	2/80	**Required if Loop is sent**
		NM110- NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
352	2310F	REF01	S	Reference Identification Qualifier	2/3	UPIN number **=1G** State license number **=0B** (zero B) Provider commercial number. **=G2** **G2 Required to report Tribal Provider (REF02 = 9999)**
		REF02	S	Referring Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
354	2320	SBR01	R	Payer Responsibility Sequence Number Code	1/1	COB Payment Sequence Indicator P - Primary S - Secondary T - Tertiary A - Payer Four B - Payer Five C - Payer Six D - Payer Seven E - Payer Eight F - Payer Nine G - Payer Ten H - Payer Eleven U – Unknown **NOTE: Required to report SVD or CAS segment (paid and patient responsibility) in loop 2430**

		SBR02	R	Individual Relationship Code	2/2	01 - Spouse 18 - Self 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		SBR03	S	Other Insured Group or Policy Number	1/30	Subscriber's group number
		SBR04	S	Other Insured Group Name	1/60	Subscriber's group name
		SBR05- SBR08				Not Used by HIPAA
		SBR09	S	Claim Filing Indicator Code	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity **16 - HMO Medicare Risk** 17 - Dental HMO AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS **CI - Commercial Insurance Company** DS - Disability FI - Federal Employees Association **HM - HMO** LM - Liability Medical MA - Medicare Part A MB - Medicare Part B **MC - Medicaid** OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
358	2320	CAS01	R	Claim Adjustment Group Code 1	1/2	1st occurrence of segment. General category of payment adjustment: CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** **NOTE: Required in Loop 2430**
		CAS02	R	Adjustment Reason Code 1a	1/5	
		CAS03	R	Adjustment Amount 1a	1/18	
		CAS04	S	Adjustment Quantity 1a	1/15	

		CAS05	S	Adjustment Reason Code 1b	1/5	
		CAS06	S	Adjustment Amount 1b	1/18	
		CAS07	S	Adjustment Quantity 1b	1/15	
		CAS08	S	Adjustment Reason Code 1c	1/5	
		CAS09	S	Adjustment Amount 1c	1/18	
		CAS10	S	Adjustment Quantity 1c	1/15	
		CAS11	S	Adjustment Reason Code 1d	1/5	
		CAS12	S	Adjustment Amount 1d	1/18	
		CAS13	S	Adjustment Quantity 1d	1/15	
		CAS14	S	Adjustment Reason Code 1e	1/5	
		CAS15	S	Adjustment Amount 1e	1/18	
		CAS16	S	Adjustment Quantity 1e	1/15	
		CAS17	S	Adjustment Reason Code 1f	1/5	
		CAS18	S	Adjustment Amount 1f	1/18	
		CAS19	S	Adjustment Quantity 1f	1/15	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
364-366	2320	AMT01	R	Amount Qualifier Code	1/18	**D Payor Amount Paid** **Required when sending Loop 2430) Value must be greater than or equal to (0)** **EAF** Amount Owed **A8** Noncovered Charges - Actual
		AMT02	R	Remaining Patient Liability Amount	1/18	
		AMT02	R	Non-Covered Amount	1/18	
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
367	2320	OI01 OI02		Not Used by HIPAA		
		OI03	R	Benefits Assignment Certification Indicator	1/1	Indicates whether insured has authorized benefits to be assigned to the provider N - No Y - Yes W - patient refuses to assign benefits **(Required when sending Loop 2430)**
		OI04 OI05		Not Used by HIPAA		
		OI06	R	Release of Information Code	1/1	Indicates whether provider has signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim **(Required when sending Loop 2430)**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
369	2320	MIA01	R	Covered Days	1/15	
		MIA02		Not Used by HIPAA		Lifetime Reserve Days Count
		MIA03	S	Lifetime Psychiatric Days Count	1/15	
		MIA04	S	Claim DRG Amount	1/18	
		MIA05	S	Remittance Remark Code 1	1/50	
		MIA06	S	Claim Disproportionate Share Amount	1/18	
		MIA07	S	Claim MSP Pass-through Amount	1/18	
		MIA08	S	Claim PPS Capital Amount	1/18	
		MIA09	S	PPS-Capital FSP DRG Amount	1/18	

		MIA10	S	PPS-Capital HSP DRG Amount	1/18	
		MIA11	S	PPS-Capital DSH DRG Amount	1/18	
		MIA12	S	Old Capital Amount	1/18	
		MIA13	S	PPS-Capital IME Amount	1/18	
		MIA14	S	PPS-Operating Hospital Specific DRG Amount	1/18	
		MIA15	S	Cost Report Day Count	1/15	
		MIA16	S	PPS-Operating Federal Specific DRG Amount	1/18	
		MIA17	S	Claim PPS Capital Outlier Amount	1/18	
		MIA18	S	Claim Indirect Teaching Amount	1/18	
		MIA19	S	Nonpayable Professional Component Amount	1/18	
		MIA20	S	Remittance Remark Code 2	1/50	
		MIA21	S	Remittance Remark Code 3	1/50	
		MIA22	S	Remittance Remark Code 4	1/50	
		MIA23	S	Remittance Remark Code 5	1/50	
		MIA24	S	PPS-Capital Exception Amount	1/18	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
374	2320	MOA01	S	Reimbursement Rate	1/10	
		MOA02	S	Claim HCPCS Payable Amount	1/18	**Required to report Medicare 100% Allowable**
		MOA03	S	Remittance Remark Code 6	1/50	
		MOA04	S	Remittance Remark Code 7	1/50	
		MOA05	S	Remittance Remark Code 8	1/50	
		MOA06	S	Remittance Remark Code 9	1/50	
		MOA07	S	Remittance Remark Code 10	1/50	
		MOA08	S	Claim ESRD Payment Amount	1/18	
		MOA09	S	Nonpayable Professional Component Amount	1/18	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
377	2330A	NM101	R	Entity Identifier Code	2/3	**IL** Insured or Subscriber (**Required when sending Loop 2430)**
		NM102	R	Entity Type Qualifier	1/1	**1** person **2** organization
		NM103	R	Other Insured Last Name	1/60	
		NM104	S	Other Insured First Name	1/35	
		NM105	S	Other Insured Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Other Insured Name Suffix	1/10	
		NM108	R	Identification Code Qualifer	1/2	Member identification number **=MI** HIPAA National Individual Identifier NM108=II (future use)
		NM109	R	Other Insured Primary ID	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
380	2330A	N301	R	Other Insured Address 1	1/55	
		N302	S	Other Insured Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
381	2330A	N401	R	Other Insured City	2/30	**Required when sending Loop 2430)**

		N402	S	Other Insured State	2/2	
		N403	S	Other Insured Zip Code	3/15	
		N404	S	Other Insured Country Code	2/3	
		N405 N406		Not Used by HIPAA		
		N407	S	Other Insured Sub-Country Code	1/3	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
383	2330A	REF01	R	Reference Identification Qualifier	2/3	Social security number (cannot be used for Medicare) **=SY**
		REF02	R	Other Insured Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
384	2330B	NM101	R	Entity Identifier Code	2/3	**PR** Payer (**Required when sending Loop 2430)**
		NM102	R	Entity Type Qualifier	1/1	**2** Non-Person Entity
		NM103	R	Other Payer Name	1/60	
		NM104- NM107		Not Used by HIPAA		
		NM108	R	Identification Code Qualifier	1/2	Payer identification number = **PI** *HCFA National Plan ID (future use)* ***=XV***
		NM109	R	Other Payer Primary ID	2/80	95568
		NM110- NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
386	2330B	N301	R	Other Payer Address 1	1/55	
		N302	S	Other Payer Address 2	1/55	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
387	2330B	N401	R	Other Payer City	2/30	**Required when sending Loop 2430)**
		N402	S	Other Payer State	2/2	
		N403	S	Other Payer Zip Code	3/15	
		N404	S	Other Payer Country Code	2/3	
		N405 N406		Not Used by HIPAA		
		N407	S	Other Payer Sub-Country Code	1/3	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
389	2330B	DTP01	R	Date/ Time Qualifier	3/3	**573** Date Claim Paid **(Required when sending Loop 2430)**
		DTP02	R	Datye Time Period Format Qualifier	2/3	**D8** Date
		DTP03	R	Other Payer Adjudication or Payment Date	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
390	2330B	REF01	R	Reference Identification Qualifier	2/3	Payer identification number **=2U** Claim office number **=FY** Tax ID **=EI**
		REF02	R	Other Payer Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		

Page #	Loop ID	Reference	Code	Name	Length	Notes/Comments
392-395	2330B	REF01	R	Reference Identifcation Qualifier	2/3	Prior Authorization Number **=G1** Referral number **=9F** Adjustment Indicator **=T4** Original reference number **=F8**
		REF02	R	Other Payer Referral Number	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
396	2330C	NM101	R	Entity Identifier Code	2/3	**71** Attending Physician
		NM102	R	Entity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
398	2330C	REF01	R	Reference Identification Qualifier	2/3	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Attending Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
400	2330D	NM101	R	Entity Identifier Code	2/3	**2** Operating Physician
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
402	2330D	REF01	R	Reference Identification Qualifier	2/3	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Operating Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
404	2330E	NM101	R	Entity Identifier Code	2/3	**ZZ** Mutually Defined
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
406	2330E	REF01	R	Reference Identification Qualifier	2/3	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Other Operating Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments

408	2330F	NM101	R	Entity Identifier Code	2/3	**77** Service Location
		NM102	R	Not mappedEntity Type Qualifier	1/1	**2** Non-Person Entity
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
410	2330F	REF01	R	Reference Identification Qualifier	1/50	State License Number **=0B** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Service Facility Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
412	2330G	NM101	R	Entity Identifier Code	2/3	**82** Rendering Provider
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
414	2330G	REF01	R	Reference Identification Qualifier	1/50	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Other Operating Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
416	2330H	NM101	R	Entity Identifier Code	2/3	**DN** Referring Provider
		NM102	R	Not mappedEntity Type Qualifier	1/1	**1** Person
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
418	2330H	REF01	R	Reference Identification Qualifier	1/50	State License Number **=0B** Provider UPIN Number **=1G** Provider Commercial Number **=G2**
		REF02	R	Other Payer Referring Provider Secondary ID	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
420	2330I	NM101	R	Entity Identifier Code	2/3	**85** Billing Provider
		NM102	R	Not mappedEntity Type Qualifier	1/1	**2** Non-Person Entity
		NM103-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
422	2330I	REF01	R	Reference Identification Qualifier	1/50	Provider Commercial Number **=G2** Location Number **=LU**
		REF02	R	Other Payer Billing Provider Secondary ID	1/50	

		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
423	2400	LX01	R	Service Line Number	1/6	Service line order as transmitted.
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
424	2400	SV201	R	Revenue Code	1/48	
		SV202-1	S	Procedure Code Qualifier	2/2	**HC** - CPT/HCPCS code **Required on certain Outpatient** ER - Health Insurance Prospective Payment System **HP** – HIPPS (**Required on Home Health and SNF)** IV - HIEC WK - DC-10
		SV202-2	S	Procedure Code	1/48	
		SV202-3	S	Procedure Code Modifier 1	2/2	**NOTE: 340B physician administered drug include modifier "UD' in either SV202-3, -4, -5, or -6**
		SV202-4	S	Procedure Code Modifier 2	2/2	
		SV202-5	S	Procedure Code Modifier 3	2/2	
		SV202-6	S	Procedure Code Modifier 4	2/2	
		SV202-7	S	Procedure Description	1/80	
		SV202-8		Not Used by HIPAA		
		SV203	R	Line Item Charge Amount	1/18	
		SV204	R	Quantity Qualifier	2/2	DA - Days UN - Unit
		SV205	R	Quantity	1/15	
		SV202-8		Not Used by HIPAA		
		SV207	S	Non-Covered Line Item Amount	1/18	
		SV208-SV210		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
429	2400	PWK01	R	Attachment Report Type Code	2/2	There are 61 possible codes. See HIPAA guide pages 430-431 for the list of codes.
		PWK02	R	Attachment Transmission Code	1/2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only (X12 275) EM - Email FX - By Fax
		PWK03 PWK04		Not Used by HIPAA		
		PWK05		Identification Code Qualifier	1/2	**AC** Attachment Control Number
		PWK06	S	Attachment Control Number	2/80	
		PWK07-PWK09				
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
433	2400	DTP01		Date/Time Qualifier	3/3	**472** Service
		DTP02	R	Service Line From Date	2/3	**D8 or RD8**
		DTP03	S	Service Line To Date	1/35	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
435-438	2400	REF01	R	Reference Identification Qualifier	2/3	**6R** Provider Control Number **9B** Repriced Line Item Reference Number **9D** Adjusted Repriced Line Item Reference

						Number
		REF02	R	Reference Identification	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
439-440	2400	AMT01	R	Amount Qualifier Code	1/3	Goods and services tax **=GT** Facility tax **=N8**
		AMT02	R	Monetary Amount	1/18	
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
441	2400	NTE01	S	NTE Ref Code	3/3	TPO - Third Party Organization
		NTE02	S	NTE Note	1/80	Note from Third Party Organization or Repricer
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
442	2400	HCP01	R	Service Line Pricing/Repricing Methodology	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing **10 - Other Pricing** 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	R	Service Line Repricing Allowed Amount	1/18	**REQUIRED to report Service Line Allowed Amount**
		HCP03	S	Service Line Repricing Saving Amount	1/18	
		HCP04	S	Service Line Repricing Organization Identifier	1/50	
		HCP05	S	Service Line Repricing Per Diem or Flat Rate Amount	1/9	
		HCP06	S	Service Line Repricing Approved Ambulatory Patient Group Code	1/50	
		HCP07	S	Service Line Repricing Approved Ambulatory Patient Group Amount	1/18	
		HCP08	S	Service Line Repricing Approved Revenue Code	1/48	
		HCP09	S	Service Line Repricing Approved Procedure Code Qualifier	2/2	HC - CPT/HCPCS code ER - Health Insurance Prospective Payment System HP - HIPPS IV - HIEC WK - DC-10
		HCP10	S	Service Line Repricing Approved Procedure Code	1/48	
		HCP11	S	Service Line Repricing Quantity Qualifier	2/2	DA - Days UN - Unit
		HCP12	S	Service Line Repricing Approved Quantity	1/15	

		HCP13	S	Service Line Reject Reason Code	2/2	T1 - Cannot identify provider as TPO participant T2 - Cannot identify payer as TPO participant T3 - Cannot identify insured as TPO participant T4 - Payer name or identifier missing T5 - Certification information missing T6 - Claim does not contain enough information for repricing
		HCP14	S	Service Line Policy Compliance Code	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital
		HCP15	S	Service Line Exception Code	1/2	1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 - Other
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
449	2410	LIN01		Not Used by HIPAA		
		LIN02			2/2	**N4 National Drug Code in 5-4-2 Format**
		LIN03	R	National Drug Code	1/48	**Required on all physicisan-administered drugs when billed by a provider other than a pharmacy.**
		LIN04-LIN31		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
452	2410	CTP01-CTP03		Not Used by HIPAA		
		CTP04	R	National Drug Unit Count	1/15	**Required on all physicisan-administered drugs when billed by a provider other than a pharmacy.**
		CTP05-1	R	Unit/Basis for Measurement	2/2	Basis of measurement for CTP04 F2 - International Unit GR - Gram ML - Milliliter ME - Milligram UN - Unit
		CTP05-2-CTP05-15		Not Used by HIPAA		
		CTP06-CTP11		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
452	2410	REF01	R	Reference Identification Qualifier	2/3	**XZ Link Sequence Number** **VY Link Sequence Number**
		REF02	R	Link Sequence Number	1/50	
		REF03 REF04		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
456	2420A	NM101	R	Entity Identifier Code	2/3	**72** Operating Physician
		NM102	R	Entity Type Qualifier	1/1	**1 Person**

		NM103	R	Service Line Operating Provider Last Name	1/60	
		NM104	R	Service Line Operating Provider First Name	1/35	
		NM105	S	Service Line Operating Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Operating Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID NM108=XX
		NM109	S	Service Line Operating Provider Primary ID XX	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
41		REF01	R	Reference Identification Qualifier	1/50	State license number **= 0B** (zero B). Provider UPIN number **= 1G** Provider commercial number **= G2** Location number **= LU**
42		REF02	R	Service Line Operating Provider Secondary ID	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
461	2420B	NM101	R	Entity Identifier Code	2/3	**ZZ** Mutually Defined
		NM102	R	Entity Type Qualifier	1/1	**1 Person**
		NM103	R	Service Line Other Other Operating Provider Last Name	1/60	
		NM104	R	Service Line Other Operating Provider First Name	1/35	
		NM105	S	Service Line Other Operating Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Other Operating Provider Name Suffix	1/10	
		NM109	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX**
		NM109	S	Service Line Other Operating Provider Primary ID	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
464	2420B	REF01	R	Reference Identification Qualifier	2/3	State license number **= 0B** (zero B). Provider UPIN number **= 1G** Provider commercial number **= G2** Location number **= LU**
		REF02	R	Service Line Other Operating Provider Secondary ID	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
466	2420C	NM101	R	Entity Identifier Code	2/3	**82** Rendering Provider
		NM102	R	Entity Type Qualifier	1/1	**1 Person**

		NM103	R	Service Line Rendering Provider Last Name	1/60	
		NM104	R	Service Line Rendering Provider First Name	1/35	
		NM105	S	Service Line Rendering Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Rendering Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **=XX**
		NM109	R	Service Line Rendering Provider Primary ID XX	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
469	2420C	REF01	R	Reference Identification Qualifier	2/3	State license number **= 0B** (zero B Provider UPIN number **= 1G** Provider commercial number **= G2** Location number **= LU**
		REF02	R	Service Line Rendering Provider Secondary ID	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
471	2420D	NM101	R	Entity Identifier Code	2/3	**DN** Referring Provider
		NM102	R	Entity Type Qualifier	1/1	**1 Person**
		NM103	R	Service Line Referring Provider Last Name	1/60	
		NM104	R	Service Line Referring Provider First Name	1/35	
		NM105	S	Service Line Referring Provider Middle Name	1/25	
		NM106		Not Used by HIPAA		
		NM107	S	Service Line Referring Provider Name Suffix	1/10	
		NM108	R	Identification Code Qualifier	1/2	HIPAA National Provider ID **= XX**
		NM109	R	Service Line Referring Provider Primary ID XX	2/80	
		NM110-NM112		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
474	2420D	REF01	R	Reference Identification Qualifier	2/3	State license number **= 0B** (zero B). Provider UPIN number **= 1G** Provider commercial number **= G2**
		REF02	R	Service Line Referring Provider Secondary ID 1G	1/50	
		REF03		Not Used by HIPAA		
		REF04-1 REF04-2				
		REF04-3-REF04-6		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
476	2430	SVD01	R	Other Payer Primary Identifier	2/80	**Required to report Paid Amount and Patient Responsibility when greater than zero (0)**
		SVD02	R	Service Line Paid Amount	1/18	**NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV203 (Insti) Line Item**

						Charge Amount – Amount must be greater than or equal to zero (0)
		SVD03-1	R	Procedure Code Qualifier	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code HP - Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code IV - HEIC code WK - Advanced Billing (ABC) code
		SVD03-2	R	Procedure Code	1/48	
		SVD03-3	S	Procedure Code Modifier 1	2/2	
		SVD03-4	S	Procedure Code Modifier 2	2/2	
		SVD03-5	S	Procedure Code Modifier 3	2/2	
		SVD03-6	S	Procedure Code Modifier 4	2/2	
		SVD03-7	S	Procedure Code Description	1/80	
		SVD03-8		Not Used by HIPAA		
		SVD04	R	Revenue Code	1/48	
		SVD05	R	Paid Service Unit Count	1/15	
		SVD06	S	Bundled or Unbundled Line Number	1/6	References the service line number which this line was bundled into.
age #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
495	2430	CAS01	R	Service Line Adjustment Group Code 1	1/2	General category of payment adjustment CO – Contractual Obligations CR – Correction and Reversals OA – Other Adjustments PI – Payor Initiated Reductions **PR – Patient Responsibility** **NOTE: Loop 2430 Required to report Patient Responsibility when greater than 0**
		CAS02	R	Adjustment Reason Code 1a	1/5	Service Line adjustment reason code **Member Cost Share (PR qualifier), reason codes:** **1 = Deductible Amount** **2 = Coinsurance Amount** **3 = Co-payment Amount** **Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/**
		CAS03	R	Adjustment Amount 1a	1/18	Montary Amount
		CAS04	S	Adjustment Quantity 1a	1/15	Unit of Service
		CAS05	S	Adjustment Reason Code 1b	1/5	Service Line adjustment reason code
		CAS06	S	Adjustment Amount 1b	1/18	Montary Amount
		CAS07	S	Adjustment Quantity 1b	1/15	Unit of Service
		CAS08	S	Adjustment Reason Code 1c	1/5	1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount
		CAS09	S	Adjustment Amount 1c	1/18	Montary Amount
		CAS10	S	Adjustment Quantity 1c	1/15	Unit of Service
		CAS11	S	Adjustment Reason Code 1d	1/5	Service Line adjustment reason code
		CAS12	S	Adjustment Amount 1d	1/18	Montary Amount
		CAS13	S	Adjustment Quantity 1d	1/15	Unit of Service
		CAS14	S	Adjustment Reason Code 1e	1/5	Service Line adjustment reason code
		CAS15	S	Adjustment Amount 1e	1/18	Montary Amount

		CAS16	S	Adjustment Quantity 1e	1/15	Unit of Service
		CAS17	S	Adjustment Reason Code 1f	1/5	Service Line adjustment reason code
		CAS18	S	Adjustment Amount 1f	1/18	Montary Amount
		CAS19	S	Adjustment Quantity 1f	1/15	Unit of Service
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
486	2430	DTP01	R	Date/Time Qualifier	3/3	**573 Date Claim Paid or Processed** **NOTE: Required when sending Loop 2430**
		DTP02	R	Date Time Period Format Qualifier	2/3	**D8** Date Expressed in Format CCYYMMDD **NOTE: Required when sending Loop 2430**
		DTP03	R	Service Adjudication or Payment Date	1/35	**NOTE: Required when sending Loop 2430**
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
487	2430	AMT01		Amount Qualifier Code	1/3	**EAF** Amount Owed
		AMT02	R	Remaining Patient Liability	1/18	
		AMT03		Not Used by HIPAA		
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
488	Transaction Set Trailer	SE01	R	Number of Included Segments	1/10	
		SE02	R	Other Payer ID Referring Provider	4/9	

Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
C.9	Functional Group Trailer	GE01	R	Number of Transactional Sets Included	1/6	
		GE02	R	Group Control Number	1/9	
Page #	**Loop ID**	**Reference**	**Code**	**Name**	**Length**	Notes/Comments
C.10	Interchange Control Trailer	IEA01	R	Number of Included Functional Groups	1/5	
		IEA01	R	Interchange Control Number	9/9	

Health Net, LLC

HIPAA Transaction 837 Professional
Standard Companion Guide

Refers to the Implementation Guides Based on X12 version 005010X222A1

Companion Guide Version Number: 2.1

February 22, 2019

Disclosure Statement

This Companion Guide describes the EDI requirements for the submission of CA and Arizona Encounters to Health Net. Throughout the remainder of this document Health Net, LLC will be referred to HNT to describe the all regions of Health Net.

Preface

This Companion Document to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Health Net, LLC Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usage of data expressed in the ASC X12N 837 Implementation Guides.

EDITOR'S NOTE:
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1 Introduction

1.1 Scope

This Companion document supports the implementation of a batch processing application.

HNT will accept inbound submissions that are formatted correctly in X12 requirements. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide.

HNT EDI applications will edit for these conditions and reject files that are out of compliance.

This companion document will specify everything that is necessary to conduct EDI for this standard transaction. This includes;

- Specifications on the communications link
- Specifications on the submission methods
- Specifications on the transactions

1.2 Overview

This companion guide complements the ASC X12N 837 Professional implementation guide currently adopted by HIPAA.

This companion guide will be the vehicle that HNT uses with its trading partners to further qualify the HIPAA adopted implementation guide. This companion guide is compliant with the corresponding HIPAA implementation guide in terms of data element and code sets standards and requirements.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are:

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Trading partner profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

1. Health Care Claim: Professional
   - 837 (005010X222A1)

1.4 Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between trading partners. The computer system generating the transactions must supply complete and accurate information while

the system receiving the transactions must be capable of interpreting and utilizing the information in ASC X12N format, without human intervention.

The transactions must be sent in a specific format that will allow HNT's computer application to translate the data. HNT supports the standard transactions adopted from HIPAA. Maintains a dedicated staff for the purpose of enabling and processing X12 EDI transmissions with its trading partners.

It is the goal of HNT to establish trading partner relationships and to conduct EDI as opposed to paper information flows whenever and wherever possible.

1.5 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.
HIPAA covered healthcare providers that choose to submit transactions electronically, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, the National Provider Identifier (NPI) is meant to be a lasting identifier, and would not change based on changes in a health care provider's name, address, ownership, membership in health plans or Healthcare Provider Taxonomy classification.
HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans (including Health Net), must use only the NPI in the primary identifier position to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

This companion guide has been updated to reflect how the NPI will be integrated in the 837 X12 transaction.

2 Getting Started

2.1 Working with Health Net, LLC

Contact HNT EDI Dept. for all EDI related customer service requests. (Contact information is identified in section 5 below.)

There are three units within HNT that work internally to complete EDI service requests from our trading partners.

The first unit is HNT EDI Operations Dept. This group will serve as the trading partner's central point of contact. This group will also facilitate the implementation of trading partners through all steps of external testing.

The second unit is HNT EDI IT infrastructure group. This is a technical team that implements the communication link and ensures that trading partner to payer connectivity is established properly.

The third unit is HNT EDI IT Translator team. This group is responsible for our inbound and outbound X12 Translator applications.

2.2 Trading Partner Registration

To register as a trading partner with HNT the following sequence of events will take place.

1. Initial conversations are held between the trading partner and HNT
2. Verbal agreements are reached to agree on the transactions that will be conducted.
3. A trading partner agreement and associated companion guides are provided and reviewed.
4. Submitter Id and Receiver Id are established for the purpose of identification.
5. Required trading partner profiling is built into our HNT EDI translator.
6. Test files are exchanged and test runs conducted.
7. Once a brief testing phase is completed and a trading partner agreement is in place; the trading partner is registered.

2.3 Certification and Testing Overview

HNT requires its trading partners to show evidence of third party certification. This is consistent with industry standard conventions that have been adopted for HIPAA Transactions and Code Sets implementation.

HNT will also show evidence of third party certification for standard transactions.

This requirement exists so that the process to test and implement a trading partner for the purpose of conducting EDI with standard transactions is a smooth and efficient process.

The complexity of X12 files when not tested and certified by a third party will cause delays in the ability to enable the X12 submissions in a production environment.

HNT wants to spend the majority of the testing period time, working with prospective trading partners on the agreed components of this companion document rather than X12 or HIPAA implementation guide syntax.

HNT will be certified incorporating the following WEDI/SNIP levels of testing where applicable:
Level 1, Integrity Testing (X12 Syntax)
Level 2, Requirement Testing (HIPAA Implementation Guide Syntax)
Level 3, Balancing Testing (i.e. 835 claim line balancing to the claim document)
Level 4, Situation Testing (Use of Situational Segments that business relevant
Level 5, Code Sets Testing
Level 6, Product Types/Types of Service Testing (i.e. provider specialties)

3 Testing with the Payer

HNT would like to establish with the trading partner a set of scenarios that are intended for testing. This can be a high level description of the contents of the transaction. It should be a representation or cross section of the majority of conditions that will be encountered with production data from these transactions.

HNT requires testing be completed with all trading partners. The testing phase will consist of several smaller phases of testing, as appropriate.

3.1 HIPAA Compliance Testing

HNT uses an industry standard data translator to validate transactions meet the 6 levels of HIPAA compliance, and to translate them into an acceptable format for internal processing. The 997/999 Acknowledgement will be tested during this phase. Any issues identified during this phase of testing will have to be addressed in order for subsequent phases to continue. HNT will use the 277CA for claims acknowledgements.

3.2 Trading Partner Agreement Testing

Trading partner specific setup, as defined in either the trading partner agreement or companion guide will be verified. Generally, this will be done in conjunction with Compliance testing.

3.3 Functional and Regression Testing

Once the transactions have successfully tested through GXS and trading partner specifications, they will be processed through our internal system to ensure they are handled appropriately. Response transactions will be generated during this phase, where applicable.

3.4 Parallel Testing

Depending on the stage of the HNT implementation, a period of parallel testing may be required. This would involve sending the current proprietary transaction format, as well as, sending the same transactions in the x12 format, to our test system. This phase will allow for the comparative analysis necessary to ensure appropriate handling by our system.

4 Connectivity with the Payer / Communications

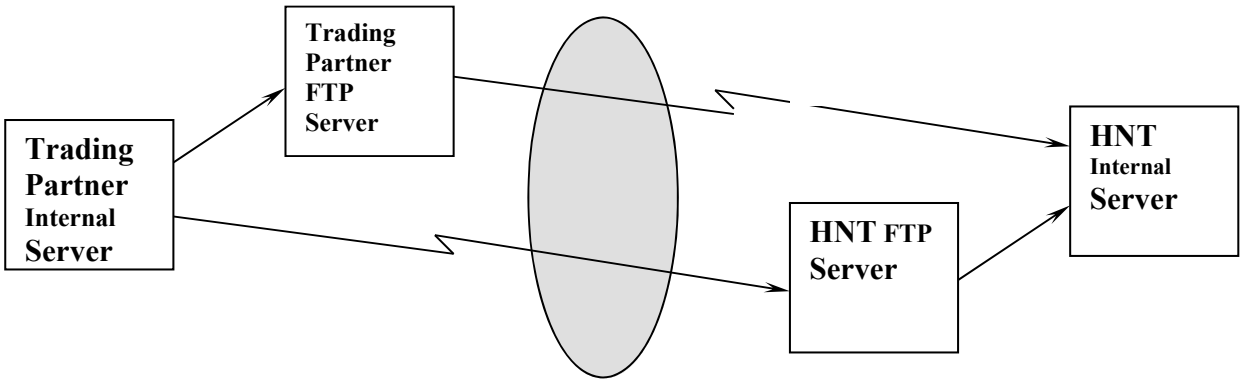
4.1 Process flows

Three file exchange methods are supported to enable batch data file transmission; (1) FTP of encrypted data over the Internet, (2) use of Connect: Direct (NDM) over the AT&T AGNS (formerly Advantis) SNA network, and (3) FTP over frame relay for trading partners with very high volumes.

4.1.1 FTP of Encrypted data over the Internet

One method of exchanging data files is encrypting the file, sending it over the Internet where it is then decrypted. For data inbound to HNT (see Figure 4.1), the trading partner would encrypt the data on an internal server and then transfer to either a trading partner owned FTP server or to HNT FTP server. Then, HNT will retrieve the encrypted file from either the trading partner FTP server or from HNT FTP server to an internal server where the file is decrypted and processed.

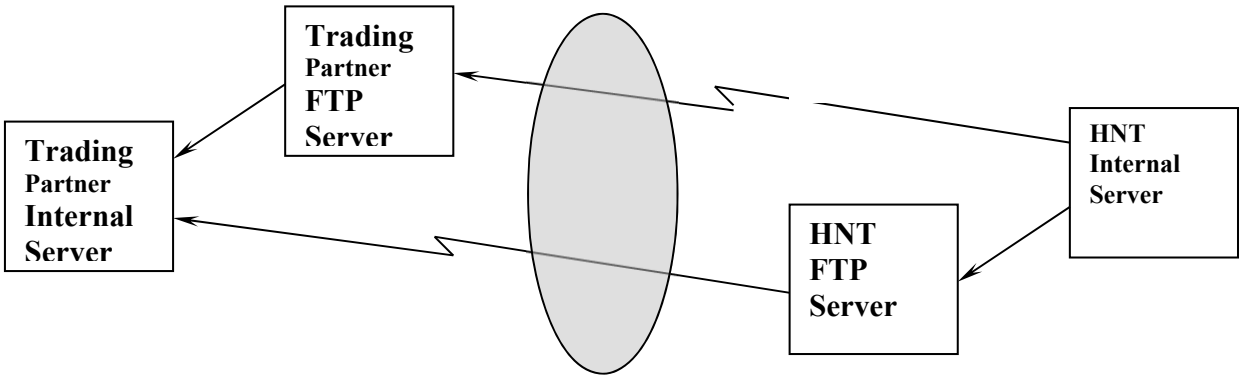
Figure 4.1.1A
FTP of Encrypted Data over the Internet from Trading Partner to HNT



For data outbound from HNT (see Figure 4.1.1B), HNT will generate the X12 data file and encrypt it. Once encrypted, the file will be sent either to HNT's FTP server or the trading partners FTP server. Then the trading partner can retrieve the file from the appropriate FTP server, transfer it to their internal system, encrypt it and process.

Figure 4.1.1B

FTP of Encrypted Data over the Internet from HNT to Trading Partner



4.1.2 Use of Connect: Direct (NDM) over the AT&T AGNS (Advantis) SNA Network

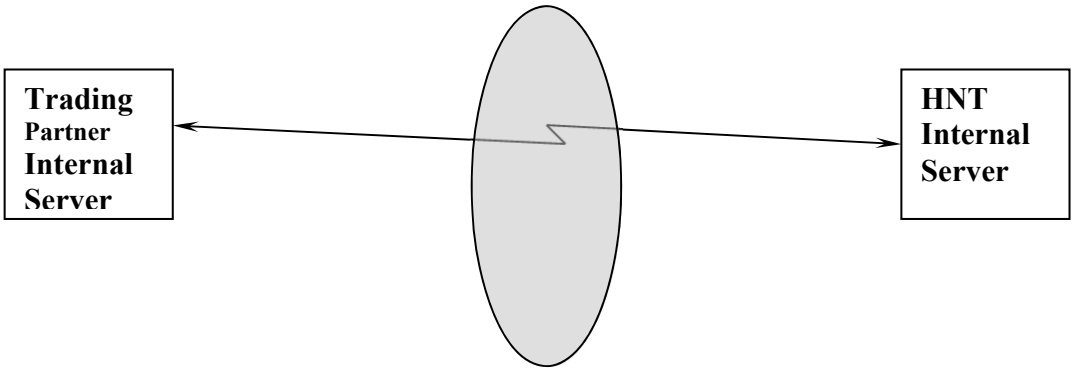
Data may also be exchanged over the AT&T AGNS (formerly Advantis) SNA network (see Figure 4.3). The transmission software must be Sterling

Commerce Connect:Direct (formerly NDM). For data inbound to HNT, the trading partner will make the data file available on their internal server. HNT will retrieve the data from the trading partner server with Connect:Direct (preferred) or the trading partner my initiate the transfer and send the data to HNT's internal server.

Data outbound from HNT takes just the opposite path with either HNT (preferred) or the trading partner initiating the file transfer.

Data transferred over the AGNS network may be encrypted or sent in clear text.

Figure 4.1.2
Connect:Direct Transfer over the AT&T AGNIS Network



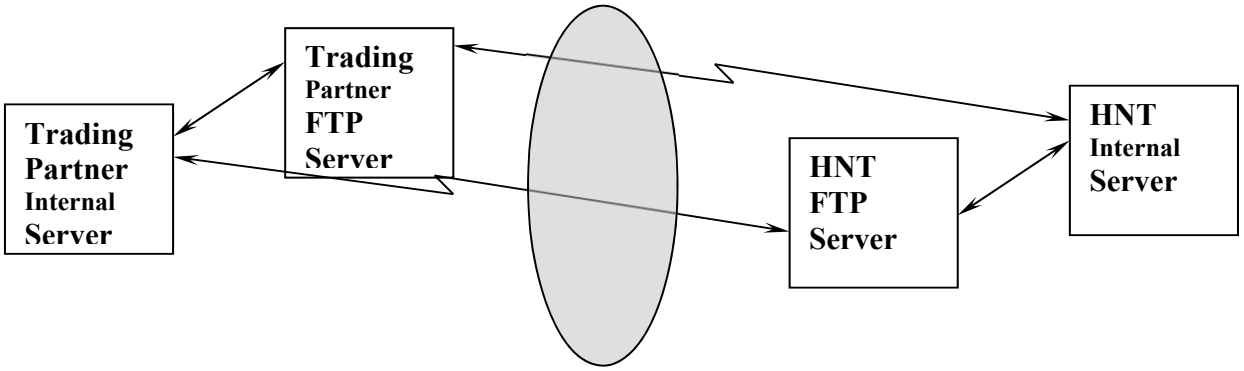
4.1.3 FTP Over Frame Relay

For trading partners with very large data volume to exchange with HNT, a private virtual circuit may be established over a frame relay link (see Figure 4.4). Once established, data will be exchanged similarly to the FTP over the Internet approach except the data will not flow over the Internet.

Data transferred over the frame relay network may be encrypted or sent in clear text.

Figure 4.1.3

FTP Over Frame Relay



4.2 Transmission Administrative Procedures

Before establishing data communications with HNT, a trading partner relationship must exist. As part of the process establishing the relationship, HNT and the trading partner must exchange certain technical information. This information is needed by both parties in order to establish communications.

The information requested will include:

1. Contacts; business, data and communications
2. Dates; testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, userID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be retransmitted, the trading partner will contact their primary contact at HNT. At that time, procedures will be followed for HNT to accept and re-transmit a file.

4.3 Communication protocol specifications

4.3.1 FTP over the Internet

The following items are required to exchange data with HNT utilizing FTP over the Internet. The trading partner is responsible for the acquisition and installation of these items. This list assumes that HNT FTP server will be used.

1. Internet Connectivity; if large files will be exchanged, then the trading partner should consider a broadband connection.
2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include confirming FTP connectivity, exchanging PGP public keys and performing end-to-end communications testing.

Before sending data to HNT, the data must be encrypted with PGP and then sent to the Health Net FTP using the FTP client over the Internet connection. When receiving data from Health Net, the FTP client will be used to get the data from the HNT FTP server after which PGP will be used to decrypt the data.

4.3.2 Connect: Direct over the AT&T AGNS Network

The following items are required to exchange data with HNT utilizing Connect: Direct (formerly NDM) over the AT&T AGNS network (formerly Advantis).

1. SNA Connectivity to the AT&T AGNS network.
2. Connect:Direct software loaded and configured on an applicable host system. HNT runs Connect:Direct on an OpenVMS system. Not all Connect:Direct versions are compatible with Connect:Direct for OpenVMS. The trading partner must confirm that their version is compatible.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Connect:Direct parameters (APPLID, LUs, etc.), submission of security requests to AT&T and end-to-end communications testing.

Using Connect:Direct, data may be “pushed” or “pulled” by either party. HNT prefers to initiate the connection. Data is exchanged when one party initiates a Connect:Direct session with the other and either “pushes” or “pulls” a file to/from the other party.

4.3.3 FTP over Frame Relay

This method of communications is only appropriate for trading partners with a very high and frequent volume. The initial setup of this method can be lengthy.

The following items are required to exchange data with HNT utilizing FTP over Frame Relay.

1. Connectivity to a Frame Relay network common with HNT.

2. Computer with FTP client and connectivity to the Internet.
3. Optionally, PGP software for encryption/decryption. RSA (also know as Legacy) keys must be generated and exchanged with HNT via e-mail (public keys only).
4. E-mail capability to exchange configuration and testing information.

Initial setup will include the exchange of Frame Relay PVC parameters and submission of a request to the frame relay carrier for connectivity. Once connectivity is established at the frame relay level, this method is similar to the FTP over the Internet method.

4.4 Passwords

HNT requires the use of UserIDs and Passwords to access its systems and servers. If HNT's FTP server is to be used to exchange data, HNT will assign each trading partner a unique UserID and Password. The UserID and other information will be communicated with the trading partner via e-mail. However, the password will be communicated via another method such as phone or fax.

In the event a trading partner forgets their password, HNT will change the password after verifying the authenticity of the request.

HNT will not utilize a trading partner owned FTP server that is not protected with a UserID and password.

4.5 Encryption

HNT requires the encryption of data that is exchanged via the Internet or any other public network. HNT utilizes PGP with 1024 or 2048 bit keys for file encryption.

5 Contact information

5.1 HNT EDI Department

HNT EDI Dept. is the central point of contact for all trading partner EDI activity including questions relating to file submissions. They will triage the issue and route EDI questions to one of three EDI areas for resolution.

Once resolution is reached, trading partners will receive a response from this same central EDI Dept.

The three areas within HNT EDI that work on EDI customer service issues are;

- HNT IT EDI Translator Team
- HNT IT Payer Connectivity and Infrastructure Team
- HNT EDI Business Operations Team

Contact Phone numbers for our HNT EDI Department:
North East and AZ: 1-866-334-4638
CA and OR: 1-800-977-3568
.

6 Control Segments / Envelopes

6.1 ISA-IEA

See Transaction Specifications, Section 10.

6.2 GS-GE

See Transaction Specifications, Section 10.

6.3 ST-SE

See Transaction Specifications, Section 10.

7 Payer Specific Business Rules and Limitations

- All monetary amounts are to include decimal points with two positions allowed to the right of the decimal point to represent cents.
- CLM segments per patient loop is limited to 100 CLM segments
- Service lines per CLM loop must be limited to 50 service lines
- Billing Provide Name Contact Information (Loop ID 2010AA) is limited to one instance.
- The following segments should **not** be sent:
  - Loop 2010AA REF - Credit/Debit Card Billing Information.
  - Loop 2010BA REF– Property and Casualty Number
  - Loop 2010BD NM1 and REF– Credit/Debit Card Holder Name and Information
  - Loop 2010CA REF– Property and Casualty Claim Number
  - Loop 2300 AMT – Credit/Debit Card Maximum

8 Acknowledgements and or Reports

997/999 and 277CA Acknowledgement will be sent so the trading partner will get confirmation that we received their 837 submission.

9 Trading Partner Agreements

Trading Partner Agreements specify the terms and conditions by which transactions are exchanged electronically with HNT.

This companion document will be an addendum to the trading partner agreement that is signed by both HNT and the trading partner with whom EDI is to be conducted.

Health Net, LLC's trading partner agreement is attached as an appendix to this companion document. The version of X12N that Health Net, LLC is supporting will be identified in the trading partner agreement. As versions offered by HNT change to newer releases of X12N and adopted by HIPAA, the trading partner agreement will be amended to reflect the version changes as they occur and become required.

10 Transaction Specification Information

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
C.3	Interchange Control Header	ISA01	Authorization Information Qualifier	R	2/2	00 – No Authorization Information Present
		ISA02	Authorization Information	R	10/10	Spaces
		ISA03	Security Information Qualifier	R	2/2	00 – No Security Information Present
		ISA04	Security Information	R	10/10	Spaces
		ISA05	Interchange Sender Qualifier	R	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA06	ISA Sender ID	R	15/15	(**As agreed upon**)
		ISA07	Interchange Receiver Qualifier	R	2/2	30 – Federal Tax ID ZZ – Mutually Defined
		ISA08	ISA Receiver ID	R	15/15	HNT Tax ID - 954402957 (**As agreed upon**)
		ISA09	Interchange Date	R	6/6	Date of Transmission (YYMMDD)
		ISA10	Interchange Time	R	4/4	Time of Transmission (HHMM)
		ISA11	Repetition Separator	R	1/1	
		ISA12	Interchange Control Version Number	R	5/5	00501
		ISA13	ISA Control Number	R	9/9	Control number assigned by the sender, Must be identical to control number in IEA02
		ISA14	Acknowledgement Indicator	R	1/1	**1** - Send TA1, **0** - Do not send TA1
		ISA15	Usage Indicator	R	1/1	**T** - Test, **P** - Production
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
C.7	Functional Group Header	GS01	Functional Identifier Code	R	2/2	**HC** - Health Care Claim (837)
		GS02	GS Sender's Code	R	2/15	(**As agreed upon**)
		GS03	GS Receiver's Code	R	2/15	HNCA-ENC (**As agreed upon**)
		GS04	Group GS Date	R	8/8	Functional group creation date (CCYYMMDD)
		GS05	Group GS Time	R	4/8	Functional group creation time (HHMM)
		GS06	Group Control Number	R	1/9	Control number assigned by the sender
		GS07	Responsible Agency Code		1/2	**X** accredited standards committee
		GS08	Version /Release ID Code	R	1/12	005010X222A1
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
70	Transaction Set Header	ST01	Transaction Set Identifier Code	R	3/3	**837** - Health Care Claim: Professional
		ST02	Transaction Set Control Number	R	4/9	Unique control number assigned by sender's translator
		ST03	Transaction Set Version	R	1/35	Matches GS08 value

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
71	Beginning of Hierarchical Transaction	BHT01	Hierarchical Structure Code	R	4/4	**0019** (Information Source, Subscriber, Dependent)
		BHT02	Transaction Set Purpose Code	R	2/2	00 - Original 18 - Reissue
		BHT03	Originator Application Transaction Identifier	R	1/50	
		BHT04	Application Creation Date	R	8/8	CCYYMMDD
		BHT05	Application Creation Time	R	4/8	
		BHT06	Claim or Encounter Indicator	R	2/2	Identifies cap vs. fee for service claims RP - Reporting (**Encounters/ Capitation**)
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
74	1000A	NM101	Entity Identifier Code	R	1/1	**41** (Submitter)
		NM102	Entity Type Qualifier	R	1/60	**1** - person, **2** - Non-Person
		NM103	Submitter Name	R	1/60	
		NM104	Submitter First Name	S	1/35	
		NM105	Submitter Middle Name	S	1/25	
		NM106 NM107	Not Used by HIPAA			
		NM108	Identification Code	R	1/2	46 Electronic Transmitter ID Number ETIN).
		NM109	Submitter Electronic Transmitter ID	R	2/80	9-digit HNT Submitter ID **(Assign by Health Net)**
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
76	1000A	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Submitter Contact Name 1	S	1/60	
		PER04/06/08	Contact Telephone Number 1	R	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 1	R	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 1	R	1/256	**PER03,05,07=FX**
		PER04/06/08	Contact Email Address 1	R	1/256	**PER03,05,07=EM**
		PER09	Not Used by HIPAA			
		PER02	Submitter Contact Name 2	S	1/60	Used if more contact information needed. Inbound: Populated by EDI translator. Outbound: Determined by EDI Business.
		PER04/06/08	Contact Telephone Number 2	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 2	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 2	S	1/256	**PER03,05,07=FX**
		PER04/06/08	Contact Email Address 2	S	1/256	**PER03,05,07=EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop Id**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

79	1000B	NM101	Entity Identifier Code	R	2/3	**40** (Receiver)
		NM102	Entity Type Qualifier	R	1/1	**2** (Non-Person Entity)
		NM103	Receiver Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**46** Electronic Transmitter ID Number (ETIN)
		NM109	Receiver Electronic Transmitter ID Number	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
83	2000A	PRV01	Provider Code	R	1/3	**BI** (Billing)
		PRV02	Reference Identification Qualifier	R	2/3	**PXC** (Provider Taxonomy Code)
		PRV03	Billing Provider Taxonomy Code	R	1/50	***(REQUIRED)***
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
84	2000A	CUR01	Entity Identifier Code	R	2/3	**85** (Billing Provider)
		CUR02	Currency Code	R	3/3	
		CUR03-CUR16	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
87	2010AA	NM101	Entity Identifier Code	R	2/3	**85** (Billing Provider)
		NM102	Entity Type Qualifier	R	1/1	1=Person 2=Organization
		NM103	Billing Provider Name	R	1/60	
		NM104	Billing Provider First Name	S	1/35	
		NM105	Billing Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Billing Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Billing Provider Primary NPI	R	2/80	**REQUIRED**
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
87	2010AA	N301	Billing Provider Address 1	R	1/55	
		N302	Billing Provider Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
92	2010AA	N401	Billing Provider City	R	2/30	
		N402	Billing Provider State	S	2/2	
		N403	Billing Provider Zip Code	S	3/15	(Nine digit zip code)
		N404	Billing Provider Country Code	S	2/3	Required only if country is not USA.

		N405 N406	Not Used by HIPAA			
		N407	Billing Provider Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
94	2010AA	REF01	Reference Identification Qualifier	**R**	2/3	**EI Employer's identification number (IRS ID number)** SY Social Security Number
		REF02	Billing Provider Taxpayer ID	R	1/50	
		REF02	Billing Provider SSN	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
96	2010AA	REF01	Reference Identification Qualifier	S	2/3	**0B** (State License Number) **1G** (Provider UPIN Number**)**
		REF02	Billing Provider Identification	S	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
98	2010AA	PER01	Contact Function Code	R	2/2	**IC** Billing provider
		PER02	Billing Provider Contact Name 1	S	1/60	
		PER04/06/08	Contact Telephone Number 1	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 1	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 1	S	1/256	**PER03,05,07 = FX**
		PER04/06/08	Contact Email Address 1	S	1/256	**PER03,05,07 = EM**
		PER09	Not Used by HIPAA			
		PER02	Billing Provider Contact Name 2	S	1/60	Used if more Billing Provider contact information needed.
		PER04/06/08	Contact Telephone Number 2	S	1/256	**PER03,05,07=TE**
		PER06/08	Contact Telephone Extension 2	S	1/256	**PER05,07=EX**
		PER04/06/08	Contact Fax Number 2	S	1/256	**PER03,05,07 = FX**
		PER04/06/08	Contact Email Address 2	S	1/256	**PER03,05,07 = EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes** **S**	**Length**	Notes/ Comments
101	2010AB	NM101	Entity Identifier Code	R	2/3	87 Pay to provider
		NM102	Entity Type Qualifier	R	1/1	1 person 2 non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

Page	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
116	2000B	SBR01	Payer Responsibility Sequence Number Code	R	1/1	P - Primary S - Secondary T - Tertiary A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility 11 U - Unknown
		SBR02	Individual Relationship Code	S	2/2	Individual Relationship Code "18' - Self, if patient is subscriber. Blank otherwise
		SBR03	Insured Group or Policy Number	S	1/50	
		SBR04	Insured Group Name	S	1/60	
		SBR05	Insurance Type Code	S	1/3	12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 - Medicare Secondary ESRD Beneficiary in 12 month coordination period with employer's group health plan 14 - Medicare Secondary, No-fault Insurance including Auto as Primary 15 - Medicare Secondary Worker's Compensation 16 - Medicare Secondary PHS or Other Federal Agency 41 - Medicare Secondary Black Lung 42 - Medicare Secondary Veteran's Administration 43 - Medicare Secondary Disabled Beneficiary Under Age 65 with LGHP 47 - Medicare Secondary, Other Liability Insurance Primary
		SBR06-SBR08	Not Used by HIPAA			
		SBR09	Claim Filing Indicator Code	S	1/2	11 - Other Non-Federal Programs 12 - PPO 13 - POS 14 - EPO 15 - Indemnity 16 - HMO Medicare Risk 17 - Dental Maintenance Organization AM - Automobile Medical BL - Blue Cross/Blue Shield CH - CHAMPUS CI - Commercial Insurance Company DS - Disability HM - HMO FI - Federal Employees Program LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veteran Administration Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
119	2000B	PAT01-PAT04	Not Used by HIPAA			
		PAT05	Date Time Period Format Qualifier	R	2/3	**D8 - Date** Applies to Subscriber, blank for dependent
		PAT06	Insured Date of Death	R	1/35	
		PAT07	Unit or Basis Measurement Code	R	2/2	**01** (Actual Pounds)
		PAT08	Insured (Patient) Weight	R	1/10	
		PAT09	Pregnancy Indicator	R	1/1	Y - Yes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
121	2010BA	NM101	Entity Identifier Code	R	2/3	**IL** Insured or Subscriber
		NM102	Entity Type Qualifier	R	1/1	1 - person, 2 – Non-Person
		NM103	Subscriber Last Name	R	1/60	
		NM104	Subscriber First Name	S	1/35	
		NM105	Subscriber Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Subscriber Name Suffix	S	1/10	
		NM108	Subscriber Primary ID	S	2/80	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use*)
		NM109	Subscriber Primary ID	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
124	2010BA	N301	Subscriber Address 1	R	1/55	
		N302	Subscriber Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	Notes/ Comments
125	2010BA	N401	Subscriber City Name	R	2/30	
		N402	Subscriber State	S	2/2	
		N403	Subscriber Zip Code	S	3/15	
		N404	Subscriber Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Subscriber Sub-Country Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
127	2010BA	DMG01	Date Time Period Format Qualifier	R	2/3	**D8** Date
		DMG02	Subscriber Birth Date	R	1/35	
		DMG03	Subscriber Gender Code	R	1/1	F - Female M - Male U - Unknown
		DMG04-DMG11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
129	2010BA	REF01	Reference Identification Qualifier	R	2/3	**SY** SSN (cannot be used for Medicare)
		REF02	Subscriber SSN	R	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
130	2010BA	REF01	Reference Identification Qualifier	R	2/3	**Y4** Agency Claim Number
		REF02	Property/Casualty Agency ID number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
131	2010BA	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Property Casualty Patient Contact Name	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number	R	1/256	
		PER05	Communication Number Qualifier	R	2/2	**EX** Telephone Ext.
		PER06	Contact Telephone Extension	S	1/256	
		PER07- PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
133	2010BB	NM101	Entity Identifier Code	R	2/3	**PR** Payer
		NM102	Entity Type Qualifier	R	1/1	**2 –** Non-Person
		NM103	Payer Name	R	1/60	
		NM104- NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	Payer Primary ID XV	S	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
135	2010BB	N301	Payer Address 1	R	1/55	
		N302	Payer Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
136	2010BB	N401	Payer City Name	R	30	
		N402	Payer State	S	2	
		N403	Payer Zip Code	S	3/15	
		N404	Payer Country Code	S	3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Payer Sub-Country Code	S	3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
138	2010BB	REF01	Reference Identification Qualifier	R	2/3	**2U** Supplemental payer id number **FY** Claim office number **EI** Federal Taxpayer's ID Number
		REF02	Payer Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
140	2010BB	REF01	Reference Identification Qualifier	R	2/3	**LU** Provider Location ID Number **G2** Provider Commercial ID Number
		REF02	Billing Provider Secondary ID	R	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
144	2000C	PAT01	Dependent Relationship Code	R	2/2	01 - Spouse 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		PAT02- PAT04	Not Used by HIPAA			
		PAT06	Insured Date of Death	R	1/35	**D8** Date
		PAT08	Insured (Patient) Weight	R	1/10	**01** Actual Pounds
		PAT09	Pregnancy Indicator	R	1/1	Y - Yes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
147	2010CA	NM101	Entity Identification Code	R	2/3	**QC** Patient
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Dependent Last Name	R	1/60	
		NM104	Dependent First Name	R	1/35	
		NM105	Dependent Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Dependent Suffix Name	S	1/10	
		NM108- NM111	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
149	2010CA	N301	Dependent Address 1	R	1/55	
		N302	Dependent Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
150	2010CA	N401	Dependent City Name	R	2/30	
		N402	Dependent State	S	2/2	
		N403	Dependent Zip Code	S	3/15	
		N404	Dependent Country Code	S	2/3	Required only if country not USA.
		N405 N406	Not Used by HIPAA			
		N407	Dependent Sub-Country Code	S	2/3	Required only if country not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
152	2010CA	DMG01	Date Time Period Format Qualifier		2/3	**D8** Date
		DMG02	Dependent Birth Date	R	1/35	
		DMG03	Dependent Gender Code	R	1/1	F - Female M - Male U - Unknown (Note: Required on Outbound)
		DMG04- DMG11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
154	2010CA	REF01	Reference Identification Qualifier	R	2/3	**Y4** Property/Casualty Agency identification number
		REF02	Dependent Secondary ID Y4	R	1/50	
		REF03 REF04	Not Used by HIPAA			

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
155	2010CA	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Property Casualty Patient Contact Name	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number	R	1/256	
		PER05	Communication Number Qualifier	S	2/2	**EX** Telephone Ext.
		PER06	Contact Telephone Extension	S	1/256	
		PER07-PER09	Not Used by HIPAA		1/60	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
157	2300	CLM01	Patient Account Number	R	1/38	
		CLM02	Total Claim Charge Amount	R	1/18	
		CLM03 CLM04	Not Used by HIPAA			
		CLM05-01	Facility Type Code	R	1/2	Place of service
		CLM05-02	Facility Code Qualifier	R	1/1	**B** Claim submission reason code.
		CLM5-03	Claim Frequency Code	R	1/1	1 = Original 7 = Replacement/Adjustment 8 = Void
		CLM06	Provider Signature Indicator	R	1/1	**www.nubc.org** Y - Yes N - No
		CLM07	Provider Accept Assignment Code	S	1/1	A - Assigned B - Assignment Accepted on Clinical Lab Services Only C - Not Assigned
		CLM08	Assignment of Benefits Indicator	R	1/1	Y - Yes N - No W - Not Applicable
		CLM09	Release of Information Indicator	R	1/1	I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has a signed statement permitting release of medical billing data related to a claim
		CLM10	Patient Signature Source Code	S	1/1	P - Signature generated by provider because patient was unavailable.
		CLM11-1	Related Causes Code 1	R	2/3	AA - Auto Accident EM - Employment OA - Other Accident
		CLM11-2	Related Causes Code 2	S	2/3	AA - Auto Accident EM - Employment OA - Other Accident
		CLM11-3	Not Used by HIPAA			
		CLM11-4	Auto Accident State or Province Code	S	2/2	Auto accident state or province code
		CLM11-5	Auto Accident Country Code	S	2/3	Required only if country is not USA.
		CLM12	Special Program Indicator	S	2/3	02 - Physically Handicapped Children's Program 03 - Special Federal Funding 05 - Disability 7 Third Party Processing Delay 09 - Second Opinion or Surgery
		CLM13-CLM19	Not Used by HIPAA			

		CLM20	Delay Reason Code	S	1/2	1 - Proof of Eligibility Unknown or Unavailable 2 - Litigation, 3 - Authorization Delays 4 - Delay in Certifying Provider, 5 - Delay in Supplying Billing Forms 6 - Delay in Delivery of Custom-made Appliances 7 - Third Party Processing Delay 8 - Delay in Eligibility Determination 9 - Original Claim Rejected or Denied Due to a Reason Unrelated to Billing Limitation Rules 10 - Administration Delay in Prior Approval Process 11 Other 15 Natural Disaster
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
164-181	2300	DTP01	Onset of Current Illness or Injury Date	R	1/35	**431** Onset of Current Symptoms or Illness **454** Initial Treatment **453** Acute Manifestation **439** Accident **484** Last Menstrual Period **471** Hearing or Vision Prescription **297** Last Worked **304** Last Seen **296** Work Return **435 Hospital Admission** **096** Hospital Discharge **090** Assumed Care **091** Relinquished Care **444** Property Casualty First **050** Repricer Received **NOTE: 435 Admission required on Inpatient Claims**
		DTP02	Initial Treatment Date	R	1/35	**D8** - Date (when DTP01 = 314 or 361) or **RD8** - Date Range (when DTP01 = 314)
		DTP03	Last Seen Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
186		CN101	Contract Type Code	R	2/2	01 - Diagnosis Related Group (DRG) 02 - Per Diem 03 - Variable Per Diem 04 - Flat 05 - Capitated 06 - Percent 09 – Other
		CN102	Contract Amount	S	1/18	
		CN103	Contract Percentage	S	1/6	
		CN104	Contract Code	S	1/50	
		CN105	Terms Discount Percentage	S	1/6	
		CN106	Contract Version Identifier	S	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
188	**2300**	**AMT01**	**Amount Qualifier Code**	R	1/3	**F5** Patient Amount Paid/Responsibility
		AMT02	**Patient Amount Paid**	R	1/18	**(REQUIRED)** Monetary Amount – Patient Amount Paid/Responsibility **If Loop 2430 CAS*PR is sent. Value of all CAS*PR must match AMT*F5 Amount**
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

189-206	2300	REF01	Referencing Identification Qualifier	R	2/3	**F5** Medicare Version Code **EW** Mammography Certification **4N** Special Payment Reference **G1 (G - one)** Prior Authorization Number **9F** Referral Number **F8** Original Reference ID Number **X4** CLIA number **9C** Repricer's claim number for a previously adjusted (resubmitted) claim **9A** Repricer's claim number **D9** Clearinghouse or Value Added Network unique claim ID **1J** NPI of Home Health or Hospice Care Facility **EA** Medical Record Identification Number **P4** Project Code **LX** IDE number **NOTE: REF*F8 REQUIRED if CLM05-03 = 7 or 8**
		REF02	Reference Identification Reference Information	R	1/50	**NOTE: If F8 is sent Original Payer Claim Control Number**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
211	2300	CR102	Patient Weight	S	1/10	**LB** Pound **NOTE: Required when CLM05-01 is '41' or '42'**
		CR103	Not Used by HIPAA			
		CR104	Ambulance Transport Reason Code	R	1/1	A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transport E - Patient transferred to rehabilitation facility
		CR106	Transport Distance	R	1/15	**DH** Miles
		CR107 CR108	Not Used by HIPAA			
		CR109	Round Trip Purpose Description	S	1/80	
		CR110	Stretcher Purpose Description	S	1/80	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
214	2300	CR201-CR207	Not Used by HIPAA			
		CR208	Patient Condition Code for Spinal Manipulation	R	1/1	A - Acute Condition C - Chronic Condition D - Non-acute E - Non-Life Threatening F - Routine G - Symptomatic M - Acute Manifestation of a Chronic Condition
		CR209	Not Used by HIPAA			
		CR210	Patient Condition Description - Spinal Manipulation 1	S	1/80	

		CR211	Patient Condition Description - Spinal Manipulation 2	S	1/80	
		CR212	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
216	2300	CRC01	Code Category		2/2	**07** Certification condition code applies indicator. N No, Y Yes
		CRC02	Ambulance Certification Condition Indicator 1	R	1/1	
		CRC03	Ambulance Condition Indicator Code 1a	R	2/3	01 Patient was admitted to a hospital 04 Patient was moved by stretcher 05 Patient was unconscious or in shock 06 Patient was transported in an emergency situation 07 Patient had to be physically restrained 08 Patient had visible hemorrhaging 09 Ambulance service was medically necessary 12 Patient is confined to a bed or chair
		CRC04	Ambulance Condition Indicator Code 1b	S	2/3	See codes in CRC03 (field 48)
		CRC05	Ambulance Condition Indicator Code 1c	S	2/3	See codes in CRC03 (field 48)
		CRC06	Ambulance Condition Indicator Code 1d	S	2/3	See codes in CRC03 (field 48)
		CRC07	Ambulance Condition Indicator Code 1e	S	2/3	See codes in CRC03 (field 48)
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
219	2300	CRC01	Vision Code Category 1	R	2/2	E1 - Spectacle Lenses E2 - Contact Lenses E3 - Spectacle Frames
		CRC02	Vision Certification Condition Indicator 1	R	1/1	Y - Yes N - No
		CRC03	Vision Condition Indicator Code 1a	R	2/3	L1 - General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met L2 - Replacement Due to Loss or Theft L3 - Replacement Due to Breakage or Damage L4 - Replacement Due to Patient Preference L5 - Replacement Due to Medical Reason
		CRC04	Vision Condition Indicator Code 1b	S	2/3	See CRC03 (field 67)
		CRC05	Vision Condition Indicator Code 1c	S	2/3	See CRC03 (field 67)
		CRC06	Vision Condition Indicator Code 1d	S	2/3	See CRC03 (field 67)
		CRC07	Vision Condition Indicator Code 1e	S	2/3	See CRC03 (field 67)
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
221	2300	CRC01	Code Category	R	2/2	**75** Functional limitations
		CRC02	Homebound Certification Condition Indicator	R	1/1	
		CRC03	Homebound Indicator	R	2/3	IH - Independent at Home
		CRC04-CRC07	Not Used by HIPAA		1/1	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
221	2300	CRC01	Code Category		2/2	**ZZ** Mutually defined

		CRC02	EPSDT Certification Condition Indicator	R	1/1	Y - Yes N - No
		CRC03	EPSDT Condition Indicator Code 1	R	2/3	AV - Available - Not Used NU - Not Used S2 - Under Treatment ST - New Services Requested
		CRC04	EPSDT Condition Indicator Code 2	S	2/3	See CRC03 (field 89)
		CRC05	EPSDT Condition Indicator Code 3	S	2/3	See CRC03 (field 89)
		CRC06 CRC07	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
226	2300	HI01-1	Principal Diagnosis Qualifier	R	1/3	BK - ICD-9 ABK - ICD-10
		HI01-2	Principal Diagnosis	R	1/30	
		HI02-1	Diagnosis Qualifier 2	R	1/3	BK - ICD-9 ABK - ICD-10
		HI02-2	Diagnosis Code 2	S	1/30	
		HI03-1	Diagnosis Qualifier 3	R	1/3	BK - ICD-9 ABK - ICD-10
		HI03-2	Diagnosis Code 3	S	1/30	
		HI04-1	Diagnosis Qualifier 4	R	1/3	BK - ICD-9 ABK - ICD-10
		HI04-2	Diagnosis Code 4	S	1/30	
		HI05-1	Diagnosis Qualifier 5	R	1/3	BK - ICD-9 ABK - ICD-10
		HI05-2	Diagnosis Code 5	S	1/30	
		HI06-1	Diagnosis Qualifier 6	R	1/3	BK - ICD-9 ABK - ICD-10
		HI06-2	Diagnosis Code 6	S	1/30	
		HI07-1	Diagnosis Qualifier 7	R	1/3	BK - ICD-9 ABK - ICD-10
		HI07-2	Diagnosis Code 7	S	1/30	
		HI08-1	Diagnosis Qualifier 8	R	1/3	BK - ICD-9 ABK - ICD-10
		HI08-2	Diagnosis Code 8	S	1/30	
		HI09-1	Diagnosis Qualifier 9	R	1/3	BK - ICD-9 ABK - ICD-10
		HI09-2	Diagnosis Code 9	S	1/30	
		HI010-1	Diagnosis Qualifier 10	R	1/3	BK - ICD-9 ABK - ICD-10
		HI10-2	Diagnosis Code 10	S	1/30	
		HI011-1	Diagnosis Qualifier 11	R	1/3	BK - ICD-9 ABK - ICD-10
		HI11-2	Diagnosis Code 11	S	1/30	
		HI012-1	Diagnosis Qualifier 12	R	1/3	BK - ICD-9 ABK - ICD-10
		HI12-2	Diagnosis Code 12	S	1/30	
			Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
239	2300	HI01-2	Principal Anesthesia Related Code	S	1/30	**BP** Health Care Financing Administration Common Procedural Coding System Principal Procedure
		HI02-2	Additional Anesthesia Related Code	S	1/30	**BO** Health Care Financing Administration Common Procedural Coding System
		HI03-HI12	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
242	2300	HI01-2	Condition Indicator Code 1	S	1/30	**BG** Condition
		HI02-2	Condition Indicator Code 2	S	1/30	See HI01-2 for codes
		HI03-2	Condition Indicator Code 3	S	1/30	See HI01-2 for codes
		HI04-2	Condition Indicator Code 4	S	1/30	See HI01-2 for codes

		HI05-2	Condition Indicator Code 5	S	1/30	See HI01-2 for codes
		HI06-2	Condition Indicator Code 6	S	1/30	See HI01-2 for codes
		HI07-2	Condition Indicator Code 7	S	1/30	See HI01-2 for codes
		HI08-2	Condition Indicator Code 8	S	1/30	See HI01-2 for codes
		HI09-2	Condition Indicator Code 9	S	1/30	See HI01-2 for codes
		HI10-2	Condition Indicator Code 10	S	1/30	See HI01-2 for codes
		HI11-2	Condition Indicator Code 11	S	1/30	See HI01-2 for codes
		HI12-2	Condition Indicator Code 12	S	1/30	See HI01-2 for codes
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
252	2300	HCP01	Claim Pricing/Repricing Methodology	R	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at a Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing 10 - Other Pricing 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	Claim Repricing Allowed Amount	R	1/18	
		HCP03	Claim Repricing Saving Amount	S	1/18	
		HCP04	Claim Level Repricing Organization ID	S	1/50	
		HCP05	Claim Repricing Per Diem or Flat Rate	S	1/9	
		HCP06	Claim Repricing Approved Ambulatory Patient Group Code	S	1/50	
		HCP07	Claim Repricing Approved Ambulatory Patient Group Amount	S	1/18	
		HCP08-HCP12	Not Used by HIPAA			
		HCP13	Claim Repricing Reject Reason Code	S	2/2	T1 - Cannot Identify Provider as TPO (3rd Party Organization) Participant T2 - Cannot Identify Payer as TPO Participant T3 - Cannot Identify Insured as TPO Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing T6 - Claim does not contain enough information for repricing
		HCP14	Claim Repricing Policy Compliance Code	S	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance) 3 - Not Medically Necessary (Non-Compliance) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital
		HCP15	Claim Repricing Exception Code	R	1/2	1 - Non-Network professional provider in Network hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 – Other **NOTE: REQUIRED if Known** **1 or 3 = Out of Network** **6 = In Network**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
257	2310A	NM101	Entity Identifier Code	R	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Referring Provider Last Name	R	1/60	
		NM104	Referring Provider First Name	S	1/35	
		NM105	Referring Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Referring Provider Name Suffix	S	1/10	
		NM109	Referring Provider Primary ID XX	R	2/80	**XX** NPI (HIPAA National Provider ID)
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
257	2310A	NM101	Entity Identifier Code	R	2/3	**P3** Primary Care Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	PCP Provider Last Name	R	1/60	
		NM104	PCP Provider First Name	S	1/35	
		NM105	PCP Provider Middle Name	S	1/25	
		NM107	PCP Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** NPI (HIPAA National Provider ID)
		NM109	PCP Provider Primary ID	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
260	2310A	REF01	Reference Identifier Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number (**REQUIRED**) **1G** Provider UPIN number
		REF02	Referring Provider Secondary ID	S	1/50	**REF*G2*9999 = Tribal Provider**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments** In the absence of a valid Rendering Provider Name or NPI (i.e. PA, PT, or nurse) please use the Physician Name and NPI that the services were provided under or the Physician Name and NPI that the member is assigned to.
262	**2310B**	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider **REQUIRED *if different than Billling***
		NM102	**Entity Type Qualifier**	**R**	**1/1**	**1 Person**
		NM103	**Rendering Provider Last/Organization Name**	**R**	**1/60**	
		NM104	Rendering Provider First Name	S	1/35	
		NM105	Rendering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Rendering Provider Name Suffix	S	1/10	
		NM108	**Identification Code Qualifier**	**R**	**1/2**	**XX** NPI (HIPAA National Provider ID)
		NM109	**Rendering Provider Primary ID**	**R**	**2/80**	**REQUIRED *if different than Billling***

		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
265	2310B	PRV01	Provider Code		1/3	**PE** Performing
		PRV02	Reference Identifier Qualifier		2/3	**PXC** Rendering provider specialty type
		PRV03	**Rendering Provider Taxonomy Code**	R	1/50	***REQUIRED if Rendering Provider is present***
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
267	2310B	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Rendering Provider Secondary ID G2	S	1/50	**REF*G2*9999 = Tribal Provider**
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
269	2310C	NM101	Entity Identifier Code	R	2/3	**77** Service Location **NOTE: Required if Rendering Provider is present**
		NM102	Entity Type Qualifier	R	1/1	**2** (non-Person)
		NM103	Service Facility Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Facility Primary ID	R	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
272	2310C	N301	Service Facility Address 1	R	1/55	
		N302	Service Facility Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
273	2310C	N401	Service Facility City	R	2/30	
		N402	Service Facility State	S	2/2	
		N403	Service Facility Zip Code	S	3/15	
		N404	Service Facility Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Service Facility Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
275	2310C	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Service Facility Secondary ID	S	1/50	

		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
277	2310C	PER01	Contact Function Code	R	2/2	**IC** Information Contact
		PER02	Service Facility Contact Name 1	S	1/60	
		PER03	Communication Number Qualifier	R	2/2	**TE** Telephone
		PER04	Contact Telephone Number 1	S	1/256	
		PER05	Communication Number Qualifier	S	2/2	**EX** Telephone Ext
		PER06	Contact Telephone Extension 1	S	1/256	
		PER07- PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
280	2310D	NM101	Entity Identifier Code	R	2/3	**DQ** Referring Provider Entity Identifier Code
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Supervising Provider Last Name	R	1/60	
		NM104	Supervising Provider First Name	S	1/35	
		NM105	Supervising Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Supervising Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** NPI (HIPAA National Provider ID)
		NM109	Supervising Provider Primary ID XX	R	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
283	2310D	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number
		REF02	Supervising Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
285	2310E	NM101	Entity Identifier Code	R	2/3	**PW** Pickup address
		NM102	Entity Type Qualifier	R	1/1	**Note: Required when CLM05-01 = '41'** **2** non-person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
287	2310E	N301	Ambulance Pickup Address 1	R	1/55	
		N302	Ambulance Pickup Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
288	2310E	N401	Ambulance Pickup City	R	2/30	
		N402	Ambulance Pickup State	R	2/2	
		N403	Ambulance Pickup Zip Code	R	3/15	
		N404	Ambulance Pickup Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Pickup Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

	2310F	NM101	Entity Identifier Code	R	2/3	**45** drop off location **Note: Required when CLM05-01 = '41'**
		NM102	Entity Type Qualifier	R	1/1	**2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
292	2310F	N301	Ambulance Drop-Off Address 1	R	1/55	
		N302	Ambulance Drop-Off Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
293	2310F	N401	Ambulance Drop-Off City	R	2/30	
		N402	Ambulance Drop-Off State	R	2/2	
		N403	Ambulance Drop-Off Zip Code	R	3/15	
		N404	Ambulance Drop-Off Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Drop-Off Sub Country Code	S	1/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
295	2320	SBR01	Payer Responsibility Sequence Number Code	R	1/1	A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven **P - Primary** S - Secondary T - Tertiary U - Unknown **NOTE: Required to report Paid Amount and non-zero Member Cost Share in Loop 2430**
		SBR02	Individual Relationship Code	R	2/2	01 - Spouse 18 - Self 19 - Child 20 - Employee 21 - Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
		SBR03	Other Insured Group or Policy Number	S	1/50	
		SBR04	Other Insured Group Name	S	1/60	

		SBR05	Insurance Type Code	S	1/3	12 - Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 - Medicare Secondary End-Stage Renal Disease Beneficiary in 12 month coordination period with employer's group health plan 14 - Medicare Secondary, No-fault Insurance including Auto as Primary 15 - Medicare Secondary Worker's Compensation 16 - Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 - Medicare Secondary Black Lung 42 - Medicare Secondary Veteran's Administration 43 - Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 - Medicare Secondary, Other Liability Insurance is Primary
		SBR06 SBR08	Not Used by HIPAA			
		SBR09	Claim Filing Indicator Code	S	1/2	11' - Other Non-Federal Programs, '12' - PPO, '13' - POS, '14' - EPO, '15' - Indemnity, '16' - HMO Medicare Risk, '17' - Dental Maintenance Organization 'AM' - Automobile Medical, 'BL' - Blue Cross/Blue Shield, 'CH' - CHAMPUS, 'CI' - Commercial Insurance Company, 'DS' - Disability, 'HM' - HMO, 'FI' - Federal Employees Program, 'LM' - Liability Medical, 'MA' - Medicare Part A, 'MB' - Medicare Part B, 'MC' - Medicaid, 'OF' - Other Federal Program, 'TV' - Title V, 'VA' - Veteran Administration Plan, 'WC' - Workers' Compensation Health Claim, 'ZZ' - Mutually Defined
Seg:	**CAS**	**Occur 5**	**Claim Level Adjustments**	**S**	**Page: 299**	
299-304	2320	CAS01	Claim Adjustment Group Code 1	R	1/2	General category of payment adjustment CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** **NOTE: Required at Loop 2430**
		CAS02	Adjustment Reason Code 1a	R	1/5	
		CAS03	Adjustment Amount 1a	R	1/18	
		CAS04	Adjustment Quantity 1a	S	1/15	
		CAS05	Adjustment Reason Code 1b	S	1/5	
		CAS06	Adjustment Amount 1b	S	1/18	
		CAS07	Adjustment Quantity 1b	S	1/15	
		CAS08	Adjustment Reason Code 1c	S	1/5	
		CAS09	Adjustment Amount 1c	S	1/18	
		CAS10	Adjustment Quantity 1c	S	1/15	
		CAS11	Adjustment Reason Code 1d	S	1/5	
		CAS12	Adjustment Amount 1d	S	1/18	
		CAS13	Adjustment Quantity 1d	S	1/15	
		CAS14	Adjustment Reason Code 1e	S	1/5	
		CAS15	Adjustment Amount 1e	S	1/18	
		CAS16	Adjustment Quantity 1e	S	1/15	

		CAS17	Adjustment Reason Code 1f	S	1/5	
		CAS18	Adjustment Amount 1f	S	1/18	
		CAS19	Adjustment Quantity 1f	S	1/15	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
305-307	2320	AMT01	Amount Qualifier Code	R	1/3	**D** Payor Amount Paid **(Required when sending SVD segment)** **EAF** Amount Owed **A8** Non-covered Charges - Actual
		AMT02	Amount	R	1/18	
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
308	2320	OI01 OI02	Not Used by HIPAA			
		OI03	Benefits Assignment Certification Indicator	R	1/1	Indicates whether insured has authorized benefits to be assigned to the provider N - No W - Not Applicable (Use when patient refuses to assign benefits) Y – Yes **(Required when sending segment)**
		OI04	Patient Signature Source Code	R	1/1	P - Signature generated by provider
		OI05	Not Used by HIPAA			
		OI06	Release of Information Code	R	1/1	Indicates whether provider has signed authorization for release of medical information I - Informed Consent to Release Medical Information for conditions or diagnoses regulated by federal statutes Y - Yes, provider has signed statement perm
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
310	2320	MOA01	Reimbursement Rate	S	1/10	
		MOA02	Claim HCPCS Payable Amount	S	1/18	
		MOA03	Remittance Remark Code 1	S	1/50	
		MOA04	Remittance Remark Code 2	S	1/50	
		MOA05	Remittance Remark Code 3	S	1/50	
		MOA06	Remittance Remark Code 4	S	1/50	
		MOA07	Remittance Remark Code 5	S	1/50	
		MOA08	Claim ESRD Payment Amount	S	1/18	End Stage Renal Disease payment amount
		MOA09	Nonpayable Professional Component Amount	S	1/18	Professional component amount billed but not payable
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
313	2330A	NM101	Entity Identifier Code	R	2/3	**IL** Insured or Subscriber **(Required when sending SVD segment)**
		NM102	Entity Type Qualifier	R	1/1	**1** - person **2** - organization
		NM103	Other Insured Last Name	R	1/60	
		NM104	Other Insured First Name	S	1/35	
		NM105	Other Insured Middle Name	S	1/25	
		NM106	Not Used by HIPAA			

		NM107	Other Insured Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**MI** Member identification number ***II*** *HIPAA National Individual Identifier (future use)*
		NM109	Other Insured Primary ID	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
316	2330A	N301	Other Insured Address 1	R	1/55	
		N302	Other Insured Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
317	2330A	N401	Other Insured City	R	2/30	**(Required when sending SVD segment**
		N402	Other Insured State	S	2/2	
		N403	Other Insured Zip Code	S	3/15	
		N404	Other Insured Country Code	S	2/3	
		N405 N406	Not Used by HIPAA			
		N407	Other Insured Sub-Country Code	S	2/3	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
319	2330A	REF01	Reference Identification Qualifier		2/3	**SY** Social security number (cannot be used for Medicare)
		REF02	Other Insured Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
320	2330B	NM101	Entity Identifier Code	R	2/3	**PR** Payer **(Required when sending SVD segment)**
		NM102	Entity Type Qualifier	R	1/1	**2** Non-Person Entity
		NM103	Other Payer Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	½	**PI** Payer identification number ***XV*** *HCFA National Plan ID (future use)*
		NM109	Other Payer Primary ID 2	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
322	2330B	N301	Other Payer Address 1	R	1/55	
		N302	Other Payer Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
323	2330B	N401	Other Payer City	R	2/30	
		N402	Other Payer State	S	2/2	
		N403	Other Payer Zip Code	S	3/15	
		N404	Other Payer Country Code	S	2/3	
		N405 N406	Not Used by HIPAA			
		N407	Other Payer Sub-Country Code	S	2/3	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

325	2330B	DTP01	Date/Time Qualifier	R	3/3	**573** Date Claim paid
		DTP02	Date Time Period Format Qualifier	R	2/3	**D8** Date Expressed in Format CCYYMMDD
		DTP03	Other Payer Adjudication or Payment Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
326	2330B	REF01	Reference Identification Qualifier	R	2/3	**2U** Payer identification number **FY** Claim office number **EI** Tax ID
		REF02	Other Payer Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
328	2330B	REF01	Reference Identification Qualifier	R	2/3	**G1** Prior Authorization Number **9F** Referral number **T4** Adjustment Indicator **F8** Original reference number
		REF02	Other Payer Control ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
332	2330C	NM101	Entity Identifier Code	R	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
334	2330C	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number
		REF02	Other Payer Referring Provider 1 Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
336	2330D	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider
		NM102	Entity Type Qualifier	R	1/1	**1** person **2** non-person
		NM103- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
338	2330D	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number
		REF02	Other Payer Rendering Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
340	2330E	NM101	Entity Identifier Code	R	2/3	**77** Service Location
		NM102	Entity Type Qualifier	R	1/1	**1** Person

		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
342	2330E	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Service Facility Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
340	2330F	NM101	Entity Identifier Code	R	2/3	**DQ** Supervising Physician
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
345	2330F	REF01	Reference Identification Qualifier	R	2/3	**0B** State License Number **LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Supervising Provider Secondary ID	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
347	2330G	NM101	Entity Identifier	R	2/3	**85** Billing Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person **2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
349	2330G	REF01	Reference Identification Qualifier	R	2/3	**LU** Location Number **G2** Provider Commercial Number
		REF02	Other Payer Billing Provider Secondary ID	R	1/50	**LU** Location Number
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
350	2400	LX01	Service Line Number	R	1/6	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
351	2400	SV101-1	Procedure Code Qualifier	R	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing (ABC) code
		SV101-2	Procedure Code	R	1/48	
		SV101-3	Procedure Code Modifier 1	S	2/2	**NOTE: 340B physician administered drug include modifier "UD' in either SV101-3, -4, -5, or -6**
		SV101-4	Procedure Code Modifier 2	S	2/2	
		SV101-5	Procedure Code Modifier 3	S	2/2	
		SV101-6	Procedure Code Modifier 4	S	2/2	
		SV101-7	Procedure Code Description	S	1/80	Additional information when procedure code does not definitively describe condition.
		SV101-8	Not Used by HIPAA			

		SV102	Line Item Charge Amount	R	1/18	Submitted charge amount (implied decimal) Note: Zero is acceptable
		SV103	Quantity Qualifier	R	2/2	MJ - Minutes UN - Unit
		SV104	Quantity	R	1/15	Number of units (floating point)
		SV105	Place of Service Code	S	1/2	
		SV106	Not Used by HIPAA			
		SV107-1	Diagnosis Code Pointer 1	R	1/2	Diagnosis code pointer
		SV107-2	Diagnosis Code Pointer 2	S	1/2	Additional diagnosis code pointer
		SV107-3	Diagnosis Code Pointer 3	S	1/2	Additional diagnosis code pointer
		SV107-4	Diagnosis Code Pointer 4	S	1/2	Additional diagnosis code pointer
		SV108	Not Used by HIPAA			
		SV109	Emergency Indicator	S	1/1	Y - Yes
		SV110	Not Used by HIPAA			
		SV111	EPSDT Indicator	S	1/1	Y - Yes
		SV112	Family Planning Indicator	S	1/1	Y - Yes
		SV113	Not Used by HIPAA			
		SV114	Not Used by HIPAA			
		SV115	Co-Pay Status Code	S	1/1	0 - Copay Exempt
		SV116-SV121	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
359	2400	SV501-1	Product/Service ID Qualifier		2/2	**HC** (HCPCS) Codes
		SV501-2	Durable Medical Equipment Procedure Code	R	1/48	
		SV501-3-SV501-8	Not Used by HIPAA			
		SV503	Length of Medical Necessity	R	1/15	**DA** Length of medical necessity in days (floating point)
		SV504	DME Rental Price	R	1/18	DME Rental Price (implied decimal)
		SV505	DME Purchase Price	R	1/18	DME Purchase Price (implied decimal)
		SV506	Rental Unit Price Indicator	R	1/1	1 - Weekly 4 - Monthly 6 - Daily
		SV507	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
362	2400	PWK01	Attachment Report Type Code	R	2/2	03 Report Justifying Treatment Beyond Utilization Guidelines 04 Drugs Administered 05 Treatment Diagnosis 06 Initial Assessment 07 Functional Goals 08 Plan of Treatment 09 Progress Report 10 Continued Treatment 11 Chemical Analysis 13 Certified Test Report 15 Justification for Admission 21 Recovery Plan A3 Allergies/Sensitivities Document A4 Autopsy Report AM Ambulance Certification AS Admission Summary B2 Prescription B3 Physician Order B4 Referral Form BR Benchmark Testing Results

						BS Baseline BT Blanket Test Results CB Chiropractic Justification CK Consent Form(s) CT Certification D2 Drug Profile Document DA Dental Models DB Durable Medical Equipment Prescription DG Diagnostic Report DJ Discharge Monitoring Report DS Discharge Summary EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) HC Health Certificate HR Health Clinic Records I5 Immunization Record IR State School Immunization Records LA Laboratory Results M1 Medical Record Attachment MT Models NN Nursing Notes OB Operative Note OC Oxygen Content Averaging Report OD Orders and Treatments Document OE Objective Physical Examination (including vital signs) Document OX Oxygen Therapy Certification OZ Support Data for Claim P4 Pathology Report P5 Patient Medical History Document PE Parenteral or Enteral Certification PN Physical Therapy Notes PO Prosthetics or Orthotic Certification PQ Paramedical Results PY Physician's Report PZ Physical Therapy Certification RB Radiology Films RR Radiology Reports RT Report of Tests and Analysis Report RX Renewable Oxygen Content Averaging Report SG Symptoms Document V5 Death Notification XP Photographs
3	PWK02	1/2	Attachment Transmission Code	R	2	AA - Available on Request at Provider Site BM - By Mail EL - Electronically Only EM - Email FX - By Fax FT - File Transfer
	PWK03 PWK04		Not Used by HIPAA			
	PWK05					**AC** Attachment Control Number
4	PWK06	2/80	Attachment Control Number	S	80	
	PWK07- PWK09					

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
366	2400	PWK01	Report Type Code		2/2	
		PWK02	DMERC Attachment Transmission Code	R	1/2	AB - Previously Submitted to Payer AD - Certification Included in this Claim AF - Narrative Segment Included in this Claim AG - No Documentation is Required NS - Not Specified (Paperwork available on request at provider's site)

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
368	2400	CR101	Unit or Basis for Measurement Code		2/2	**LB** Pound
		CR102	Patient Weight	S	1/10	
		CR103				Not Used by HIPAA
		CR104	Ambulance Transport Reason Code	R	1/1	A - Patient was transported to nearest facility for care of symptoms, complaints, or both B - Patient was transported for the benefit of a preferred physician C - Patient was transported for the nearness of family members D - Patient was transport E - Patient transported to Rehabilitation Facility
		CR105	Unit or Basis for Measurement Code		2/2	**DH** Miles
		CR106	Transport Distance	R	1/15	
		CR107 CR108	Not Used by HIPAA			
		CR109	Round Trip Purpose Description	S	1/80	
		CR110	Stretcher Purpose Description	S	1/80	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
371	2400	CR301	DME Certification	S	1/1	I - Initial R - Renewal S - Revised
		CR302	Unit or Basis for Measurement Code			**MO** Months
		CR303	DME Duration	S	1/15	
		CR304 CR305	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
373	2400	CRC01	Code Category		2/2	**07** Ambulance Certification
		CRC02	Ambulance Certification Condition 1	S	1/1	Y - Yes N - No . Note: This segment can occur up to 3 times. 1st occurrence
		CRC03	Ambulance Condition Indicator 1	S	2/3	01 - Patient was admitted to a hospital 04 - Patient was moved by stretcher 05 - Patient was unconscious or in shock 06 - Patient was transported in an emergency situation 07 - Patient had to be physically restrained 08 - Patient had visible hemorrhaging 09 - Ambulance service medically necessary 12 - Patient is confined to a bed or chair
		CRC04	Ambulance Condition Indicator 2	S	2/3	See CRC03 for list.
		CRC05	Ambulance Condition Indicator 3	S	2/3	See CRC03 for list.
		CRC06	Ambulance Condition Indicator 4	S	2/3	See CRC03 for list.
		CRC07	Ambulance Condition Indicator 5	S	2/3	See CRC03 for list.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
376	2400	CRC01	Code Category		2/2	**70** Hospice
		CRC02	Hospice Employee Indicator	S	1/1	Y - Yes N - No
		CRC03				**65** Open
		CRC04- CRC07	Not Used by HIPAA			

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
378	2400	CRC01	Code Category		2/2	**09 D**urable Medical Equipment Certification
		CRC02	DME Certification Condition	S	1/1	Y - Yes N - No
		CRC03	DME Certification Condition Indicator 1	S	2/3	38 - Certification signed by the physician is on file at the supplier's office ZV - Replacement Item
		CRC04	DME Certification Condition Indicator 2	S	2/3	38 - Certification signed by the physician is on file at the supplier's office ZV - Replacement Item
		CRC05-CRC07	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
380	2400	DTP01	Date/Time Qualifier	R	3/3	**472** Service
		DTP02	Date Time Period Format Qualifier		2/3	**D8 or RD8**
		DTP03	Service Line To Date	S	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
386	2400	DTP03	Prescription Date	R	1/35	**DTP01 = 471** Prescription **DTP02 = D8**
		DTP03	Certification Revision Date	R	1/35	**DTP01 = 607** Certification Revision **DTP02 = D8**
		DTP03	Begin Therapy Date	R	1/35	**DTP01 = 463** Begin Therapy **DTP02 = D8**
		DTP03	Last Certification Date	R	1/35	**DTP01 = 461**Last Certification **DTP02 = D8**
		DTP03	Date Last Seen	R	1/35	**DTP01 = 304** Last Seen **DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
387	2400	DTP03	Most Recent Hemoglobin or Hematocrit Date	R	1/35	Test Date. **DTP01 = 738 DTP02 = D8**
		DTP03	Most Recent Serum Creatine Date	R	1/35	Test Date. **DTP01 = 739 DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
390	2400	DTP03	Shipped Date	R	1/35	**DTP01 = 011** Shipped **DTP02 = D8**
		DTP03	Last X-Ray Date	R	1/35	**DTP01 = 455** Last X-Ray **DTP02 = D8**
		DTP03	Initial Treatment Date	R	1/35	**DTP01 = 454** Initial Treatment **DTP02 = D8**
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
391-392	2400	QTY01	Quantity Qualifier		2/2	
		QTY02	Ambulance Patient Count	R	1/15	**PT** Patients
		QTY02	Obstetric Anesthesia Additional Units	R	1/15	**FL** Units
		QTY03 QTY04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
393	2400	MEA01	Test Result ID 1	R	2/2	OG - Original TR - Test Results
		MEA02	Test Result Qualifier 1	R	1/3	HT – Height R1 – Hemoglobin R2 – Hematocrit R3 - Epoetin Starting Dosage R4 - Creatinine
		MEA03	Test Result Value 1	R	1/20	
		MEA01	Test Result ID 2	R	2/2	2nd occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 2	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 2	R	1/20	
		MEA01	Test Result ID 3	R	2/2	3rd occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 3	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 3	R	1/20	

		MEA01	Test Result ID 4	R	2/2	4th occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 4	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 4	R	1/20	
		MEA01	Test Result ID 5	R	2/2	5th occurrence. See Field 101 for codes
		MEA02	Test Result Qualifier 5	R	1/3	See Field 102 for codes
		MEA03	Test Result Value 5	R	1/20	
		MEA04-MEA12	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
395	2400	CN101	Contract Type Code	R	1/2	01 - Diagnosis Related Group (DRG) 02 - Per Diem 03 - Variable Per Diem 04 – Flat 05 – Capitated 06 – Percent 09 - Other
		CN102	Contract Amount	S	1/18	
		CN103	Contract Percentage	S	1/6	
		CN104	Contract Code	S	1/50	
		CN105	Terms Discount Percentage	S	1/6	
		CN106	Contract Version Number	S	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
397-398	2400	REF01	Reference Identification Qualifier	R	2/3	**9B** Repriced Line Item Reference Number **9D** Adjusted Repriced Line Item Reference Number
		REF02	Reference Identification	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
399	2400	REF01	Reference Identification Qualifier	R	2/3	**G1** Prior Authorization Number
		REF02	Prior Authorization Number 2	R	1/50	See first REF02 above for codes/notes.
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
401-406	2400	REF01	Reference Identification Qualifier	R	2/3	**6R** Provider Control Number **BT** Batch Number **EW** Mammography Certification Number **X4** CLIA Number **F4** CLIA Facility Certification Number
		REF02	Line Item Control Number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
407	2400	REF01		R	2/3	**9F** Referral Number
		REF02	Referral Number	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
409-410	2400	AMT01	Amount Qualifier Code	R	1/3	**T** Tax **F4** Postage Claimed
		AMT02	Postage Claimed Amount	R	1/18	
		AMT03	Not Used by HIPAA			
Page	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
415	2400	PS101	Purchased Service Provider Identifier	R	1/50	
		PS102	Purchased Service Charge Amount	R	1/18	
		PS103	Not Used by HIPAA			
416	2400	HCP01	Line Pricing/Repricing Methodology	R	2/2	00 - Zero Pricing (Not Covered Under Contract) 01 - Priced as Billed at 100% 02 - Priced at the Standard Fee Schedule 03 - Priced at a Contractual Percentage 04 - Bundled Pricing 05 - Peer Review Pricing 06 - Per Diem Pricing 07 - Flat Rate Pricing 08 - Combination Pricing 09 - Maternity Pricing **10 - Other Pricing** 11 - Lower of Cost 12 - Ratio of Cost 13 - Cost Reimbursed 14 - Adjustment Pricing
		HCP02	**Line Repricing Allowed Amount**	R	1/18	**REQUIRED to report Service Line Allowed Amt**
		HCP03	Line Repricing Saving Amount	S	1/18	
		HCP04	Line Level Repricing Organization ID	S	1/50	
		HCP05	Line Repricing Per Diem or Flat Rate	S	1/9	
		HCP06	Line Repricing Approved Ambulatory Patient Group Code	S	1/50	
		HCP07	Line Repricing Approved Ambulatory Patient Group Amount	S	1/18	
		HCP08	Not Used by HIPAA			
		HCP09	Line Repricing Procedure Code Qualifier	S	2/2	ER - Jurisdiction Specific Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing Concepts (ABC) Codes
		HCP10	Line Repricing Procedure Code	S	1/48	
		HCP11	Line Repricing Procedure Quantity Qualifier	S	2/2	MJ - Minutes UN - Unit
		HCP12	Line Repricing Procedure Quantity	S	1/15	
		HCP13	Line Repricing Reject Reason Code	S	2/2	T1 - Cannot Identify Provider as TPO (Third Party Organization) Participant T2 - Cannot Identify Payer as TPO Participant T3 - Cannot Identify Insured as TPO Participant T4 - Payer Name or Identifier Missing T5 - Certification Information Missing T6 - Claim does not contain enough information for repricing
		HCP14	Line Repricing Policy Compliance Code	S	1/2	1 - Procedure Followed (Compliance) 2 - Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 - Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 - Not Followed Other (Non-Compliance Other) 5 - Emergency Admit to Non-Network Hospital

		HCP15	Line Repricing Exception Code	S	1/2	1 - Non-Network Professional Provider in Network Hospital 2 - Emergency Care 3 - Services or Specialist not in Network 4 - Out-of-Service Area 5 - State Mandates 6 - Other
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
416	2410	LIN01	Not Used by HIPAA			
		LIN03	National Drug Code or UPC	R	1/48	**N4** National Drug Code in 5-4-2 Addendum 222A1changed element name. **REQUIRED if PAD is administered by a physician not a pharmacy.**
		LIN04-LIN31				Not Used by HIPAA
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
426	2410	CTP01-CTP03	Not Used by HIPAA			
		CTP04	National Drug Unit Count	R	1/15	Quantity
		CTP05-1	Unit/Basis for Measurement	R	2/2	Basis of measurement for CTP04. F2 - International Unit GR – Gram ME – Milligram ML – Milliliter UN - Unit
		CTP05-2-CTP05-15	Not Used by HIPAA			
		CTP06-CTP11	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
428	2410	REF01	Prescription Number Qualifier	R	2/3	VY - Link Sequence Number XZ - Pharmacy Prescription Number
		REF02	Prescription Number	R	1/50	
		REF03 REF04	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
430	2420A	NM101	Entity Identifier Code	R	2/3	**82** Rendering Provider
		NM102	Entity Type Qualifier	R	1/1	**1 - Person** **2 - Non-Person**
		NM103	Service Line Rendering Provider Last/Organization Name	R	1/60	
		NM104	Service Line Rendering Provider First Name	S	1/35	
		NM105	Service Line Rendering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Service Line Rendering Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Rendering Provider Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
433	2420A	PRV01	Provider Code	R	1/3	**PE** Performing

		PRV02	Reference Identification Qualifier	R	2/3	**PXC** Provider Taxonomy Code
		PRV03	Service Line Rendering Provider Taxonomy Code	R	1/50	
		PRV04-PRV06	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
434	2420A	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** Provider UPIN number **LU** Location number
		REF02	Service Line Rendering Provider Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
436	2420B	NM101	Entity Identifier Code	R	2/3	**QB** Purchase Service Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person 2 Non-Person Entity
		NM103-NM106	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Purchased Service Provider Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
439	2420B	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Service Line Purchased Service Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
441	2420C	NM101	Entity Identifier Code	R	2/3	**77** Service Facility last/organization name
		NM102	Entity Type Qualifier	R	1/1	**2** (Service Location)
		NM103	Service Line Service Facility Name	R	1/60	
		NM104-NM107	Not Used by HIPAA			
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Service Line Service Facility Primary ID XX	S	2/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
444	2420C	N301	Service Facility Address 1	R	1/55	
		N302	Service Facility Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
445	2420C	N401	Service Facility City	R	2/30	
		N402	Service Facility State	S	2/2	
		N403	Service Facility Zip Code	S	3/15	
		N404	Service Facility Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Service Facility Sub-Country Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
447	2420C	REF01	Reference Identification Qualifier	R	2/3	**LU** Location Number. **G2** Provider commercial number
		REF02	Service Line Service Facility Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record.			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
449	2420D	NM101	Entity Identifier Code	R	2/3	**DQ** Supervising Physician
		NM102	Entity Type Qualifier	R	1/1	**1 -** Person
		NM103	Supervising Provider Last Name	R	1/60	
		NM104	Supervising Provider First Name	R	1/35	
		NM105	Supervising Provider Middle Name	R	1/25	
		NM106	Not Used by HIPAA			
		NM107	Supervising Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier	R	1/2	**XX** HIPAA National Provider ID
		NM109	Supervising Provider Primary ID	S	2/80	
		NM110- NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
452	2420D	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **LU** Location Number. **G2** Provider commercial number
		REF02	Supervising Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
454	2420E	NM101	Entity Identifier Code	R	2/3	**DK** Ordering Physician
		NM102	Entity Type Qualifier	R	1/1	**1** Person
		NM103	Ordering Provider Last Name	R	1/60	
		NM104	Ordering Provider First Name	R	1/35	
		NM105	Ordering Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Ordering Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier		1/2	**XX** HIPAA National Provider ID
		NM109	Ordering Provider Primary ID	S	2/80	

		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
457	2420E	N301	Ordering Provider Address 1	R	1/55	
		N302	Ordering Provider Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
458	2420E	N401	Ordering Provider City	R	2/30	
		N402	Ordering Provider State	S	2/2	
		N403	Ordering Provider Zip Code	S	3/15	
		N404	Ordering Provider Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ordering Provider Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
460	2420E	REF01	Reference Identification Qualifier	R	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Ordering Provider Secondary ID	R	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record for REF01= G2			COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
462	2420E	PER01	Contact Function Code	R		**IC**
		PER02	Ordering Provider Contact Name	S	1/60	
		PER04/06/08	Ordering Provider Telephone	S	1/80	**PER03/05/07 = TE**
		PER04/06/08	Ordering Provider Telephone Extension	S	1/80	**PER05/07 = EX**
		PER04/06/08	Ordering Provider Fax Number	S	1/80	**PER03/05/07 = FX**
		PER04/06/08	Ordering Provider Email Address	S	1/80	**PER03/05/07 = EM**
		PER09	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
465	2420F	NM101	Entity Identifier Code	S	2/3	**DN** Referring Provider
		NM102	Entity Type Qualifier	S	1/1	**1** Person
		NM103	Referring Provider Last Name	S	1/60	
		NM104	Referring Provider First Name	S	1/35	
		NM105	Referring Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	Referring Provider Name Suffix	S	1/10	
		NM108	Identification Code Qualifier		1/2	**XX** HIPAA National Provider ID
		NM109	Referring Provider Primary ID XX	S	1/80	
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
468	2420F	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	Referring Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04	Other Payer IDs mapped on CBS record for REF01= G2			COB Data.

Page #:	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
465	2420F	NM101	Entity Identifier Code	R	2/3	**P3** Primary Care Provider
		NM102	Entity Type Qualifier	R	1/1	**1** Person. If not the primary care provider, this is the initial referring provider
		NM103	PCP Provider Last Name	S	1/60	
		NM104	PCP Provider First Name	S	1/35	
		NM105	PCP Provider Middle Name	S	1/25	
		NM106	Not Used by HIPAA			
		NM107	PCP Provider Name Suffix	S	1/10	
		NM109	PCP Provider Primary ID XX	S	1/80	**XX** HIPAA National Provider ID
		NM110-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
468	2420F	REF01	Reference Identification Qualifier	S	2/3	**0B** State license number **G2** Provider commercial number **1G** UPIN
		REF02	PCP Provider Secondary ID	S	1/50	
		REF03	Not Used by HIPAA			
		REF04				COB Data.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
470	2420G	NM101	Entity Identifier Code		2/3	**PW** Pickup Up Address
		NM102	Entity Type Qualifier		1/1	**2** Non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
472	2420G	N301	Ambulance Pickup Address 1	R	1/55	
		N302	Ambulance Pickup Address 2	S	1/55	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
473	2420G	N401	Ambulance Pickup City	R	2/30	
		N402	Ambulance Pickup State	S	2/2	
		N403	Ambulance Pickup Zip Code	S	3/15	
		N404	Ambulance Pickup Country Code	S	2/3	Required only if country is not USA.
		N405 N406	Not Used by HIPAA			
		N407	Ambulance Pickup Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
475	2420H	NM101	Entity Identifier Code	R	2/3	**45** Drop off Location
		NM102	Entity Type Qualifier	R	1/1	**2** non-person
		NM103-NM112	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
477	2420H	N301	Ambulance Dropoff Address 1	R	1/55	
		N302	Ambulance Dropoff Address 2	S	1/55	
478	2420H	N401	Ambulance Dropoff City	R	2/30	
		N402	Ambulance Dropoff State	S	2/2	
		N403	Ambulance Dropoff Zip Code	S	3/15	
		N404	Ambulance Dropoff Country Code	S	2/3	

		N405 N406	Not Used by HIPAA			
		N407	Ambulance Dropoff Country Sub-Code	S	2/3	Required only if country is not USA.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
480	2430	SVD01	Other Payer Primary Identifier	R	2/80	Must match Loop 2330B NM109 REQUIRED to report PAID Amount
		SVD02	Service Line Paid Amount	R	1/18	Note: Zero is acceptable **NOTE: Loop 2430 CAS03 and SVD02 must balance to Loop 2400 SV103 (Prof) Line Item Charge Amount. SVD02 must balance to a value greater than or equal to zero (0)**
		SVD03-1	Procedure Code Qualifier	R	2/2	ER - Jurisdictionally Defined Procedure and Supply Codes HC - CPT/HCPCS code IV - HEIC code WK - Advanced Billing (ABC) code
		SVD03-2	Procedure Code	R	1/48	
		SVD03-3	Procedure Code Modifier 1	S	2/2	
		SVD03-4	Procedure Code Modifier 2	S	2/2	
		SVD03-5	Procedure Code Modifier 3	S	2/2	
		SVD03-6	Procedure Code Modifier 4	S	2/2	
		SVD03-7	Procedure Code Description	S	1/80	
		SVD03-8 SVD04	Not Used by HIPAA			
		SVD05	Paid Service Unit Count	R	1/15	
		SVD06	Bundled or Unbundled Line Number	S	1/6	References the service line number which this line was bundled into.
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
	2430	CAS01	Claim Adjustment Group Code	R	1/2	General category of payment adjustment: CO - Contractual Obligations CR - Correction and Reversals OA - Other Adjustments PI - Payor Initiated Reductions **PR - Patient Responsibility** NOTE: **Required to report non-zero Member Cost Share** and paid amount. When submitting Member Cost Share use code PR and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below
	2430	CAS02	Adjustment Reason Code	R	1/5	Line Adjustment Reason Code – Required Member Cost Share (PR qualifier), reason codes: **1 = Deductible Amount** **2 = Coinsurance Amount** **3 = Co-payment Amount** Claim Adjustment Reason Codes are available via Washington Publishing: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
	2430	CAS03	Monetary Amount	R	1/18	
	2430	CAS04	Quantity	S	1/5	Unit of Service
	2430	CAS05	Claim Reason Code	S	1/2	Line Adjustment Reason Code

	2430	CAS06	Monetary Amount	S	1/5	
	2430	CAS07	Quantity	S	1/5	Unit of Service
	2430	CAS08	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS09	Monetary Amount	S	1/5	
	2430	CAS10	Quantity	S	1/5	Units of service
	2430	CAS11	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS12	Monetary Amount	S	1/5	
	2430	CAS13	Quantity	S	1/5	Units of service
	2430	CAS14	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS15	Monetary Amount	S	1/5	
	2430	CAS16	Quantity	S	1/5	Units of service
	2430	CAS17	Claim Reason Code	S	1/2	Line Adjustment Reason Code
	2430	CAS18	Monetary Amount	S	1/5	
	2430	CAS19	Quantity	S	1/5	Units of service
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
490	2430	DTP01	Date/Time Qualifier	R	3/3	**573** Date Claim Paid or Processed
		DTP02	Date Time Period Format Qualifier	R	2/3	**D8** Date Expressed in Format CCYYMMDD
		DTP03	Service Adjudication or Payment Date	R	1/35	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
491	2430	AMT01	Amount Qualifier Code		1/3	**EAF** (implied decimal) (Amount owed)
		AMT02	Remaining Patient Liability	R	1/18	
		AMT03	Not Used by HIPAA			
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
492	2440	LQ01	Form Identification Code	R	1/3	AS - Form Type Code UT - HCFA DMERC Certificate of Medical Necessity Forms
		LQ02	Form Identifier	R	1/30	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
494	2440	FRM01	Question Number/Letter	R	1/20	
		FRM02	Question Response	S	1/1	N - No W - Not Applicable Y - Yes
		FRM03	Question Response Text	S	1/50	
		FRM04	Question Response Date	S	8/8	
		FRM05	Question Response Percent	S	1/6	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
496	Transaction Set Trailer	SE01	Number of Included Segments	R	1/10	
		SE02	Transaction Set Control Number	S	4/9	

Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
C.9	Functional Group Trailer	GE01	Number of Transactional Sets Included	R	1/6	
		GE02	Group Control Number	S	1/9	
Page #:	**Loop ID**	**Reference**	**Name**	**Codes**	**Length**	**Notes/ Comments**
C.10	Interchange Control Trailer	IEA01	Number of Included Functional Groups	R	1/5	
		IEA02	Interchange Control Number	S	9/9	

Appendix

EDITOR'S NOTE:
This page is blank because books should end on a left hand page.

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Bright Futures.
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE									
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	●	★	●	★	★	★	★
Hearing		●[8]	●[9]	⟷	⟷	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	⟷	●[10]	⟷	⟷	●	⟷	⟷	⟷	●	⟷
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																					★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																						●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20]	⟷																											
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	⟷	●	⟷	★	★	★	★	★	⟷		●	⟷
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	⟷	●	⟷	★	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]				⟷	⟷	⟷	⟷	●	⟷	⟷	⟷	⟷	⟷	⟷	⟷																
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟷ = range during which a service may be provided

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

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FMMR336 (2)

H E A L T H N E T

Q/CARE PROVIDER ASSIGNMENT REGISTER - MEDI-CAL

ELIGIBILITY PERIOD : 12/01/03 - 12/31/03 (3)

ADD REPORT

(4) REPORT DATE : 12/15/03

>>>>>>>>>>>>>> PLEASE REFER TO THE HEALTH NET MEDI-CAL MANUAL FOR KEY TO REPORTS <<<<<<<<<<<<<<

TAX ID : 233456789 - THE DOCTOR'S GROUP (5)

PROVIDER : A088877 - TALLULAH BELLE (6)

PROV ADDR : 7654 CROSSROADS STREET, CITY, CA ZIP

(7) PROVIDER COUNTY : 00
COUNTY NAME

(8) MEMBER NAME / ADDRESS/PHONE	(9) HN MEMBER ID	(10) D-O-B	(11) SEX	(12) 1ST ELIG EFF DATE	(13) PCP/CLNC EFF DATE	(14) ELIG STAT	(15) PRIOR PCP ID/NAME	(16) OHC CODE	(17) ETHNIC CODE	(18) LANG CODE	(19) PUB HLTH	(20) MEDI-CAL ID CIN ID (21) / * = PSEUDO (22)
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SAMPLE "ADD" REPORT

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Health Net®
A Better Decision

PROVIDER UPDATE

__ Contractual _ Legislative X Regulatory __ News & Announcements

FEBRUARY 1, 2008 UPDATE #08-056 1 PAGE

This update applies to:

Physicians

State:

☒ California

Line of business:

☐ HMO/POS
☐ PPO
☐ EPO
☐ AIM
☐ Healthy Families
☐ Healthy Kids
☐ Medicare Advantage (HMO/PPO)
☒ Medi-Cal

Provider Services:

(800) 675-6110
www.healthnet.com

Provider Communications:

provider.communications@healthnet.com
(916) 935-1529
(800) 937-6086 – fax

Administration of Fluoride Varnish

The information in this update applies to participating providers in Fresno, Kern, Los Angeles, Sacramento, San Diego, Stanislaus, and Tulare counties.

Effective immediately, the Department of Health Care Services (DHCS) approved the administration of fluoride varnish, up to three times in a twelve-month period, for Medi-Cal members under age six.

The American Academy of Pediatrics (AAP) recommends that primary care physicians (PCPs) start treatment after the first tooth erupts, or at six months of age. Medical assistants, nurse practitioners (NPs), physician assistants (PAs), and registered nurses (RNs) are approved to administer treatment under the oversight of a PCP.

BILLING AND REIMBURSEMENT

When submitting claims for reimbursement, providers should use HCPCS code D1203 (topical application of fluoride – child).

Providers who have capitated arrangements with participating physician groups (PPGs) are reimbursed through existing capitation payment, or by additional reimbursement directly from the PPG.

PURCHASING FLUORIDE VARNISH

Providers may purchase fluoride varnish through the following Web sites:

- Duraphat®: www.colgateprofessional.com/app/cop/jsp/products/productHome.jsp?prodcode=011400100
- Duraflor®: www.medicom.com/faq.ch2
- CavityShield®: www.omniipharma.com/cavityshield.asp
- VarnishAmerica™: www.medicalproductslaboratories.com/products/varnishamerica/varnishamerica.html

PROVIDER TRAINING

To facilitate increased acceptance of this treatment, county-specific Child Health and Disability Prevention (CHDP) offices provide training for PPGs and PCPs.

Additionally, providers can access the First Smiles Web site at www.first5oralhealth.org to obtain more detailed information regarding treatment, and to schedule training.

Providers may also visit the DHCS Web site at www.dhcs.ca.gov to review a copy of the most recent Medi-Cal Managed Care Division (MMCD) All Plan Letter 07008, dated April 2007.

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Advanced Directive Education: Date_____
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California Advance Health Care Directive Information

This form lets you have a say about how you want to be treated if you get very sick. It lets you:

- **Choose a health care agent.** A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.
- **Make your own health care choices.** You can choose the kind of health care you want so if you are too sick to decide for yourself, those who care for you will not have to guess what you want.

What will happen if I do not choose a health care agent?
If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you. If you want your agent to be someone other than family, you must write his or her name on the form.

What kind of decisions can my health care agent make?
Agree to, say no to, change, stop or choose:

- ✓ doctors, nurses, social workers
- ✓ hospitals or clinics
- ✓ medications or tests
- ✓ what happens to your body and organs after you die

Other decisions your agent can make:

- ✓ **Life support treatments –** medical care to try to help you live longer
- ✓ **CPR or cardiopulmonary resuscitation -** This may involve:
  - – pressing hard on your chest to keep your blood pumping
  - – electrical shocks to jump start your heart
  - – medicines in your veins
- ✓ **Breathing machine or ventilator -** The machine pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine.
- ✓ **Dialysis -** A machine that cleans your blood if your kidneys stop working.
- ✓ **Feeding Tube -** A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed into your stomach by surgery.
- ✓ **Blood transfusions -** To put blood in your veins.
- ✓ **Surgery**
- ✓ **Medicines**
- ✓ **End of life care –** if you might die soon your health care agent can:
  - – call in a spiritual leader
  - – decide if you die at home or in the hospital

Your health care provider will answer any questions you may have about this important document.
~ If you want an Advance Directive form ask a member of the clinic staff ~

Información de Cuidado Médico por Adelanto de California

Esta forma deja que usted indique como usted quiere ser atendido en el caso que muy enfermo. Le deja:

- **Escojer a un representante para la atención a la salud.** Un representante para la atención a la salud es una persona que puede tomar decisiones médicas en su nombre si usted está demasiado enfermo para hacerlo.
- **Hacer sus propias decisiones sobre su cuidado médico.** Le permite escojer qué tipo de atención médica qué usted desea. De esta manera, los quien lo atiendan no tendraán qué adivinar qué desea usted si está demasiado enfermo para decirles ustes mismo.

¿Qué pasa si no elijo a un representante de atención a la salud?
Si usted está demasiado enfermo para tomar sus propias decisiones, sus médicos le pedirán a sus familiares más cercanos que tomen decisiones en su nombre. Si usted desea que su representante sea alguien fuera de su familia, debe escribir el nombre de la persona en esta forma.

¿Qué tipo de decisiones puede tomar mi representante?
Dar permiso, rechazar, cambiar, parar, o elegir:

- ✓ a sus médicos, enfermeras, y trabajadores socials
- ✓ sus hospitales o clínicas
- ✓ medicinas o exámenes medicos
- ✓ decidir que va a pasar con su cuerpo y órganos después que usted muera

Otras decisiones que puede tomar mi representante

- ✓ **Tratamientos para mantener la vida -**atención médica para tratar de ayudarle a vivir mas tiempo
- ✓ **RCP o resucitación cardio-pulmonar** - Esto puede incluir:
  – presionar fuertemente sobre su pecho para mover su sangre
  – toques elétricos para "pasar corriente" a su corazón
  – darle medicinas por las venas
- ✓ **Máquina para respirar o ventilador mecánico -** La máquina bombea aire a sus pulmones y respira por usted. Usted no puede hablar cuando esta conectado a la máquina
- ✓ **Diálisis -** Un aparato que limpia su sangre si sus riñones dejan de server
- ✓ **Sonda de alimentación** Un tubo que se usa para alimentarlo si usted no puede tragar. Se pone por la garganta hasta el estómago. También se pone con una operación
- ✓ **Transfusioines de sangre -** Dar sangre por sus venas
- ✓ **Cirugía**
- ✓ **Medicamentos**
- ✓ **Cuidados al fin de la vida –** si usted se esta muriendo su representante podrá:
  – Ilamar a un lider espiritual.
  – decidir si usted se muere en casa o en el hospital.

El médico responderá cualquier pregunta que pueda tener sobre este documento importante. Si desea una forma de Cuidado Médico por Adelanto, pedir a un miembro del personal de la clínica.

Affordable Care Act and USPSTF Recommendations & CDC/ACIP Vaccination Schedules

USPSTF - A and B Recommendations – Edited recommendations based on DHCS Criteria

http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008

Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.		

USPSTF A and B Recommendations by Date

Release Date of Current Recommendation	Topic	Description	Grade
September 2014*	Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B
September 2014*	Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B
September 2014*	Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B
September 2014	Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B
August 2014*	Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B

June 2014*	Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B
May 2014*	Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B
May 2014	Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B
January 2014	Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B
December 2013	Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B

December 2013*	BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B
September 2013*	Breast cancer preventive medication	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B
August 2013	Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B
June 2013	Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B
May 2013*	Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B

April 2013*	HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A
April 2013*	HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A
January 2013	Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B
June 2012*	Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B
May 2012	Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B
May 2012	Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B

May 2012	Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B
March 2012*	Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A
January 2012*	Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B
July 2011*	Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A
January 2011*	Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B
January 2010	Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B

December 2009	Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B
June 2009	Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A
May 2009	Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A
May 2009	Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A
April 2009	Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A
April 2009	Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A
March 2009	Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A

March 2009	Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A
March 2009	Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12 to 18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B
October 2008	Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B
October 2008	Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A
July 2008	Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A
July 2008	Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B
June 2008	Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A

June 2008	Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B
June 2008	Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A
June 2008	Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B
June 2008	Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B
March 2008	Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A
March 2008	Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	A
December 2007	Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A
September 2007	Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A

May 2006	Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B
May 2006	Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B
July 2004	Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A
February 2004	Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A
February 2004	Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B
September 2002†	Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B

†The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-screening.
*Previous recommendation was an “A” or “B.”

VACCINATION SCHEDULES FROM ACIP WEB SITE MAY 2015

http://www.cdc.gov/vaccines/schedules/hcp/index.html

If you are this age ↓	talk to your healthcare professional about these vaccines →												
	Flu[1] ***Influenza***	**Td/Tdap**[2] ***Tetanus Diphtheria, pertussis***	**Shingles**[3] ***Zoster***	**Pneumococcal**[4]		**Meningococcal**[5]	**MMR**[6], † ***Measles, mumps, rubella***	**HPV**[7], † ***Human papillomavirus***		**Chickenpox**† ***Varicella***	**Hepatitis A**†	**Hepatitis B**†	**Hib**[8] ***Haemophilus influenzae* type b**
				PCV13	**PPSV23**			**for women**	**for men**				
19-21 years	Flu vaccine every year	1 dose of Tdap[2] Td booster every 10 years		1 dose	1 or 2 doses	1 or more doses	1 or 2 doses	3 doses	3 doses	2 doses	2 doses	3 doses	1 or 3 doses
22-26 years									3 doses				
27-49 years													
50-59 years													
60-64 years			1 dose										
65+ year				1 dose	1 dose								

Recommended For You: This vaccine is recommended for you ***unless*** your healthcare professional tells you that you cannot safely receive it or that you do not need it.

May Be Recommended For You: This vaccine is recommended for you if you have certain risk factors due to your health, job or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

Birth to 15 Months

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos
Hepatitis B[1] (HepB)	←1st dose→	←2nd dose→			←3rd dose→			
Rotavirus[2](RV) **RV1 (2-dose series); RV5 (3-dose series)**			←1st dose→	←2nd dose→	See footnote 2			
Diphtheria, tetanus, & acellular pertussis[3](DTaP: <7 yrs)			←1st dose→	←2nd dose→	←3rd dose→			←4th dose→
Tetanus, diphtheria, & acellular pertussis[4] (Tdap: ≥7 yrs)								
***Haemophilus influenzae* type b[5] (Hib)**			←1st dose→	←2nd dose→	See footnote 5		←3rd or 4th dose, See footnote 5→	
Pneumococcal conjugate[6] (PCV13)			←1st dose→	←2nd dose→	←3rd dose→		←4th dose→	
Pneumococcal polysaccharide[6](PPSV23)								
Inactivated poliovirus[7] (IPV:<18 yrs)			←1st dose→	←2nd dose→	←3rd dose→			
Influenza[8](IIV; LAIV) 2 doses for some: See footnote 8					Annual vaccination (IIV only) 1 or 2 doses			

18 Months to 18 Years

Vaccines	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-8 yrs	9-10 yrs	11-12 yrs	13-15 yrs	16-18 yrs
Hepatitis B[1] (HepB)	←3rd dose→								
Diphtheria, tetanus, & acellular pertussis[3](DTaP: <7 yrs)	←4th dose→			←5th dose→					
Tetanus, diphtheria, & acellular pertussis[4] (Tdap: ≥7 yrs)							(Tdap)		
Haemophilus influenzae type b[5] (Hib)									
Pneumococcal conjugate[6] (PCV13)									
Pneumococcal polysaccharide[6](PPSV23)									
Inactivated poliovirus[7] (IPV)(<18 yrs)	←3rd dose→			←4th dose→					
Influenza[8](IIV; LAIV) 2 doses for some: See footnote 8	Annual vaccination (IIV only) 1 or 2 doses		Annual vaccination (LAIV or IIV) 1 or 2 doses				Annual vaccination (LAIV or IIV) 1 dose only		
Measles, mumps, rubella[9] (MMR)				←2nd dose→					
Varicella[10] (VAR)				←2nd dose→					
Hepatitis A[11] (HepA)	←2 dose series, See footnote 11→								
Human papillomavirus[12] (HPV2: females only; HPV4: males and females)							←(3 dose series)→		
Meningococcal[13] (Hib-Men-CY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	See footnote 13						←1st dose→		Booster

Vaccine Administration Record for Adults

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure they understand the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Patient name _____

Birthdate _____ Chart number _____

PRACTICE NAME AND ADDRESS

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td) Give IM.[3]									
Hepatitis A[6] (e.g., HepA, HepA-HepB) Give IM.[3]									
Hepatitis B[6] (e.g., HepB, HepA-HepB) Give IM.[3]									
Human papillomavirus (HPV) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give MMRII Subcut or IM; give Priorix Subcut.[3]									
Varicella (VAR) Give Subcut or IM.[3]									
Meningococcal ACWY (MenACWY) Give MenACWY IM.[3]									
Meningococcal B (e.g., MenB-4C, MenB-FHbp) Give MenB IM.[3]									

CONTINUED ON THE BACK ▶

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (Sanofi); Boostrix (GSK)
Td	Tenivac (Sanofi); Tdvax (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB (see note #1)	Engerix-B (GSK); Recombivax HB (Merck); Heplisav-B (Dynavax); PreHevbrio (VBI)
HepA-HepB	Twinrix (GSK)
HPV	Gardasil 9 (Merck)
MMR	MMR II (Merck); Priorix (GSK)
VAR	Varivax (Merck)
MenACWY	MenQuadfi (Sanofi); Menveo (GSK)
MenB-4C (see note #1)	Bexsero (GSK)
MenB-FHbp (see note #1)	Trumenba (Pfizer)

How to Complete this Record

1. For hepatitis B and meningococcal B vaccines, record the trade name (see table at right); for all other vaccines, record the standard abbreviation (e.g., Tdap).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut), or intranasal (NAS), and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting should keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Immunize.org

FOR PROFESSIONALS www.immunize.org / **FOR THE PUBLIC** www.vaccineinformation.org

www.immunize.org/catg.d/p2023.pdf

Item #P2023 (9/18/2023)

Scan for PDF

Vaccine Administration Record for Adults (continued)

Patient name _____

Birthdate _____ Chart number _____

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure they understand the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Pneumococcal conjugate (e.g., PCV13, PCV15, PCV20) Give IM.[3]									
Pneumococcal polysaccharide (e.g., PPSV23) Give IM or Subcut.[3]									
Influenza (IIV, ccIIV, RIV, LAIV) Give IIV, ccIIV, and RIV IM.[3] Give LAIV NAS.[3]									
Zoster (shingles) Give RZV IM.[3]									
COVID-19 (e.g., COV-mRNA; COV-aPS) Give IM.[3]									
Hib Give IM.[3]									
RSV Give IM.[3]									
Other									

Abbreviation	Trade Name and Manufacturer
PCV13, PCV15, PCV20	Prevnar 13 (Pfizer); Vaxneuvance (Merck); Prevnar 20 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
aIIV (adjuvanted inactivated influenza vaccine [IIV])	Fluad (GSK)
ccIIV (cell culture-based IIV)	Flucelvax (Seqirus)
HD-IIV (high-dose IIV)	Fluzone High-Dose (Sanofi)
LAIV (live attenuated influenza vaccine]	FluMist (AstraZeneca)
RIV (recombinant influenza vaccine)	Flublok (Sanofi)
SD-IIV (standard dose IIV)	Fluarix, FluLaval (GSK); Afluria (Seqirus); Fluzone (Sanofi)
RZV (recombinant zoster vaccine)	Shingrix (GSK)
COV-mRNA (see note #1)	Comirnaty (Pfizer-BioNTech); Spikevax (Moderna)
COV-aPS (see note #1)	Novavax (Novavax)
Hib	ActHIB (Sanofi); Hiberix (GSK); PedvaxHib (Merck)
RSV (respiratory syncytial virus vaccine) (see note #1)	Arexvy (GSK); Abrysvo (Pfizer)

How to Complete this Record

1. For RSV and COVID-19 vaccines, record the trade name (see table at right); for all other vaccines, record the standard abbreviation (e.g., RZV) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut), or intranasal (NAS), and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting should keep a reference list of vaccinators that includes their initials and titles.

نص نموذجي لما بعد ساعات الدوام

يمكن استخدام أحد النصوص التالية من قبل الأطباء والمجموعات الطبية كأساس لضمان حصول أعضاء Health Net على الرعاية الطبية السريعة بعد ساعات الدوام أو عندما تكون عياداتكم مغلقة.

هام: خدمات الهاتف الفعالة بعد ساعات الدوام تضمن للمتصلين الاتصال بشخص أو جهاز تسجيل صوتي خلال 30 ثانية.

1. المكالمات التي يرد عليها شخص (مثل خدمات الرد على المكالمات أو مراكز الرعاية المركزية):

إذا شعر الشخص المتصل بأنه يواجه مشكلة صحية طارئة، انصح المتصل بإقفال الخط والاتصال فوراً بالرقم 911 أو التوجه إلى أقرب عيادة أو منشأة طوارئ.

إذا شعر الشخص المتصل أن الوضع يتطلب المعالجة العاجلة أو الحاجة لبحث الأمر مع طبيب أو منشأة طبية، قم بالاتصال بالطبيب عن طريق القيام بواحدة أو أكثر من الإجراءات التالية:

- ضع الشخص المتصل في وضع الانتظار للحظة ومن ثم قم بوصله بالطبيب المناوب
- اطلب من الشخص المتصل تزويدك برقم هاتفه وأخبره بأن الطبيب سيتصل به خلال 30 دقيقة (قم فوراً بإرسال رسالة للطبيب لإعلامه عن ذلك)
- أعطي الشخص المتصل رقم البيجر (جهاز الإخطار) وأخبره أن الطبيب سيتصل به خلال 30 دقيقة أو قم بتوجيه الشخص المتصل إلى أقرب مركز للرعاية العاجلة (urgent care).
- إذا عبر المتصل عن حاجته لخدمات مترجم، قم بتأمين مترجم عن طريق الاتصال بخدمات الترجمة

أمثلة:

مرحباً، لقد اتصلت بـ <خدمات الرد على المكالمات/مركز الرعاية المركزية> للدكتور <اسم العائلة>. إذا كانت هذه حالة طبية طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، رجاء أن تبقى على الخط وسوف أصلك به.

مرحباً، لقد اتصلت بـ <خدمات الرد على المكالمات/مركز الرعاية المركزية> للدكتور <اسم العائلة>. إذا كانت هذه حالة طبية طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، يستطيع الدكتور <اسم العائلة> مساعدتك. رجاء أن تتصل بالطبيب عن طريق البيجر (جهاز الإخطار) على الرقم <هاتف>. يمكنك ترقب استلام مكالمة منه خلال 30 دقيقة.

2. المكالمات التي يرد عليها جهاز التسجيل (مسجلة):

مرحباً، لقد اتصلت بـ <أدخل اسم الطبيب/المجموعة الطبية> إذا كانت هذه حالة طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، (اختر الخيار المناسب):

- رجاء أن تبقى على الخط وسوف أصلك بالدكتور <اسم العائلة>
- *يمكنك الاتصال بالطبيب المناوب مباشرة عن طريق الاتصال بالرقم <هاتف>*
- *اضغط على <رقم> للتحويل إلى مركزنا للرعاية العاجلة. يقع مركزنا للرعاية العاجلة في <عنوان مركز الرعاية العاجلة> (يجب تزويد خيارات اللغة المناسبة للموقع).*
- *اضغط على <رقم> لإخطار الطبيب المناوب. يمكنك توقع استلام مكالمة من الطبيب خلال 30 دقيقة.*

أمثلة:

مرحباً، لقد اتصلت بـ <اسم الطبيب/المجموعة الطبية> للدكتور <اسم العائلة>. إذا كانت هذه حالة طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، رجاء أن تترك رسالة صوتية مع ذكر اسمك ورقم هاتفك وسبب اتصالك ويمكنك ترقب استلام رسالة من الطبيب خلال 30 دقيقة.

مرحباً، لقد اتصلت بـ <أدخل اسم الطبيب/المجموعة الطبية>. إذا كانت هذه حالة طبية طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، يمكنك الاتصال به مباشرة عن طريق الاتصال بالرقم <هاتف> أو اضغط على <رقم> لإخطار الطبيب المناوب. يمكنك توقع استلام مكالمة من الطبيب خلال 30 دقيقة.

ԱՇԽԱՏԱՆՔԱՅԻՆ ԺԱՄԵՐԻՑ ՀԵՏՈ ՏԵՔՍՏԻ ՆՄՈՒՇ

Հետևյալ տեքստերից որևէ մեկը որպես կաղապար կարող է օգտագործվել բժիշկների և բժշկական խմբերի կողմից, երաշխավորելու համար, որ բժշկական խնամքը իր ժամանակին մատչելի կդառնա Health Net-ի անդամներին՝ աշխատանքային ժամերից հետո կամ երբ ձեր գրասենյակները փակ են:

ԿԱՐԵՎՈՐ՝ Աշխատանքային ժամերից հետո արդյունավետ հեռախոսային սպասարկումը կերաշխավորի, որ զանգահարողները կարողանան 30 վայրկյանի ընթացքում միանալ պատասխանող անձի կամ սարքի:

I. ԱՆՁԻ ԿՈՂՄԻՑ ՊԱՏԱՍԽԱՆՎՈՂ ՀԵՌԱԽՈՍԱԿԱՆՉԵՐ (ինչպես՝ պատասխանող ծառայությունը կամ կենտրոնացված զտման համակարգը)՝

Եթե զանգահարողը հավատացած է, որ գտնվում է բժշկական արտակարգ վիճակում, զանգահարողին խորհուրդ տվեք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ շարժվել դեպի ամենամոտիկ շտապ օգնության կայանը կամ բժշկական հաստատությունը:

Եթե զանգահարողը հավատացած է, որ կացությունը հրատապ է կամ նշի, որ հարկավոր է խոսել բժշկի հետ, հեշտացրեք բժշկի հետ կապի հաստատումը, կատարելով հետևյալներից մեկը կամ ավելին՝

- Զանգահարողից խնդրեք սպասել մի պահ և զանգահարողին միացրեք հերթապահ բժշկին
- Վերցրեք զանգահարողի հեռախոսի համարը և նրան խորհուրդ տվեք, որ բժիշկը հեռախոսականչին կպատասխանի 30 րոպեի ընթացքում (անմիջապես պատգամ ուղարկեք բժշկին)
- Զանգահարողին տվեք հերթապահ բժշկի փեյջերի համարը և զանգահարողին խորհուրդ տվեք, որ բժիշկը անդամին կզանգահարի 30 րոպեի ընթացքում, կամ զանգահարողին ուղարկեք ամենամոտիկ շտապ խնամքի կենտրոնի վայրը
- Եթե զանգահարողը նշի կարիքը բանավոր թարգմանության ծառայությունների, հեշտացրեք կապը՝ ձեռք բերելով բանավոր թարգմանչական ծառայությունները

Օրինակներ՝

Բարև, դուք հասել եք բժիշկ <Ազգանուն>-ի <պատասխանող ծառայություն/կենտրոնացված զտման համակարգ>: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, խնդրում եմ գծի վրա սպասել և ես ձեզ կմիացնեմ նրան:

Բարև, դուք միացել եք բժիշկ <Ազգանուն>-ի համար <պատասխանող ծառայության/կենտրոնացված զտման համակարգ>-ին: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, բժիշկ <ազգանուն>-ը կարող է ձեզ օգնել: Խնդրում ենք նրան <փեյջ անել/զանգահարել> <հեռախոսի համար> համարով: Պատասխան հեռախոսականչի սպասեք 30 րոպեի ընթացքում:

II. ՊԱՏԱՍԽԱՆՈՂ ՍԱՐՔԻ ՄԻՋՈՑՈՎ ՊԱՏԱՍԽԱՆՎԱԾ ՀԵՌԱԽՈՍԱԿԱՆՉԵՐ

Բարև, դուք միացել եք <տեղադրեք Բժշկի/Բժշկական խմբի անունը>: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել (կատարեք համապատասխան ընտրությունը)՝

- *Խնդրում ենք սպասել և ձեզ կմիացնեն բժիշկ <Ազգանուն>-ին*
- *Հերթապահ բժշկին կարող եք միանալ ուղղակի զանգահարելով <հեռախոսի համար>*

- *Սեղմեք <թվանշան> մեր հրատապ խնամքի կենտրոն փոխանցվելու համար: Մեր հրատապ խնամքի կենտրոնը գտնվում է <հրատապ խնամքի կենտրոնի հասցե> (Վայրի համար հարկավոր է ընծայել լեզվական համապատասխան ընտրանքներ)*
- *Սեղմեք <թվանշան> հերթապահ բշկին փեյջ անելու համար: Պատասխան հեռախոսականչի սպասեք 30 րոպեի ընթացքում:*

Օրինակներ՝

Բարև, դուք միացել եք բժիշկ <Ազգանուն>-ի համար <Բժշկի անուն/Բժշկական խումբ>-ին: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, խնդրում ենք պատգամ թողնել նշելով ձեր անունը, հեռախոսի համարը և զանգահարման պատճառը, և կարող եք պատասխան կանչ սպասել 30 րոպեի ընթացքում:

Բարև, դուք միացել եք <Բժշկի անուն/Բժշկական խումբ>-ին: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, նրան կարող եք միանալ ուղղակի զանգահարելով <հեռախոսի համար> կամ սեղմելով <թվանշան>, որպեսզի միանաք հերթապահ բժշկի փեյջերին: Պատասխան հեռախոսականչի սպասեք 30 րոպեի ընթացքում:

非營業時間腳本範例

醫師和醫療團體可以使用下列腳本之一做為範本，確保即使在非營業時間或診所休診時間 Health Net 會員仍可及時取得醫療照護。

重要：在非營業時間提供有效率的電話服務可確保會員來電時能在 30 秒內接通電話服務人員或答錄機服務。

I. 電話服務人員接聽電話 (例如代客接聽電話服務或集中檢傷分類服務)：

如果來電會員認為自己發生醫療緊急情況，請告訴來電會員先掛斷電話，然後馬上撥 911 或前往最近的急診室 / 醫療機構。

如果來電會員認為情況緊急，或表示需要和醫師通話，請採取以下一項或多項動作，協助聯絡醫師：

- 暫時保留來電會員的電話，然後把來電會員轉接給待命醫師
- 留下來電會員的電話號碼，並告訴來電會員，醫師會在 30 分鐘內回電 (立即傳送訊息給醫師)
- 把待命醫師的傳呼號碼給來電會員，並告訴來電會員，醫師會在 30 分鐘內回會員電話；或指示來電會員前往最近的緊急照護中心
- 如果來電會員表示需要口譯服務，請使用口譯服務以協助聯絡

範例：

您好，這裡是<姓氏>醫師的<代客接聽電話服務 I 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請別掛斷，我會幫您轉接電話。

您好，這裡是<姓氏>醫師的<代客接聽電話服務 I 集中檢傷分類服務>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，<姓氏>醫師可以協助您。請<傳呼 I 撥打> <電話號碼> 聯絡醫師。您應該會在 30 分鐘內接到回電。

II.答錄機接聽電話：

您好，這裡是 <輸入醫師姓名 I 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話 (選擇適當的選項)：

- *請稍候，我們會為您轉接<姓氏>醫師。*
- *您可以撥 <電話號碼> 直接聯絡待命醫師。*
- *請按 <號碼>，就可以轉接我們的緊急照護中心。我們緊急照護中心的地址是 <緊急照護中心地址> (應針對該地點提供適當的語言選項。)*
- *請按 <號碼>，就可以傳呼待命醫師。您應該會在 30 分鐘內接到回電。*

範例：

您好，這裡是 <醫師 I 醫療團體名稱> 的<姓氏>醫師。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，請留下您的姓名、電話號碼，以及來電的原因，您應該會在 30 分鐘內接到回電。

您好，這裡是 <醫師姓名 I 醫療團體名稱>。如果是醫療緊急情況，請先掛斷電話，然後馬上撥 911 或前往最近的急診室。如果您想和待命醫師通話，您可以撥 <電話號碼> 或按 <號碼> 進行傳呼，就可以直接聯絡待命醫師。您應該會在 30 分鐘內接到回電。

非营业时间示例话术

以下任一话术均可供医生或医疗团队作为模板使用，确保在非营业时间或诊所关闭时，保户仍能及时获得医疗服务。

重要提示：有效的非营业时间电话服务应确保来电者在 30 秒内接通人工服务或自动留言系统。

I. 人工接听来电（如电话接听服务或集中分诊中心）：

如果来电者认为自己正处于医疗紧急情况，请告知其立即挂断电话并拨打 911，或前往最近的急诊室/医疗机构。

如果来电者认为情况紧急，或表示希望与医生通话，请通过以下一种或多种方式协助其联系医生：

- 让来电者暂时不要挂断电话，然后将其转接至值班医生
- 记录来电者的电话号码，并告知医生将在 30 分钟内回电（请立即将信息发送给医生）
- 为来电者提供值班医生的呼叫器号码，并告知其医生将在 30 分钟内回电；或者将来电者引导至最近的急诊护理中心
- 如来电者表示需要口译服务，请协助其获取相应的口译支持

示例：

您好，您已拨通 <Last Name> 医生的<电话接听服务/集中分诊中心>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，请保持在线，我将为您转接。

您好，您已拨通 <Last name> 医生的<电话接听服务/集中分诊中心>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，<Last Name> 医生可为您提供帮助。请通过 <telephone number> 联系其<呼叫器/电话>。您将在 30 分钟内收到回电。

II. 电话由自动留言系统接听：

您好，您已拨通 <insert Name of Doctor/Medical Group>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话（请选择相应选项）：

- 请稍候，我们将为您转接 <Last Name> 医生
- 您可直接拨打 <telephone number> 联系值班医生
- 请按 <number> 转接至我们的急诊护理中心。我们的急诊护理中心位于 <urgent care center address>（应提供该地址的其他语言版本）。
- 请按 <number> 呼叫值班医生。您将在 30 分钟内收到回电

示例：

您好，您已拨通 <Last Name> 医生所属的 <Name of Doctor/Medical Group>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，请留言说明您的姓名、电话以及来电原因，您将在 30 分钟内收到回电。

您好，您已拨通 <Name of Doctor/Medical Group>。如果您正处于医疗紧急情况，请立即挂断电话并拨打 911，或前往最近的急诊室。如果您希望与值班医生通话，可直接拨打 <telephone number>，或按 <number> 呼叫值班医生。您将在 30 分钟内收到回电。

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within 30 minutes (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within 30 minutes, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>. You may expect a call back within 30 minutes.

II. CALLS ANSWERED BY AN ANSWERING MACHINE:

Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within 30 minutes*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within 30 minutes.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within 30 minutes.

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within 30 minutes (immediately send a message to physician)
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- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>.You may expect a call back within 30 minutes.

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Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within 30 minutes*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within 30 minutes.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within 30 minutes.

متن نمونه برای بعد از ساعات کاری

یکی از متن های زیر توسط پزشکان و گروه های پزشکی به عنوان الگو استفاده خواهد شد تا اطمینان حاصل شود که اعضای Health Net به مراقبت پزشکی بموقع بعد از ساعات کاری یا هنگام تعطیلی مطب ها دسترسی داشته باشند.

نکته مهم: خدمات تلفنی مؤثر بعد از ساعات کاری تضمین می کند که تماس گیرندگان بتوانند با یک صدای زنده یا ماشین پیامگیر در ظرف 30 ثانیه صحبت کنند.

I. تماس هایی که توسط یک صدای زنده جواب داده می شوند (از قبیل خدمات پاسخگوئی یا تریاژ مرکزی شده):

اگر تماس گیرنده تصور می کند که مشکلی دارد که اورژانس پزشکی است، به تماس گیرنده توصیه نمائید که گوشی را گذاشته و فوراً شماره 911 را بگیرد یا به نزدیک ترین بخش اورژانس/مرکز پزشکی برود.

اگر تماس گیرنده تصور می کند که در وضعیت فوری است یا بیان می کند که می خواهد با یک پزشک صحبت کند، یکی از اقدامات زیر را برای تسهیل تماس با پزشک انجام دهید:

- تماس گیرنده را برای یک لحظه منتظر نگه داشته و سپس تماس گیرنده را به پزشک کشیک وصل کنید.
- شماره تلفن تماس گیرنده را گرفته و به وی بگوئید که پزشک در ظرف 30 دقیقه با وی تماس خواهد گرفت (فوراً یک پیغام را برای پزشک ارسال کنید)
- شماره پیجر پزشک کشیک را به تماس گیرنده بدهید و به وی بگوئید که پزشک در ظرف 30 دقیقه با عضو تماس خواهد گرفت، یا تماس گیرنده را به نزدیک ترین مرکز مراقبت فوری هدایت کنید.
- اگر تماس گیرنده اشاره کند که به خدمات مترجم شفاهی نیاز دارد، تماس را توسط دسترسی به خدمات مترجم شفاهی تسهیل کنید

مثال ها:

سلام، شما با <خدمات پاسخگوئی/تریاژ مرکزی شده> برای دکتر <نام خانوادگی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، لطفاً گوشی را نگه دارید و شما را به وی وصل خواهم کرد.

سلام، شما با <خدمات پاسخگوئی/تریاژ مرکزی شده> برای دکتر <نام خانوادگی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، دکتر <نام خانوادگی> می تواند به شما کمک کند. لطفاً با وی به شمارهٔ <شماره تلفن> <پیج/تماس> بگیرید. می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.

II. تماس هایی که توسط ماشین پیامگیر جواب داده می شوند:

سلام.، شما با <نام پزشک/گروه پزشکی را وارد کنید> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید (گزینه مناسب را انتخاب کنید):

- *لطفاً گوشی را نگه داشته و شما را در تماس با دکتر<نام خانوادگی> قرار خواهیم داد*
- *می توانید توسط تماس با شمارهٔ <شماره تلفن> مستقیماً با پزشک کشیک تماس بگیرید.*
- *شمارهٔ <شماره> را برای انتقال به مرکز مراقبت فوری ما فشار دهید. مرکز مراقبت فوری ما در <نشانی مرکز مراقبت فوری> واقع شده است (گزینه های زبان مناسب بایستی برای این مرکز ارائه شود.)*
- *شمارهٔ <شماره> را برای پیج کردن پزشک کشیک فشار دهید. می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.*

مثال ها:

سلام، شما با <نام پزشک/گروه پزشکی> برای دکتر <نام خانوادگی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، لطفاً پیغام بگذارید که شامل نام، شماره تلفن و دلیل تماس شما می شود و می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.

سلام.، شما با <نام پزشک/گروه پزشکی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، می توانید توسط تماس با شمارهٔ <شماره تلفن> و فشردن شمارهٔ <شماره> برای پیج کردن پزشک کشیک، مستقیماً با وی تماس بگیرید. می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.

PIV TXWV TXOG COV LUS KAW CIA THAUM COV SIJHAWM KAWS

Cov kws kho mob thiab pab pawg kho mob siv tau cov lus uas lawv qab ntawm no los pab kom cov tswv cuab mus txais tau kev kho mob tom qab cov sijhawm tsis ua haujlwm lossis thaum koj lub chaw haujlwm kaws.

TSEEM CEEB: Txoj kev pab teb xov tooj tom qab cov sijhawm kaws yuav pab tau cov neeg hu tuaj txais tau ib tug neeg lub suab lossis lub tshuab teb xovtooj ua ntej 30 second.

I. COV XOVTOOJ UAS IB TUG NEEG LUB SUAB TEB (xws li lub chaw teb xovtooj/chaw kho mob):

Yog tus neeg hu tuaj ntseeg tias nws muaj ib yam mob xwm txheej ceev, qhia rau tus neeg hu tuaj kom nws khwb lub xovtooj thiab hu 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev/lub chaw kho mob uas nyob ze tshaj rau ntawm nws.

Yog tus neeg hu tuaj ntseeg tias nws muaj ib yam mob nrawm lossis xav nrog ib tug kws kho mob tham, pab kom nws tham tau nrog ib tug kws kho mob thaum koj ua ib qho lossis ntau tshaj raws li cov lawv qab ntawm no:

- Muab tus neeg hu tuaj tsab xovtooj tso tos tib pliag ces txuas tus neeg hu tuaj mus rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov
- Nug tus neeg hu tuaj rau nws tus xovtooj thiab qhia rau nws tias tus kws kho mob mam li rov qab hu tuaj rau nws ua ntej 30 feeb (hu tso lus tamsid rau tus kws kho mob)
- Muab tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim tus xovtooj ntawm nws lub pager rau tus neeg hu tuaj thiab qhia rau tus neeg hu tuaj tias tus kws kho mob mam li hu rau the tswv cuab ua ntej 30 feeb, lossis qhia kom tus neeg hu tuaj cia li mus rau lub chaw kho mob nrawm uas nyob ze tshaj rau ntawm nws.
- Yog tias tus neeg hu tuaj hais tias lawv xav tau kev pab txhais lus, pab kom nws tham tau nrog ib tug kws txhais lus

Cov piv txwv:
Nyob zoo, koj tau hu tuaj rau <lub chaw teb xovtooj/chaw kho mob> rau tus kws kho mob Dr. <Lub Xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, thov mloog twj ywm ces kuv mam li txuas koj tsab xovtooj mus.

Nyob zoo, koj tau hu tuaj rau <lub chaw teb xovtooj/chaw kho mob> rau tus kws kho mob Dr. <Lub xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, tus kws kho mob Dr. <Lub Xeem> yuav pab tau koj. Thov <nias tso koj tus xovtooj/hu> nws ntawm <xovtooj>. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

II. TSAB XOVTOOJ UAS LUB TSHUAB KAW LUS TEB:

Nyob zoo, koj tau hu tuaj rau <hais tus Kws Kho Mob/Pab Pawg Kho Mob lub npe>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov (xaiv qhov haum rau koj):

- *Thov tos mentsis ces koj tsab xovtooj mam li txuas mus rau tus kws kho mob Dr. <Lub Xeem>*
- *Koj cia li hu mus cuag tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov thaum koj hu rau <xovtooj>*
- *Nias <tus lej> kom txuas tau koj tsab xovtooj mus rau qhov chaw kho mob nrawm. Peb lub chaw kho mob nrawm nyob ntawm <lub chaw kho mob nrawm qhov chaw nyob> (Koj yuav tsum muaj ib txoj kev los xaiv kom siv tau nws hom lus los qhia txog qhov chaw kho mob.)*

- *Nias <tus lej> kom tso tau koj tus xovtooj rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb*

Cov piv txwv:
Nyob zoo, koj tau hu tuaj rau <Tus Kws Kho Mob/Pab Pawg Kho Mob lub Npe> rau tus kws kho mob Dr. <Lub Xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, thov kaws lus cia nrog koj lub npe, xovtooj thiab qhia vim li cas koj hu tuaj, ces koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

Nyob zoo, koj tau hu tuaj rau <Tus Kws Kho Mob/Pab Pawg Kho Mob lub Npe>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, koj cia li hu ncaj nraim mus tau rau nws ntawm <xovtooj> lossis nias <tus lej> kom tso tau koj tus xovtooj cia rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

PIV TXWV TXOG COV LUS KAW CIA THAUM COV SIJHAWM KAWS

Cov kws kho mob thiab pab pawg kho mob siv tau cov lus uas lawv qab ntawm no los pab kom cov tswv cuab mus txais tau kev kho mob tom qab cov sijhawm tsis ua haujlwm lossis thaum koj lub chaw haujlwm kaws.

TSEEM CEEB: Txoj kev pab teb xov tooj tom qab cov sijhawm kaws yuav pab tau cov neeg hu tuaj txais tau ib tug neeg lub suab lossis lub tshuab teb xovtooj ua ntej 30 second.

I. COV XOVTOOJ UAS IB TUG NEEG LUB SUAB TEB (xws li lub chaw teb xovtooj/chaw kho mob):

Yog tus neeg hu tuaj ntseeg tias nws muaj ib yam mob xwm txheej ceev, qhia rau tus neeg hu tuaj kom nws khwb lub xovtooj thiab hu 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev/lub chaw kho mob uas nyob ze tshaj rau ntawm nws.

Yog tus neeg hu tuaj ntseeg tias nws muaj ib yam mob nrawm lossis xav nrog ib tug kws kho mob tham, pab kom nws tham tau nrog ib tug kws kho mob thaum koj ua ib qho lossis ntau tshaj raws li cov lawv qab ntawm no:

- Muab tus neeg hu tuaj tsab xovtooj tso tos tib pliag ces txuas tus neeg hu tuaj mus rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov
- Nug tus neeg hu tuaj rau nws tus xovtooj thiab qhia rau nws tias tus kws kho mob mam li rov qab hu tuaj rau nws ua ntej 30 feeb (hu tso lus tamsid rau tus kws kho mob)
- Muab tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim tus xovtooj ntawm nws lub pager rau tus neeg hu tuaj thiab qhia rau tus neeg hu tuaj tias tus kws kho mob mam li hu rau the tswv cuab ua ntej 30 feeb, lossis qhia kom tus neeg hu tuaj cia li mus rau lub chaw kho mob nrawm uas nyob ze tshaj rau ntawm nws
- Yog tias tus neeg hu tuaj hais tias lawv xav tau kev pab txhais lus, pab kom nws tham tau nrog ib tug kws txhais lus

Cov piv txwv:
Nyob zoo, koj tau hu tuaj rau <lub chaw teb xovtooj/chaw kho mob> rau tus kws kho mob Dr. <Lub Xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, thov mloog twj ywm ces kuv mam li txuas koj tsab xovtooj mus.

Nyob zoo, koj tau hu tuaj rau <lub chaw teb xovtooj/chaw kho mob> rau tus kws kho mob Dr. <Lub xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, tus kws kho mob Dr. <Lub Xeem> yuav pab tau koj. Thov <nias tso koj tus xovtooj/hu> nws ntawm <xovtooj>. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

II. TSAB XOVTOOJ UAS LUB TSHUAB KAW LUS TEB:

Nyob zoo, koj tau hu tuaj rau <hais tus Kws Kho Mob/Pab Pawg Kho Mob lub npe>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov (xaiv qhov haum rau koj):

- *Thov tos mentsis ces koj tsab xovtooj mam li txuas mus rau tus kws kho mob Dr. <Lub Xeem>*
- *Koj cia li hu mus cuag tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov thaum koj hu rau <xovtooj>*
- *Nias <tus lej> kom txuas tau koj tsab xovtooj mus rau qhov chaw kho mob nrawm. Peb lub chaw kho mob nrawm nyob ntawm <lub chaw kho mob nrawm qhov chaw nyob> (Koj yuav tsum muaj ib txoj kev los xaiv kom siv tau nws hom lus los qhia txog qhov chaw kho mob.)*

- *Nias <tus lej> kom tso tau koj tus xovtooj rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb*

Cov piv txwv:
Nyob zoo, koj tau hu tuaj rau <Tus Kws Kho Mob/Pab Pawg Kho Mob lub Npe> rau tus kws kho mob Dr. <Lub Xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, thov kaws lus cia nrog koj lub npe, xovtooj thiab qhia vim li cas koj hu tuaj, ces koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

Nyob zoo, koj tau hu tuaj rau <Tus Kws Kho Mob/Pab Pawg Kho Mob lub Npe>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, koj cia li hu ncaj nraim mus tau rau nws ntawm <xovtooj> lossis nias <tus lej> kom tso tau koj tus xovtooj cia rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

គំរូលំនាំ បនញ្ជាប់ពីម្ល្ងាងធេ ីការ

លំនាំមួយនៅខាងក្រោម អាចនឹងបានប្រើដោយវេជ្ជបណ្ឌិត និងក្រុមពេទ្យ ធ្វើជាគំរូដើម្បីធ្វើឲ្យប្រាកដថាសមាជិក Health Net មានសមត្ថភាពទទួលការថែទាំសុខភាពទាន់ពេលវេលា បន្ទាប់ពីម៉ោងធ្វើការ ឬនៅពេលការិយាល័យវេជ្ជបណ្ឌិតរបស់អ្នកបិទ។

សារៈសំខាន់ : ប្រសិទ្ធិភាពនៃសេវាតាមទូរស័ព្ទបន្ទាប់ពីម៉ោងធ្វើការ ធ្វើឲ្យប្រាកដថាអ្នកទូរស័ព្ទមក អាចទាក់ទងមកសំឡេងរស់រវើក ឬម៉ាស៊ីនឆ្លើយ ក្នុងពេល 30 វិនាទី។

I. ការទូរស័ពទ្មមកបានឆើ្រយដោយសំឡេងរស់រវើក (ដូចជាម៉ាស៊ីនឆ្លើយ ឬមជ្ឈដ្ឋានស្មាក់ការ) :

បើអ្នកទូរស័ព្ទមក ជឿ្បថាគាត់មានអាសន្នខាងសុខភាព ត្រូវប្រាប់អ្នកទូរស័ព្ទមកឲ្យដាក់ចុះ និងហៅលេខ 911 ជាប្រញាប់ ឬធ្វើដំណើរទៅបន្ទប់សង្គ្រោះអាសន្ន/មន្ទីរពេទ្យ ដែលស្ថិតនៅជិតបំផុត។

បើអ្នកទូរស័ព្ទមក ជឿ្បថាស្ថានការណ៍គឺជាបន្ទាន់ ឬបើគាត់ប្រាប់ថាត្រូវការនិយាយជាមួយនឹងវេជ្ជបណ្ឌិត ត្រូវសរំបសរំលួការទាក់ទងជាមួយនឹងវេជ្ជបណ្ឌិត ដោយធ្វើការមួយ ឬច្រើនយ៉ាងនៅខាងក្រោម :

- ប្រាប់អ្នកទូរស័ព្ទមក ឲ្យចាំមួយភ្លេត ហើយបន្ទាប់មកតភ្ជាប់អ្នកទូរស័ព្ទមក ទៅវេជ្ជបណ្ឌិតប្រចាំការ
- យកលេខទូរស័ព្ទរបស់អ្នកទូរស័ព្ទមក ហើយប្រាប់គាត់ថាវេជ្ជបណ្ឌិតនឹងទូរស័ព្ទទៅវិញ ក្នុងពេល 30 នាទី (បញ្ជូនសារទៅវេជ្ជបណ្ឌិត ភ្លាមៗ)
- ឲ្យលេខកោះហៅរបស់វេជ្ជបណ្ឌិតប្រចាំការ ទៅអ្នកទូរស័ព្ទមក និងប្រាប់អ្នកទូរស័ព្ទមក ថាវេជ្ជបណ្ឌិតនឹងទូរស័ព្ទទៅសមាជិកវិញ ក្នុងពេល 30 នាទី ឬណែនាំអ្នកទូរស័ព្ទមក ឲ្យទៅកន្លែងមណ្ឌលថែទាំជាបន្ទាន់ ដែលស្ថិតនៅជិតបំផុត
- បើអ្នកទូរស័ព្ទមក ប្រាប់ថាត្រូវការសេវាពីអ្នកបកប្រែ ត្រូវសរំបសរំលួការទាក់ទង ដោយទាក់ទងទៅសេវាពីអ្នកបកប្រែ

ឧទាហរណ៍ :

សួស្តី អ្នកបានទាក់ទងមក <សេវាខាងការឆ្លើយ/មជ្ឈដ្ឋានស្មាក់ការ> សរំាប់វេជ្ជបណ្ឌិត <នាមត្រកូល>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្គ្រោះអាសន្នដែលស្ថិតនៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ សូមរង់ចាំសិន ហើយខ្ញុំនឹងតភ្ជាប់អ្នក។

សួស្តី អ្នកបានទាក់ទងមក <សេវាខាងការឆ្លើយ/មជ្ឈដ្ឋានស្មាក់ការ> សរំាប់វេជ្ជបណ្ឌិត <នាមត្រកូល>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្គ្រោះអាសន្នដែលស្ថិត នៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ វេជ្ជបណ្ឌិត <នាមត្រកូល> អាចជួយអ្នកបាន។ សូម <កោះហៅ/ហៅ> ទៅគាត់តាមលេខ <លេខទូរស័ព្ទ>។ គាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។

II. ការទូរស័ពទ្មមក បានឆើ្រយដោយម្ល្ងាស៊ីនឆើ្រយ :

សួស្តី អ្នកបានទាក់ទងមក <បញ្ជូលឈ្មោះវេជ្ជបណ្ឌិត/ក្រុមពេទ្យ>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្គ្រោះអាសន្នដែលស្ថិតនៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ (ព្រឹសរើសជំរើសត្រឹមត្រូវ) :

- *សូមរង់ចាំសិន ហើយខ្ញុំនឹងតភ្ជាប់អ្នក ទៅវេជ្ជបណ្ឌិត <នាមត្រកូល>*
- *អ្នកអាចទាក់ទងវេជ្ជបណ្ឌិតប្រចាំការផ្ទាល់ ដោយទូរស័ព្ទទៅលេខ <លេខទូរស័ព្ទ>*
- *ចុចលេខ <លេខ> ដើម្បីបញ្ជូនទៅមណ្ឌលថែទាំជាបន្ទាន់។ មណ្ឌលថែទាំជាបន្ទាន់របស់យើងបិតនៅវា <អាសយដ្ឋានមណ្ឌលថែទាំជាបន្ទាន់> (ជំរើសអាសាត្រឹមត្រូវ គួរតែបានផ្តល់សំរាប់ទីកន្លែង)។*
- *ចុចលេខ <លេខ> ដើម្បីកោះហៅវេជ្ជបណ្ឌិតប្រចាំការ។ គាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។*

ឧទាហរណ៍ :

សួស្តី អ្នកបានទាក់ទងមក <ឈ្មោះវេជ្ជបណ្ឌិត/ក្រុមពេទ្យ> សំរាប់វេជ្ជបណ្ឌិត <នាមត្រកូល>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្រ្គោះអាសន្នដែលស្ថិតនៅជិតបំផុត។
បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ សូមទុកសំឡេង ដោយមានឈ្មោះ និងលេខទូរស័ព្ទរបស់អ្នក ព្រមទាំងមូលហេតុនៃការទូរស័ព្ទមក ហើយគាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។

សួស្តី អ្នកបានទាក់ទងមក <ឈ្មោះវេជ្ជបណ្ឌិត/ក្រុមពេទ្យ>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្រ្គោះអាសន្នដែលស្ថិតនៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹង វេជ្ជបណ្ឌិតប្រចាំការ អ្នកអាចទាក់ទងទៅគាត់ដោយផ្ទាល់ ដោយទូរស័ព្ទទៅលេខ <លេខទូរស័ព្ទ> ឬចុចលេខ <លេខ> ដើម្បីកោះហៅវេជ្ជបណ្ឌិតប្រចាំការ។ គាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។

업무시간 후 샘플 스크립트

*의사 및 메디컬 그룹은 병원 업무 시간 후 또는 병원이 문을 닫은 경우 **Health Net** 회원들이 적절한 시간에 의료 서비스를 받으실 수 있도록 다음 스트립트 중 하나를 템플릿으로 이용할 수 있습니다.*

중요사항: 병원 업무 시간 후 효과적인 전화 서비스는 전화하신 분들에게 실제 음성 또는 자동 응답 서비스를 30초 이내에 제공합니다.

I. 실제 음성 전화 응답 (자동 응답 또는 중앙 분류 등)

전화를 건 사람이 의료 응급상황이라고 생각하는 경우, 전화를 끊고 즉시 911로 전화하거나 가장 가까운 응급실이나 병원을 찾아가도록 조언합니다.

전화를 건 사람이 긴급한 상황이라고 생각하거나 의사와 상담이 필요한 경우, 다음 중 하나 이상의 조치를 취해 의사와 연락을 원활히 할 수 있습니다.

- 전화를 잠시 대기하고 당직 의사에게 전화를 건 사람을 연결합니다
- 전화를 건 사람의 전화번호를 받고 의사가 30 분 이내에 전화를 할 것이라고 알려줍니다 (즉시 의사에게 메시지 전송)
- 전화를 건 사람에게 당직 의사의 호출 번호를 알려주고 의사가 30 분 이내에 전화를 할 것이라고 알려 주거나 전화를 건 사람에게 가장 가까운 긴급 치료 센터 위치를 알려줍니다
- 전화를 건 사람이 통역 서비스가 필요한 경우, 통역 서비스에 연락하여 문의를 원활하게 할 수 있도록 해 줍니다

예시:
안녕하십니까? Dr. <성>의 <자동 응답 서비스/중앙 분류 서비스>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면, 잠시 전화를 끊지 말고 기다려 주시면 제가 당직 의사와 연결해 드리겠습니다.

안녕하십니까? Dr. <성>의 <자동 응답 서비스/중앙 분류 서비스>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 Dr. <성>가 도와드릴 것입니다. <전화번호>번으로 <호출/전화>하십시오. 30분 이내에 전화를 받을 수 있을 것입니다.

II. 자동 응답기가 답변하는 전화:

안녕하십니까? <의사/메디컬 그룹 이름 삽입 >에 전화해 주셔서 감사합니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 (적당한 옵션 선택하십시오):

- *잠시 전화를 끊지 말고 기다리시면 Dr. <성>과 연결해 드리겠습니다*
- *<전화번호>번으로 전화하여 직접 당직 의사와 통화할 수 있습니다*
- *<번호>를 누르시면 긴급 치료 센터와 연결됩니다 긴급 치료 센터는 <긴급 치료 센터 주소>에 있습니다 (위치에 대한 적당한 언어 옵션이 제공되어야 합니다.)*
- *<번호>를 눌러 당직 의사를 호출합니다. 30분 이내에 전화를 받을 수 있을 것입니다*

예시:
안녕하십니까? <의사/메디컬 그룹 이름>의 Dr. <성>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 귀하의 이름과 전화번호, 전화를 한 이유에 대해 메시지를 남겨주십시오. 30분 이내에 전화 드리겠습니다.

안녕하십니까? <의사/메디컬 그룹 이름>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 직접 <전화번호>로 전화하거나 <번호>로 호출하여 당직 의사와 상담할 수 있습니다. 30분 이내에 전화를 받을 수 있을 것입니다.

ОБРАЗЕЦ ОПРОСНОГО ЛИСТА ПО ОБСЛУЖИВАНИЮ В НЕРАБОЧИЕ ЧАСЫ

Врачи и медицинские группы могут использовать один из приведенных ниже опросных листов в качестве шаблона, чтобы убедиться в том, что участники Health Net имеют доступ к своевременной медицинской помощи в нерабочее часы, либо когда ваши офисы закрыты.

ВАЖНОЕ ПРИМЕЧАНИЕ: эффективное телефонное обслуживание в нерабочие часы подразумевает, что в течение 30 секунд после начала звонка позвонившему ответил оператор или автоответчик.

I. ЗВОНКИ, НА КОТОРЫЕ ОТВЕЧАЕТ ОПЕРАТОР (служба телефонных ответов или централизованное распределение звонков):

Если позвонивший считает, что ему или ей необходима неотложная медицинская помощь, посоветуйте позвонившему повесить трубку и немедленно позвонить по номеру 911, либо направьте его в ближайшее приемное отделение неотложной медицинской помощи/медицинское учреждение.

Если позвонивший полагает, что его ситуация не терпит отлагательства, либо же он выражает потребность поговорить с врачом, обеспечьте ему связь с врачом при помощи одного или нескольких из следующих действий:

- Немедленно переведите позвонившего в режим ожидания, а затем соедините его с дежурным врачом
- Возьмите номер телефона у позвонившего, и сообщите ему или ей, что врач перезвонит ему в течение 30 минут (немедленно пошлите сообщение врачу)
- Дайте позвонившему номер пейджера дежурного врача, и сообщите позвонившему, что врач позвонит ему в течение 30 минут, либо направьте его в ближайший центр оказания неотложной помощи
- Если позвонивший нуждается в помощи переводчика, обеспечьте ему связь при помощи переводческих услуг.

Примеры:
Здравствуйте, вы позвонили в <служба телефонных ответов/централизованное распределение звонков> доктору <Фамилия>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, либо обратитесь в ближайшее к вам приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, пожалуйста, оставайтесь на линии и я соединю вас.

Здравствуйте, вы позвонили в <служба телефонных ответов/централизованное распределение звонков> доктору <Фамилия>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, либо обратитесь в ближайшее к вам приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, вам поможет доктор <Фамилия>. Пожалуйста <отошлите сообщение на пейджер/позвоните> ему/ее по <телефону>. Вам перезвонят в течение 30 минут.

II. ЗВОНКИ НА АВТООТВЕТЧИК:

Здравствуйте, вы позвонили, <вставьте имя доктора/название медицинской группы>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, либо обратитесь в ближайшее к вам приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, то (выберите подходящий вариант):

- *Пожалуйста, оставайтесь на линии, и вас соединят с доктором <Фамилия>*

- *Вы можете напрямую позвонить дежурному врачу по телефону <номер телефона>*
- *Нажмите <номер> , чтобы соединиться с нашим центром экстренной медицинской помощи. Наш центр экстренной медицинской помощи расположен по адресу: <адрес центра экстренной медицинской помощи> (необходимо обеспечить по данному адресу возможность языкового выбора)*
- *Нажмите <номер> , чтобы отправить сообщение на пейджер дежурного врача. Вам перезвонят в течение 30 минут.*

Примеры:
Здравствуйте, вы позвонили <имя доктора/название медицинское группы> доктору <Фамилия>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленной позвоните по номеру 911, либо обратитесь в ближайшее приемное отделение неотложное медицинской помощи. Если вы хотите поговорить с дежурным врачом, пожалуйста, оставьте сообщение с вашим именем, номером телефона и причиной звонка. Вам перезвонят в течение 30 минут.

Здравствуйте, вы позвонили <имя доктора/название медицинской группы>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, или обратитесь в ближайшее приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, то вы можете связаться с ним/нею напрямую, позвонив по номеру <номер телефона> или нажмите <номер>, чтобы отправить сообщение на пейджер дежурного врача. Вам перезвонят в течение 30 минут.

EJEMPLO DE TEXTO PARA USAR FUERA DEL HORARIO DE ATENCIÓN

Los médicos y grupos médicos pueden utilizar uno de los siguientes textos como plantilla para garantizar que los afiliados tengan acceso a una atención médica oportuna fuera del horario de atención o cuando sus consultorios están cerrados.

IMPORTANTE: Un servicio telefónico eficaz fuera del horario de atención garantiza que las personas que llaman puedan comunicarse con una voz en vivo o un contestador automático dentro de los 30 segundos.

I. LLAMADAS RESPONDIDAS POR UNA VOZ EN VIVO (como un servicio de mensajes telefónicos o un servicio centralizado de clasificación según las prioridades de atención):

Si la persona que llama cree que está teniendo una emergencia médica, indíquele que cuelgue y que llame al 911 de inmediato, o bien, que se dirija a la sala de emergencias/al centro médico más cercano.

Si la persona que llama cree que la situación es de urgencia o indica que necesita hablar con un médico, póngala en contacto con el médico siguiendo uno o más de los pasos a continuación:

- Déjela en espera por un momento y luego comuníquela con el médico de guardia
- Solicítele el número de teléfono e indíquele que un médico le devolverá la llamada dentro de los 30 minutos (envíe un mensaje al médico de inmediato)
- Proporciónele el número del buscapersonas del médico de guardia e indíquele que el médico llamará al afiliado dentro de los 30 minutos, o bien, diríjala al centro de atención de urgencia más cercano
- Si una persona que llama indica que necesita servicios de intérprete, póngala en contacto con quien pueda brindarle dichos servicios

Ejemplos:
Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, permanezca en línea mientras le comunico.

Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, el Dr./la Dra. <Apellido> puede ayudarle. Por favor, <llámelo/a> al <número de teléfono>. Calcule que se le devolverá la llamada dentro de los 30 minutos.

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMÁTICO:

Hola, usted se ha comunicado con <insertar el nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia (seleccione la opción correspondiente):

- *Por favor, espere un momento mientras le comunico con el Dr./la Dra. <Apellido>*
- *Usted puede comunicarse directamente con el médico de guardia llamando al <número de teléfono>*
- *Oprima <número> para transferir la llamada a nuestro centro de atención de urgencia, que está ubicado en <dirección del centro de atención de urgencia> (Se deben proporcionar las opciones de idioma correspondientes a la ubicación.)*
- *Oprima <número> para llamar al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.*

Ejemplos:
Hola, usted se ha comunicado con <Nombre del Médico/Group Médico> para el Dr./la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, deje un mensaje con su nombre, su número de teléfono y el motivo por el que llama, y calcule que se le devolverá la llamada dentro de los 30 minutos.

Hola, usted se ha comunicado con <Nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, puede comunicarse directamente con éste llamando al <número de teléfono> u oprimiendo <número> para acceder al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.

EJEMPLO DE TEXTO PARA USAR FUERA DEL HORARIO DE ATENCIÓN

Los médicos y grupos médicos pueden utilizar uno de los siguientes textos como plantilla para garantizar que los afiliados a Health Net tengan acceso a una atención médica oportuna fuera del horario de atención o cuando sus consultorios están cerrados.

IMPORTANTE: Un servicio telefónico eficaz fuera del horario de atención garantiza que las personas que llaman puedan comunicarse con una voz en vivo o un contestador automático dentro de los 30 segundos.

I. LLAMADAS RESPONDIDAS POR UNA VOZ EN VIVO (como un servicio de mensajes telefónicos o un servicio centralizado de clasificación según las prioridades de atención):

Si la persona que llama cree que está teniendo una emergencia médica, indíquele que cuelgue y que llame al 911 de inmediato, o bien, que se dirija a la sala de emergencias/al centro médico más cercano.

Si la persona que llama cree que la situación es de urgencia o indica que necesita hablar con un médico, póngala en contacto con el médico siguiendo uno o más de los pasos a continuación:

- Déjela en espera por un momento y luego comuníquela con el médico de guardia
- Solicítele el número de teléfono e indíquele que un médico le devolverá la llamada dentro de los 30 minutos (envíe un mensaje al médico de inmediato)
- Proporciónele el número del buscapersonas del médico de guardia e indíquele que el médico llamará al afiliado dentro de los 30 minutos, o bien, diríjala al centro de atención de urgencia más cercano
- Si una persona que llama indica que necesita servicios de intérprete, póngala en contacto con quien pueda brindarle dichos servicios

Ejemplos:
Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, permanezca en línea mientras le comunico.

Hola, usted se ha comunicado con el <servicio de mensajes telefónicos/servicio centralizado de clasificación según las prioridades de atención> del Dr./de la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, el Dr./la Dra. <Apellido> puede ayudarle. Por favor, <llámelo/a> al <número de teléfono>. Calcule que se le devolverá la llamada dentro de los 30 minutos.

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMÁTICO:

Hola, usted se ha comunicado con <insertar el nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia (seleccione la opción correspondiente):

- *Por favor, espere un momento mientras le comunico con el Dr./la Dra. <Apellido>*
- *Usted puede comunicarse directamente con el médico de guardia llamando al <número de teléfono>*
- *Oprima <número> para transferir la llamada a nuestro centro de atención de urgencia, que está ubicado en <dirección del centro de atención de urgencia> (Se deben proporcionar las opciones de idioma correspondientes a la ubicación.)*
- *Oprima <número> para llamar al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.*

Ejemplos:
Hola, usted se ha comunicado con <Nombre del Médico/Group Médico> para el Dr./la Dra. <Apellido>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, por favor, deje un mensaje con su nombre, su número de teléfono y el motivo por el que llama, y calcule que se le devolverá la llamada dentro de los 30 minutos.

Hola, usted se ha comunicado con <Nombre del Médico/Group Médico>. Si es una emergencia médica, por favor, cuelgue y marque 911 de inmediato, o bien, vaya a la sala de emergencias más cercana. Si desea hablar con el médico de guardia, puede comunicarse directamente con éste llamando al <número de teléfono> u oprimiendo <número> para acceder al buscapersonas del médico de guardia. Calcule que se le devolverá la llamada dentro de los 30 minutos.

SAMPLE NA SCRIPT PAGKATAPOS NG ORAS NA MAY PASOK

Magagamit ng mga manggagamot at medikal na pangkat ang isa sa mga sumusunod na script bilang template upang matiyak na may access ang mga miyembro ng Health Net sa napapanahong pangangalagang medikal pagkatapos ng oras ng negosyo o kapag sarado ang inyong mga tanggapan.

MAHALAGA: Tinitiyak ng mabisang serbisyo ng telepono pagkatapos ng oras ng negosyo na magagawang abutin ng mga tumatawag ang isang live na boses o answering machine sa loob ng 30 segundo.

I. MGA TAWAG NA SINASAGOT NG ISANG LIVE NA BOSES (gaya ng isang serbisyo sa pagsagot o centralized na triage):

Kung pinaniniwalaan ng tumatawag na siya ay nakakaranas ng isang medikal na emergency, payuhan ang tumatawag na mag-hang up at agad na tumawag sa 911 o pumunta sa pinakamalapit na emergency room/medikal na pasilidad.

Kung pinaniniwalaan ng tumatawag na agaran ang sitwasyon o nagsaad ng pangangailangang makipag-usap sa isang manggagamot, ayusin ang pakikipag-ugnay sa manggagamot sa pamamagitan ng paggawa sa isa o higit pa sa sumusunod:

- I-hold nang ilang sandali ang tumatawag at pagkatapos ay ikonekta ang tumatawag sa on-call na manggagamot
- Kunin ang numero ng tumatawag at payuhan siya na tatawag sa kanya ang isang manggagamot sa loob ng 30 minuto (agad na magpadala ng mensahe sa manggagamot)
- Ibigay sa tumatawag ang numero sa pager ng on-call na manggagamot at payuhan ang tumatawag na tatawagan ng manggagamot ang miyembro sa loob ng 30 minuto, o idirekta ang tumatawag sa pinakamalapit na lokasyon ng center ng agarang pangangalaga
- Kung isinaad ng tumatawag ang pangangailangan para sa mga serbisyo ng tagasalin ng wika, ayusin ang pakikipag-ugnay sa pamamagitan ng pag-access sa mga serbisyo ng tagasalin ng wika

Mga Halimbawa:

Kamusta, naabot mo ang <answering service/centralized na triage> para kay Doktor <Last Name>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa on-call na manggagamot, mangyaring manatili sa linya at ikokonekta kita.

Kamusta, naabot mo ang <answering service/centralized na triage> para kay Doktor <Last Name>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa on-call na manggagamot, matutulungan ka ni Doktor <Last Name>. Mangyaring <i-page/tawagan> siya sa <numero ng telepono>.Maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto.

II. MGA TAWAG NA SINASAGOT NG ISANG ANSWERING MACHINE:

Kamusta, naabot mo ang <ipasok ang Pangalan ng Doktor/Medikal na Pangkat>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa manggagamot na on-call (piliin ang naaangkop na pagpipilian):

- *Mangyaring maghintay at ikokonekta ka kay Doktor <Apelyido>*
- *Maaari mong direktang maabot ang manggagamot na on-call sa pamamagitan ng pagtawag sa <numero ng telepono>*
- *Pindutin ang <numero> upang lumipat sa aming center ng agarang pangangalaga. Matatagpuan ang aming center ng agarang pangangalaga sa <address ng center ng agarang pangangalaga> (Dapat ibigay ang mga naaangkop na pagpipilian sa wika para sa lokasyon.)*
- *Pindutin ang <numero> upang i-page ang manggagamot na on-call. Maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto*

Mga Halimbawa:

Kamusta, naabot mo ang <answering service/centralized na triage> para kay Doktor <Last Name>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa manggagamot na on-call, mangyaring mag-iwan ng mensahe kasama ang iyong pangalan, numero ng telepono at dahilan ng pagtawag, at maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto.

Kamusta, naabot mo ang <ipasok ang Pangalan ng Doktor/Medikal na Pangkat>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa manggagamot na on-call, maaabot mo siya nang direkta sa pamamagitan ng pagtawag sa <numero ng telepono> o pindutin ang <numero> upang i-page ang manggagamot na on-call. Maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto

BẢN MẪU TRẢ LỜI ĐIỆN THOẠI SAU GIỜ LÀM VIỆC

Một trong những bản mẫu trả lời điện thoại sau đây có thể được bác sĩ và các nhóm y khoa dùng để trả lời điện thoại, nhằm giúp cho Hội viên Health Net được giúp đỡ đúng lúc về các vấn đề y tế sau giờ làm việc hoặc khi văn phòng bác sĩ hay văn phòng nhóm y khoa, đóng cửa.

LƯU Ý QUAN TRỌNG: Dịch vụ trả lời điện thoại hữu hiệu sau giờ làm việc sẽ bảo đảm cho người gọi được nói chuyện trực tiếp với nhân viên, hoặc được trả lời bằng máy nhắn tin, trong vòng 30 giây.

I. ĐIỆN THOẠI GỌI VÀO ĐƯỢC NHÂN VIÊN ĐẠI DIỆN TRỰC TIẾP TRẢ LỜI (như nhân viên văn phòng dịch vụ trả lời điện thoại, hoặc văn phòng cứu xét mức độ nguy cấp để chữa trị):

Nếu người gọi nghĩ là họ đang trong tình trạng cấp cứu y tế, hãy bảo họ gác máy và gọi 911 ngay lập tức, hoặc bảo họ đến phòng cấp cứu/cơ sở y tế gần nhất.

Nếu người gọi nghĩ là họ đang trong tình trạng khẩn cấp, hoặc người gọi cho biết là họ cần nói chuyện với bác sĩ, hãy giúp họ liên lạc với bác sĩ bằng một trong những cách sau đây:

- Hãy để người gọi chờ trong vài giây, sau đó nối đường dây điện thoại cho người gọi được nói chuyện với bác sĩ trực
- Xin số điện thoại của người gọi và cho họ biết là bác sĩ sẽ gọi lại cho họ trong vòng 30 phút (cùng lúc, nhắn tin cho bác sĩ trực ngay lập tức)
- Cho người gọi số điện thoại nhắn tin của bác sĩ trực và cho họ biết là bác sĩ sẽ gọi lại cho họ trong vòng 30 phút, hoặc hướng dẫn người gọi đi đến trung tâm chăm sóc khẩn cấp gần nhất
- Nếu người gọi cho biết là họ cần thông dịch viên, hãy liên lạc ngay với văn phòng dịch vụ thông dịch

Thí dụ:
Kính chào quý vị, quý vị đã gọi <văn phòng dịch vụ trả lời điện thoại/văn phòng cứu xét mức độ nguy cấp để chữa trị> của Bác sĩ <Họ của bác sĩ>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, vui lòng chờ máy và tôi sẽ nối đường dây điện thoại đến bác sĩ cho quý vị.

Kính chào quý vị, quý vị đã gọi <văn phòng dịch vụ trả lời điện thoại/văn phòng cứu xét mức độ nguy cấp để chữa trị> của Bác sĩ <Họ của bác sĩ>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, Bác sĩ <Họ của bác sĩ> sẽ giúp đỡ quý vị. Vui lòng <nhắn tin/gọi> bác sĩ tại số <số điện thoại>. Quý vị sẽ được bác sĩ gọi lại trong vòng 30 phút.

II. ĐIỆN THOẠI GỌI VÀO ĐƯỢC TRẢ LỜI BẰNG MÁY NHẮN TIN:

Kính chào quý vị, quý vị đã gọi <ghi vào đây tên bác sĩ/nhóm y khoa>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, (chọn một trong những trường hợp phù hợp):

- *Vui lòng chờ máy và quý vị sẽ được nối đường dây điện thoại đến Bác sĩ <Họ của bác sĩ>*
- *Quý vị có thể trực tiếp gọi cho bác sĩ trực tại số <số điện thoại>.*
- *Xin bấm số <số> để được chuyển sang trung tâm chăm sóc khẩn cấp của chúng tôi. Trung tâm chăm sóc khẩn cấp của chúng tôi nằm tại <địa chỉ trung tâm chăm sóc khẩn cấp> (Dùng ngôn ngữ thích hợp khi cho địa chỉ của địa điểm.)*
- *Xin bấm số <số> để nhắn tin cho bác sĩ trực. Quý vị sẽ được gọi lại trong vòng 30 phút*

Thí dụ:
Kính chào quý vị, quý vị đã gọi văn phòng của < tên bác sĩ/nhóm y khoa) để tìm gặp Bác sĩ <Họ của bác sĩ>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp

cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, vui lòng nhắn tin nơi đây, cho biết tên họ của quý vị, số điện thoại và lý do quý vị gọi hôm nay, và quý vị sẽ được gọi lại trong vòng 30 phút.

Kính chào quý vị, quý vị đã gọi <tên bác sĩ/nhóm y khoa>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, quý vị có thể trực tiếp gọi cho bác sĩ tại số <số điện thoại> hoặc bấm số <số> để nhắn tin. Quý vị sẽ được gọi lại trong vòng 30 phút.

Applied Behavioral Analysis (ABA) Prior Authorization Request Form

Provider facility/group name: _____

Provider taxpayer identification number (TIN): _____

Provider address: _____ **Provider city, state, zip:** _____

Provider phone #: _____ **Provider fax number:** _____

Case supervisor name and credentials: _____

Case supervisor national provider identifier (NPI): _____

Case supervisor phone number: _____ **Case supervisor email:** _____

Case supervisor availability for call back (*please indicate days and times*): _____

Member ID number: _____ **Member DOB:** _____

Member first name: _____ **Member last name:** _____

Member address: _____

Proposed authorization start date: _____ **Proposed authorization end date:** _____

Addendums to existing authorizations can no longer be accommodated. If you require changes to your current authorization, such as adjustments to dates of service or hours, a new prior authorization request form must be submitted for utilization review. As a result, the existing authorization will be ended.

Please ensure the prior authorization request form is completed in its entirety, rather than only including the additional hours or codes needed. The start date should be the date the change is needed, and the end date must correspond to the end date of the current authorization. Please include all codes you plan to deliver and the total hours per week/month needed for the remaining weeks (not just the additional hours or codes needed). Lastly, you must include a letter detailing the clinical rationale that supports the request for an increase in hours and/or changes in dates of service.

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HCPCS Codes

H0031	_____	**Hours** per auth period.		
H0032	_____	**Hours** per	Week	Month
H2014	_____	**Hours** per	Week	Month
H2019	_____	**Hours** per	Week	Month
S5111	_____	**Sessions** per	Week	Month

CPT Codes

97151	_____	**Hours** per auth period.		
97152	_____	**Hours** per auth period.		
0362T	_____	**Hours** per auth period.		
97153	_____	**Hours** per	Week	Month
97154	_____	**Hours** per	Week	Month
97155	_____	**Hours** per	Week	Month
97156	_____	**Hours** per	Week	Month
97157	_____	**Hours** per	Week	Month
97158	_____	**Hours** per	Week	Month
0373T	_____	**Hours** per	Week	Month

Submit the completed form to the Health Net* Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.

*Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Applied Behavioral Analysis (ABA) Prior Authorization Request Form

Provider facility/group name: _____

Provider taxpayer identification number (TIN): _____

Provider address: _____ **Provider city, state, zip:** _____

Provider phone #: _____ **Provider fax number:** _____

Case supervisor name and credentials: _____

Case supervisor national provider identifier (NPI): _____

Case supervisor phone number: _____ **Case supervisor email:** _____

Case supervisor availability for call back (*please indicate days and times*): _____

Member ID number: _____ **Member DOB:** _____

Member first name: _____ **Member last name:** _____

Member address: _____

Proposed authorization start date: _____ **Proposed authorization end date:** _____

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Applied Behavioral Analysis (ABA) Prior Authorization Request Form

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Case supervisor availability for call back (*please indicate days and times*): _____

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Member first name: _____ **Member last name:** _____

Member address: _____

Proposed authorization start date: _____ **Proposed authorization end date:** _____

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Applied Behavioral Analysis (ABA) Recommendation and Referral Form

This form is intended to fulfill the requirement set forth by the Department of Health Care Services (DHCS) that applied behavioral analysis (ABA) services require a medical necessity recommendation from a physician or licensed psychologist. This form must be completed by a physician or licensed psychologist.

Upon completion, give the original form to the parent/caregiver or their chosen in-network ABA provider. As the referring physician or licensed psychologist you may also submit this completed form directly to the Health Net* Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.

Member name: _____ **DOB:** _____ **Medi-Cal ID:** _____

Parent/caregiver Name: _____ **Relationship to member:** _____ **Phone number:** _____

Primary diagnosis: _____

Referring physician or licensed psychologist: _____ **Contact phone number:** _____

Referral reason(s): _____

ABA recommended: Yes No

Additional treatment recommendation(s): _____

Has the parent/caregiver chosen an in-network ABA provider? Yes No

If no, as the referring physician or licensed psychologist, submit this completed form to the Behavioral Health Autism Center and an Autism Center utilization review clinician will contact the parent/caregiver to connect them to an in-network ABA provider. Please advise the parent/caregiver to contact Behavioral Health at 888-935-5966 to obtain a list of in-network ABA providers.

Signature of physician or licensed psychologist: _____ **License type and ID number:** _____

Date: _____

Submit the completed form to the Health Net Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.

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Referral reason(s): _____

ABA recommended: Yes No

Additional treatment recommendation(s): _____

Has the parent/caregiver chosen an in-network ABA provider? Yes No

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Primary diagnosis: _____

Referring physician or licensed psychologist: _____ **Contact phone number:** _____

Referral reason(s): _____

ABA recommended: Yes No

Additional treatment recommendation(s): _____

Has the parent/caregiver chosen an in-network ABA provider? Yes No

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Signature of physician or licensed psychologist: _____ **License type and ID number:** _____

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26-298 (2/26)

PCP:	
SECTION: Office Management	
POLICY AND PROCEDURE: **Appointments and Patient Recall**	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
A system is established that provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care.

PROCEDURE:

A. Staff shall notify and remind members of scheduled appointments and/or preventive screening appointments.

B. The PCP will provide an initial health assessment for each adult and pediatric member within 120 days of the date of enrollment, unless the member's PCP determine that the member's medical record contains complete and current information consistent with the assessment requirements within periodicity time requirements.

C. The Health Plan will follow its procedure to advise the plan members of the availability and value of scheduling an IHA appointment. The Health Plan will provide monthly eligibility reports to PCPs, listing the member's names, addresses, and telephone numbers. If a member or guardian refuses to have an IHA performed, this information must be documented in the member's medical record.

D. Staff will follow up on missed and/or canceled appointments via mail or phone. At least two attempts to reach the patient will be made and documented in the patient's record.

E. Appointment Rescheduling - When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice, and consistent with the objectives of this policy.

F. The PCP will ensure that appointments are designed according to the patient's clinical needs and within the following timeliness standards:

1. Urgent Care: within 48 hours
2. Prenatal Care: within 10 days
3. Non-urgent Care: within 10 days
4. Well child Visits: within 10 days
5. Specialty Care within 15 Days
6. Specialty Care within 15 days

Asthma Action Plan

Patient Name _____ Weight _____ Date of Birth _____ Peak Flow _____

Doctor's Name _____ Phone _____

Doctor's Clinic Name _____

Symptom Triggers _____

Asthma Severity

Green Zone "Go! All Clear!"

- Breathing is easy
- Can play, work and sleep without asthma symptoms

Peak Flow Range
(80% - 100% of personal best)

The GREEN ZONE means take the following medicine(s) every day.

Controller Medicine(s) **Dose**

_____

_____

_____

Spacer Used _____

Take the following medicine if needed 10-20 minutes before sports, exercise or any other strenuous activity.

_____

Yellow Zone "Caution..."

- Breathing is easy
- Cough or wheeze
- Chest is tight

Peak Flow Range
(50% - 80% of personal best)

The YELLOW ZONE means keep taking your GREEN ZONE controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s) **Dose**

_____

_____

If beginning cold symptoms, call your doctor before starting oral steroids.

_____

Use Quick Reliever (two - four puffs) every 20 minutes for up to one hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after one hour, follow RED ZONE instructions. If you are in the YELLOW ZONE for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone "STOP! Medical Alert!"

- Medicine is not helping
- Nose opens wide to breathe
- Breathing is hard and fast
- Trouble Walking
- Trouble Talking
- Ribs show

Peak Flow Range
(Below 50% of personal best)

The **RED ZONE** means start taking your RED ZONE medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to a **hospital emergency department or call 911 immediately.**

Reliever Medicine(s) **Dose**

_____

_____

_____

_____

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NEW CODE

LAST NAME:	FIRST NAME:	MRN#

PLACE OF SCREENING:
AUDIOMETER:

CIRCLE ONE: ANSI - 69
ISO - 61

SCORING: Child responds at 25 dB: ☑
Child does not respond at 25 dB: -

DATE OF LAST CALIBRATION:

AGE:

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000

LEFT Ear	1000	2000	3000	4000

2nd Screen Date:_____	1000	2000	3000	4000

1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION:

AGE:

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000

LEFT Ear	1000	2000	3000	4000

2nd Screen Date:_____	1000	2000	3000	4000

1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION:

AGE:

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000

LEFT Ear	1000	2000	3000	4000

2nd Screen Date:_____	1000	2000	3000	4000

1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

Alcohol Use Disorders Identification Test (AUDIT)

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly

(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

Cuestionario de prueba de detección de alcohol AUDIT - Spanish

Patient name: _____

Date of birth: _____

Debido que ingerir alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Si se siente incómodo al llenar este formulario, hágaselo saber a su proveedor de atención médica.

Una bebida estándar equivale a:

- 1.5 oz de licor (por ejemplo, un trago de whisky)
- 12 oz cerveza
- 5 oz de vino

1. ¿Con qué frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 veces a la semana	4 o más veces a la semana
2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?	1 ó 2	3 ó 4	5 ó 6	7, 8, o 9	10 o más
3. ¿ Con qué frecuencia toma 6 o más bebidas alcohólicas en un solo día?	Nunca	Menos de una vez al mes	Mensualmente	Semanal mente	A diario o casi a diario
4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez había empezado?	Nunca	Menos de una vez al mes	Mensualmente	Semanal mente	Diariamente o casi diariamente
5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanal mente	Diariamente o casi diariamente
6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?	Nunca	Menos de una vez al mes	Mensualmente	Semanal mente	Diariamente o casi diariamente
7. ¿Con qué frecuencia en el curso del último año ha tenido remordimientos o sentimientos de culpa después de haber bebido?.	Nunca	Menos de una vez al mes	Mensualmente	Semanal mente	Diariamente o casi diariamente
8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?	Nunca	Menos de una vez al mes	Mensualmente	Semanal mente	Diariamente o casi diariamente
9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?	No		Sí, pero no en el curso del ultimo año		Sí, el último año
10. ¿Algún familiar, amigo, médico o profesional sanitario ha mostrado preocupación por su consumo de bebidas alcohólicas o le han sugerido que deje de beber?	No		Sí, pero no en el curso del ultimo año		Sí, el último año
	0	1	2	3	4

¿Alguna vez ha estado en tratamiento por problemas con el alcohol? ☐ nunca ☐ Actualmente ☐ en el pasado

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

(For the clinician or behavioralist)

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a zone of use, which can be circled on the bottom left corner.

Score*	**Zone**	**Action**
0-3: Women 0-4: Men	I – Low Risk	Brief education
4-12: Women 5-14: Men	II – Risky	Brief intervention
13-19: Women 15-19: Men	III – Harmful	Brief intervention/consider referral
20+: Men 20+: Women	IV – Dependent	Referral to specialized treatment

Brief education: An opportunity to educate patients about low-risk consumption levels and the risks of excessive alcohol use.

Brief intervention: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention.

The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Patients with numerous or serious negative consequences from their drinking, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up. The recommended behavior change in this case is to either cut back to low-risk drinking levels or abstain from use.

Referral to specialized treatment: A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

***** Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

AUDIT-C - Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	Men[1]	Women[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

≥ 3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥ 4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. *Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Internal Med. 1998 (3): 1789-1795.*
2. *Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. Arch Internal Med Vol 163, April 2003: 821-829.*
3. *Frequently Asked Questions guide to using the AUDIT-C can be found via the website: www.oqp.med.va.gov/general/uploads/FAQ%20AUDIT-C*

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

AUDIT-C is available for use in the public domain.

Cuestionario de prueba de detección de alcohol AUDIT-C (Spanish)

Patient name: _____

Date of birth: _____

Debido que ingerir alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Si se siente incómodo al llenar este formulario, hágaselo saber a su proveedor de atención médica.

Una bebida estándar equivale a:

- 1.5 oz de licor (por ejemplo, un trago de whisky)
- 12 oz cerveza
- 5 oz de vino

AUDIT – C

1. ¿Con qué frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 veces a la semana	4 o más veces a la semana
2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?	1 ó 2	3 ó 4	5 ó 6	7, 8, o 9	10 o más
3. ¿ Con qué frecuencia toma 6 o más bebidas alcohólicas en un solo día?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario

Scoring:

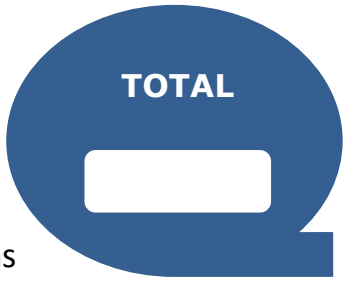
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions

Autoclave Maintenance and Run Log -- Year _____

Please Date and Initial

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
MONTHLY SPORE TESTING RESULTS												
MONTHLY CLEANING												
ANNUAL CALIBRATION												

Sterility is **EVENT related**, not time related; Pack is considers sterile unless and event causes contamination (example: punctured, torn, cracked packs = unsterile; evidence of water damage or yellowed packs = unsterile). Have process to routine evaluation of sterile packs
Log Process: Write date and Load # on Pack (if more than 1 load is run in the same day, write date and load #1 and then date and load #2 etc)

Date	Time	Load #	Item(s) Autoclaved	Temperature (250-254 Degrees)	Steam Pressure (15-17 psi)	Duration of Run (30 minutes)	Person Responsible

EXPOSURE EVENT NUMBER: _____

SAMPLE Blood and Body Fluid Exposure Report Form

Facility name: _____

Name of exposed worker:

Last: _____ **First:** _____ **ID #:** _____

Date of exposure: _____/_____/_____ **Time of exposure:** _____:_____ **AM PM** (Circle)

Job title/occupation: _____ **Department/work unit:** _____

Location where exposure occurred: _____

Name of person completing form: _____

Section I. Type of Exposure *(Check all that apply.)*

☐ **Percutaneous (Needle or sharp object that was in contact with blood or body fluids)**
(Complete Sections II, III, IV, and V.)

☐ **Mucocutaneous** *(Check below and complete Sections III, IV, and VI.)*
___ **Mucous Membrane** ___ **Skin**

☐ **Bite (***Complete Sections III, IV, and VI.)*

Section II. Needle/Sharp Device Information

(If exposure was percutaneous, provide the following information about the device involved.)

Type of device: _____ ☐ Unknown/Unable to determine

Brand/manufacturer: _____ ☐ Unknown/Unable to determine

Did the device have a sharps injury prevention feature, i.e., a "safety device"?

☐ Yes ☐ No ☐ Unknown/Unable to determine

If yes, when did the injury occur?

☐ Before activation of safety feature was appropriate
☐ During activation of the safety feature
☐ Safety feature improperly activated
☐ Safety feature failed after activation
☐ Safety feature not activated
☐ Other: _____

Describe what happened with the safety feature, e.g., why it failed or why it was not activated: _____

_____

_____

Section III. Employee Narrative

Describe how the exposure occurred and how it might have been prevented:

_____

_____

_____

NOTE: This is not a CDC or OSHA form. This form was developed by CDC to help healthcare facilities collect detailed exposure information that is specifically useful for the facilities' prevention planning. Information on this page (#1) may meet OSHA sharps injury documentation requirements and can be copied and filed for purposes of maintaining a separate sharps injury log. Procedures for maintaining employee confidentiality must be followed.

Section IV. Exposure and Source Information

A. Exposure Details: *(Check all that apply.)*

1. Type of fluid or material (For body fluid exposures only, check which fluid in adjacent box.)

☐ Blood/blood products
☐ Visibly bloody body fluid*
☐ Non-visibly bloody body fluid*
☐ Visibly bloody solution
(e.g., water used to clean a blood spill)

***Identify which body fluid**

___ Cerebrospinal	___ Urine	___ Synovial
___ Amniotic	___ Sputum	___ Peritoneal
___ Pericardial	___ Saliva	___ Semen/vaginal
___ Pleural	___ Feces/stool	___ Other/Unknown

2. Body site of exposure. *(Check all that apply.)*

☐ Hand/finger ☐ Eye ☐ Mouth/nose ☐ Face ☐ Arm ☐ Leg

☐ Other (Describe: _____)

3. If percutaneous exposure:

Depth of injury *(Check only one.)*

☐ Superficial (e.g., scratch, no or little blood)
☐ Moderate (e.g., penetrated through skin, wound bled)
☐ Deep (e.g., intramuscular penetration)
☐ Unsure/Unknown

Was blood visible on device before exposure? ☐ Yes ☐ No ☐ Unsure/Unknown

4. If mucous membrane or skin exposure: *(Check only one.)*

Approximate volume of material

☐ Small (e.g., few drops) ☐ Large (e.g., major blood splash)

If skin exposure, was skin intact? ☐ Yes ☐ No ☐ Unsure/Unknown

B. Source Information

1. Was the source individual identified? ☐ Yes ☐ No ☐ Unsure/Unknown

2. Provide the serostatus of the source patient for the following pathogens.

	Positive	Negative	Refused	Unknown
HIV Antibody	☐	☐	☐	☐
HCV Antibody	☐	☐	☐	☐
HbsAg	☐	☐	☐	☐

3. If known, when was the serostatus of the source determined?

☐ Known at the time of exposure
☐ Determined through testing at the time of or soon after the exposure

Section V. Percutaneous Injury Circumstances

A. What device or item caused the injury?

Hollow-bore needle

☐ Hypodermic needle
__ Attached to syringe
__ Attached to IV tubing
__ Unattached
☐ Prefilled cartridge syringe needle
☐ Winged steel needle (i.e., butterfly^{R} type devices)
__ Attached to syringe
__ Attached to IV tubing
__ Unattached
☐ IV stylet
☐ Phlebotomy needle
☐ Spinal or epidural needle
☐ Bone marrow needle
☐ Biopsy needle
☐ Huber needle
☐ Other type of hollow-bore needle (type: _____)
☐ Hollow-bore needle, type unknown

Suture needle

☐ Suture needle

Glass

☐ Capillary tube
☐ Pipette (glass)
☐ Slide
☐ Specimen/test/vacuum
☐ Other: _____

Other sharp objects

☐ Bone chip/chipped tooth
☐ Bone cutter
☐ Bovie electrocautery device
☐ Bur
☐ Explorer
☐ Extraction forceps
☐ Elevator
☐ Histology cutting blade
☐ Lancet
☐ Pin
☐ Razor
☐ Retractor
☐ Rod (orthopaedic applications)
☐ Root canal file
☐ Scaler/curette
☐ Scalpel blade
☐ Scissors
☐ Tenaculum
☐ Trocar
☐ Wire
☐ Other type of sharp object
☐ Sharp object, type unknown

Other device or item

☐ Other: _____

B. Purpose or procedure for which sharp item was used or intended.

(Check <u>one procedure</u> type and complete information in corresponding box as applicable.)

☐ Establish intravenous or arterial access (Indicate type of line.)
☐ Access established intravenous or arterial line (Indicate type of line <u>and</u> reason for line access.)
☐ Other specimen collection
☐ Injection through skin or mucous membrane (Indicate type of injection.)
☐ Obtain blood specimen (through skin) (Indicate method of specimen collection.)
☐ Suturing
☐ Cutting
☐ Other procedure
☐ Unknown

Type of Line
___ Peripheral ___ Arterial
___ Central ___ Other

Reason for Access
___ Connect IV infusion/piggyback
___ Flush with heparin/saline
___ Obtain blood specimen
___ Inject medication
___ Other:_____

Type of Injection
___ IM injection ___ Epidural/spinal anesthesia
___ Skin test placement ___ Other injection
___ Other ID/SQ injection

Type of Blood Sampling
___ Venipuncture ___ Umbilical vessel
___ Arterial puncture ___ Finger/heelstick
___ Dialysis/AV fistula site ___ Other blood sampling

C. When and how did the injury occur? (From the left hand side of page, select the point during or after use that most closely represents when the injury occurred. In the corresponding right hand box, select *one or two* circumstances that reflect how the injury happened.)

☐ During use of the item →

Select one or two choices:

__ Patient moved and jarred device
__ While inserting needle/sharp
__ While manipulating needle/sharp
__ While withdrawing needle/sharp
__ Passing or receiving equipment
__ Suturing
__ Tying sutures
__ Manipulating suture needle in holder
__ Incising
__ Palpating/Exploring
__ Collided with co-worker or other during procedure
__ Sharp object dropped during procedure

☐ After use, before disposal of item →

Select one or two choices:

__ Handling equipment on a tray or stand
__ Transferring specimen into specimen container
__ Processing specimens
__ Passing or transferring equipment
__ Recapping (missed or pierced cap)
__ Cap fell off after recapping
__ Disassembling device or equipment
__ Decontamination/processing of used equipment
__ During clean-up
__ In transit to disposal
__ Opening/breaking glass containers
__ Collided with co-worker/other person
__ Sharp object dropped after procedure
__ Struck by detached IV line needle

☐ During or after disposal of item →

Select one or two choices:

__ Placing sharp in container:
  __ Injured by sharp being disposed
  __ Injured by sharp already in container
__ While manipulating container
__ Over-filled sharps container
__ Punctured sharps container
__ Sharp protruding from open container
__ Sharp in unusual location:
  __ In trash
  __ In linen/laundry
  __ Left on table/tray
  __ Left in bed/mattress
  __ On floor
  __ In pocket/clothing
  __ Other unusual location
__ Collided with co-worker or other person
__ Sharp object dropped
__ Struck by detached IV line needle

☐ Other (Describe):_____

_____

_____

_____

☐ Unknown

Blood Pressure Monitor Request Form

Self-measured blood pressure (SMBP) is an evidence-based strategy that can improve blood pressure control for individuals with hypertension. SMBP is most effective when an individual has access to a validated blood pressure device for home use coupled with ongoing clinical support.

Email: inquiries@stancehealthsolutions.com or call 818-956-6691

Section A: Medi-Cal member information

(Note: Missing information will delay the delivery of the durable medical equipment.)

Last name: _____ First name: _____

Phone: _____ Date of birth: _____ Height: _____ Weight: _____

Medi-Cal ID #: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Section B: Billing information

Diagnosis: _____

HCPCS code: A4670 – Automatic blood pressure monitor

Modifier required: NU

Section C: Provider information

Last name: _____ First name: _____

National provider identifier #/Tax identification _____

Office phone: _____ Office contact name: _____

Clinic street address _____

City: _____ State: _____ ZIP: _____

Provider's signature: _____ Today's date: _____

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25-1089 (10/25)

Blood Pressure Monitor Request Form

Self-measured blood pressure (SMBP) is an evidence-based strategy that can improve blood pressure control for individuals with hypertension. SMBP is most effective when an individual has access to a validated blood pressure device for home use coupled with ongoing clinical support.

Email: inquiries@stancehealthsolutions.com or call 818-956-6691

Section A: Medi-Cal member information

(Note: Missing information will delay the delivery of the durable medical equipment.)

Last name: _____ First name: _____

Phone: _____ Date of birth: _____ Height: _____ Weight: _____

Medi-Cal ID #: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Section B: Billing information

Diagnosis: _____

HCPCS code: A4670 – Automatic blood pressure monitor

Modifier required: NU

Section C: Provider information

Last name: _____ First name: _____

National provider identifier #/Tax identification _____

Office phone: _____ Office contact name: _____

Clinic street address _____

City: _____ State: _____ ZIP: _____

Provider's signature: _____ Today's date: _____

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BE INFORMED

If you are a patient being treated for any form of breast cancer, or prior to performance of a biopsy for breast cancer, your physician and surgeon is required to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 1704.5 of the California Health & Safety Code.

The information about methods of treatment was developed by the State Department of Health Services to inform patients of the advantages, disadvantages, risks and descriptions of procedures.

INFÓRMESE

Si es usted un paciente que está recibiendo tratamiento contra cualquier forma de cáncer en el seno, o en la etapa prévia a un biopsia por cáncer en el seno, su médico o cirujano tiene la obligación de darle a usted un sumario escrito de los métodos alternativos de tratamiento disponibles considerados eficaces. Esto es en cumplimiento con la Sección 1704.5 del Código de Salud y Seguridad del Estado de California.

La información sobre los métodos de tratamiento fueron desarrollados por los Servicios de Salud del Estado de California para informar a los pacientes sobre las ventajas y desventajas, riesgos y descripciones de los procedimientos.

通知

如果你是乳癌病患者或如要进行乳癌的切片測驗，按照加省衛生安全規則第 1704.5 部份，你的醫生必要向你提供一份有關各種有效治療的報告書。

各種治療的資料是由加省衛生服務局所提供，來使病人知道各種不同治療的好處、壞處、危險和治療的程序。

Bright Futures

IMPLEMENTATION TIP SHEET

Promoting Oral Health

Oral health is a critical component of child and adolescent development. It includes a range of health promotion and disease prevention concerns including extremes from dental caries to proper development and alignment of facial bones, jaw, and teeth. In particular, dental caries is a preventable and transmissible infectious disease that health care professionals focus on to prevent negative impacts on eating, speaking, and learning.[1] Prolonged exposure to human or cow's milk or fruit juice (even 100%) causes harm to teeth as bacteria in the mouth convert the sugars in milk or juice to acids. The acids attack the enamel and lead to dental caries. The same is true for the dietary intake of foods and beverages containing high amounts of added sugars. Twenty-one percent of children ages 2 to 5 years, 51% of children ages 6 to 11, and 54% adolescents ages 12 to 19 have caries, a disease that can be prevented with routine care and minimized with early detection.[2] Children at higher risk include children and youth with special health care needs, children in low- and moderate-income households, and children of color (though sociodemographic status should be viewed as the initial indicator of risk).

Early prevention and promotion activities begin by ensuring each child or adolescent has a dental home—a place where the dentist and patient have an ongoing relationship that supports comprehensive, continuously accessible, coordinated, and family-centered care. Establishing and maintaining a connection between medical and dental homes, as well as public health, early care and education, and school settings, set the stage for optimal oral health care for all children and adolescents and their families.

ORAL HEALTH SERVICES

Children may be referred for oral health assessment as early as 6 months, after the first tooth erupts, and no later than 12 months of age. Oral health assessments look at risk factors, protective factors, and clinical findings to make an assessment and develop a treatment plan (see Oral Health Risk Assessment Tool or Guía de evaluación de riesgos para la salud buccal). Specific activities conducted during the oral health risk assessment vary by age, with intentional efforts to understand the risk of oral health concerns at each stage in a child's or adolescent's development.

The child should have an established dental home by age 12 months and should be seen by a dentist every 6 months or more frequently, as needed. In addition to oral health risk assessments, other activities that occur within the dental home include conversations about oral hygiene, fluoride, and feeding/nutrition practices. These conversations vary by developmental stage and reinforce brushing with a fluoridated toothpaste twice daily, flossing daily, and eating healthy foods including vegetables, fruits, whole grains, lean meats, and dairy products. Conversations with families of young children may also focus on pacifiers and thumb

ABOUT BRIGHT FUTURES

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau, Health Resources and Services Administration. The *Bright Futures Guidelines* provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. Bright Futures content can be incorporated into many public health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed especially for families are also available. Learn more about Bright Futures and get Bright Futures materials by visiting brightfutures.aap.org.

sucking, while adolescent visits may include referrals to an orthodontist to resolve abnormal development or a periodontist to prevent irreversible damage caused by periodontal disease.

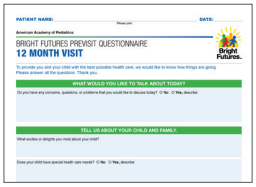
Fluoride is a key element in preventing and controlling caries. Regular and frequent exposure to small amounts of fluoride replaces minerals in dental enamel that have been damaged by acids produced by bacteria in plaque. Often drinking water and routine toothbrushing offer sufficient amounts of fluoride. After a child reaches 6 months, children who are at high caries risk and drink fluoride deficient (less than 0.6 parts per million fluoride) water (eg, well water, bottled water without fluoride) should begin taking fluoride supplements (drops, chewable tablets, or bottled fluoridated water). A dietary assessment for additional fluoride sources can help reduce the intake of excess fluoride. These dietary sources may include drinking water, beverages (eg, soda, juice, infant formula), prepared food, and toothpaste.[3] Medical and dental health professionals can apply fluoride varnish between ages 6 months and 5 years, beginning when the first tooth erupts.[3] In a primary care setting, fluoride varnish should be applied at least once every 6 months for all children and every 3 months for children at high risk for caries and until the establishment of a dental home.

AGE-SPECIFIC GUIDANCE FROM HEALTH SUPERVISION VISITS

Health care professionals include oral health conversations within health supervision visits, focusing on various oral health concerns and reaffirming messages from the dental home. Key ideas presented in anticipatory guidance for each stage promote optimal oral health for children and adolescents and their families. The following table discusses the critical components of these visits as they relate to oral health. Note that oral health is prioritized during the 4-, 6-, 12-, and 15-month health supervision visits.

MAKE THE MOST OF HEALTH SUPERVISION VISITS BY USING THE BRIGHT FUTURES TOOL & RESOURCE KIT

The *Bright Futures Tool & Resource Kit*, 2nd Edition, provides the forms and materials that health care professionals need to carry out preventive health supervision and health screening for infants, children, and adolescents. These materials can help health care professionals discuss oral health with families.


BRIGHT FUTURES PREVISIT QUESTIONNAIRE
12 MONTH VISIT

Example: 12-Month Visit Previsit Questionnaire

Well Child | 12 Month Visit

Example: 12-Month Visit Documentation Form

BRIGHT FUTURES HANDOUT ▶ PARENT
12 MONTH VISIT

Example: 12-Month Visit Parent Education Handout

The *Toolkit's* Core Tools provide valuable resources that help health care professionals focus on oral health during the health supervision visit. Reviewing parents' and adolescents' responses on the **Previsit Questionnaires** gives insights related to oral health, providing a foundation for discussion during the visit. The **Visit Documentation Form** is a convenient resource for documenting activities during the visit. This form can be adapted for use in electronic health record systems. The **Parent-Patient Education Handout** can help reinforce the discussion and provide additional information on promoting oral health.

Stage	Summary of Anticipatory Guidance
Infancy (Prenatal to 11 months)	• Health care professionals ask questions about maternal diet, good oral health hygiene, and attendance at regular dental checkups to set the stage for optimal child oral health. • In the early months of infancy, guidance focuses on – Holding the infant while feeding. – Never putting an infant to bed with a bottle. – Using a cloth or soft toothbrush with tap water and a small smear of toothpaste to gently clean gums and new teeth. • As an infant reaches 6 months, guidance expands to include – Introducing fluoride varnish and fluoridated water or fluoride supplements. – Minimizing exposure to natural or refined sugars in the infant's mouth. – Weaning off bottles as the infant approaches 12 months. – Discussing the recommendation of no juice until age 1. – Finding a dental home.
Early Childhood (1 to 4 years)	• Routines are a critical component of early childhood. Health care professionals support families by reinforcing tooth brushing as a routine conducted twice daily. • At the 12-month health supervision visit, health care professionals focus on the importance of a dental home, providing information about what families can expect. • Health care professionals continue to emphasize – Eating a healthy diet. – Avoiding sweetened food and beverages. – Keeping bottles out of cribs or beds. – Avoiding sippy cups with juice. – Using fluoride varnish and fluoridated water or fluoride supplements.
Middle Childhood (5 to 10 years)	• Oral health is integrated into larger discussions of children's physical growth and development, which are priority areas in health supervision visits. • Health care professionals continue to focus on – Oral health hygiene (daily tooth brushing and flossing). – Connections to a dental home. – The importance of caring for permanent teeth. – Limiting sweetened beverages and snacks. – The importance of dental sealants. • As children become engaged in contact sports, health care professionals emphasize the importance of using a mouth guard.
Adolescence (11 to 21 years)	• Similar to the middle childhood years, oral health is integrated into the priority areas of physical health and development. • Health care professionals shift conversations during adolescent years to help them understand the importance of – Routine oral health hygiene (daily tooth brushing and flossing). – Limiting soda and sweetened beverages. – Reducing in-between meal snacks. – Chewing sugarless gum. – Using a mouth guard during contact sports. • In later adolescence health supervision visits, health care professionals begin conversations about smoking and drug use that can impact oral health.

FOR MORE INFORMATION

As health care professionals support child and adolescent oral health, several resources can be helpful. The following tools can be used to learn current research, support families, and improve services.

- **Bright Futures: Oral Health—Pocket Guide, 3rd Edition:** Produced by the National Maternal and Child Oral Health Resource Center, this guide provides detailed information about oral health supervision including oral health risk assessment. This guide is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition.
- **Brush, Book, Bed:** This tool from the American Academy of Pediatrics (AAP) supports nighttime routine building for families while promoting both optimal oral health and literacy development.
- **Campaign for Dental Health:** This website is devoted to improved dental care and fluoridation and offers the most recent research and activities.
- **Oral Health Prevention Primer:** This AAP website was built to help health care professionals address oral health in practice, understand the roles of oral health allies, and learn how to achieve optimal oral health through advocacy and collaboration.
- **Smiles for Life—A National Oral Health Curriculum:** This curriculum aims to educate health care professionals on ways to promote oral health.

REFERENCE

[1] Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Impact of poor oral health on children's school attendance and performance. *Am J Public Health*. 2011;101(10):1900–1906

[2] Fleming E, Afful J. Prevalence of total and untreated dental caries among youth: United States, 2015–2016. NCHS Data Brief, no 307. Hyattsville, MD: National Center for Health Statistics; 2018 https://www.cdc.gov/nchs/products/databriefs/db307.htm. Accessed February 4, 2020

[3] American Academy of Pediatric Dentistry. Guideline on fluoride therapy: American Academy of Pediatric dentistry reference manual, Clinical guidelines. https://www.aapd.org/research/oral-health-policies--recommendations/fluoride-therapy/. Accessed February 13, 2020

Contact us by email or telephone at:
brightfutures@aap.org | 630/626-6783

Content for this Tip Sheet has been adapted from
Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition.
Last updated: March 2020
Downloaded from: http://brightfutures.aap.org

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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health net

Health Net* Contracted Cancer Centers			
Center Name	**Center Address**	**Phone**	**NCI / NCORP**
City of Hope Comprehensive Cancer Center	1500 E. Duarte Rd Duarte, CA 91010	800-826-4673	NCI
Epic Care - Dublin	6380 Clark Avenue Dublin, California 94568	925-875-1677	NCORP
Epic Care Cyberknife Center	3003 Oak Road, Suite 103 Walnut Creek, California 94597	925-391-2220	NCORP
Epic Care Partners in Cancer Care	1480 64th Steet, Suite 100 Emeryville, California 94608	510-629-6682	NCORP
Mercy Cancer Center - Carmichael	Dignity Health Cancer Institute, 6511 Coyle Avenue, Suite 200 Carmichael, California 95608	916-863-8700	NCORP
Mercy Cancer Center - Elk Grove	Dignity Health Medical Foundation 9394 Big Horn Boulevard Elk Grove, California 95758	916-735-4735	NCORP
Mercy Cancer Center - Rocklin	Dignity Health Medical Foundation 550 West Ranch View Drive, Suite 3000 Rocklin, California 95765	916-409-1400	NCORP
Mercy Cancer Center - Sacramento	Dignity Health Cancer Institute 3301 C Street, Suite 550 Sacramento, California 95816	916-864-9632	NCORP
Mercy San Juan Medical Center	Dignity Health Cancer Center 6501 Coyle Avenue Carmichael, California 95608	916-863-8700	NCORP
Moores Cancer Center	UC San Diego Health 3855 Health Sciences Dr. La Jolla, CA 92037	858-822-6100	NCI
Pacific Central Coast Health Center - San Luis Obispo	Oncology and Hematology Health Center 715 Tank Farm Road San Luis Obispo, California 93401	805-543-5577	NCORP
Providence Medical Foundation - Santa Rosa	3555 Round Barn Circle Santa Rosa, California 95403	707-528-1050	NCORP
Providence Queen of The Valley	1000 Trancas Street Napa, California 94558	707-252-4411	NCORP

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health net

Health Net* Contracted Cancer Centers, continued			
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Providence Saint Joseph Medical Center/Disney Family Cancer Center	501 South Buena Vista Street Burbank, California 91505	818-748-4900	NCORP
Providence Santa Rosa Memorial Hospital	1165 Montgomery Drive Santa Rosa, California 95405	707-525-5300	NCORP
UC Davis Comprehensive Cancer Center	2279 45th Street Sacramento, California 95817	916-734-5959	NCI
USC Norris Comprehensive Cancer Center	1441 Eastlake Avenue Los Angeles, CA 90033	323-865-3000	NCI
Woodland Memorial Hospital	Dignity Health Medical Foundation 1325 Cottonwood Street Woodland, California 95695	530-662-3961	NCORP

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CalViva HEALTH health net

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Woodland Memorial Hospital	Dignity Health Medical Foundation 1325 Cottonwood Street Woodland, California 95695	530-662-3961	NCORP

Care Management Referral Form

DIRECTIONS:

For Medi-Cal members, email the completed form to CASHP.ACM.CMA@healthnet.com in a HIPAA-secure, encrypted manner or fax it to 1-866-581-0540 with a fax cover sheet to hide any protected health information (PHI).

Part 1: Referring Source		
First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information		
Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP code:
Member phone number:		

Member Diagnosis/Health Condition (check all that apply):

- ☐ Asthma
- ☐ Back pain
- ☐ Behavioral health
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Autism
  - ☐ Other (specify) _____
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Hemophilia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Obesity-weight management
- ☐ High-risk pregnancy
  Estimated date of delivery (EDD): __/__/__
- ☐ Prematurity and/or developmental delays
- ☐ Sickle cell disease
- ☐ Hepatitis
- ☐ Transplant
- ☐ Traumatic brain injury
- ☐ Other:_____

Please check if any of the following referral reasons apply to the member:

- ☐ Member needs prenatal care education and support services.
- ☐ Member needs disease management/health coaching for his/her illness or condition.
- ☐ Member needs referral for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
- ☐ Member needs education on prescriptions and compliance.
- ☐ Concerned about high emergency room utilization or frequent hospitalizations.
- ☐ Member needs transportation to medical appointments.
- ☐ Member needs assistance with medical equipment.
- ☐ Member needs assistance with behavioral health services.
- ☐ Safety concerns.
- ☐ Other (specify) _____

_____

Care Management Referral Form

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- ☐ Behavioral health
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Autism
  - ☐ Other (specify) _____
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Hemophilia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Obesity-weight management
- ☐ High-risk pregnancy
  Estimated date of delivery (EDD): __/__/__
- ☐ Prematurity and/or developmental delays
- ☐ Sickle cell disease
- ☐ Hepatitis
- ☐ Transplant
- ☐ Traumatic brain injury
- ☐ Other:_____

Please check if any of the following referral reasons apply to the member:

- ☐ Member needs prenatal care education and support services.
- ☐ Member needs disease management/health coaching for his/her illness or condition.
- ☐ Member needs referral for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
- ☐ Member needs education on prescriptions and compliance.
- ☐ Concerned about high emergency room utilization or frequent hospitalizations.
- ☐ Member needs transportation to medical appointments.
- ☐ Member needs assistance with medical equipment.
- ☐ Member needs assistance with behavioral health services.
- ☐ Safety concerns.
- ☐ Other (specify) _____

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments.

Care Management Referral Form

DIRECTIONS: Select the member's plan below and email or fax the completed referral.

- **CA Commercial (Ambetter HMO/PPO, Employer Group plans (HMO, PPO, POS)) and Medicare Employer Groups** – Email completed form to Case.Management.Referrals@healthnet.com or fax completed form to **800-745-6955**.
- **CA Medicare** (including Medicare Advantage) for shared risk non-delegated plans. – Email completed form to centenecmescalationsmedicare@centene.com or fax completed form to **866-290-5957** for physical health and behavioral health care management.
- **CA Medi-Cal** – Email completed form to **CASHP.ACM.CMA@healthnet.com** or fax completed form to **866-581-0540**.
- **Referral to palliative care** – Email completed form to CareConnections@Healthnet.com.

☐ *URGENT Request* ☐ UC Blue & Gold Plan Member

Part 1: Referring Source

First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information

Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP Code:
Member phone number:		

Member Diagnosis/Health Condition (check all that apply):

- ☐ Asthma
- ☐ Back pain
- ☐ Behavioral health
  - ☐ Anxiety
  - ☐ Autism
  - ☐ Depression
  - ☐ Other (specify) _____
- ☐ Bursitis/tendonitis
- ☐ CAD
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Clinical Trials
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Frozen shoulder
- ☐ Golf/tennis elbow
- ☐ Heart failure
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High risk pregnancy
  Estimated date of delivery __/__/__
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Migraine/tension headache
- ☐ Musculoskeletal
- ☐ Obesity-weight management
- ☐ Osteoarthritis
- ☐ Prematurity and/or developmental delay
- ☐ Rheumatoid arthritis
- ☐ Sickle cell
- ☐ Transplant
- ☐ Traumatic brain injury
- ☐ Other: _____

Please check if any of the following referral reasons apply to the member:

- ☐ Member needs assistance with palliative care: _____
- ☐ Concerned about high emergency room utilization or frequent hospitalizations.
- ☐ Exhaustion of benefits.
- ☐ Member needs assistance with behavioral health needs.
- ☐ Member needs assistance with medical equipment.
- ☐ Member needs assistance with resources for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
- ☐ Member needs education on prescriptions and compliance.
- ☐ Member needs education/support with managing his/her chronic condition(s).
- ☐ Member needs prenatal care education and support services.
- ☐ Member needs transportation to medical appointments.
- ☐ Safety concerns.
- ☐ Other (specify) _____

*Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. "CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments.

Please use this page to provide additional information (as needed).

Date

Name of Parent

Address

City State Zip Code

REFERRAL TO CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM

Dear _____:

I am writing to inform you that a referral has been made to CCS on behalf of your child, _____. This referral is based on concerns I have regarding your child's health. I believe it would be best to have a pediatric specialist assist me in evaluating the need for further tests or treatments. It is possible that one of the CCS program specialists will need to examine your child personally.

CCS is a state program operated in each county for infants, children and adolescents. The program uses pediatric physicians, dentists, and special care centers who are expert in the diagnosis and treatment of certain medical conditions. I think your child would benefit from this expertise. After receiving CCS' assessment, we can work together to develop a plan to improve your child's health.

Your current health care plan does not cover services to diagnose and treat CCS eligible medical conditions. However, if your child is found to have a CCS eligible medical condition, the diagnosis and treatment services will be covered by the CCS program. You will be receiving a package of materials from the CCS program in the mail very soon. The package will have a CCS application and information on how CCS can help your child. Please complete and sign the application and return it to the CCS program as soon as possible. Completing this application will, in most cases, allow CCS to continue to cover those services even if your health insurance coverage is lost. If your child's condition is not CCS eligible, my office will continue providing for the medical needs your child may have. If your insurance coverage changes in any way, it is important that you notify my office and the CCS program immediately.

If you have any questions or concerns about your child's health or this referral, please contact me at my office. The local CCS program will be in contact with you and will notify you about their application process.

Thank you for the opportunity to provide health care for your child. I will be continuing to follow your child's health very closely and coordinating services with the CCS providers where your child may also receive care.

Name of Doctor

CCS/GHPP DISCHARGE PLANNING SERVICE AUTHORIZATION REQUEST (SAR)

Hospital Information

1. Date of request	2. Hospital name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person/discharge planner	6. Telephone number ( )	7. Fax number ( )

Client Information

8. Client name—last | first | middle

9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yyyy)
12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address

18. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

19. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number

27. Enrolled in commercial insurance plan? ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

28. Diagnosis

29.

Plan to discharge to: ☐ Home ☐ Transfer to (specify):_____

Specific Discharge Planning Services Requested

30. Provider's name | Provider number | Telephone number ( ) | Contact person

Address | City | State | ZIP code

Description of services	EPSDT SS? ☐ Yes ☐ No	Procedure code	Units	Quantity
Additional information	Frequency/duration			

31. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address | City | State | ZIP code

Description of services	EPSDT SS? ☐ Yes ☐ No	Procedure code	Units	Quantity
Additional information	Frequency/duration			

32. Signature of discharge planner	33. Title

34. Name of discharging physician	35. Date

36. Client name—last	first	middle

37. Date of request	38. Contact person/discharge planner	39. Telephone number ( )

Specific Discharge Planning Services Requested *(continued)*

40. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address	City	State	ZIP code

Description of services	EPSDT SS? ☐ Yes ☐ No	Procedure code	Units	Quantity
Additional information	Frequency/duration			

41. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address	City	State	ZIP code

Description of services	EPSDT SS? ☐ Yes ☐ No	Procedure code	Units	Quantity
Additional information	Frequency/duration			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

42. Signature of discharge planner	43. Title
44. Name of discharging physician	45. Date

INSTRUCTIONS

1. and 35. Date of request: Date the request is being made.

Hospital Information

2. Hospital name: Enter the legal name of the hospital requesting the services.
3. Provider number: Enter inpatient National Provider Identification (NPI) number.
4. Address: Enter the hospital's address.
5. and 38. Contact person: Enter the name of the person who can be contacted regarding the request.
6. and 39. Contact person telephone number: Enter the phone number of the contact person.
7. Fax number: Enter the fax number of the hospital or contact person.

Client Information

8. and 36. Client name: Enter the client's name, last, first, and middle.
9. Alias (AKA): Enter patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons (GHPP) number. If number not known, leave blank.
13. Medical record number: Enter the patient's hospital or office medical number.
14. Home phone number: Enter the home phone number where the client's parent/legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client's parent/legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client's parent/legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the client's address. Do not use a P.O. Box number.
19. Mailing address: Enter mailing address if different than 18.
20. County of residence: Residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter client's primary care physician's name; if it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter client's primary physician's phone number.

Insurance Information

26. Enrolled in Medi-Cal? Check the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.
27. Enrolled in a commercial insurance plan? Check the appropriate box. If the answer is yes, check type of commercial insurance plan and enter the name of the insurance plan on the line provided.

Diagnosis/Discharge Plan

28. Diagnosis: Enter the diagnosis, if known, relating to the requested services.
29. Plan to discharge: Check the appropriate box. If "transfer to" is checked, please specify where on line provided.

Specific Discharge Planning Services Requested

30., 31., 40., and 41. Provider's name: Enter name of the provider who will be performing the services requested.
Provider number: Enter the provider's provider number.
Telephone number: Enter phone number of the provider.
Contact person: Enter name of contact person at the provider's office. Address: Enter provider's address.
Description of services: Describe service that is being requested.
EPSDT SS?: Check appropriate box. If yes, contact the State for prior authorization. Procedure code: Enter the procedure code for the service being requested.
Units: For NDC, enter total number of fills plus refills. For all other codes enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written details/instructions here.
Frequency/duration: Enter the frequency or duration of the procedures/services being requested.

Signature

32. and 42. Signature of discharge planner: Discharge planner signs here.
33. and 43. Title: Enter the title of person signing the document.
34. and 44. Name of discharging physician: Enter the name of the discharging physician.
35. and 45. Date: Enter the date signed.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Authorized Representative	Date
_____	_____
Type or Print Name	Name of Provider
_____	_____
Title	Address

State of California -- Health and Welfare Agency

Department of Health Services
Child Health and Disability Prevention Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

TO PROTECT THE HEALTH OF CHILDREN, CALIFORNIA LAW REQUIRES A HEALTH EXAMINATION ON SCHOOL ENTRY, PLEASE HAVE THIS REPORT FILLED OUT BY A HEATH EXAMINER AND RETURN IT TO THE SCHOOL - THE SCHOOL WILL KEEP AND MAINTAIN IT AS CONFIDENTIAL INFORMATION.

PART 1 **TO BE FILLED OUT BY PARENT AND GUARDIAN**

CHILD'S NAME _____ Last _____ First _____ Middle **Birthdate**: _____ Month Day Year

ADDRESS _____ Street _____ City _____ Zip Code _____ School

PART II
HEALTH EXAMINATION **Date:** _____

Required Tests and Evaluations*	Check When Completed
Health and Developmental History	
Physical Examination	
Nutritional Assessment	
Vision Screening	
Audlometric (hearing) Screening	
Blood Test (for anemia)	
Urine Test	
Tuberculin Test	
Other	

* All test and evaluations must be done after the child 41/2 years of age

IMMUNIZATION RECORD

VACCINE	Date Each Dose Was Given				
	1st	2nd	3rd	4th	5th
Polio (TOPV/IPV) (circle one)	/ /	/ /	/ /	/ /	/ /
DPT/Td/DT (circle one)	/ /	/ /	/ /	/ /	/ /
Measles*	/ /				
Rubella*	/ /				
Mumps*	/ /				

- Record only doses given on or after first birthday.

Note to examiner: Please give the family a completed, or updated, yellow California Immunization Record or other personal Immunization record.

Note to School: Please record Immunization dates on the blue California School Immunization Record (PM 286).

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (Optional)

Fill out if parent of guardian has signed release of health information below.

RESULTS AND RECOMMENDATIONS

? Examination revealed no condition relevant to the school program
? Conditions found in the examination of after further evaluation which are of importance to schooling or physical activity are: (please explain)

Name, address and telephone number of health examiner:

_____ _____
Signature of Health Examiner Date

RELEASE OF HEALTH INFORMATION

I give permission to share the additional results of this examination with the school as stated in Part III.
? Please check the box if you do not want the health examiner to fill out Part III.

_____ _____
Signature of Parent or Guardian Date

If unable to get the examination done, call the Child Health and Disability Prevention Program in your local health department. If you do not want your child to have an examination, you may sign the waiver (PM 171B) form obtained from your child's school.

PM 171A (6/84)

State of California -- Health and Welfare Agency

Department of Health Services
Child Health and Disability Prevention Program

INFORME DEL EXAMEN DE LA SALUD PARA EL INGRESO A LA ESCUELA

PARA PROTEGER LA SALUD DE LOS NIÑOS, LA LEY DE CALIFORNIA EXIGE QUE ANTES DE INGRESAR A LA ESCUELA ELLOS TENGAN UN EXAMEN MEDICO DE SU SALUD, POR FAVOR, PIDALE A QUIEN HA HECHO EL EXAMEN QUE LLENE ESTE INFORME Y LLEVELO A LAS ESCUELA - ESTE INFORME SERA GUARDADO Y MANTENIDO POR LA ESCUELA EN FORMA CONFIDENCIAL.

PARTE 1 **PARA SER LLENADA POR EL PADRE/LA MADRE O EL GUARDIAN**

NOMBRE DEL NIÑO/DE LA NIÑA Apellido _____ Primer Nombre _____ Segundo Nombre _____ **Fecha de Nacimiento:** Mes _____ Día _____ Año _____

DIRECCION Calle _____ Ciudad _____ Zona Postal _____ Escuela _____

PARTE II

EXAMEN DE LA SALUD **Fecha:** _____

Pruebas y Evaluaciones Requeridas*	Indique Cuando se Completaron
Historia de la Salud y au Desarrollo	
Examen Fisico	
Evaluación de la Nutrición	
Pruebas Visuales	
Pruebas con el Audiometro (auditivas)	
Anállsis de la Sangre (para anemia)	
Análisis de Orina	
Pruebas con la Tuberculina	
Otra:	

RECORD DE LAS INMUNIZACIONES

Vacuna	Fecha en que Cada Dosis Fue Dada				
	1a.	2a.	3a.	4a.	5a.
Polio (TOPV/IPV) (marque una)	/ /	/ /	/ /	/ /	/ /
DPT/Td/DT (marque una)	/ /	/ /	/ /	/ /	/ /
Sarampión*	/ /				
Rubéola*	/ /				
Paperas*	/ /				

- Récord de las dosis dadas sólo en o después del primer cumpleanos.

Aviso al Examinador: Por favor dé a la famillia una vez completado, o a la fecha, el Récord de Inmunización de California en papal amarillo u otro récord de Inmunización personal.

Aviso a la Escuela: Por favor pongan las fechas de las Inmunizaciones en la página azul del Récord de Inmunizaciones de la Escuelas en California (PM 286).

*Todas las pruebas y evaluaciones deben ser hechas después que el/la niño(a) tenga 4 1/2 años de edad.

PARTE III INFORMACION ADICIONAL DEL EXAMINADOR DE LA SALUD (Opcional)

Liene esta parte si el padre/la madre o el guardián ha firmado más abajo el consentimiento para divulgar el informe sobre la salud.

RESULTADOS Y RECOMENDACIONES

? El examen reveló que no hay condiciones que conciernen al programa escolar.

? Las condiciones encontradas en el examen o después dé una evaluación posterior importantes para la actividad escolar a física son: (por favor explique)

Nombre, dirección y teléfono del examinador.

_____ _____
Firma del Examinador de la Salud Fecha

PERMISO PARA DIVULGAR EL INFORME SOBRE LA SALUD

Doy permiso para compatir con la escuela los resultados adicionales de este examen como se indice en la Parte III.

? Por favor marque el casillero si Ud, no desea que el examinador liene le Parte III.

_____ _____
Firma del Padre/de la Madre o Guardián Fecha

Si no puede obtener el examen llame al Programa de Salud para la Prevención de Incapacidades en Niños y Jóvenes (Child Health and Disability Prevention Program) en su departmento local de salud. SI Ud. no desea que su niño(a) tenga un examen, puede firmar la order (PM 171B), formulario que consigue en las escuela dondo va su niño(a).

PM 171A (6/84)

CONSENT FORM
California Child Health & Disability Prevention Program

I hereby give my consent for _____
(NAME OF PATIENT)
to receive the health screening tests and immunizations recommended by the CHDP Program. I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below. I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

(Check box)

☐ School _____
NAME

_____
ADDRESS

_____

☐ Health Care Provider_____
NAME

_____
ADDRESS

_____

☐ Other _____
NAME

_____
ADDRESS

_____ _____
SIGNATURE OF PARENT, GUARDIAN, OR EMANCIPATED MINOR DATE

_____ _____
NAME OF PARENT, GUARDIAN, OR EMANCIPATED MINOR DATE

Screening Provider: This form signed by parent, guardian, or emancipated minor and must be retained in patient's file.

PM 211 (Bilingual) (5/80)

CONSENTIMIENTO
Programa en California Para la Salud y Prevencion
de Incapacidades en Ninos (CHDP)

Por este medio mi permiso para que_____
(Nombre del paciente)
reciba un examèn de salud è immunizaciones recomendadas por CHDP. Por este medio doy mi authorizaciòn para dar informaciòn tocante a los resultados del examen al personal de CHDP. Tambien authorizo dar informaciòn a los suguientes lugares con contraseña(s) abajo. Yo entiendo que la informaciòn dada al personal de CHDP se mantendrá estrictaments confidencial y se usará solamente para facilitar la provisiòn de servicios de salud, y permitir la colecciòn de estadisticas tocantes a los resultados de estos examenes.

☐ Escuela _____
NOMBRE

_____
DIRECCION

_____

☐ Proveedor de
servicios de salud _____
NOMBRE

_____
DIRECCION

_____

☐ Otro _____
NOMBRE

_____
DIRECCION

_____ _____
FIRMA DEL PARIENTE, ACUDIENTE, O MENOR DE EDAD EMANCIPADO FECHA

_____ _____
NOMBRE DEL PARIENTE, A CUDIENTE, O MENOR DE EDAD EMANCIPADO FECHA

Screening Provider: This form must be signed by parent, guardian, or emancipated minor and must be retained in patient's file.

PM 211 (Bilingual) (5/80)

Table 2. First-Line Drugs for TB Disease

Drug	Supplied	Daily	Intermittent	Side Effects	Monitoring	Comments
Isoniazid:	Tabs: 300mg 100mg 50mg Susp: 50mg/5ml Inj: 100mg/ml (IM or IV)	Adults: 300mg Children: 10–15mg/kg (>20kg receives 300mg)	Adults 2 or 3X weekly: 15mg/kg up to 900mg Children 2X weekly: 20–30 mg/kg up to 900 mg	Hepatitis; peripheral neuropathy; mild CNS effects; skin rash; increased Dilantin levels.	LFTs (not routine) unless known or suspected liver disease or other hepatotoxic drugs used concurrently.	Give pyridoxine 25mg/day to prevent neuropathy in elderly, D.M., nutritionally deficient, renal disease, pregnancy, HIV, alcoholics.
Rifampin:	Caps: 300mg 150mg Inj: 600mg vial (IM or IV)	Adults: 10mg/kg up to 600mg Children: 10–20 mg/kg up to 600mg	Adults 2 or 3X weekly 10mg/kg up to 600mg Children 2X weekly: 10–20 mg/kg up to 600 mg	Orange discoloration of secretions; cholestatic or hepatocellular hepatitis; febrile (flu-like) reaction; thrombocytopenia; drug interactions; skin rash.	LFTs (not routine) unless known or suspected liver disease or other hepatotoxic drugs used concurrently. Baseline CBC.	Warn patient about orange discoloration of urine and other body secretions. Discoloration of contact lens. Induces hepatitis microsomal enzymes.
Ethambutol:	Tabs: 400mg 100mg	Adults: 15–25mg/kg Children: 15–25mg/kg up to 2.5gm	Adults 2X weekly: 50mg/kg Adults 3X weekly: 30mg/kg Children 2Xweekly: 50 mg/kg	Optic neuritis (reversible with discontinuation of drug; very rare at 15mg/kg if renal function is normal); skin rash.	Red-green color discrimination and visual acuity done at baseline and monthly.	Dose adjustment needed for renal disease; use with caution if eye testing is not feasible.
Pyrazinamide:	Tabs: 500mg scored	Adults: 20–25mg/kg up to 2 gm Children: 15–30mg/kg up to 2000mg	Adults 2X weekly: 50mg/kg up to 3gm Adults 3X weekly: 40mg/kg up to 4gm Children 2 or 3X weeky: 50 mg/kg	Hepatitis; GI upset; hyperuricemia; arthralgis; photosensitive dermatitis.	LFTs at start of therapy and monthly. Uric acid (not routine).	Dose adjustment needed for renal disease. Safety not established in pregnancy.
Rifabutin:	Caps: 150mg	Adults: 5 mg/kg up to 300mg Children: Unknown	Adults 2 or 3X weekly: 5mg/kg up to 300mg Children: Unknown	As for rifampin and risk of uveitis when used with macrolides, PI's and azole antifungal agents.	As for rifampin.	As for rifampin.
Rifapentine:	Film-Coated Tabs: 150mg	Not given daily	Adults once weekly: 10mg/kg up to 600mg Children: not studied	As for rifampin.	As for rifampin.	As for rifampin.

Checklist for Safe Vaccine Storage and Handling

Are you doing everything you should to safeguard your vaccine supply? Review this list to see where you might make improvements in your vaccine management practices. Check each listed item with either a "yes" or "no."

For more detailed guidance on vaccine storage and handling, see CDC's *Vaccine Storage and Handling Toolkit* at www.cdc.gov/vaccines/hcp/storage-handling

Establish Storage and Handling Policies

	yes	no
1. We have designated a primary vaccine coordinator and at least one alternate coordinator to be in charge of vaccine storage and handling at our facility.	☐	☐
2. Both the primary and alternate vaccine coordinator(s) have completely reviewed either CDC's *Vaccine Storage and Handling Toolkit* (www.cdc.gov/vaccines/hcp/storage-handling) or equivalent training materials offered by our state or local health department's immunization program.	☐	☐
3. We have detailed, up-to-date, written standard operating procedures for general vaccine management, including procedures for routine activities and an emergency vaccine retrieval and storage plan for power outages and other problems. Our procedures are based on CDC's *Vaccine Storage and Handling Toolkit* and/or on instructions from our state or local health department's immunization program.	☐	☐
4. We review these policies with all staff annually and with new staff, including temporary staff, when they are hired.	☐	☐

Manage New Vaccine Shipments and Inventory

	yes	no
5. We maintain a vaccine stock record to account for and document every dose of vaccine. We update the record to log in new vaccine shipments and document the following:		
a. Date of delivery and the initials of person who unpacked the box	☐	☐
b. Vaccine and diluent name and manufacturer	☐	☐
c. Number and expiration date for each lot	☐	☐
d. Number of doses received	☐	☐
e. Condition of each vaccine and diluent upon arrival	☐	☐
f. Cold chain monitor reading if included in the shipping container	☐	☐
g. Number of doses used	☐	☐
h. Balance of remaining doses after subtracting the amount used	☐	☐
6. We document periodic (e.g., weekly or monthly) inventory checks to verify the quantities and condition of vaccines being stored.	☐	☐

Use Proper Storage Equipment

	yes	no
7. We store vaccines in separate, self-contained units that refrigerate or freeze only. If we must use a household-style combination unit, we use it only for storage of our refrigerated vaccines, maintaining frozen vaccines in a separate stand-alone freezer.	☐	☐
8. We store vaccines in units with enough room to maintain the year's largest inventory without crowding.	☐	☐
9. We never store any vaccines in a dormitory-style unit (a small combination freezer-refrigerator unit with the freezer compartment inside the refrigerator).	☐	☐
10. We use an appropriate temperature monitoring device (TMD) for ***each*** vaccine storage or transport unit.	☐	☐

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	yes	no
11. We use only calibrated TMDs that have a Certificate of Calibration Testing* ("Report of Calibration") and are calibrated every 2 to 3 years from the last calibration testing date or according to the manufacturer's suggested timeline. If storing Vaccines for Children (VFC) vaccine, our TMD is a digital data logger (DDL).	☐	☐
12. We have planned back-up storage unit(s) in the event of a power failure or other unforeseen event.	☐	☐

* Certificate of Calibration Testing ("Report of Calibration") with calibration measurements traceable to a laboratory with accreditation from the International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement (MRA) signatory body.

Ensure Optimal Operation of Storage Units

	yes	no
13. We have a "Do Not Unplug" sign (e.g., www.immunize.org/catg.d/p2090.pdf) next to the electrical outlets for the refrigerator and freezer and a "Do Not Stop Power" warning label (e.g., www.immunize.org/catg.d/p2091.pdf) by the circuit breaker for the electrical outlets. Both signs include emergency contact information.	☐	☐
14. We perform regular maintenance on our vaccine storage units to assure optimal functioning. For example, we keep the units clean, dusting the coils and cleaning beneath the units as recommended by the manufacturer.	☐	☐

Maintain Correct Temperatures

	yes	no
15. We always keep at least one accurate (+/-0.5°C [+/-1°F]), calibrated temperature monitoring device (TMD) with the vaccines in the refrigerator and a separate calibrated TMD with the vaccines in the freezer.	☐	☐
16. We use a temperature monitoring device (TMD) (digital data logger [DDL] preferred and required for vaccine storage) that:		
a. has a detachable probe that has been buffered against sudden temperature changes by being immersed in a vial filled with liquid (e.g., glycol, ethanol, glycerin), loose media (e.g., sand, glass beads), or a solid block of material (e.g., aluminum, Teflon®).	☐	☐
b. includes an alarm for out-of-range temperatures.	☐	☐
c. has a low-battery indicator.	☐	☐
d. displays current, minimum, and maximum temperatures.	☐	☐
e. can measure temperatures within +/-0.5°C (+/-1°F).	☐	☐
f. has a logging interval (or reading rate) that can be programmed by the user to measure and record temperatures at least every 30 minutes.	☐	☐
17. We maintain the refrigerator temperature at 2–8°C (36–46°F), and we aim for 5°C (41°F).	☐	☐
18. We maintain the freezer temperature between -50°C and -15°C (-58°F and +5°F). We maintain the temperature for an *ultracold* freezer (if applicable) between -90°C and -60°C (-130°F and -76°F).	☐	☐
19. We set the thermostat for the storage unit at the factory-set or midpoint temperatures.	☐	☐
20. We keep extra containers of water in the refrigerator (e.g., in the door and/or on the floor of the unit where the vegetable bins were located) to help maintain cool temperatures. We keep ice packs, ice-filled containers, or frozen water bottles in the freezer to help maintain cold temperatures and to have frozen water bottles available for conditioning in the event of an emergency.	☐	☐

Maintain Daily Temperature Logs

	yes	no
21. If we are using a TMD (preferably a DDL) that records minimum and maximum temperatures, we check and record these temperatures once per day at the start of each workday. (Access Immunize.org's temperature logs at www.immunize.org/clinical/topic/storage-handling.)	☐	☐
22. If we are using a TMD that does not record minimum and maximum temperatures, we check and record the current temperatures of the refrigerator and freezer at least twice each workday. (Access Immunize.org's temperature logs at www.immunize.org/clinical/topic/storage-handling.)	☐	☐
23 We consistently record temperatures on the log either in Celsius or Fahrenheit. We never mix temperature scales when we record our temperatures.	☐	☐

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	yes	no
24. We follow the directions on the temperature log to call appropriate personnel if the temperature in a storage unit goes out of range.	☐	☐
25. If out-of-range temperatures occur in the unit, we complete the *Vaccine Storage Troubleshooting Record* (www.immunize.org/catg.d/p3041.pdf) to document actions taken when the problem was discovered and what was done to prevent a recurrence of the problem.	☐	☐
26. Trained staff (other than staff designated to record the temperatures) review the temperature logs weekly.	☐	☐
27. We keep temperature logs on file for at least 3 years.	☐	☐

Store Vaccines Correctly

	yes	no
28. We post signs (e.g., www.immunize.org/catg.d/p3048.pdf) on the doors of the refrigerator and freezer that indicate which vaccines should be stored in the refrigerator and which in the freezer.	☐	☐
29. We do not store any food or drink in any vaccine storage unit.	☐	☐
30. We store vaccines in the middle of the refrigerator or freezer (away from walls and vents), leaving room for air to circulate around the vaccine. We never store vaccine in the doors.	☐	☐
31. We have removed all vegetable and deli bins from the storage unit, and we do not store vaccines in these empty areas.	☐	☐
32. If we must use a combination refrigerator-freezer unit, we store vaccines only in the refrigerator section of the unit. We do not place vaccines in front of the cold-air outlet that leads from the freezer to the refrigerator (often near the top shelf). In general, we try to avoid storing vaccines on the top shelf, and we place water bottles in this location.	☐	☐
33. We check vaccine expiration dates and rotate our supply of each type of vaccine so that vaccines with the earliest expiration dates are located closest to the front of the storage unit, facilitating easy access.	☐	☐
34. We store vaccine in their original packaging with the lids closed in clearly labeled containers.	☐	☐

Take Emergency Action As Needed

	yes	no
35. In the event that vaccines are exposed to improper storage conditions, we take the following steps:		
a. We restore proper storage conditions as quickly as possible. If necessary, we label the vaccine "Do Not Use" and move it to a unit where it can be stored under proper conditions. We do not discard the vaccine before discussing the circumstances with our state or local health department and/or the appropriate vaccine manufacturers.	☐	☐
b. We follow the *Vaccine Storage Troubleshooting Record's* (www.immunize.org/catg.d/p3041.pdf) instructions for taking appropriate action and documenting the event.	☐	☐
c. We contact our clinic supervisor or other appropriate clinic staff to report the incident. We contact our state or local health department and/or the appropriate vaccine manufacturers for consultation about whether the exposed vaccine can still be used.	☐	☐
d. We address the storage unit's mechanical or electrical problems according to guidance from the unit's manufacturer or a qualified repair service.	☐	☐
e. In responding to improper storage conditions, we do not make frequent or large changes in thermostat settings. After changing the setting, we give the unit at least a day to stabilize its temperature.	☐	☐
f. We do not use exposed vaccines until our state/local health department's immunization program or the vaccine manufacturer has confirmed that the vaccine is acceptable for use. We review this information with our clinic medical director before returning the vaccine to our supply. If the vaccine is not acceptable for use, we follow our state or local health department instructions for vaccine disposition.	☐	☐

If we answer "yes" to all of the above, we give ourselves a pat on the back! If not, we assign someone to implement needed changes!

PCP:	
SECTION: Personnel	
POLICY AND PROCEDURE: **Child Abuse Reporting**	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Health care practitioners who have knowledge of or observe a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report the suspected incident of abuse or neglect to a "child protective agency".

PROCEDURE:

I. Reporting

A. The report must be made to a "child protective agency". A child protective agency is a county welfare or probation department or a police or sheriffs department (P.C. 11165.9, P.C. 11166[a])

1. Written reports must be submitted on a Department of Justice form – Form SS 8572 (DOJ SS 8572) which can be requested from your local child protective agency

2. A report must be made **immediately (or as soon as possible) by phone**

3. **A written report must be forwarded to the child protective agency within 36 hours of receiving the information regarding the incident**

4. A single report may be made if two or more persons have knowledge of suspected child abuse or neglect

5. Have the following information ready to report:
   - Name of reporter
   - Name and present location of the child
   - Nature and extent of the injury, and any evidence of prior abuse
   - Any other information, including what led you to suspect child abuse, if requested by the child protective agency (P.C. § 11167 [a])

6. **Failure to make a required report is a misdemeanor punishable by up to six months in jail and/or up to a $1,000 fine (P.C. 1172[e]). Persons who fail to report can also be subject to a civil lawsuit, and found liable for damages, especially if the child-victim or another child is further victimized because of the failure to report**

II. Indicators of Abuse

A. Physical Abuse

1. Physical Indicators of Physical Abuse
   - Fractures, lacerations, bruises that cannot be explained, or explanations which are improbable given the extent of the injury
   - Burns (cigarette, rope, scalding water, iron, radiator)
   - Infected burns, indicating delay in seeking treatment
   - Facial injuries (black eyes, broken jaw, broken nose, bloody nose, bloody or swollen lips) with implausible or nonexistent explanations
   - Subdural hematomas, long-bone fractures, fracture in different states of healing
   - Pattern of bruising (e.g., parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time

2. Behavioral Indications of Physical Abuse
   - Hostile, aggressive, verbally abusive towards others
   - Fearful or withdrawn behavior
   - Self-destructive (self-mutilates, bangs head, etc.)
   - Destructive (breaks windows, sets fires, etc.)
   - Out-of-control behavior (seems angry, panics, easily agitated)
   - Frightened of going home, frightened of parents/caretakers or, at the other extreme, is overprotective of parent(s) or caretaker(s)
   - Attempts to hide injuries; wears excessive layers of clothing, especially in hot weather
   - Difficulty sitting or walking
   - Clingy, forms indiscriminate attachments
   - Apprehensive when other children cry
   - Wary of physical contact with adults
   - Exhibits drastic behavioral changes in and out of parental/caretaker presence
   - Suffers from seizures or vomiting
   - Exhibits depression, suicide attempts, substance abuse, or sleeping and eating disorders

B. Sexual Abuse

1. Physical Indicators of Sexual Abuse; the following may be indicative of sexual abuse:
   - Wears torn, stained, or bloody underclothing
   - Physical trauma or irritation to the anal/genital area (pain, itching, swelling, bruising, bleeding, laceration, abrasions), especially if injuries are unexplained or there is an inconsistent explanation

- Knowledge of a child's history of previous or recurrent injuries/diseases
- Swelling or discharge from vagina/penis
- Visible lesions around mouth or genitals
- Complaint of lower abdominal pain
- Painful urination, defecation
- Sexually transmitted diseases
- Difficulty in walking or sitting due to genital or anal pain
- Psychosomatic symptoms (stomachaches, headaches)

2. Behavioral Indicators of Sexual Abuse
   - Sexualized behavior (has precocious knowledge of explicit sexual behavior and engages self or others in overt or repetitive sexual behavior)
   - Compulsive indiscreet masturbation
   - Excessive curiosity about sexual matters or genitalia (self or others)
   - Unusually seductive with classmates, teachers and other adults
   - Excessive concern about homosexuality, especially by boys

3. Behavioral Indicators of Sexual Abuse in Younger Children; the following may be exhibited by younger children who are experiencing sexual abuse:
   - Wetting pant, bed wetting or fecal soiling
   - Eating disturbances such as overeating, under eating
   - Fears or phobias
   - Compulsive behavior
   - School problems or significant change in school performance (attitude and grades)
   - Age-inappropriate behavior, including pseudomaturity or regressive behavior such as bed wetting or thumb sucking
   - Inability to concentrate
   - Drastic behavior changes
   - Speech disorders
   - Frightened of parent/caretaker or of going home

4. Behavioral Indicators of Sexual Abuse in Older Children and Adolescents; the following are behaviors that may be exhibited by older children and adolescents who are experiencing sexual abuse:
   - Withdrawal, clinical depression, apathy, chronic fatigue
   - Overly compliant behaviors
   - Poor hygiene or excessive bathing
   - Poor peer relations and social skills; inability to make friends; non-participation in sports and social activities
   - Acting out; running away; aggressive, antisocial, or delinquent behavior

- Alcohol or drug abuse
- Prostitution or excessive promiscuity
- School problems, frequent absences, sudden drop in school performance
- Refusal to dress to physical education
- Fearfulness of showers or restrooms; of home life, as demonstrated by arriving at school early or leaving late; of going outside or participating in familiar activities; of males (in cases of male perpetrator and female victim)
- Self-consciousness of body beyond that expected for age
- Sudden acquisition of money, new clothes, or gifts with no reasonable explanation
- Suicide attempt, self-mutilation, or other-destructive behavior
- Crying without provocation
- Setting fires
- Pseudo-mature (seems mature beyond chronological age)
- Eating disorders

C. Neglect
   1. Physical Indicators of Neglect; Neglect may be suspected when one or more of the following conditions exist:
      - Failure to thrive – the child fails to gain weight at the expected rate for a normal child
      - Malnutrition or poorly balanced diet (bloated stomach, extremely thin, dry, flaking skin, pale, fainting)
      - Inappropriate dress for weather
      - Dirty unkempt, extremely offensive body odor
      - Unattended medical or dental conditions (e.g., infections, impetigo)
      - Evidence of poor or inadequate supervision for the child's age
   2. Behavioral Indicators of Neglect
      - Clingy or indiscriminate attachment
      - Depressed, withdrawn, or apathetic
      - Antisocial or destructive behavior
      - Fearfulness
      - Substance abuse
      - Speech, eating, or habit disorders (biting, rocking, whining)
      - Often sleepy or hungry
      - Brings only candy, chips, and soda for lunch or consistently "forget" to bring food

III. Definitions

A. Physical abuse: characterized by physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, biting, burning, or otherwise harming a child. Any injury resulting from physical punishment that requires medical treatment is considered outside the realm of normal disciplinary measures.

B. Neglect: the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

C. Severe neglect: the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or heath is endangered, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

D. Sexual abuse: refers to sexual assault or sexual exploitation

1. Sexual assault includes rape, statutory rape, rape in concert, incest, sodomy, and lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation. It includes, but is not limited to, all of the following:
   - Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen
   - Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person
   - Any intrusion by one person into the genital or anal opening of another person, including the use of any object for this purpose, excepting acts performed for a valid medical reason
   - The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, excepting acts that may reasonably be construed to be normal caretaker responsibilities; interaction with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose
   - The intentional masturbation of the perpetrator's genitals in the presence of a child (P.C. 11165.1[b])

2. Sexual exploitation refers to any of the following:
   - Depicting a minor engaged in obscene acts in violation of law; preparing, selling, or distributing obscene matter that depicts minors; employment of minor to perform obscene acts

- Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assists other to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. "Person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution
- Any person who depicts a child in, or who knowingly develops, duplicates, prints or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3 (P.C. 11165.1[c])

PCP:	Page 1 of 1
SECTION: Access/Safety	
POLICY AND PROCEDURE: Clean and Sanitary Environment	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Site environment will be maintained in a clean and sanitary condition. Environmental safety includes the hygienic condition of the site.

PROCEDURE:

I. GENERAL APPEARANCE

A. Patient areas, restrooms, furniture, walls, floors and carpets will be unsoiled, neat, tidy, uncluttered and in good repair.
   1. Cleaning will be performed regularly, as scheduled, by staff or contracted service. Office cleaning schedule is maintained a evidence of completion (see attachment sample).
   2. Staff are responsible to keep work areas neat and clean.
   3. Staff are responsible for reporting to the office manager/provider if any equipment, furniture, carpet, etc. is in need of repair. Office manager or provider will arrange for repair or replacement as needed.
   4. Staff are responsible to report to the office manager/provider any soiled carpet, walls, etc. that would require professional cleaning, repair or replacement. Office manager/provider will arrange for services.

II. SANITARY SUPPLIES

A. Appropriate sanitary supplies will be available for restroom use, including toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes.
B. Staff will check restrooms frequently for presence of supplies and replenish supplies as necessary.

Clorox Regular Bleach

Overview:

Size/Count 60.0 oz.

- Kills 99.9% of common household germs
- Patented whitest whites technology
- Not harmful to septic systems

Q. What organisms does Clorox® Regular-Bleach kill?

A. **Bacteria**
Staphylococcus aureus (Staph.)
Salmonella choleraesuis
Pseudomonas aeruginosa
Streptococcus pyogenes (Strep.)
Escherichia coli O157:H7 *(E. coli)*
Shigella dysenteriae
Methicillin Resistant Staphylococcus aureus (MRSA)

Fungi
Trichophyton mentagrophytes (can cause Athlete's Foot)
Candida albicans (a yeast)

Viruses
Rhinovirus Type 17 (a type of virus that can cause colds)
Influenza A (Flu virus)
Hepatitis A virus
Rotavirus
Respiratory Syncytial Virus (RSV)
HIV-1 (Human Immunodeficiency Virus)*
Herpes simplex Type 2
Rubella virus
Adenovirus Type 2
Cytomegalovirus

CBAS TREATMENT REQUEST FORM

If you have questions about how to complete this Community-Based Adult Services (CBAS) Request Form, please call Health Net at 800-526-1898, and select option 1 to speak with a Referral Specialist. **Submit completed form via fax to 833-581-5908.**

☐ **Expedited Request** - Please check if this is for a new participant who is hospitalized or anticipated to be admitted to a skilled nursing facility.

*Indicates required field

Member information

Member phone number*

Date of birth* (MM/DD/YYYY)

Member ID/Medi-Cal ID*

Last name*

First name*

Provider/CBAS facility information

Facility NPI*

Facility TIN

Contact name

Facility address

City

ZIP code

Facility name

Phone

Fax

Authorization request (S5102)

Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Quantity per month	Diagnosis code (ICD-10)*

Services*

Face-to-face assessment (T1023)

☐ Initial

☐ Modification

Please attach copy of history and physical with face-to-face assessment request.

3-day individual plan of care (IPC) assessment for new CBAS (H2000)

☐ Initial

☐ Modification

Medical day care services (S5102)

☐ Initial

☐ Continuation/Renewal[1]

☐ Modification[1] (Increase/Decrease)

☐ Reinstate services

☐ Transfer

[1]Please attach IPC, participant attendance records and transfer reason (if applicable) for continued authorization requests.

All CBAS requests require completion of this form. All required fields must be filled in. Incomplete forms will be rejected. Copies of all supporting clinical information are required. Lack of clinical information may result in delayed determination.

Requesting provider/CBAS representative

Name (print): _____ Date: _____

Signature: _____

Disclaimer: Please check member eligibility prior to rendering services. A prior authorization is not a guarantee of payment. Payment may be denied in accordance with the Plan's policies and procedures and applicable law.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient, then any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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25-1143 (11/25)

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CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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*Indicates required field

Member information

Member phone number*

Date of birth* (MM/DD/YYYY)

Member ID/Medi-Cal ID*

Last name*

First name*

Provider/CBAS facility information

Facility NPI*

Facility TIN

Contact name

Facility address

City

ZIP code

Facility name

Phone

Fax

Authorization request (S5102)

Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Quantity per month	Diagnosis code (ICD-10)*

Services*

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Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | **Age** | ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** *(mm/dd/yyyy)* | **Country of Birth**

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | **Date of First Specimen Collection** *(mm/dd/yyyy)* | **Date of Diagnosis** *(mm/dd/yyyy)* | **Date of Death** *(mm/dd/yyyy)*

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | **City** | **State** | **ZIP Code**

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis?
☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

CONFIDENTIALITY AND RELEASE OF INFORMATION FORM

SAMPLE COPY

As employees of _____, we are required to observe Health Net's Member Rights. These rights include the right to confidentiality and release of information.

Any release of medical records information must have a consent signed by the patient. When requesting information from another facility, doctor's office, insurance company or a release of records directly to the patient, a Patient Access of Medical Records Authorization is to be completed.

The purpose of confidentiality is to protect the patient's right to privacy to prevent civil or criminal prosecution. The information in the medical record is confidential because it is considered a private communication that exists both legally and ethnically between the physician and his or her patient. This special communication is to be protected from unauthorized disclosure. Therefore, we must, in all ways possible, preserve the confidentiality of that communication.

All personnel shall strictly adhere to legal requirements governing release of information and shall not release any information to any person not directly concerned with the care of the patient except as above. In addition, all employees must avoid any type of gossip or discussion of patient care, diagnosis or treatment. Inadvertent comments could result in harm to the patient and make you and/or the health plan physically legally liable. Violation of the patient's right to medical confidentiality is grounds for immediate termination.

I do hereby affirm that I have read and understood the above and agree that I will strictly observe the rules set forth.

_____ _____

Signature Date

_____ _____

Signature Date

CONFIRMATION OF PREGNANCY FORM

To qualify for the incentive:

- Complete this form for Health Net Medi-Cal members only and fax to Health Net within seven days of the visit.
- This form must be signed by a primary care physician (PCP), nurse practitioner (NP), or physician's assistant (PA).
- A timely prenatal visit is in the first trimester of pregnancy or within 42 days of enrollment into Health Net Medi-Cal.
- This form must be kept in the patient's medical record.

Fax to Health Net at 877-783-0287

Member Information

First name:	**Last name:**	
Medi-Cal ID # (CIN #):	**Date of birth:**	
9	**Phone number:**	
Address:	**City:**	**ZIP code:**
Medical group name (also known PPG):		

Member Primary Spoken Language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin ☐ Farsi ☐ Korean ☐ Arabic ☐ Other_____

Pregnancy Information - Required

Date of visit with provider: _____

Pregnancy diagnosis confirmed: ☐ **Yes** **LMP:_____ or EDD:_____**	**Is this a high-risk pregnancy?** ☐ **Yes** ☐ **No**

Rendering Practitioner Information

Practitioner name:		**Clinic name:**
Practitioner NPI:	☐ **PCP** ☐ **NP** ☐ **PA**	**Clinic address:**
Office contact name:		**City:** / **County:**
Office phone number:		**ZIP code:**

☐ **I confirm that this document is also filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

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CONFIRMATION OF PREGNANCY FORM

To qualify for the incentive:

- Complete this form for CalVIva Health members only and fax to Health Net within seven days of the visit.
- This form must be signed by a primary care physician (PCP), nurse practitioner (NP), or physician's assistant (PA).
- A timely prenatal visit is in the first trimester of pregnancy or within 42 days of enrollment into CalViva Health.
- This form must be kept in the patient's medical record.

Fax to Health Net at 877-783-0287

Member Information

First name:	**Last name:**	
Medi-Cal ID # (CIN #):	**Date of birth:**	
9	**Phone number:**	
Address:	**City:**	**ZIP code:**
Medical group name (also known PPG):		

Member Primary Spoken Language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin ☐ Farsi ☐Korean ☐ Arabic ☐ Other_____

Pregnancy Information - Required

Date of visit with provider: _____

Pregnancy diagnosis confirmed: ☐ **Yes** **LMP:**_____ **or EDD:**_____	**Is this a high-risk pregnancy?** ☐ **Yes** ☐ **No**

Rendering Practitioner Information

Practitioner name:		**Clinic name:**
Practitioner NPI:	☐ **PCP** ☐ **NP** ☐ **PA**	**Clinic address:**
Office contact name:		**City:** / **County:**
Office phone number:		**ZIP code:**

☐ **I confirm that this document is also filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments. If you no longer wish to receive fax notices from Provider Communications, please email us at provider.communications@healthnet.com indicating the fax number(s) covered by your request. We will comply with your request within 30 days or less.

FRM1175600EH03w (8/23)

CONFIRMATION OF PREGNANCY FORM

To qualify for the incentive:

- Complete this form for Community Health Plan of Imperial Valley members only and fax to Health Net within seven days of the visit.
- This form must be signed by a primary care physician (PCP), nurse practitioner (NP), or physician's assistant (PA).
- A timely prenatal visit is in the first trimester of pregnancy or within 42 days of enrollment into the Plan.
- This form must be kept in the patient's medical record.

Fax to Health Net at 877-783-0287

Member Information

First name:	**Last name:**	
Medi-Cal ID # (CIN #):	**Date of birth:**	
9	**Phone number:**	
Address:	**City:**	**ZIP Code:**
Medical group name (also known PPG):		

Member primary spoken language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Mandarin ☐ Farsi ☐ Korean ☐ Arabic ☐ Other_____

Pregnancy Information - Required

Date of visit with provider: _____

Pregnancy diagnosis confirmed: ☐ **Yes** **LMP:_____ or EDD:_____**	**Is this a high-risk pregnancy?** ☐ **Yes** ☐ **No**

Rendering Practitioner Information

Practitioner name:		**Clinic name:**
Practitioner NPI:	☐ **PCP** ☐ **NP** ☐ **PA**	**Clinic address:**
Office contact name:		**City:** / **County:**
Office phone number:		**ZIP Code:**

☐ **I confirm that this document is also filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV patients. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.
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Updated: February 17, 2021

modivcare
FORMERLY LOGISTICARE
200 Lincoln Way, Suite 200 Garden Grove, CA 92841
Phone: 1-866-666-8645 Fax: 1-877-457-3352

Consent for Minors to Travel without an Escort

1. I,_____, residing at _____ _____(Address) hereby affirm that I am the Parent/ Legal Guardian of_____(name of minor.)(Child).
2. The Child is_____years old. The Child's date of birth is _____. The Child's Medi-Cal number is _____.
3. I hereby consent to the Child riding unaccompanied for medical and non-medical transportation with any transportation provider under contract to ModivCare.
4. I understand the risks that can be reasonably anticipated by medical and non-medical transport of the Child including possible medical equipment, aircraft, vehicle failure, traffic hazards, adverse weather conditions, pilot or driver error, interruption of medical treatment during transport, or consequences of actions of persons outside the control of transport personnel. I also understand the risks associated with the Child's condition including the possible worsening of the Child's condition during transport or the inability to fully treat or diagnose due to unavailability of more sophisticated medical equipment or facilities not normally available during transport. I consider the above risks of transport are outweighed by the advantage of the Child receiving transport.
5. By giving this consent and release of liability, I hereby represent that the Child is fully capable of being transported without an adult escort, will not be disruptive, will follow all rules communicated by the driver and does not need an escort to provide emotional or any other type of support.
6. I understand that if any of the factors set forth in paragraph 5, above, cease to apply, then ModivCare will no longer transport the minor without an escort.
7. I agree to inform ModivCare, within 48 hours if, for any reason, I cease being the Legal Guardian of the Child and to inform ModivCare of the name and address of the new Legal Guardian.

In consideration of ModivCare's agreement to transport the minor without an escort, I hereby release ModivCare and its employees, officers, agents and subcontractors from any and all liability, caused of actions, or claims, in connection with the Child's transportation by ModivCare and its subcontractors. I understand the content of this form and have been notified of the risks of transport.

Mail the completed form to the address listed above or fax to the fax number listed above. The completed form must be on file at the ModivCare office for any trips to be set up without an escort for the Child. Once a completed consent form is on file, it is considered to be active and valid for all transports until the consent is withdrawn.

_____

_____

SIGNATURE OF GUARDIAN
DATE

_____

PRINTED NAME OF GUARDIAN

_____

NAME OF MINOR TO WHOM THIS CONSENT APPLIES

_____

_____

WITNESS SIGNATURE
DATE

_____

PRINTED NAME OF WITNESS

I have accurately and completely read the foregoing document to Parent/Legal Guardian in_____(insert language), the Parent's/Legal Guardian's primary language. He/she stated that he/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

_____ _____

Date Name of Translator

For internal use only:

……
……

_____

_____

DATE RECEIVED BY MODIVCARE

_____

NAME OF MODIVCARE STAFF MEMBER

STERILIZATION CONSENT FORM (NON-FEDERALLY FUNDED)

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____
(Doctor or Clinic)

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I understand that I can change my mind at any time.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will undergo an operation known as a

_____

The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form except in specific instances that have been fully explained to me.

I wish to waive the 30-day waiting period to _____ days (not less than 72 hours).

I am at least 18 years of age.

OR

I am under 18 **AND**

I have entered into a valid marriage, **OR**

I am on active duty with the U.S. armed services, **OR**

I have received a declaration or emancipation pursuant to Section 64 of the Civil Code, **OR**

I am over 15 years old, live apart from my parents or guardians, and manage my own financial affairs.

I was born on _____
(Month) (Day) (Year)

I, _____, hereby consent of my own free will to undergo an operation intended to sterilize me, to be performed by _____
(Doctor)

by a method called _____ .

I am not in labor and it has been at least 24 hours since I gave birth or had an abortion. I am not seeking to obtain or obtaining an abortion at this time.

I am not under the influence of alcohol or other substances that affect my state of awareness.

I understand that I may have a witness of my choice present during the time my consent is obtained.

My consent expires 180 days from the date of my signature below.

I have received a copy of this form.

_____ _____
(Signature) *(Date [Month/Day/Year])*

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

_____ _____
(Interpreter) *(Date [Month/Day/Year])*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)

consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 18 years old, or meets the necessary age requirements under applicable regulations, and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

I certify that I explained orally to the person to be sterilized the requirements for informed consent as set forth on this form and in applicable regulations.

_____ _____
(Signature of Person Obtaining Consent) *(Date)*

_____
(Facility)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____,
(Name of individual to be sterilized) *(Date of sterilization operation)*

I explained to him/her the nature of the sterilization operation, _____

_____
(Specify type of operation)

the fact that it is intended to be a final and irreversible procedure, and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 18 years old, or meets the necessary age requirements under applicable regulations, and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below ***except*** in the case of premature delivery, or emergency abdominal surgery, or patient waiver where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1. At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

2. I certify that this sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

   a. Premature delivery:
      Individual's expected date of delivery: _____
   b. Emergency abdominal surgery (describe circumstances):
      _____
      Date individual intended to be sterilized: _____
   c. Patient waived the 30-day waiting period to _____ days. (Not less than 72 hours.)

_____ _____
(Physician) *(Date)*

FORMULARIO DE PERMISO LA ESTERILIZACIÓN (CON FONDOS NO FEDERALES)

NOTA: SI EN CUALQUIER MOMENTO DECIDE NO HACERSE ESTERILIZAR ELLO NO RESULTARA EN QUE SE LE RETIREN O RETENGAN CUALQUIERA DE LOS BENEFICIOS PROPORCIONADOS POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS DEL GOBIERNO FEDERAL.

PERMISO PARA ESTERILIZACIÓN

He pedido y recibido información sobre la esterilización de

_____
(Doctor o Clínica)

Cuando me informé al respecto, se me dijo que la decisión de permitir que se me esterilice es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no permitir que se me esterilice. Si decido no permitir que se me esterilice, esta decisión no afectará mis derechos a cuidados o tratamientos futuros. Entiendo que puedo cambiar de opinión en cualquier momento.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA **PERMANENTE** E **IRREVOCABLE.** HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, TENER O PROCREAR HIJOS.

Se me ha informado acerca de los métodos anticonceptivos temporarles que están disponibles y que se me podrán proporcionar, los que sí me permitirán procrear un hijo en el futuro. He rechazado estas alternativas y he elegido ser esterilizado(da).

Entiendo que se me hará una operación conocida bajo el nombre de

_____

Los malestares, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no será realizada por lo menos 30 días después de haber firmado este formulario, con excepción de situaciones especificas que me han sido minuciosamente explicadas.

Deseo renunciar el derecho de tener 30 días de espera. En cambio, estoy de acuerdo en esperar _____ días. (No menos de 72 horas.)

Tengo por lo menos 18 años de edad.

O

Soy menor de 18 años de edad, ***Y***

Estoy casado(da) legalmente, ***O***

Estoy en servicio activo en las fuerzas armadas de los EEUU, ***O***

He recibido una declaración de emancipación de acuerdo a la Sección 64 del Código Civil, ***O***

Tengo más de 15 años de edad, vivo separado(da) de mis padres o guardianes, y manejo mis asuntos financieros.

Nací en _____
(Mes) (Día) (Año)

Yo, _____, por mi firma doy mi permiso a que se me haga una operación cuyo fin es el de estirilizarme, y que será hecha por _____
(Doctor)
por el método conocido como _____ .

No estoy en trabajo de parto y han transcurrido por lo menos 24 horas desde que di a luz o tuve un aborto. Yo no estoy buscando u obteniendo un aborto en este momento.

No estoy bajo la influencia del alcohol u otras substancias que afecten mis facultades.

Entiendo que puedo tener un te`stigo de mi preferencia presente en el momento que dé el permiso para que se me esterilice.

Mi permiso se vence a los 180 días de la fecha de mi firma.

He recibido una copia de éste formulario.

_____ _____
(Firma) *(Fecha [Mes/Día/Año])*

DECLARACIÓN DEL INTÉRPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada:

He traducido la información y consejos oralmente por la persona que obtiene este permiso, a la persona a ser esterilizada. También le he leído el formulario de permiso en español y le he explicado su contenido. Según mi mejor entender el/ella ha comprendido esta explicación.

_____ _____
(Intérprete) *(Fecha [Mes/Día/Año])*

DECLARACIÓN DE LA PERSONA QUE OBTIENE ESTE PERMISO

Antes de que _____ firmara este
(Nombre de la Persona)
formulario de permiso, le expliqué la naturaleza de la operación para la esterilización llamada _____
el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los malestares, riesgos y beneficios que la acompañan.

Yo advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarles. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento a cualquier momento y que el/ella no perderá ninguno de los servicios de salud o cualquier otros beneficios proporcionados con fondos federales.

De acuerdo a mi mejor entender y creer la persona a ser esterilizada tiene por lo menos 18 años de edad, o reune los requisitos necesarios de edad bajo los reglamentos en vigor, y parece mentalmente competente. El/Ella sabiendo y voluntariamente ha solicitado ser esterilizado(da) y parece comprender la naturaleza y consecuencias del procedimiento.

Yo certifico que le he explicado a la persona a ser esterilizada los requisitos por el entendimiento de permiso. Según está suscrito en este formulario y en regulaciones pertinentes.

_____ _____
(Firma de la Persona que Obtiene el Permiso) *(Fecha)*

_____
(Establecimiento)

_____
(Dirección)

DECLARACIÓN DEL MÉDICO

Poco antes de efectuar la operación para la esterilización de _____
_____ el _____,
(Nombre de la Persona a ser Esterilizada) *(Fecha de la Operación de Esterilización)*
yo le expliqué la naturaleza de la operación llamada

_____
(Tipo de Operación)
el hecho de que es un procedimiento final e irrevocable, y los malestares, riesgos y beneficios derivados del mismo.

Yo advertí a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarles. Yo le expliqué que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su permiso puede ser retirado en cualquier momento y que por ello el/ella no perderá ninguno de los cuidados médicos o beneficios proporcionados con fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 18 años de edad, o reune los requisitos de edad necesarios bajo los reglamentos en vigor, y parece mentalmente competente. Ha pedido voluntariamente y con pleno conocimiento ser esterilizado(da) y parece comprender la naturaleza y consecuencias del procedimiento.

(Instrucciones para el uso de los párrafos finales alternos: Utilice el primer párrafo que sigue, excepto en casos de parto prematuro, cirugía abdominal de emergencia o renuncia del paciente pare que la esterilización se efectúe en menos de 30 días después de la fecha de la firma del formulario de permiso. En dichos casos, deberá usarse el segundo párrafo. Tache el párrafo que no utilice.)

1. Por lo menos 30 días han transcurrido entre la fecha en que la persona firmó el formulario de permiso y la fecha en que se efectuó la operación de esterilización.

2. Yo certifico que esta esterilización fue efectuada antes de los 30 días pero después de 72 horas de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y dé la información requerida):

   a. Parto prematuro:
      Fecha en que debería haber ocurrido el parto: _____
   b. Cirugía abdominal de emergencia (describa las circunstancias):
      _____
      Fecha en que la persona intentó ser esterilizada: _____
   c. El/La paciente renunció el derecho al período de espera de 30 días a cambio de un período de espera de _____ días. (No menos de 72 horas.)

_____ _____
(Médico) *(Fecha)*

State of California -- Health and Human Services Agency **CONSENT FORM - PM 330** Department of Health Services

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de _____ (doctor o clinica). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE** E **IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos metodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como:

_____
(Nombre del procedimiento)

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicios ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ____/____/____.
Mes Día Año

Apellido

Nombre *I.*

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por _____
(Nombre del Doctor)

utilizando un método conocido como _____
(Nombre del procedimiento)

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

_____ *Fecha:* ____/____/____
Firma de la persona a se esterilizada *Mes Día Año*

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma _____ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

_____ *Fecha:* ____/____/____
Firma del intérprete *Mes Día Año*

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que _____
(Nombre de la persona a ser esterilizada)
firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como _____ .
(Nombre del procedimiento)
También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la péridida de ningún servicio médico o beneficio subsidiado con fondos federales

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

_____ *Fecha:* ____/____/____
Firma de quien recibe el consentimiento *Mes Día Año*

_____
Nombre del lugar donde el paciente recibió la información

_____
Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco aqntes de operar a _____ en
(Nombre de la persona a ser esterilizada)
____/____/____ *(Fecha de esterilización),* le explique la naturaleza del metodo de esterilizacion conocido como _____ ,
Mes Día Año *(Nombre del procedimiento)*
también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(1) Han pasado por lo menos trienta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(2) La esterilización se realizó en menos de 30 días, pero despuétes de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

A ☐ Fecha de parto prematuro: ____/____/____ **Fecha anticipada** del parto: ____/____/____ (Debe ser 30 dias a partir de la firma de la persona).
Mes Día Año *Mes Día Año*

B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: ____

_____

_____ *Fecha:* ____/____/____
Firma del Doctor a cargo de la cirugía *Mes Día Año*

CONTROLLED SUBSTANCE LOG

MEDICATION NAME: _____ **PROVIDER'S NAME _____**

DOSE (mg/ml – mg/tab): _____ PROVIDER'S DEA NUMBER _____

ORIGINAL QUANTITY (ORIGINAL NUMBER OF DOSES): _____

DATE	PATIENT NAME	DISPENSED/GIVEN BY	QUANTITY DISPENSED	BALANCE AVAILABLE

PCP:	Page 1 of 1
SECTION: Infection Control	
POLICY AND PROCEDURE: Decontamination of Surfaces	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The site will follow decontamination procedures on contaminated surfaces according to Cal-OSHA Standards, 8 CCR §5193; CA H&S Code §118275. The site will utilize products from the Current EPA product lists and information available from the EPA, Antimicrobial Division (703) 305-1284 or (703) 308-0127.

PROCEDURE:

I. ROUTINE DECONTAMINATION

A. Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel.

II. SPILL PROCEDURE

A. Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s).

III. DISINFECTANT PRODUCTS

A. Products used for decontamination have a current EPA-approved status. Product will effectively kill HIV/HBV/TB. If manufacturer's product label indicates it will kill TB, it is understood that product will effectively kill HIV and HBV. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination."

IV. 10% BLEACH SOLUTION

A. If 10% bleach solution is used, it is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting [due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite]. Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, *specific* to every bleach product, are followed carefully.

Delegation of Services Agreements – Change in Regulations

Recently, Title 16, Division 13.8, Article 4, section 1399.540 has been amended to include several requirements for the delegation of medical services to a physician assistant. There are four specific changes with this amendment:

Background:
The Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet requirements of Section 1399.540.
The DSA is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Regulatory Requirements:

1) A physician assistant may provide medical services, which are delegated in writing by a supervising physician who is responsible for patients, cared for by the physician assistant. The physician assistant may only provide services which he or she is competent to perform, which are consistent with their education, training and experience, and which are delegated by the supervising physician.

2) The delegation of services agreement is the name of the document, which delegates the medical services. More than one supervising physician may sign the delegation of services agreement only if each supervising physician has delegated the same medical services. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

3) The Physician Assistant Board or their representative may require proof or demonstration of competence from any physician assistant for any medical services performed.

4) If a physician assistant determines a task, procedure or diagnostic problem exceeds his or her level of competence, and then the physician assistant shall either consult with a physician or refer such cases to a physician.

Question: What if a physician assistant works for more than one supervising physician at a hospital or clinic? Do we need to have separate DSAs for each supervising physician?

Answer: The Board has had questions regarding how the DSA would be written if a physician assistant works for more than one supervising physician at a hospital or clinic. If the duties and medical services performed are consistent with each supervising physician, then one DSA can be written to include several supervising physicians. Each supervising physician must sign and date the DSA, along with the signature of the physician assistant.

Question: What if a physician assistant works for one supervising physician who is an ob-gyn, and also works for an ortho supervising physician, and both are at the same clinic or hospital?

Answer: If the duties and medical services provided by the physician assistant differ from one supervising physician to another, then it is recommended that a separate DSA be written for each supervising physician. However, one DSA could be used, but it would need to be separated with which duties are allowed under each supervising physician. Again, signatures and dates from all parties must be included on the DSA.

Question: What if the physician assistant works at several different clinics – can one DSA be written?

Answer: A separate DSA should be made for each hospital or clinic, regardless of how many supervising physicians the physician assistant works with.

Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.

Question: How long should I retain my DSA?

Answer: You should retain the DSA as long as it is valid. Additionally, it is recommended that you keep a copy of your DSA for at least one to three years after it is no longer the current DSA in case you need to reference the document. However, there is no legal requirement to retain the DSA once it is no longer valid and current.

DELEGATION OF SERVICES AGREEMENT
BETWEEN
A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT
and
SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION OF A PHYSICIAN ASSISTANT

Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

The following two sample documents are attached to assist you with meeting this legal requirement:

- Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and,
- Supervising Physician's Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are **not** required to submit it to the Physician Assistant Board. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Board who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant's license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT BOARD

rev 11/08

SAMPLE
DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT_____
(Name)

Physician assistant, graduated from the _____
(Name of PA Training Program)

physician assistant training program on _____.
(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on _____.
(Date)

He/she was first granted licensure by the Physician Assistant Board on _____, which expires on _____, unless renewed.
(Date) (Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the PA and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

_____

_____

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

_____

_____

The PA is authorized to perform the following therapeutic procedures:

_____

_____

The PA is authorized to assist in the performance of the following therapeutic procedures:

_____

_____

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

_____

_____

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized Schedule(s). The PA has taken and passed the drug course approved by the Board on _____ (attach certificate). DEA #:_____.
Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval (circle authorized Schedule(s). DEA #:_____.

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

_____
(List Types of Patients and Situations)
_____

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. _____ YES _____ NO

The PA may also enter a drug order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at _____ and, in _____ hospital(s) and
(Address / City) (Address / City)
_____ skilled nursing facility (facilities) for care of
(Name of Facility)
patients admitted to those institutions by physician(s) _____ .
(Name/s))

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The _____ emergency room at _____
(Name of Hospital) (Phone Number)
is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.
Notify _____ at _____ immediately
(Name of Physician) (Phone Number/s))
(or within _____ minutes).

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_____ _____
Date Physician's Signature (Required)

_____
Physician's Printed Name

_____ _____
Date Physician Assistant's Signature (Required)

_____
Physician Assistant's Printed Name

SAMPLE ONLY

SUPERVISING PHYSICIAN'S RESPONSIBILITY
FOR SUPERVISION OF PHYSICIAN ASSISTANT

SUPERVISOR_____, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _____. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named _____.
(Name of PA)

_____ Examination of the patient by a supervising physician the same day as care is given by the PA.

_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within _____ of the encounter.
(Number of Days May- Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Board may be used. Written documentation of those mechanisms is located at _____.
(Give Location)

_____ INTERIM APPROVAL. For physician assistants operating under interim approval, the supervising physician shall review, sign, and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

_____Phone: _____
(Printed Name and Specialty)

_____Phone: _____
(Printed Name and Specialty)

PROTOCOLS NOTE: This document **does not** meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_____ _____
Date Physician's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE BOARD
SAMPLE ONLY

[PLEASE REVIEW BEFORE SENDING – Directions for staff sending the agreement

If PPG is not delegated for CCM or SNP, please remove entire section for Complex Case Management pg 12-14, Special Needs Program Case Management pg 15-36 and revise delegation grid header as applicable.]

If PPG does not have Medicare LOB, please delete the lines on page 7 and 8 related to Medicare-certified facilities

If PPG does not have Community Care (Exchanges) LOB, please delete "MUST UTILIZE HEALTH NET'S PRIOR AUTHORIZATION LIST FOR COMMUNITY CARE HMO MEMBERS ONLY" from pages 6, 8 and 9

<Date>

«Contact_Name»
«Contact_Title»
«Address»
«City», «State» «Zip»
Sent via «Email»:

Re: Provider Delegation Agreement
«PPG_Name» #«Commercial_PPG»

Dear «Contact_Name»:

Health Net of California, Inc., (Health Net) Delegation Oversight Committee has reviewed and accepted the documentation and findings from your annual assessment. You have met Health Net's criteria for the delegation of Utilization Management/Complex Case Management (CCM)/Special Needs Program (SNP) in connection with your Health Net Provider Participation Agreement.

Please have an authorized representative (Medical Director or Administrator) review and sign the enclosed "Provider Delegation Agreement" and return it to Health Net by **<Date, 15 calendar days from the date of the letter>**. Please retain a copy for your files.

Attached is the delineation of delegated Utilization Management, CCM and SNP responsibilities.

Health Net will continue to oversee your delegated activities. I will work with you on an on-going basis during the upcoming year to monitor your compliance with the delegated activities and to assist you with corrective actions as appropriate. Health Net agrees to provide available member experience data related to PPG's performance of utilization management and case management functions to the PPG on request.

If you have any questions, please call me at <insert MPM phone number> or e-mail me at <insert MPM email address>@healthnet.com. Congratulations on your successful management of delegated responsibilities and thank you for your cooperation and support.

Sincerely,

Clinical Compliance Auditor
Delegation Oversight
Health Net of California, Inc.

Attachments: Provider Delegation Agreement

Provider Delegation Agreement

In connection with its Health Net of California, Inc., ("Health Net") Provider Participation Agreement, «PPG_Name» agrees to accept responsibility for delegation of Utilization Management/CCM/SNP activities (per the attached grid).

Effective «audit or contract date», «PPG_Name» agrees to comply with the responsibilities (including the performance requirements) set forth in the Health Net / Participating Physician Group / Provider Delineation of Delegated Utilization Management/CCM/SNP Responsibilities grid. Health Net may determine that a periodic visit is indicated. In such case, Health Net will contact you to establish a time and date for the visit. At a minimum, Health Net will schedule an annual visit to evaluate the delegated activities.

In compliance with accreditation standards and regulatory requirements «PPG_Name» shall not restrict the rights and obligations of Member Physician to communicate freely with Members regarding their medical condition and treatment alternatives, including medication treatment options, regardless of benefit coverage limitations.

«PPG_Name» (if contracted to serve Medicare Advantage members) recognizes its responsibility to conform to the delegation requirements in a manner consistent with CMS regulations.

«PPG_Name» agrees to abide by mutually agreed upon corrective action plans. In the event that «PPG_Name» does not perform the delegated responsibilities as defined in the attached Health Net / Participating Physician Group / Provider Delineation of Delegated Utilization Management/CCM/SNP Responsibilities grid, and in accordance with Health Net, NCQA and regulatory standards, Health Net reserves the right, upon written notice, to revoke the delegation of some or all these responsibilities for Health Net members as set forth herein. Except in the event of risk to Members, «PPG_Name» will be provided a thirty- (30) day cure period prior to delegation being revoked.

This agreement shall remain in effect unless the «PPG_Name» is notified otherwise by Health Net.

Health Net of California, Inc. Date: <insert DOC approval date>

Elaine Robinson-Frank

Elaine Robinson-Frank RN, MPH
Vice President Delegation Oversight

«PPG_Name» #«Commercial_PPG»

_____ Date: _____
Signature

_____
Please Print Signer's Name and Title Here

Please sign and return one copy of this agreement by <Date, 15 calendar days from the date of the letter> to:

Health Net of California, Inc.
<CCA name>, Clinical Compliance Auditor
M/S: <CA-116-02-02>
<650 East Hospitality Lane

San Bernardino, CA 92408>
Via email: <MPM Email Address>

health net

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Delegate Name: «PPG_Name» **Delegation Date:** «audit or contract_Date»

☐ Commercial HMO Delegate # «Commercial_PPG»
☐ Seniority Plus Delegate# «Seniority_Plus_PPG»
☐ Medi-Cal Delegate# «Medi-Cal_PPG»
☐ Community Care Delegate# «Commercial_PPG»
☐ Sapphire Delegate #«Seniority_Plus_PPG»

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Utilization Management						
UM Program	☒ Yes ☐ No	• Develop, implement and submit to Health Net a Utilization Management Plan/Program outlining program structure, accountability, scope, criteria, and process used to make determinations of benefit coverage and medical necessity. • Establish Behavioral Health aspects of the UM Program (if applicable) • Establish policies and procedures to assure that appropriately licensed professionals supervise all medical necessity decisions. • Ensure appropriate licensed practitioners make all medical necessity denial determinations. • Ensure a senior physician, with an unrestricted license, has substantial involvement in UM Program and implementation. • Ensure involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the program (if applicable). • Have written UM decision-making	Annually: • UM Program Description • UM Program Evaluation • UM Work plan Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly: • ICE UM Work plan/Reports	Monitor and oversee delegated function to ensure standards are met.	• Initial assessment utilizing Health Net Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net Provider Delegation Assessment Tool (PDAT).	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of UM delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		criteria that are objective and based on medical evidence, criteria is reviewed annually and also the procedures for applying the criteria. • Establish policies and procedures to meet communication services for members and practitioners to include access to staff during and after business hours. • Evaluate UM Program annually.				
Prospective Review Other Outpatient Services ☒ Specialty Referrals ☒ Diagnostics ☒ DME ☒ Infusion / Home Health Services ☒ Orthotic/Prosthetic ☒ Outpatient Surgeries	☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No	Conduct pre-certification reviews following Health Net policies and members benefit package per the Health Net Participating Provider Agreement (PPA) PPA. Utilizes **nationally recognized** UM decision-making criteria that are objective and based on medical evidence Develop written policies and procedures for applying the criteria based on individual needs to include assessment of the local delivery system. MUST UTILIZE HEALTH NET'S PRIOR AUTHORIZATION LIST FOR COMMUNITY CARE HMO MEMBERS ONLY	Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly: ICE UM Work plan/Reports Include the number of approvals and denials generated by the delegated entity. Specialty Referral reports quarterly	Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards.	• Initial assessment utilizing Health Net PDAT. • Annual assessment utilizing Health Net PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of UM delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Prospective Review Inpatient ☒ Acute ☒ Elective ☒ SNF ☒ Hospice (If by DoFR hospice is a carve out, delegate is responsible for services not related to hospice)	☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No	Conduct pre-certification following Health Net policies and member's benefit package and per the PPA. Utilizes **nationally recognized** UM decision-making criteria that are objective and based on medical evidence Develop written policies and procedures for applying the criteria based on individual needs to include assessment of the local delivery system. MUST UTILIZE HEALTH NET'S PRIOR AUTHORIZATION LIST FOR COMMUNITY CARE HMO MEMBERS ONLY	Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly: • ICE UM Work plan/Reports	• Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards. • Monitor and oversee delegated function to ensure standards are met.	• Review ICE UM Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net PDAT. • Annual assessment utilizing Health Net PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of UM delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
The following procedures must be performed at Medicare-certified facilities: ☒ Carotid artery stenting ☒ Lung-volume reduction surgery ☒ Ventricular assist device (VAD) destination therapy	☒ Yes ☐ No	Health Net participating providers must first confirm that the facility is participating with Health Net. Then, providers must refer to the CMS website at www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp to ensure the facility is Medicare-certified to perform the specified procedure. Once on the CMS website, providers should consult the list in the left-hand menu bar for information on the applicable procedure.				

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Concurrent Review Inpatient ☒ Acute ☒ SNF ☒ Hospice (If by DoFR hospice is a carve out, delegate is responsible for services not related to hospice)	☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No	• Conduct onsite and/or telephonic Utilization Management concurrent reviews as per the PPA. • Conduct inpatient case management for high-risk and / or catastrophic cases. • Identify discharge-planning needs prior to discharge and make all necessary arrangements for members. • Coordinate activities with Health Net's Care managers and Ancillary Providers as requested and/or required. • Utilizes **nationally recognized** UM decision-making criteria that are objective and based on medical evidence • Develop written policies and procedures for applying the criteria based on individual needs to include assessment of the local delivery system. MUST UTILIZE HEALTH NET'S PRIOR AUTHORIZATION LIST FOR COMMUNITY CARE HMO MEMBERS ONLY	Weekly inpatient logs identifying denials of care to include admission and discharge date and specific reasons for denial of days and/or levels of care. Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly: • ICE UM Work plan/Reports	• Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards. • Monitor and oversee delegated function to ensure standards are met. • Track and compare provider's performance to that of the regions, network and top performing providers.	• Review ICE UM Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net PDAT. • Annual assessment utilizing Health Net PDAT annual audit tool. • Review of Delegates based on identified over/under utilization trends as established by Health Net. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Health Net to conduct telephonic or on-site UM reviews when warranted. • Potential revocation of UM delegation if CAP objectives are not achieved within agreed time frame. • Continued noncompliance may lead a breach of the PPA and subsequent termination of the PPA.
Retrospective Review {professional and diagnostic services} ☒ ER services ☒ Inpatient Services	☒ Yes ☐ No ☒ Yes ☐ No	• Conduct retrospective review on individual cases and aggregate decision data to identify specific issues arising from an episode of care (e.g. ER claims). • Communicate identified issues to respective providers.	Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly:	• Monitor and oversee delegated function to ensure standards are met. • Collect Delegate specific encounter data and compare to plan-wide data to identify more effective methods of managing of	Review monthly encounter data.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of UM delegation if CAP

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
☒ Outpatient Services	☒ Yes ☐ No	• Submit all encounter data. • Follow prudent layperson standard as set forth by CA Health and Safety Code section 1371.4 (c) and NCQA standard UM 12A when reviewing all emergency services. MUST UTILIZE HEALTH NET'S PRIOR AUTHORIZATION LIST FOR COMMUNITY CARE HMO MEMBERS ONLY	• ICE UM Work plan/Reports	health care resources.		objectives are not achieved within agreed time frame. • Continued noncompliance may lead a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Case Management Ambulatory	☒ Yes ☐ No	• Develop process to include policies and procedures for ambulatory case management. • Conduct ambulatory case management/care coordination on patient population based on need. Ensure process for applying the criteria is based on individual needs to include assessment of the local delivery system. • Refer high risk/catastrophic members to Health Net for case management if applicable • Ensure process reviews the member's individual needs encompassing overall health status, family support, community resources available. • Coordinate activities with Health Net's Care Managers and Ancillary Providers as indicated.	Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly: ICE UM Work plan/Reports	• Establish, publish and distribute information to identify and manage high risk/high cost diagnoses. • Provide Health Risk Assessment and other predictive indicators to the Delegate. • Health Net to provide referral form and definitions for referral of complex members for case management if applicable • Provide additional care management support to Delegate as requested. • Monitor and oversee delegated function to ensure standards are met.	• Review of ICE UM Work plan/reports with written evaluation sent back to Delegate.	• Health Net may conduct review to reassess areas of non-compliance..
Denial of Service for Medical Necessity/ Benefit coverage ☒ Specialty Referrals/ Outpatient diagnostics ☒ Outpatient Surgeries ☒ Inpatient Services ☒ SNF Services	☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No	• Establish standards for denial of services, process of denial, notification of denial, and timeliness of denials as per the PPA and applicable Federal and State requirements, and NCQA standards. • Issue first level denials on the basis of clinical data reviewed or coverage limitation. • Ensure denial files include all pertinent clinical information, specific criteria cited, physician involvement in denial determinations, alternative treatment plan, how member can	Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports Medi-Cal Delegates Only: Quarterly: • ICE UM Work plan/Reports	Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards.	• Review of ICE UM Work plan/reports with written evaluation sent back to Delegate. • Initial assessment utilizing Health Net PDAT. • Annual assessment utilizing Health Net PDAT for review of denial files. • Focused reviews to measure areas	• Require Corrective Action Request(s) for elements of non-compliance. • Health Net may conduct review to reassess areas of non-compliance. • Health Net may put Delegate on prospective/retrospective review of all service denial letters. • Potential

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
☒ Infusion / Home Health Services ☒ DME ☒ Orthotic/ Prosthetic	☒ Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No	obtain a copy of the criterion used to make the determination and required appeal language to include the expedited external review process. • Monitor denial activity through UM Committee.			of noncompliance as warranted.	revocation of UM delegation if CAP objectives are not achieved within agreed time frame. • Continued noncompliance may lead a breach of the PPA and subsequent termination of the PPA.
Appeals and Grievances	☒ No Not a delegated function.	Instruct member to contact Health Net for all appeals and grievances.	N/A	Conduct all member appeals and grievances	N/A	N/A
Experimental and Investigational Procedures	☒ No Not a delegated function.	• Immediately forward all pertinent documentation for investigational or experimental treatment to Health Net. • Retain responsibility for care managing member and assisting member in obtaining routine services within network if member is in clinical trial.	N/A	• Review request and issue response per Health Net policy. • If denied, refer for third party review. • Inform member and Delegate of results of third party review.	N/A	N/A

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Case Management – Complex Case Management Member Identification	☒ Yes ☐ No	• Identify high risk members who might benefit from case management services utilizing screening criteria, address members as identified by Health Net in the Operations Manual. • Establish multiple avenues for members to be considered for complex case management including active participation in Health Net member identification process (Health Risk Assessment (HRA) and other predictive modeling processes). • Assesses the characteristics and needs of its member population. • Reviews and updates the CM processes to address member needs. • Establish and utilize a case management system that: ➢ Uses evidence based clinical guidelines for assessment and management of members. ➢ Documents date and time of staff interventions. ➢ Have automated prompts for follow-up with members.	Case Management Files are reviewed at the time of the annual audit and as deemed necessary. Semi-annual reporting to Health Net on cases referred to Delegate through Health Net member identification process Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports	• Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards. • Provide Health Risk Questionnaire and other predictive indicators to the Delegate. • Monitor and oversee delegated function to ensure standards are met.	• Annual assessment utilizing Health Net PDAT. • Delegate Meetings. • Ongoing feedback on identified high risk members; may include but is not limited to completing feedback grid or participating in case conferences. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Health Net provides training as warranted. • Potential revocation of CM delegation if CAP objectives are not achieved within agreed time frame. • Continued noncompliance may lead a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Case Management – Complex Case Management Case Management Process	☒ Yes ☐ No	Establish and maintain procedures that address: • Member's rights to decline or disenroll from case management. • Documentation of clinical history including medications and condition specific issues. • Initial assessments of: ➢ Activities of Daily Living ➢ mental health status including cognitive functions ➢ life planning activities • Evaluation of: ➢ cultural and linguistic needs ➢ visual and hearing needs ➢ care giver resources and involvement ➢ available benefits within the organization and from community resources • Development of: ➢ A Care Management plan including prioritized goals including those of the caregivers and desired level of involvement, and barriers to meeting those goals. ➢ A schedule for regular follow up and communication with members. ➢ A plan to communicate to member a self-management plan. • Assessing member's progress against the care management plan.	• Case Management Files are reviewed at the time of the annual audit and as deemed necessary. • Semi-annual reporting to Health Net on cases referred to Delegate through Health Net member identification process. Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports	• Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards. • Provide Health Risk Questionnaire and other predictive indicators to the Delegate. • Monitor and oversee delegated function to ensure standards are met.	• Annual assessment utilizing Health Net PDAT. • Delegate Meetings. • Ongoing feedback on identified high risk members; may include but is not limited to completing feedback grid or participating in case conferences. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Health Net provides training as warranted. • Potential revocation of CM delegation if CAP objectives are not achieved within agreed time frame. • Continued noncompliance may lead a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Case Management – Complex Case Management Satisfaction with and Measuring Effectiveness	☒ Yes ☐ No	Establish and maintain procedures that address: **SATISFACTION** • Obtaining feedback from members and analyzing such feedback. **MEASURING EFFECTIVENESS** Measuring the effectiveness of case management program using 3 measures selected by Delegate based on the review of their case management program. For each such measure the Delegate: • Identifies relevant processes or outcomes • Uses valid methods that provide quantitative results • Sets performance goals • Identifies clearly measure specifications • Analyzes results • Identifies opportunities for improvement • Plans for intervention and re-measurement **ACTION AND REMEASUREMENT** • Implementing at least one intervention to improve performance based on criteria above. • Re-measuring to determine performance.	• Case Management Files are reviewed at the time of the annual audit and as deemed necessary. • Semi-annual reporting to Health Net on cases referred to Delegate through Health Net member identification process. Commercial and Medicare Advantage Semi-Annually: • ICE UM Work plan/Reports	• Establish, publish and distribute performance standards and guidelines to providers that are consistent with Federal and State requirements, and NCQA standards. • Provide Health Risk Questionnaire and other predictive indicators to the Delegate. • Monitor and oversee delegated function to ensure standards are met.	• Annual assessment utilizing Health Net PDAT. • Delegate Meetings. • Ongoing feedback on identified high risk members; may include but is not limited to completing feedback grid or participating in case conferences. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Health Net provides training as warranted. • Potential revocation of CM delegation if CAP objectives are not achieved within agreed time frame. • Continued noncompliance may lead a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Delegate Name: _____ **Delegation Date:** _____

☐ Dual Eligible (DSNP)

☐ Chronic Special Needs Plan (CNSP)

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Targeted Special Needs Individuals	☒ Yes ☐ No	Delegate has a model of care to manage the delivery of specialized services and benefits for: • Dual-eligible special needs individuals (DSNP) • Individuals with chronic conditions (CSNP) • Meets all of the standards for Complex Case Management as set forth in NCQA PHM and SNP standards as set forth by CMS. • Delegate has written care plans on 100% of its members • Delegate has an Interdisciplinary Care Team (ICT) meeting on 100% of its members at a minimum of annually.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met.	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the Participating Provider Agreement (PPA) and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Goals	☒ Yes ☐ No	Delegate has written care management P&Ps and systems to assure access to: • Medical services across life cycle • Mental health services • Social services • Translation and linguistic services • Coordination of care through a central point of contact • Seamless transitions across healthcare settings, care providers and health services • Preventive health services • Appropriate utilization of services in all settings where appropriate • Promote member independence and self-management • Improve member health status through improved mobility and functional status • Pain management services • Improve member's health status through improved satisfaction with health status and healthcare services • Improve member's health status by developing SMART and prioritized goals identified and stratified with member. • Identification of barriers to meeting members' goals.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute performance standards and guidelines to providers that are consistent with CMS SNP requirements. • Monitor and oversee delegated function to ensure standards are met.	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Staff Structure and Roles	☒ Yes ☐ No	Delegate has appropriate staff to perform administrative and clinical oversight duties. These staff include some or all of the following: • Medical Director • Administrator, director or executive staff (with implementation at committee or local level as needed) Delegate assures that staff effectively performs administrative and clinical oversight duties. These duties include some or all of the following: • Review medical charts • Conduct/document performance assessments • Conduct/document and/or observe interdisciplinary team meetings	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers the performance standards and guidelines that are consistent with CMS SNP requirements • Provide staff job descriptions as needed • Monitor and oversee delegated function to ensure standards are met • Provide Benefit coordinator, account liaison, plan representative, Quality Improvement Specialist and HIPPA compliance officer as needed by Delegate	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
	☒ Yes ☐ No	Delegate has appropriate staff to perform care management and coordination of services and benefits. These staff include some or all of the following: • Care manager or coordinator • Durable medical equipment coordinator • Utilization review coordinator • Discharge planning specialist • Nurse Manager or coordinator • Health information specialist • Training • Data analysis	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Maintain a call center for 24-hour telephonic care management • Maintain a website for member educational material and plan information • Facilitate translation services	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
	☒ Yes ☐ No	Delegate assures that care management staff performs duties including some or all of the following: • Facilitates the implementation of the individualized care plan for each member • Schedules or facilitates scheduling appointments and follow-up services. • Facilitates transportation services Requests consultation and diagnostic reports from network specialists	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Maintain a call center for 24-hour telephonic care management • Maintain a website for member educational material and plan information • Facilitate translation services	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
	☒ Yes ☐ No	Delegate assigns each member to an interdisciplinary care team (ICT) composed of primary, ancillary, and specialty care providers, where appropriate. Required members of the ICT include the following: : • Medical expert • Mental health/behavioral health expert (if member has identified BH needs) • Social services expert The ICT may include some or all of the following: • Primary care physician • Registered nurse • Restorative health specialist (physical, occupational, speech, recreation) • Board-certified physician • Dietitian, nutritionist • Caregiver/family member • Preventive health/health promotion specialist • Pharmacist • Pastoral specialist	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements~~, and NCQA standards.~~ • Monitor and oversee delegated function to ensure standards are met • HN's Pharmacy Department to provide Medication Therapy Management (MTM) program. only • Provide Behavioral and/or mental health specialist psychiatrist, psychologist, drug or alcohol therapist • Review interdisciplinary care team meeting minutes and attendance including member and or caregiver attendance • Review documentation in individualized care plan. Identification of vulnerable members with special needs and how needs were met with benefits and services	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
	☒ Yes ☐ No	Delegate assures that the interdisciplinary care team works together to manage member care by performing duties including some or all of the following: • Conduct care coordination meetings on a regular schedule (these may be face to face or web-based) • If regular meetings are not held, documentation and justification for lack of meetings will be required. • Conduct case rounds on a regular schedule • Conduct conference calls among plan, providers, and members if appropriate • Use e-mail, fax, and written correspondence to communicate • Delegate analyzes data demonstrating the beneficiary/caregiver/member participation in the ICT meetings and takes action to improve deficiencies	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Call line or other mechanism for member inquiries and input • Maintain a mechanism for member complaints and grievances • Review interdisciplinary care team meeting minutes and attendance including member and/or caregiver attendance • Review documentation in individualized care plan. Identification of vulnerable members with special needs and how needs were met with benefits and services	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Provider Network	☒ Yes ☐ No	Delegate assures that providers and facilities have specialized clinical expertise pertinent to the targeted special needs population beyond the scope of the interdisciplinary team. Specialized clinical experts' duties may include: • Assess, diagnose, and treat in collaboration with the interdisciplinary team • Provide specialized services such as wound management services/referral to wound specialist • Conduct home visits to include home safety assessments utilizing contracted vendors • Conduct risk prevention programs such as fall prevention or wellness promotion • Provide hospital-based or urgent care facility-based emergency services • The Delegate/provider contacts beneficiaries to remind them of upcoming appointments • The Delegate/provider contacts beneficiaries to follow up on missed appointments	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• 24-hour access to a clinical consultant • Disease management programs • Provide pharmacotherapy consultation and management clinics • Provide home-based palliative or end-of-life care • Review interdisciplinary care team meeting minutes and attendance including member and or caregiver attendance • Review documentation in individualized care plan identification of vulnerable members with special needs and how needs were met with benefits and services • Annually conduct Geo access survey	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Provider Network	☒ Yes ☐ No	Delegate has a process to coordinate the delivery of standard services and benefits through a provider and facility network having clinical expertise pertinent to the targeted special needs population. The process includes some or all of the following: • The beneficiary's interdisciplinary care team approves all referrals to the provider network prior to the delivery of services when such referrals require prior authorization • The interdisciplinary care team, determines whether beneficiaries require services outside the existing provider network and approves services prior to delivery • Communicates need for add-on benefits to HN based on issues identified in the beneficiary's individualized care plan. • The Delegate has a process to track and analyze services and benefits utilization • The Delegate disseminates the results of the utilization analysis to the interdisciplinary team.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Contract with providers having the clinical expertise to meet the specialized needs of the targeted SNP population • Facilitate access to Specialist in narrow fields not frequently available within each Delegate network • Contract with facilities that provide diagnostic and treatment services to meet the specialized needs of the targeted SNP population • Establish and share policies and procedures that direct how the network providers and facilities will deliver services to members • Review individualized care plan for documentation of transition of care management consistent with SNP structure and process measures	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Provider Network	☒ Yes ☐ No	Delegate assures its providers deliver evidence-based services in accordance with nationally recognized clinical protocols and guidelines when available (see the Agency for Healthcare Research and Quality's National Guideline Clearinghouse at http://www.guideline.gov)	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	Written contract with Delegate stipulates that contracted providers deliver services in accordance with nationally recognized clinical protocols and guidelines when available	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Provider Network	☒ Yes ☐ No	Delegate has policies, procedures, and a system to coordinate the delivery of add-on benefits and services that meet the specialized needs of the most vulnerable including frail/disabled beneficiaries and beneficiaries near the end of life. The system includes: • Contracts with providers having the clinical expertise to meet the specialized needs of frail/disabled beneficiaries and beneficiaries near the end of life • Contracts with facilities that provide diagnostic and treatment services to meet the specialized needs of frail/disabled beneficiaries and beneficiaries near the end of life • Policies and Procedures that direct how the network providers and facilities will deliver services to the frail/disabled beneficiaries and beneficiaries near the end of life and notifies the interdisciplinary care team • The Delegate administrative staff approves all referrals for frail/disabled beneficiaries and beneficiaries near the end of life to the appropriate specialized providers and notifies the ICT. • The ICT approves all referrals for frail/disabled beneficiaries and beneficiaries near the end of life and notifies the providers.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Work with Delegate to approve add-on benefits • Offer transportation to facilitate access to services for frail/disabled beneficiaries and beneficiaries near the end of life	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Model of Care Training	☒ Yes ☐ No	Delegate has appropriate staff (employed, contracted, or non-contracted, temporary) trained on the model of care to coordinate and/or deliver all services and benefits including some or all of the following: • All SNP employees/contractors/ temporary staff have initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations • All network providers have initial and annual refresher training on the SNP model of care as evidenced by attendance lists and/or evaluations	Annually submit evidence of required trainings i.e.: attendance list, evaluations, newsletters, website, and/or orientation or other course material at the time of the annual audit survey process	Establish a training strategy that uses a variety of methods including some or all of the following: • Face-to-face training • Web-based interactive training • Self-study program (electronic media, print materials) • Distribute training material to Delegate • Monitor to ensure annual training has occurred	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Individualized Care Plan	☒ Yes ☐ No	Delegate has written policies, procedures, and a system to assure that the interdisciplinary care team develops and implements a comprehensive individualized plan of care for each member. The system includes some or all of the following: • Results from the initial health risk assessment are used to develop the individualized care plan • Member's medical history is used to develop the individualized care plan • Member's healthcare preferences are incorporated in the individualized care plan • Each member is assigned to an interdisciplinary care team that develops the individualized care plan with member involvement when feasible • Interdisciplinary team beneficiaries update the individualized care plan as member health status changes • Initial and annual assessments are analyzed to determine the need for add-on services and benefits, and these needs are incorporated into the individualized care plan for each member.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports Monthly: SNP Case Management Engagement Report	• Share member specific initial and annual HRA results with Delegate • Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates, P&P's as needed for activities • Work with Delegate regarding need for add-on benefits	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Individualized Care Plan	☒ Yes ☐ No	Delegate has a written process to facilitate member/caregiver participation in care planning when feasible. The process includes any of the following: • Beneficiaries and/or caregivers participate either face-to-face or telephonically in care planning • Beneficiaries and/or caregivers participate in care planning either through an exchange of written correspondence with or web-based electronic interface or virtual correspondence with their interdisciplinary team	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports Monthly: SNP Case Management Engagement Report	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates as needed for activities	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Care Transitions	☒ Yes ☐ No	Delegate has a policy and procedure to facilitate safe transitions by either conducting or assigning to providers the following tasks and monitoring system performance: • For planned transitions from beneficiaries usual setting of care to the hospital and transitions from the hospital to the next setting, identifying that a planned transition is going to happen • For planned and unplanned transitions sharing the sending settings care plan with the receiving setting within one business day of notification of the transition • For planned or unplanned transitions from any setting to any other setting, notifying the beneficiaries usual practitioner of the transition within a timeframe specified by the Delegate (i.e. two business days)	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates as needed for activities	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

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Supporting Members Through Transitions	☒ Yes ☐ No	The Delegate has a policy and procedure to facilitate safe transitions by either conducting or assigning to providers the following tasks and monitoring system performance: • For planned and unplanned transitions from any other setting, communicating with the member or responsible party about the care transition process within a timeframe specified by Delegate (i.e. 2 business days) • For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about changes to the member's health status and plan of care within a timeframe specified by Delegate (i.e. 2 business days) • For planned and unplanned transitions from any setting to any other setting, providing each member who experiences a transition with a consistent person or unit within the organization who is responsible for supporting the member through transitions between any points in the system within a timeframe specified by Delegate (i.e. 2 business days)	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates as needed for activities	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Reducing Transitions	☒ Yes ☐ No	The Delegate has a policy and procedure, based on the findings from the Delegate's monthly analysis of data, to identify individual members at risk of a transition, the Delegate minimizes unplanned transitions and works to maintain members in the least restrictive setting possible by: • Coordinating services for members at high risk of having a transition. • Educating members or responsible parties about transitions and how to prevent unplanned transitions.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates as needed for activities	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

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Analyzing Transitions	☒ Yes ☐ No	The Delegate has a policy and procedure to minimize unplanned transitions and work to maintain members in the least restrictive setting possible by: • Analyzing data at least monthly, to identify individual members at risk of transition • Analyzing rates of all member admissions to facilities and ED visits at least annually to identify areas for improvement.	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates as needed for activities	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted. •	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA. •

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Performance and Health Outcomes Measurement	☒ Yes ☐ No	Delegate collects data from a variety of sources including some or all of the following: • Claims • Encounters • Medical record reviews • Diagnostics (labs, pathology, radiography) • Utilization reports • Hospital admissions • Long term facility admissions • ED admissions	Monthly submission of claims/encounters	HN has written policies, procedures, and a system to collect and analyze data to evaluate the effectiveness of its model of care including: • Member demographics • Administrative • Pharmacy • HEDIS data • HOS data • CAHPS data • Health Risk Assessments • Internal quality assurance specialists implementing a performance improvement program • Participation by plan, provider network, and beneficiaries/caregivers	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

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Performance and Health Outcomes Measurement	☒ Yes ☐ No	Delegate takes actions to improve the model of care including some or all of the following: • Changes in policies or procedures • Changes in staffing patterns or personnel • Changes in provider or facility network • Changes in systems of operation • Communication of results internally and externally • Delegate collects and analyzes data that demonstrates beneficiaries have access to covered services and benefits, and acts to improve deficiencies that are identified • Delegate collects and analyzes data that demonstrates beneficiaries have improved health status, and acts to improve deficiencies that are identified. • Delegate collects and analyzes data on service delivery processes and outcomes, and acts to improve deficiencies that are identified. • Delegate collects and analyzes data on the utilization of evidence-based guidelines by the interdisciplinary team and provider network, and acts to improve deficiencies that are identified.	Annually submits data and analysis reports to HN Hospice referrals, pain management referrals, ER rates and readmit rates are reported annually with at least 2 year trending of month to month data. These reports will be on all the SNP beneficiaries since we do not delineate one health plan from another. Annually, based on health outcomes, Delegate provides corrective action plan to address the following: • access, • health status, • service delivery This will be done through geo-access survey process.	• Establish, publish and distribute to providers performance standards and guidelines that are consistent with CMS SNP requirements • Monitor and oversee delegated function to ensure standards are met • Establish and create documentation templates as needed for activities	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Participating Physician Group / Provider
Delineation of Delegated Utilization Management [/CCM/SNP] Responsibilities

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Performance and Health Outcomes Measurement	☒ Yes ☐ No	Delegate collects and analyzes data demonstrating the participation of beneficiaries and interdisciplinary care team beneficiaries in care planning, and acts to improve deficiencies that are identified. The data includes some or all of the following: • Written summaries of care planning meetings are included in the care plan and list attendees. • Interdisciplinary team beneficiaries maintain attendance logs for all care planning meetings • Beneficiaries are surveyed to determine the level of their own and their interdisciplinary team's participation in care planning meetings .	Annually: UM/SNP Program Description or P&Ps UM/SNP Program Evaluation Semi-annually: ICE UM/SNP Work plan/Reports Annually submits data and analysis reports to HN	HN will develop/implement audit process including tools and distribute to Delegate regarding: • Perpetual audits of complaint and grievance summaries a to assure beneficiaries and team beneficiaries participate in care planning • Collects and analyzes data on member utilization of communication mechanisms (e.g., call centers, complaint logs, etc.), and acts to improve deficiencies that are identified. • Collects and analyzes data related to add-on services and benefits including member utilization and/or satisfaction with such services and benefits, and acts to improve deficiencies that are identified.	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.
Performance and Health Outcomes Measurement	☐ Yes ☒ No	N/A	N/A	HN will: Have written policies, procedures, and a system to submit required public reporting data that inform stakeholders about the plan's performance as requested by CMS. These data include some or all of the following: • HEDIS data • Structure and process measures data • HOS data • CAHPS data	N/A	N/A

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Performance and Health Outcomes Measurement	☒ Yes ☐ No	Delegate has written policies, procedures, and a system to submit required reporting data that monitors performance as requested by CMS. This data include some or all of the following: • Community services access/utilizations rates • Facilitation of member developing advance directives/health proxy • Functional/ADLs status/deficits • Hospice referral and utilization rates • Hospital discharge outreach and follow-up rates • Pain and symptoms management effectiveness • Policies and procedures for effectiveness and staff compliance • Screening for elder/physical/sexual abuse	Annually submits data and analysis reports to HN	HN will review/audit/publish the following: • Health information for accuracy and appropriateness of data • Member/caregiver education for frequency and appropriateness • Clinical outcomes • Behavioral health/psychiatric services utilization rates • Complaints, grievances, services and benefits denials • Establish and publish disease management indicators • Disease management referrals for timeliness and appropriateness • Emergency room utilization rates • Enrollment/disenrollment rates • Provide Evidence-based clinical guidelines or protocols for utilization rates • Hospital admissions/readmissions • Immunization rates • Medication compliance/utilization rates • Medication therapy management effectiveness • Preventive programs utilization rates (e.g., smoking cessation) • Preventive screening rates • Primary care visit utilization rates •	• Review UM/SNP Work plan/reports with written evaluation provided to Delegate. • Initial assessment utilizing Health Net SNP Provider Delegation Assessment Tool (PDAT). • Annual assessment utilizing Health Net SNP PDAT. • Focused reviews to measure areas of noncompliance as warranted.	• Require Corrective Action Request(s) for elements of non-compliance. • Potential revocation of SNP Care Management delegation if CAP objectives are not achieved. • Continued noncompliance may lead to a breach of the PPA and subsequent termination of the PPA.

Activities	Delegate SNP Status Delegated (Yes) or Not Delegated (No)	Delegate Responsibilities	Frequency of Reporting	Health Net's Responsibilities	Health Net's Process for Evaluating Delegate's Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
				Satisfaction surveys for beneficiaries/caregivers Satisfaction surveys for provider network • Screening for depression and drug/alcohol abuse • Skilled nursing facility placement/readmission rates • Skilled nursing facility level of care beneficiaries living in the community having admissions/readmissions to skilled nursing facilities • Urinary incontinence rates • Wellness program utilization rates		

Radiologic Health Branch
Contact Information
February 2014

OFFICE	ADDRESS	TELEPHONE NUMBER	FAX NUMBER
Radiologic Health Branch Sacramento	**MAILING ADDRESS:** Department of Public Health Radiologic Health Branch P.O. Box 997414, MS 7610 Sacramento, CA 95899-7414 **PHYSICAL ADDRESS (for FEDEX, UPS, etc.):** Department of Public Health Radiologic Health Branch 1500 Capitol Avenue, 5th Floor, MS 7610 Sacramento, CA 95814-5006	(916) 327-5106	(916) 440-7999
Radiologic Health Branch Richmond	850 Marina Bay Parkway, Bldg. P, 1st Floor Richmond, CA 94804	(510) 620-3416	(510) 620-3874
Radiologic Health Branch Brea	500 S. Kraemer Blvd, Brea, CA 92821 Radioactive Materials (RAM), Suite 235 X-ray (Region 2*), Suite 235 X-ray (Region 5*), Suite 225	RAM (714) 524-1409 X-ray (714) 524-4450 X-ray (714) 524-5681	RAM (714) 524-1908 X-ray (714) 524-1908 X-ray (714) 524-5682
Radiologic Health Branch Los Angeles County	Radiation Management 3530 Wilshire Boulevard, 9th Floor Los Angeles, CA 90010	(213) 351-7897	(213) 351-2718
Radiologic Health Branch San Diego County	**MAILING ADDRESS:** County of San Diego Dept of Envr Health, Radiological Health Program 5500 Overland Ave, Ste 110 MS O-560 San Diego, CA, 92123	(858) 694-3621	(858) 694-3629

***Region 2 serves the following counties:**
Fresno, Inyo, Kern, Kings, Madera, Mariposa, Mono, Monterey, San Benito, San Luis Obispo, Santa Barbara, Tulare, Ventura.

***Region 5 serves the following counties:**
Imperial, Orange, Riverside, San Bernardino.

DIRECT OBSERVATION THERAPY REFERRAL

Daily / Weekly DOT (circle one) Patient Name:_____

Male/Female (circle one) Age:_____AKA:_____

Address:_____

Phone Number (Home/Message):_____ Phone Number (Work):_____

Work Name & Address: _____

DOB:_____ Social Security #:_____-_____-_____ Medi-Cal ID#: _____

CLINICAL FINDINGS

Date of Symptom Onset:_____/_____/_____ Date of Diagnosis:_____/_____/_____ Weight:_____lbs.

Site: Pulmonary/Laryngeal/Extrapulmonary(Specify)_____

Prior TB Drug Treatment: Yes/No/Unknown If Yes, any prior drug resistance? Yes/No/Unknown

Prior Drug Therapy Compliance? Yes/No/Unknown

Initial Symptoms: Cough/Sputum Production/Other_____

Date Last Chest X-Ray: _____/_____/_____ Result: Normal/Abnormal (noncavity)/Abnormal (cavity)

If Abnormal: Stable/Worsening/Improving/No Prior Films

Most Recent PPD: ____/____/____ Reaction:_____mm Last Prior PPD:____/____/____ Reaction:_____mm

BACTERIOLOGY UPDATE:

Date	Source	AFB Smear Results	AFB Culture Results	Laboratory

CURRENT MEDICATION REGIME:

Medication	Dosage/ Frequency	Date Started	Anticipated Treatment Length	Number of Doses	
				Prescribed	Dispensed
INH					
RIF					
PZA					
EMB					

REASON FOR REFERRAL/NOTES:_____

_____

_____

Next Appointment Date:_____/_____/_____ Physician Name/Phone #:_____

Person Completing Form:_____ Fax Number:_____

Today's Date: _____/_____/_____

ORIGINAL TO LOCAL TB CONTROL OFFICER

COPY TO HEALTH NET'S PUBLIC HEALTH COORDINATOR

Directory Removal for At-Risk Providers Form

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), if one of the below conditions is met, Health Net will omit a provider, provider group or category of providers similarly situated from the Health Net directory.

If any of the below applies to you, please initial next to the condition that has been met in order to be omitted from the directory, and sign and date the statement at the bottom. **Please complete and submit this form via secure fax, or scan and email to following:**

Fax number	Email address
1-866-524-1286	faxback.projects@healthnet.com

_____The provider is currently enrolled in the Safe at Home program (www.sos.ca.gov/registries/safe-home).

_____The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.

_____A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.

_____Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Group and/or provider name: _____

National Provider Identifier (NPI): _____

Address: _____

Telephone number: _____

I hereby confirm that the identified condition has been met and I should be omitted from the Health Net provider directory.

_____

Printed name (include title if signing on behalf of a provider group or other similarly situated provider).

_____

Signature Date

Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. and Centene Corporation. Health Net is a registered service mark of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.
18-042/FRM017591EW00 (1/18)

Directory Removal for At-Risk Providers Form

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), if one of the below conditions is met, Health Net will omit a provider, provider group or category of providers similarly situated from the CalViva Health directory.

If any of the below applies to you, please initial next to the condition that has been met in order to be omitted from the directory, and sign and date the statement at the bottom. **Please complete and submit this form via secure fax, or scan and email to following:**

Fax number	Email address
1-866-524-1286	faxback.projects@healthnet.com

_____The provider is currently enrolled in the Safe at Home program (www.sos.ca.gov/registries/safe-home).

_____The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.

_____A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.

_____Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Group and/or provider name: _____

National Provider Identifier (NPI): _____

Address: _____

Telephone number: _____

I hereby confirm that the identified condition has been met and I should be omitted from the CalViva Health provider directory.

Printed name (include title if signing on behalf of a provider group or other similarly situated provider).

_____

Signature Date

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties.
CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, Inc.and Centene Corporation. Health Net is a registered service mark of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.
18-043/FRM017957EW00 (1/18)

Directory Removal for At-Risk Providers Form

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), if one of the below conditions is met, Health Net will omit a provider, provider group or category of providers similarly situated from the Community Health Plan of Imperial Valley directory.

If any of the below applies to you, please initial next to the condition that has been met in order to be omitted from the directory, and sign and date the statement at the bottom. **Please complete and submit this form via secure fax, or scan and email to following:**

Fax number	Email address
866-524-1286	faxback.projects@healthnet.com

_____The provider is currently enrolled in the Safe at Home program (www.sos.ca.gov/registries/safe-home).

_____The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.

_____A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.

_____Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Group and/or provider name: _____

National Provider Identifier (NPI): _____

Address: _____

Phone number: _____

I hereby confirm that the identified condition has been met and I should be omitted from the Community Health Plan of Imperial Valley provider directory.

_____

Printed name (include title if signing on behalf of a provider group or other similarly situated provider).

_____

Signature Date

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ **Prime** ☐ **Subawardee** Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount,** *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

PCP:	Page 1 of 2
SECTION: Personnel	
POLICY AND PROCEDURE: Personnel Training: Domestic Violence Reporting	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Health care providers who provide medical services for a physical condition to a patient whom he or she knows or reasonably suspects of suffering from injuries resulting from a firearm or assaultive or abusive conduct, are required to make a report (Penal Code Section 11160 et. seq.).

PROCEDURE:

I. Reporting

A. Reports must be made both by telephone and in writing to a local law enforcement agency

1. A **telephone report** must be made **immediately** or as soon as practically possible
2. A **written report** is to be made **within two working days** of receiving the information using OCJP 920: Suspicious Injury Report Form (see attachment)
3. The report must include the following:
   - Name of the injured person, if known
   - The injured person's whereabouts
   - Character and extent of the person's injuries
   - The identity of the person who allegedly inflicted the injury
4. **Failure to make a mandated report is a misdemeanor, punishable by imprisonment in the county jail for up to six months, or a fine of up to $1,000, or both**
5. Check with the local law enforcement agency of where to report if the patient was injured in another county
6. <u>If the battered patient is a minor then the Child Abuse and Neglect Reporting Act applies. (see Child Abuse Reporting policy and procedure)</u>

II. Medical Record

A. The law (P.C. § 11161 [b]) recommends that the medical record include the following:
   - Any comments by the injured person regarding past domestic violence or regarding the name of any person suspected of inflicting the injury
   - A map of the injured person's body showing and identifying injuries and bruises
   - A copy of the reporting form

III. Important Considerations

A. Sensitivity and awareness
- Reassure patient he/she is not alone and does not deserve to be treated this way
- Be careful not to imply patient is to blame
- Patients may be scared of seeking care because they do not want police involvement
- Some patients may fear reporting for other reasons (i.e. immigration status)
- There are many barriers to leaving an abusive situation (i.e. threats from the batterer, fear of financial instability, failure of police and others to effectively intervene, hope the relationship can work, feel responsible for the battering, may be embarrassed, humiliated and degraded about the abuse)

B. Patient Safety
- Address directly the risk of retaliation by the batterer and discuss how the patient might protect her/himself from further abuse
- Discuss the patient's short-term option and plan, including whether the patient can safely return home
- Indicate on the reporting form any special concerns regarding how the report should be handled to maximize patient safety

C. Referral
- Provide patient with referrals to domestic violence services
- Assist the patient in calling a domestic crisis line if willing

D. Special Considerations
- Patients who plan to leave with their children (applies to children for whom the abusive partner is the biological or adoptive parent) should call on eof the shelter lines to learn how to file a "Good Cause Report" which can protect them from kidnapping charges

IV. Definitions

A. Assaultive or abusive conduct is defined to include a list of 24 criminal offenses, among which are murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape, abuse of spouse or cohabitant, sodomy, oral copulation and an attempt to commit any of these crimes

DRUG USE QUESTIONNAIRE (DAST-20)

	These questions refer to the past 12 months.	Circle Your Response	
1.	Have you ever used drugs other than those required for medical reasons?……	Yes	No
2.	Have you abused prescription drugs?…….	Yes	No
3.	Do you abuse more than one drug at a time?……..	Yes	No
4.	Can you get through the week without using drugs?……..	Yes	No
5.	Are you always able to stop using drugs when you want to?…….	Yes	No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?……...	Yes	No
7.	Do you feel bad or guilty about your drug use?…….	Yes	No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?…..	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?……	Yes	No
10.	Have you lost friends because of your use of drugs?…….	Yes	No
11.	Have you neglected your family because of your use of drugs?……	Yes	No
12.	Have you been in trouble at work because of drug abuse?…….	Yes	No
13.	Have you lost a job because of drug abuse?……...	Yes	No
14.	Have you gotten into fights when under the influence of drugs?……...	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?……	Yes	No
16.	Have you been arrested for possession of illegal drugs?……	Yes	No
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stop taking drug?……..	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?……...	Yes	No
19.	Have you gone to anyone for help for a drug problem?…….	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?……	Yes	No

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – State Health Programs	
Category	**Coding Edit**
Ankle-foot/knee-ankle-foot orthotics	Orthotic replacements are included in the reimbursement for orthotics
Automatic external defibrillators	External defibrillators are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*
Blood glucose monitoring	Glucose monitors/supplies are reimbursable for diabetics only and when reported with the appropriate modifier (KS or KX)
	Continuous noninvasive glucose monitors are considered experimental/investigational because the safety or efficacy of these devices have not been established by review of the available published literature
	A disposable glucose monitor is a non-covered item
	Only one home blood glucose monitor is reimbursable per 12-month period of time
	A laser skin piercing device or replacement cartridge is reimbursed at the rate for the spring powered lancet and/or lancet replacements
Breast prosthesis	A custom breast prosthesis is reimbursed at the rate of a prefabricated breast prosthesis
Canes and crutches	When an underarm, articulating, spring-assisted crutch is provided, it is reimbursed at the rate of an underarm crutch other than wood
	Only one crutch type is covered per date of service
Cervical traction devices	Cervical traction that is free-standing or attached to a headboard is reimbursed at the rate of overdoor cervical traction
	Free-standing cervical traction is eligible for reimbursement coverage when the requirements have been met and filed with the appropriate modifier.* Otherwise it is reimbursed at the rate for overdoor cervical traction
Commodes	An extra wide/heavy duty commode chair is reimbursable for a member who weighs 300 pounds or more, when reported with the appropriate modifier.* It is otherwise reimbursable at the rate for a regular commode if basic coverage criteria for a commode chair are met
	A commode chair with detachable arms is reimbursable when the clinical criteria are met and when it is reported with the appropriate modifier*
	A pail or pan for use with commode chair is included in the reimbursement for a commode chair
	A seat-lift mechanism is included in the reimbursement for a commode chair with a seat-lift mechanism
Diabetic shoes	Orthopedic shoes and accessories for members with diabetes are reimbursable when reported with codes specific to diabetic footwear
	An insert that is direct formed and molded to a member's foot without an external heat source is a non-covered item

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – State Health Programs	
Category	**Coding Edit**
	Only one pair of therapeutic shoes for members with diabetes is reimbursable per calendar year
	Therapeutic shoe inserts or modifications for members with diabetes are reimbursable up to six units per calendar year
	Diabetic shoe inserts or modifications reported with non-diabetic footwear are not eligible for reimbursement
Enteral nutrition	Enteral feeding supply kits are reimbursable once per day
	Additives for enteral formula are included in the reimbursement for enteral formulas
	Components of a more complete kit are included in the reimbursement for the kit
	Nasogastric tubes are reimbursable once a month
External infusion pumps	Supplies for maintaining a drug infusion catheter are not eligible for reimbursement in the same month as a drug infusion kit
	Components of a more complete kit are included in the reimbursement for the kit
	IV poles are included in the reimbursement of ambulatory infusion pumps
	Replacement batteries for an infusion pump are included in the monthly rental reimbursement of an infusion pump
Eye prosthesis	An eye prosthesis is eligible for replacement once the useful lifetime of the prosthesis is reached (typically five years)
Hospital headboards and accessories	Hospital bed rental is reimbursable once per month
	Hospital bed rails are included in the reimbursement for hospital beds with bed rails
	Hospital bed rails and mattresses are included in the reimbursement for hospital beds with bed rails and mattresses in their description
Lower limb prosthesis	A below-knee suction socket or suction suspension for an above-knee or knee disarticulation socket is not separately reimbursed with a knee suspension locking mechanism
	A custom fabricated socket insert is not eligible for reimbursement when reported with a replacement prosthesis or addition
	Lower extremity diagnostic test sockets are included in reimbursement for immediate prosthesis
	A maximum of two test (diagnostic) sockets for an individual prosthesis is considered for reimbursement.
	Special features for lower limb prosthesis (such as multiaxial ankle/foot, flexfoot system, high activity knee) is considered for reimbursement based on the member's functional level
	Special features/additions added at the time of provision of the preparatory prosthesis are not separately reimbursed
	Replacement prosthesis components are not reimbursable when reported with a prosthesis
Manual and power wheelchair accessories	Manual wheelchair accessories are appropriately reported when used with manual wheelchairs
	Power wheelchair accessories are appropriately reported when used with power wheelchairs

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – State Health Programs	
Category	**Coding Edit**
	The following power wheelchair accessories are non-covered items: power seat elevation system and power standing system
Modifiers	Prosthetics and orthotics that can be reported bilaterally require an RT (right) and/or LT (left) modifier
	Lower limb prostheses require a valid and appropriate functional modifier (K0-K4)
	A prosthesis is reimbursable when there is expectation that the amputee reaches or maintains a defined functional state within a reasonable time frame and when reported with the appropriate modifier
	Capped rental modifiers are restricted to usage with items listed as capped rental equipment by the Centers for Medicare and Medicaid Services (CMS)
	Items requiring an order prior to delivery (pressure reducing surfaces, power operated vehicles, seat lift mechanisms, or TENS units) are reimbursable when a written order is on file prior to delivery. In this case, report the code with modifier EY
	For DMEPOS providers, adhesive tape requires an appropriate modifier (AU, AV, AW or AX.). Adhesive tape is not reimbursable in an office setting
Nebulizers	Disposable large volume nebulizers are non-covered items
	Controlled inhalation medication delivery system is eligible for reimbursement when reported with the appropriate medication
	A pharmacy supply fee is reimbursable when reported with the appropriate medications
	A 90-day dispensing fee is reimbursable once per 90 days
	A 30-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 90-day pharmacy dispensing fee
	A 90-day pharmacy dispensing fee is not reimbursable when reported in the same time period as a 30-day pharmacy dispensing fee
	A 30-day pharmacy dispensing fee for inhalation medication(s) is reimbursable once per month
	Corrugated tubing for use with a large volume nebulizer is reimbursable once per two months
	An immersion heater for a nebulizer or durable bottle type nebulizer is reimbursable once per three years
	A non-disposable administration set used with a small volume nebulizer reimbursable once every six months
	The non-disposable administration set is reimbursable once every three months if used with a controlled dose inhalation delivery system
	A battery powered compressor is a non-covered item
	Atropine, administered by nebulizer, is reimbursable up to 558 units every three months
	Bitolterol, administered by nebulizer, is reimbursable up to 1302 units every three months
	Glycopyrrolate, administered by nebulizer, is reimbursable up to 225 units every three months
	Isoetharine HCL, administered by nebulizer, is reimbursable up to 2790 units every three months

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – State Health Programs	
Category	**Coding Edit**
	Metaproteranol sulfate, administered by nebulizer, is reimbursable up to 740 units every three months
	Terbutaline sulfate, administered by nebulizer, is reimbursable up to 558 units every three months
	Isoproterenol HCL, administered by nebulizer, is reimbursable up to 1350 units every three months
Non-contact normothermic wound warming devices	The non-contact wound warming device and accessories are not eligible for reimbursement as they are not considered safe nor effective
Orthopedic footwear	Orthopedic footwear and the associated inserts or modifications are eligible for reimbursement when the member meets coverage criteria and when submitted with the appropriate modifier*
	Custom-molded prosthetic shoes are not reimbursable when reported with partial foot prosthesis or other lower extremity prosthesis
Osteogenesis stimulators	Only one type of osteogenesis (bone) stimulator is reimbursable for covered fractures
Ostomy supplies	Components of a more complete kit are included in the reimbursement for the kit
	Options and accessories that are part of a more complete ostomy product are included in the reimbursement for the ostomy appliance
Oxygen and oxygen equipment	Only one oxygen stationary system rental is reimbursable per month for those who qualify for coverage
	Portable oxygen rental is reimbursable once per month
	Frequently serviced items, such as oxygen systems, are reimbursable as a rental only
	Accessories and supplies that are used to administer oxygen are included in the monthly oxygen rental reimbursement
	Oxygen contents reimbursement is included in the reimbursement for monthly rental of a stationary oxygen system
	Oxygen modifiers QE, QF and QG are recognized only when submitted with stationary oxygen rentals
	Oximeters and replacement probes are not covered because they do not meet the definition of DME
	Oxygen is included in monthly oxygen system rental
Parenteral nutrition	Parental nutrition administration pumps are reimbursable once per month
	Homemix nutrient and component solutions are included in the reimbursement for the complete premix solution
	Parenteral nutrients solution is reimbursable at one unit per day
	One supply kit and one administration kit are reimbursable for each day that parenteral nutrition is administered
	Use of an IV pole and parenteral nutrition pump in an outpatient setting is included in the reimbursement for the underlying nutrition service

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – State Health Programs	
Category	**Coding Edit**
Patient lifts	An electric patient lift with seat and a multi-positional patient support system with integrated lift are non-covered items
	Patient lifts for the toilet and patient lifts that are free moving or fixed are non-covered items
	A sling is included in the reimbursement for a patient lift
Pneumatic compression devices	A segmental pneumatic appliance is eligible for reimbursement when reported with a segmental pneumatic compressor
	A non-segmental pneumatic compression appliance or segmental gradient pressure pneumatic appliance is eligible for reimbursement when reported with a non-segmental pneumatic compressor
	Only one type of pneumatic compressor (lymphedema pump) is eligible for reimbursement in the same month
Pressure reducing support surfaces	Alternating pressure pad and pressure pad alternating pump replacement are included in the reimbursement for an alternating pressure pad with pump
Prosthetic repair and replacement	Labor is included in the reimbursement for the replacement prosthesis and components
	Labor for prosthetic repair is included in the reimbursement for the prosthesis when it is reported within 90 days of a prosthesis
Rentals	Rental durable medical equipment (DME) is considered for reimbursement once per month
	Maintenance and servicing, as identified by modifier MS, is eligible for reimbursement after seven months has elapsed since the last rental payment and only at a frequency of once every six months
Repair	Repair of DME is included in the initial provision of DME
Replacement	DME is eligible for replacement after its useful lifetime has been reached (typically a period of 5 years)
Transcutaneous electrical nerver stimulations (TENS)	The TENS supply allowance includes electrodes, conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries, and a battery charger in the monthly supply fee
Urological supplies	Urinary catheter insertion trays are considered for reimbursement at the frequency of two per calendar month. An additional two foley catheters are considered for reimbursement in the same month
	Bedside drainage bags for catheter maintenance are considered for reimbursement up to 6 units in a 3 month period
	Adhesive tape used with ostomy or urological supplies are eligible for reimbursement up to 40 units per month
	A percutaneous catheter anchoring device when reported with an indwelling urethral catheter is reimbursable at the rate of an adhesive catheter anchoring device
	Sterile intermittent catheters are reimbursable up to 600 times within 90 days
Walkers	When an enclosed walker with rear seat is provided it is reimbursed at the rate of a standard walker

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies – State Health Programs	
Category	**Coding Edit**
	Walker wheel attachments reported within the same month as a nonwhelled walker are not eligible for reimbursement
Wheelchair options and accessories	Options and accessories that are part of a wheelchair or wheelchair option are included in the reimbursement for the wheelchair or wheelchair option

*Use modifier KX when the coverage criteria as defined by the Durable Medical Equipment Regional Administrative Contractor (DME RAC) has been documented in the medical record.

All claims submissions remain subject to Health Net's prior authorization requirements.

Health Net does not require documentation at the time of claim submission. In the event the claim is audited, documentation may be required.

Supporting Sources:

- DME MAC
- HCPCS Level II
- Medicare National Coverage Determinations Manual (NCD)

Perinatal Services BC
An agency of the Provincial Health Services Authority

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark "X" in the box next to the answer which comes closest to how you have felt in the **past 7 days**–not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - 0 ☐ As much as I always could
   - 1 ☐ Not quite so much now
   - 2 ☐ Definitely not so much now
   - 3 ☐ Not at all

2. I have looked forward with enjoyment to things
   - 0 ☐ As much as I ever did
   - 1 ☐ Rather less than I used to
   - 2 ☐ Definitely less than I used to
   - 3 ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, some of the time
   - 1 ☐ Not very often
   - 0 ☐ No, never

4. I have been anxious or worried for no good reason
   - 0 ☐ No, not at all
   - 1 ☐ Hardly ever
   - 2 ☐ Yes, sometimes
   - 3 ☐ Yes, very often

5. I have felt scared or panicky for no very good reason
   - 3 ☐ Yes, quite a lot
   - 2 ☐ Yes, sometimes
   - 1 ☐ No, not much
   - 0 ☐ No, not at all

6. Things have been getting on top of me
   - 3 ☐ Yes, most of the time I haven't been able to cope
   - 2 ☐ Yes, sometimes I haven't been coping as well as usual
   - 1 ☐ No, most of the time I have coped quite well
   - 0 ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, sometimes
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

8. I have felt sad or miserable
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

9. I have been so unhappy that I have been crying
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Only occasionally
   - 0 ☐ No, never

10. The thought of harming myself has occurred to me
    - 3 ☐ Yes, quite often
    - 2 ☐ Sometimes
    - 1 ☐ Hardly ever
    - 0 ☐ Never

Total Score ☐

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.

The Royal College of Psychiatrists 1987. From Cox, JL, Holden, JM, Sagovsky, R (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry. 150, 782–786. Reprinted with permission.

HEALTH NET Q/CARE SYSTEM

Eligibility Specifications - 277 EZ-CAP

ITEM	TYPE	POSITION	NAME	DEFINITION
1	X (01)	01-01	Transaction Code	For full files, Transaction Code will be A (Add). For incremental update files: Transaction Code will be A (Add) if the member was added since last run/file. Transaction Code will be C (Change) for changes to member data since last run/file.
2	X(08)	02-09	File Create Date	Date file was created (CCYYMMDD)
3	X(11)	10-20	Member ID	Health Net member ID number
4	X(02)	21-22	County Code	Member county code: 10=Fresno; 19=Los Angeles; 33=Riverside; 34=Sacramento; 36=San Bernardino; 37=San Diego; 54=Tulare
5	X(02)	23-24	Aid Code	Member's current Medi-Cal aid category code
6	**X(09)**	**25-33**	**CIN Number**	**Client Index Number assigned by DHS**
7	X(02)	34-35	Relationship to Subscriber	Code defining member's relationship to subsriber, Medi-Cal always 01
8	X(30)	36-65	Last Name	Member's last name
9	X(15)	66-80	First Name	Member's first name
10	X(01)	81-81	Middle Initial	Member's middle initial
11	X(01)	82-82	Gender	Member's gender (M=male; F=female)
12	X(30)	83-112	Street Address	Member's street address
13	X(20)	113-132	City	Member's city
14	X(02)	133-134	State	Member's state
15	X(10)	135-144	Zip	Member's ZIP code (five or nine digit ZIP code)
16	X(10)	145-154	Home Phone	Home phone number including area code (no dashes, hyphen, or parentheses)
17	X(08)	155-162	Full Birth Date	Member's birth date (CCYYMMDD)
18	X(01)	163-163	Contract Type	Always "3"
19	X(01)	164-164	Other Coverage	´Y` if member has other insurance coverage, ´N` if member has no other insurance
20	X(01)	165-165	Other Coverage Primary/Secondary	P=Primary if member's other insurance coverage is primary; S=Secondary if member's other insurance coverage is secondary; Blank if member has no other insurance coverage
21	X(30)	166-195	Other Coverage Name	Name of other insurance carrier if member has other insurance coverage
22	**X(02)**	**196-197**	**Health Plan Code**	**Always "HN"**
23	X(02)	198-199	CCS Code	California Children Services Code: CA=CCS Elig Active; CC=CCS Elig Closed; CD=CCS Elig Denied; CM=Case Mgmt; CP=CCS Elig Pended; CR=CCS Elig Conflict Resolution; NA=CCS Newborn Elig Active; NC=CCS Newborn Elig Closed; ND=CCS Newborn Elig Denied; NP=CCS Newborn Elig Pending; NR=CCS Newborn Elig in Conflict Resolution

ITEM	TYPE	POSITION	NAME	DEFINITION
24	X(01)	200	Member Language Code	1=Spanish; 7=English; C=Chinese; D= Cambodian; E= Armenian; H= Hmong; N=Russian; V=Vietnamese
25	X(01)	201	Member Ethnicity Code	1=White; 2=Hispanic; 3=Black; 4=Other Asian or Pacific Islander; A= Amerasian (Asian Mother/American Father); C=Chinese; N=Asian Indian; T=Laotian; V=Vietnamese
26	X(08)	202-209	PCP Effective Date	For medical group/PPG, the PCP effective date is the begin date of the member's most current PCP affiliation for this medical group/PPG. For ancillary hospitals, the effective date is the most current ancillary affiliation date for this facility. Note: if there are breaks in eligibility periods where the member's eligibility ended and was restarted, with the same affiliations, the effective date is the most current eligibility begin date (CCYYMMDD)
27	**X(04)**	**210-213**	**Redetermination Date**	**Member's Medi-Cal redetermination date (YYMM)**
28	X(06)	214-219	Benefit Option Code	Member's Health Net Benefit Option Code. Note: if the member is termed, the Benefit Option Code reported if from when they ended with the PCP/PPG. If the member is active, it is the current Benefit Option Code.
29	X(08)	220-227	Member Effective Date	The begin date associated with the member's medical group/PPG/facility affiliation. Note: if there are instances where the member's eligibility was ended and restarted with the same affiliation, then the effective date is the most current eligibility begin date. (CCYYMMDD)
30	X(08)	228-235	Member Termination Date	The end date associated with the member's medical group/PPG/facility affiliation. Note: if the member is no longer eligible with Health Net, this will have the member's eligibility termination date. If the member is currently eligible with Health Net and affiliated with the PPG/facility, this field will be blank. (CCYYMMDD)
31	X(03)	236-238	PCP Address Number	PCP's address number where the member is assigned to receive services
32	X(01)	239	Filler	Blank
33	X(07)	240-246	Provider/Facility License	Physician or facility license number
34	X(01)	247	Member Enrollment Status Code	Current enrollment status: E = Eligible; T = Terminated; P = Pending (for pending members, contact Health Net to obtain latest status)
35	X(30)	248-277	Provider Name	For medical group/PPG, the provider name is the PCP. Format is last name, comma, first name, middle initial. For ancillary hospitals, the provider name is the facility name.

Eligibility Listing: Staff Model Roster

MOLINA STAFF MODEL
ONE GOLDEN SHORE AVE LONG BEACH, CA 90802

Program: Los Angeles – Mainstream

PCP: DIAZ, JOSE, MD **Site: 3535 NICE PACOIMA 91111**

Member	SSN	Meds ID	Gender	Date of Birth	Enroll Effective	PCP Effective	County/ Project Code	Member Address	Member Change or Drop Reason	120 Days (each * is 30 days)
>> The following is an alphabetical listing of members for the PCP:										
DOE, JOHN	333112222	19341478529632	M	9/03/1991	08/01/1998	03/01/1999	19/352	222 FILMORE ST. PACOIMA CA 99999		

ER: Indicates a member with an Enrollment Restriction

Provider Reporting

Data File Record Layouts

COMMERICAL (ACE)

File Name: ELIGIBILITY
Report Number: ACE_RPT_BRM_42

All records in this file are 512 bytes long. There are four record types: Header, Detail, COB, and the Trailer record. Data expressed in the "X" format is left justified and blank filled, data expressed in the "9" format is right-justified and zero filled.

Header Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"1" = Header record
Title	002-009	X(8)	"ELIG HDR"
Info Effective Date	010-017	X(8)	CCYYMMDD, effective date
Provider Type	018-018	X(1)	"M" = Medical Provider - "H" = Hospital Provider
Provider ID	019-022	X(4)	PPG, or Hospital Number
Provider Name	023-055	X(33)	PPG, or Hospital Name
Address	056-080	X(25)	PPG, or Hospital Address
City	081-097	X(17)	PPG, or Hospital City
State	098-099	X(2)	PPG, or Hospital State
Zip Code	100-108	X(9)	PPG, or Hospital Zip Code
Filler	109-512	X(404)	Blank Spaces (Not Used)

Detail Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"2" = Detail Record
Member's Last Name	002-018	X(17)	Member's Last Name
Member's First Name	019-028	X(10)	Member's First Name
Member's Middle Initial	029-029	X(1)	Member's Middle Initial
Person ID	030-038	X(9)	Person ID
Group ID	039-046	X(8)	Health Net Employer / Individual Group Number
Member Code	047-049	X(3)	A code that describes the member's sex and a member's relationship to the subscriber
Insight Indicator	050-050	X(1)	Y/N Member has Mental Health Benefits
Plan Code	051-054	X(4)	Medical Plan of the employer / individual group the member belongs to
Office Visit Co-pay	055-057	X(3)	Office Visit Co-pay
DME Benefit	058-060	X(3)	Durable Medical Equipment benefit Co-pay
ER Benefit	061-063	X(3)	Emergency Room Co-pay
COB ID	064-071	X(8)	Coordination of Benefits ID
Birth date	072-079	X(8)	CCYYMMDD, Member's birth date
Satellite Provider ID	080-083	X(4)	Used only for consolidated files. Displays site where member is enrolled
Physician ID	084-089	X(6)	If physician level report, Health Net assigned PCP number, otherwise will be PPG number
Provider Effective Date	090-097	X(8)	CCYYMMDD, the date member is effective with this medical group

Cancel Effective Date	098-105	X(8)	CCYYMMDD, the date member cancelled with this medical group
Product Code	106-109	X(4)	HMO=”HMO Medical”, SNN=”Silver Network”, etc.
Fund Type	110-110	X(1)	Claims Funding Type – R=Regular, S=Self, F=Flex
Rx Indicator	111-111	X(1)	Pharmacy Benefit Indicator - Y/N
PR_TY	112-112	X(1)	PR_TY
Member Address_50	113-162	X(50)	Member's full Address
Member City	163-179	X(17)	Member's City
Member State	180-181	X(2)	Member's State
Member Zip Code	182-190	X(9)	Member's Zip Code
Member Phone Number	191-200	X(10)	Member's Home Phone Number
Member Reference ID	201-209	X(9)	Member Reference ID
Spoken Language	210-212	X(3)	Member Preferred Spoken Language (ISO code)
Written Language	213-215	X(3)	Member Preferred Written Language (ISO code)
Race	216-218	X(3)	Member Race
Ethnicity	219-221	X(3)	Member ethnicity
APTC flag	222-222	X(1)	APTC flag
DLQ flag	223-223	X(1)	Delinquency flag
Dlq month indicator	224-224	X(1)	Delinquency month indicator
Dlq start date	225-232	X(8)	Delinquency start date
Dlq end date	233-240	X(8)	Delinquency end date
Tribal flag	241-241	X(1)	Tribal flag
Aid category	242-244	X(3)	Aid category
Aid code	245-246	X(2)	Aid code
Project code	247-249	X(3)	Project code
CIN number	250-258	X(9)	(Medi-Cal) Client Identification Number
Medi-Cal case id	259-272	X(14)	Medi-Cal case id
Medicare stat A	273-273	X(1)	Medicare stat A
Medicare Stat B	274-274	X(1)	Medicare Stat B
Medicare stat D	275-275	X(1)	Medicare stat D
SPD/Dual flag	276-276	X(1)	SPD/Dual flag
CCS Flag	277-278	X(2)	CCS Flag
PCP Name	279-308	X(30)	Member’s PCP Name
Redetermination date	309-316	X(8)	Annual Redetermination date
Med provider id	317-321	X(5)	Member’s medical provider id
Full payment date	322-329	X(8)	Full payment date
PCP Site id	330-337	X(8)	PCP’s site id
HCP Code	338-339	X(2)	HCP Code
RC Indicator	340-340	X(1)	Regional Center Indicator Value “Y” or “N”
RC name	341-390	X(50)	Regional Center name
Alternate Format	391-393	X(03)	Alternate Format
Member Suffix	394-396	X(03)	Member Suffix
Assignment Type	397-398	X(02)	C – Choice, PT – Provider Transfer, DF – Default Family Choice, DP – Default Prior Choice, D – Default Value
Filler	399-400	X(02)	Blank Spaces (Not Used)
OHC Policy ID	401-415	X(15)	Policy ID for Other Health Coverage
Filler	416-416	X(1)	Blank Space
OHC Effective Date	417-424	X(8)	Effective Date of Other Health Coverage
Filler	425-425	X(1)	Blank Space
OHC Expiration Date	426-433	X(8)	Expiration Date of Other Health Coverage
Filler	434-434	X(1)	Blank Space
OHC Code Curr Month	435-435	X(1)	Other Health Coverage Code from 834 file A - Pay and chase (applies to any carrier) C - Military benefits comprehensive

			E - Vision plans F - Medicare Part C health plan G - Medical parolee H - Multiple plans comprehensive I - Institutionalized K - Kaiser N - No OHC P - Preferred Provider Organization/Prepaid Health Plan/Health Maintenance Organization/Exclusive Provider Organization or not otherwise specified V - Any carrier other than the above (includes multiple coverage) W - Multiple plans non-comprehensive
Filler	436-441	X(6)	OHC Code in effect for previous month
Original Effective Date	442-449	X(8)	Original effective date with the health plan (reserved for future use)
Filler	450-450	X(1)	Blank Space
Department code	451-456	X(6)	Department code
Filler	457-512	X(56)	Blank Space (not used)

COB Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"3" = COB Record
COB Carrier id	002-009	X(8)	Table COB carrier id
COB Carrier Name	010-039	X(30)	COB Carrier Name
OHC_Address_1	040-064	X(25)	OHC_Address_1
OHC_Address_2	065-089	X(25)	OHC_Address_2
OHC_City	090-106	X(17)	OHC_City
OHC_State	107-108	X(02)	OHC_State
OHC_ZIP_Code	109-119	X(11)	OHC_ZIP Code
OHC_Carrier Phone 1	120-134	X(15)	OHC_Carrier_Phone 1
OHC_Carrier Phone 2	135-149	X(15)	OHC_Carrier_Phone 2
OHC_Carrier Phone 3	150-164	X(15)	OHC_Carrier_Phone 3
OHC_Remark 1	165-214	X(50)	OHC_Remark 1
OHC_Remark 2	215-264	X(50)	OHC_Remark 2
Filler	265-512	X(248)	Blank Spaces (Not Used)

Trailer Record

Field Name	Position	Format	Description
Record Type	001-001	X(1)	"4" = Trailer Record
Title	002-009	X(8)	"ELIG SUM"
Total Members EOM	010-017	9(8)	Total Members as of month end
Total Members in Month	018-025	9(8)	Total members eligible at least one day of the month
Total member SPC	026-033	X(8)	Member SPC
Total member SP1	034-041	X(8)	Member SP1
Filler	042-512	X(471)	Blank Spaces (Not Used)

Emergency Earthquake Plan

STAY CALM AT THE FIRST SIGN OF AN EARTHQUAKE.

Instruct any patients and staff to duck and cover under a sturdy desk, table, or other furniture.

Hold onto it and be prepared to move with it.

Stay clear of windows.

Do not try to use stairs or elevators while the building is shaking or while there is danger of being hit by glass or falling debris.

Do not rush outside or crowd exits.

After the Earthquake, check for any employee or patient injuries.

A. If person is not breathing, open the airway. If still not breathing, begin rescue breathing.

B. If person is bleeding put pressure over the wound.

C. Do not attempt to move seriously inured persons unless they are in immediate danger of further injury.

Immediately clean up any spilled medicines, drugs, or other potentially harmful materials.

Office first aid kit is located _____

Flashlights are located (highly recommended) _____

Examine the area for fire hazards and call 911 if there is a fire hazard.

Outside meeting place is _____

Employee Alarm System:

Type of system (please circle or write in): verbal (if 10 employees or less), fire pull, alarm button or pull string in each room, code words, distinct sound/signal (silent alarm, paging system), panic button, and/or other_____.

APPROVED BY: Dr. _____ Date: _____

Emergency Fire Plan

STAY CALM AT THE SIGN OF FIRE, DIAL 911, and INITIATE THE EMPLOYEE ALARM SYSTEM.

To report a fire Dial 911 and spell the last name of the doctor as it is listed on the building. BE PREPARED TO GIVE OFFICE ADDRESS AND PCP/CLINIC NAME.

Fire Extinguishers are located _____.

(Name of) Employee_____is

to immediately assist all patients in leaving the building and have them wait outside.

The designated outside meeting place for employees is _____

_____.

All employees are to review the emergency exit plan which is posted and to initial the plan.

Employee Alarm System:

Type of system (please circle or write in): verbal (if 10 employees or less), fire pull, alarm button, or pull string in each room, code words, distinct sound/signal (silent alarm, paging system), and/or other_____.

APPROVED BY: Dr. _____ Date: _____

PCP:	Page 1 of 2
I. SECTION: Access/Safety	
POLICY AND PROCEDURE: Emergency Health Care Services	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Emergency health care services shall be available and accessible twenty-four hours a day, seven days a week.

PROCEDURE:

I. EMERGENCY MEDICAL EQUIPMENT

A. Minimum emergency medical supplies/equipment, sufficient to establish and maintain a patent/open airway and manage anaphylactic reactions, shall be maintained in the facility. The equipment will include:

1. An oxygen tank which is portable.
2. An oxygen delivery system which includes tubing and mask/cannula and Adjustable Flow Meter (Oxygen Tank should be at least ¾ full.
   - Providers may NOT use small oxygen tanks where the liter flow cannot be adjusted. There is no size requirement for the tank; however, it must reflect the content balance in increments of ¼, ½, or ¾ full and full. The oxygen should last long enough to handle an emergency until the arrival of the emergency medical response team.
   - Office staff will know how to turn on and regulation the oxygen flow.
3. Population-appropriate (infants/children/adults) ambu bag(s) and oral airway(s) **devices**.
4. Epinephrine 1:1000 (injectable), Benadryl 25 mg oral, or Benadryl 50 mg./ml (injectable).
5. Naloxone
6. Chewable aspirin 81 mg.
7. Nitroglycerin spray/ tablet,
8. Bronchodilator medication(solution for nebulizer or metered dose inhaler)
9. Appropriate sized ESIP needles/ syringes
10. Tuberculin syringes (safety syringes), alcohol wipes.
11. **Bulb syringe**
12. Emergency medication dosage chart (see attached).

B. The supplies/equipment will be located in an accessible location allowing for retrieval by all staff members without the use of assistive devices.

C. The supplies and equipment will be located together and checked for expiration and operating status at least monthly. Staff responsible for checking the equipment/supplies will document:

1. The date the supplies/equipment was checked, and
2. His/her initials verifying that equipment is in working order, the oxygen tank is full, the supplies are within expiration date and the medication dosage chart is present.

D. Replacing/restocking supplies:
1. An extra oxygen tank will be maintained onsite -OR- each time the oxygen is used, the remaining supply will be checked. If the tank is 3/4 or less full, the supplier will be called to replace the used tank with a full tank.
2. The month prior to the noted expiration date, the supplies/medication will be ordered to ensure delivery before the supplies actually expire.
3. The medication and supplies will be ordered/replaced immediately after use.

II. EMERGENCY SERVICES TRAINING

A. All staff members will be trained on the emergency medical protocol. Staff will be able to:
1. Describe facility-specific actions, and,
2. Locate written emergency procedures and information.

B. Training will be completed upon hire and annually thereafter.

C. Training will be documented.

III. EMERGENCY INFORMATION

A. Emergency phone number contacts will be posted at the reception desk and at the work station. Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City and local agencies (e.g., local poison control number).

B. The list should be dated and telephone numbers updated annually and as changes occur.

EXAMPLE - DOSAGE CHART

2019 Site Review DHCS Guidelines
Emergency Medication\Anaphylactic Reaction Management
Medication Administration Reference (e.g. Medication Dosage Chart)

Anaphylaxis Kit*	Adult	Pediatric	Infant
Epinephrine (Anaphylaxis) Anaphylaxis 1:1000 (injectable)	0.01mg/kg IM (up to maximum of 0.5mg)	0.01 mg/kg IM (up to maximum of 0.3mg)	0.01 mg/kg IM (up to maximum or 0.3mg)
(1) X 1 mL vial of injectable diphenhydramine (**Benadryl**) 50 mg/mL	10mg to 50mg IV/IM (NTE 400mg/day) *If IV route, IV push at a rate of ≤25mg/min	1 to 2 mg/kg/dose IV/IM (NTE 50mg/dose) *If IV route, IV push at a rate of ≤25mg/min	1 to 2 mg/kg/dose IV/IM (NTE 50mg/dose)
(2) X 1 tab of oral diphenhydramine (**Benadryl**) 25 mg (Oral)	Take 25mg to 50mg by mouth	Not preferred. Refer to parenteral route or oral solution	Not preferred. Refer to parenteral route or oral solution
Oxygen Delivery System – tank at least ¾ full	Can consider any oxygen delivery systems if appropriate	Nasal prongs or nasal catheters preferred; can consider face mask, bead box, or incubator for older children	Nasal prongs or nasal catheters preferred
Oxygen delivered 6-8 L/minute	6 to 8 L/minute	1 to 4 L/minute	1 to 2 L/minute
Other Emergency Medications	**Adult**	**Pediatric**	**Infant**
Naloxone (Narcan®)	**Nasal (Narcan)**: Spray 4mg (content of 1 nasal spray) in one nostril as a single dose; may repeat every 2-3 minutes in alternating nostrils **Auto-injector (Evzio)**: Inject 2mg (content of 1 auto-injector) IM as a single dose; may repeat every 2-3 minutes with another Evzio auto-injector **Solution injection**: Inject 0.4mg to 2mg IM as a single dose; may repeat every 2-3 minutes up to 10 mg	**Nasal (Narcan):** 4mg (content of 1 nasal spray) as a single does in one nostril; may repeat every 2-3 minutes in alternating nostrils **Auto-injector (Evzio)**: Inject 2mg (content of 1 auto-injector) IM as a single dose; may repeat every 2-3 minutes with another Evzio auto-injector **Solution injection** (age ≥5 years old or ≥20kg): 2mg/kg IM/SQ; may repeat every 2-3 minutes prn	**Nasal (Narcan)**: 4mg (content of 1 nasal spray) as a single does in one nostril; may repeat every 2-3 minutes in alternating nostrils **Auto-injector (Evzio):** Inject 2mg (content of 1 auto-injector) IM as a single dose; may repeat every 2-3 minutes with another Evzio auto-injector **Solution injection** (age <5 years old or ≤20kg): 0.1mg/kg IM/SQ; may repeat every 2-3 minutes prn
Chewable aspirin	Chew 160mg to 325mg nonenteric coated aspirin upon presentation or within 48 hours of stroke	Aspirin is not recommended for patients <18 years of age who are recovering from chickenpox or flu symptoms due to association with Reye syndrome	Aspirin is not recommended for patients <18 years of age who are recovering from chickenpox or flu symptoms due to association with Reye's syndrome
Nitroglycerin spray/tablet	**Tablet:** 0.3mg to 0.4mg sublingually every 5 minutes up to 3 doses **Spray:** Spray 0.4mg (1 spray) sublingually every 5 minutes up to 3 doses	Safety and effectiveness of oral nitroglycerin in pediatric patients have not been established	Safety and effectiveness of oral nitroglycerin in pediatric patients have not been established
Nebulizer or metered dose inhaler (albuterol)	**Nebulizer:** 2.5mg to 5mg every 20 minutes for 3 doses, then 2.5mg to 10mg every 1 to 4 hours prn **MDI** (90mcg/actuation): 4 to 8 inhalations every 20 minutes for up to 4 hours, then 1 to 4 hours prn	**Nebulizer:** 2.5mg to 5mg every 20 minutes for 3 doses, then 2.5mg to 10mg every 1 to 4 hours prn **MDI** (90mcg/actuation)**:** 2 to 10 inhalations every 20 minutes for 2 to 3 doses; if rapid response, can change to every 3 to 4 hours prn	**Nebulizer:** 2.5mg every 20 minutes for the 1st hour prn; if there is rapid response, can change to every 3 to 4 hours prn **MDI** (90mcg/actuation)**:** 2 to 6 inhalations every 20 minutes for 2 to 3 doses; if there is rapid response, can change to every 3 to 4 hours prn
Glucose	15gm (3-4 tablets) by mouth	10gm to 20gm (0.3gm/kg) by mouth	Not preferred. Parenteral route recommended (IV dextrose or IM glucagon)

7.30.19 Jenny Nguyen, PharmD, SFHP Pharmacy

SAMPLE

Emergency Protocol

IN THE EVENT OF A MEDICAL EMERGENCY:

_____ **is to call 911**

_____ **is to start CPR.**

_____ **is to bring the ER supplies to the patient.**

_____ **is to bring the Oxygen to the patient.**

_____ **is to attend to other patients.**

LOCATION OF EMERGENCY SUPPLIES: _____

_____

LOCATION OF OXYGEN (full tank, tubing & mask/cannula): _____

_____

Employee Alarm System:

Type of system (please circle or write in): verbal (if 10 employees or less), fire pull, alarm button or pull string in each room, code words, distinct sound/signal (silent alarm, paging system), panic button, and/or other_____.

APPROVED BY: Dr. _____ **Date:** _____

Vaccine Storage Emergency Response Worksheet

What to do in case of a power failure or other event that results in vaccine storage outside of the recommended temperature range

For more detailed guidance on emergency vaccine storage and handling, see CDC's *Vaccine Storage and Handling Toolkit* at www.cdc.gov/vaccines/hcp/storage-handling/index.html.

Follow these procedures:

1. Close the door tightly.
2. Ensure the vaccine is kept at appropriate temperatures. Make sure the refrigerator or freezer is plugged in and working properly, or move the vaccines into proper storage conditions as quickly as possible.
3. Do NOT discard the affected vaccines unless directed to by your state/local health department and/or the manufacturer(s). Label the vaccines "Do Not Use" so that the potentially compromised vaccines can be easily identified.
4. Notify the state/local health department or call the manufacturer (see manufacturers' phone numbers below).
5. Document the inventory of affected vaccines below and document the circumstances of the event and the actions taken on the *Vaccine Storage Troubleshooting Record* (see www.immunize.org/catg.d/p3041.pdf).

Vaccines Stored in Refrigerator

Vaccine	Manufacturer	Lot #	Expiration Date	# of Doses (i.e., *not* # of vials)	Funding Source Public (e.g., VFC), Private, Other

Vaccines Stored in Freezer

Vaccine	Manufacturer	Lot #	Expiration Date	# of Doses (i.e., *not* # of vials)	Funding Source Public (e.g., VFC), Private, Other

Important Contact Information:

Vaccine Manufacturers

AstraZeneca	(800) 236-9933	GSK	(877) 356-8368	Pfizer[3]	(800) 438-1985
Bavarian Nordic[1]	(844) 422-8274	MassBiologics	(617) 474-3220	Pfizer-BioNTech (COVID-19)	(877) 829-2619
CSL Seqirus	(855) 358-8966	Merck	(800) 672-6372	Sanofi U.S.	(800) 822-2463
Dynavax	(844) 375-4728	Moderna	(866) 663-3762	Valneva[4]	(301) 556-4500
Emergent BioSolutions[2]	(866) 300-7602	Novavax	(844) 668-2829		

Manufacturer for less commonly used vaccine:

1. Bavarian Nordic: Rabavert (rabies), Jynneos (smallpox and mpox), Vaxchora (cholera), Vivotif (typhoid)
2. Emergent BioSolutions: Biothrax (anthax), Cyfendus (anthrax)
3. Pfizer: Ticovac (tick-borne encephalitis)
4. Valneva: Ixiaro (Japanese encephalitis), Ixchiq (chikungunya virus)

Health Departments

Local Health Department phone _____ State Health Department phone _____

Adapted by Immunize.org, courtesy of the Michigan Department of Community Health

Emergency Supplies Inventory Checklist

- **Print name and sign name and initials.**
- **Document day of month and initials when equipment is verified to be in working order, medications are within expiration dates, oxygen tank is full and medication dosage chart is present.**

YEAR_____ Dr. Name_____

Supplies and Equipment	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**AU**	**SEP**	**OCT**	**NOV**	**DEC**
Document Day in columns under month												
Oxygen (At Least ¾ FULL)												
Population appropriate (Infant/Peds/Adult) Nasal Cannula/Face Mask/Bulb syringe/Oral Airways/Ambu bag												
Emergency Medications												
Epinephrine 1:1000 Naloxone Chewable Aspirin 81 mg Nitro Spray or tablet Bronchodilator medication(solution for nebulizer or metered dose inhaler) Glucose Benadryl 25mg oral or 50mg/ml IM inj												
Tb Syringes (safety syringes) Appropriate size safety needle/syringes												
Alcohol Wipes												
Dosage Chart												

Print Name_____Signature_____Initials_____

Print Name_____Signature_____Initials_____

Print Name_____Signature_____Initials_____

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	X	
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	X	
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	X	
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)		X
31238	Nasal/sinus endoscopy, surgical; with control of hemorrhage		X
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy		X
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection		X
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery		X
31253	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed		X
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)		X
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior		X
31256	Nasal/sinus endoscopy, surgical; with maxillary antrostomy		X
31257	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior), including sphenoidotomy		X
31259	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus		X
31267	Nasal/sinus endoscopy, surgical; with removal of tissue from maxillary sinus		X
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus		X
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy		X
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from sphenoid sinus		X
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region		X
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region		X
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression		X
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression		X
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression		X
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium, transnasal or via canine fossa		X
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium		X
31297	Nasal/sinus endoscopy, surgical; with dilation of spenoid sinus ostium		X
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal sphenoid sinus osia (such as balloon dilation)		X
31505	Laryngoscopy, indirect; diagnostic (separate procedure)	X	
31510	Laryngoscopy, indirect; with biopsy	X	
31511	Laryngoscopy, indirect; with removal of foreign body		X
31512	Laryngoscopy, indirect; with removal of lesion		X
31513	Laryngoscopy, indirect; with vocal cord injection		X
31515	Laryngoscopy, direct, with or without tracheoscopy; for aspiration		X
31520	Laryngoscopy, direct, with or without tracheoscopy; diagnostic, newborn	X	
31525	Laryngoscopy, direct, with or without tracheoscopy; diagnostic, except newborn	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
31526	Laryngoscopy, direct, with or without tracheoscopy; diagnostic, with operating microscope	X	
31527	Laryngoscopy, direct, with or without tracheoscopy; with insertion of obturator		X
31528	Laryngoscopy, direct, with or without tracheoscopy; with dilation, initial		X
31529	Laryngoscopy, direct, with or without tracheoscopy; with dilation, subsequent		X
31530	Laryngoscopy, direct, operative with foreign body removal		X
31531	Laryngoscopy, direct, operative with foreign body removal; with operating microscope		X
31535	Laryngoscopy, direct, operative, with biopsy		X
31536	Laryngoscopy, direct, operative, with biopsy; with operating microscope		X
31540	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis		X
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope		X
31545	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)		X
31546	Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with graft(s) (includes obtaining autograft)		X
31560	Laryngoscopy, direct, operative, with arythenoidectomy		X
31561	Laryngoscopy, direct, operative, with arythenoidectomy; with operating microscope		X
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic		X
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope		X
31572	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral		X
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral		X
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral		X
31575	Laryngoscopy, flexible fiberoptic; diagnostic	X	
31576	Laryngoscopy, flexible fiberoptic; with biopsy	X	
31577	Laryngoscopy, flexible fiberoptic; with removal of foreign body		X
31578	Laryngoscopy, flexible fiberoptic; with removal of lesion		X
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy		X
31615	Tracheobronchoscopy through established tracheostomy incision		X
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, diagnostic, with cell washing when performed (separate procedure)	X	
31623	Bronchoscopy, rigid or flexible, with brushing or protected brushings	X	
31624	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage	X	
31625	Bronchoscopy, rigid or flexible, with bronchial or endobronchial biopsy(s), single or multiple sites	X	
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, diagnostic, with placement of fiduciary markers, single or multiple		X
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, diagnostic, with computer assisted image guided navigation (List separately in addition to code for primary procedure)	X	
31628	Bronchoscopy, rigid or flexible with transbronchial lung biopsy(s) single lobe	X	
31629	Bronchoscopy, rigid or flexible, with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
31630	Bronchoscopy, rigid or flexible, with tracheal/ bronchial dilation or closed reduction of fracture		X
31631	Bronchoscopy, rigid or flexible with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)		X
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	X	
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	X	
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (for example fibrin glue), if performed procedure)		X
31635	Bronchoscopy, rigid or flexible, with removal of foreign body		X
31636	Bronchoscopy, rigid or flexible, with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus		X
31637	Bronchoscopy, rigid or flexible, each additional major bronchus stented (list separately in addition to code for primary procedure)		X
31638	Bronchoscopy, rigid or flexible, with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)		X
31640	Bronchoscopy, rigid or flexible, with excision of tumor		X
31641	Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (for example laser therapy, cryotherapy)		X
31643	Bronchoscopy, (rigid or flexible); with placement of catheter (s) for intracavitary radioelement application		X
31645	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of thracheobronchial tree, initial (for example, drainage of lung abscess)		X
31646	Bronchoscopy, (rigid or flexible); with therapeutic aspiration of tracheobronchial tree, subsequent		X
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe		X
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe		X
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)		X
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])		X
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	X	
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g.,	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
	aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures		
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (list separately in addition to code for primary procedure[s])	X	
32601	Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, without biopsy	X	
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy	X	
32606	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy	X	
32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (for example wedge, incisional), unilateral		X
32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (for example wedge, incisional), unilateral		X
32609	Thoracoscopy; with biopsy(ies) of pleura		X
32650	Thoracoscopy, surgical; with pleurodesis (for example, mechanical or chemical) any method		X
32651	Thoracoscopy, surgical; with partial pulmonary decortication		X
32652	Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis		X
32653	Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit		X
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage		X
32655	Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure		X
32656	Thoracoscopy, surgical; with parietal pleurectomy		X
32658	Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac		X
32659	Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage		X
32661	Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass		X
32662	Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass		X
32663	Thoracoscopy, surgical; with lobectomy, total or segmental		X
32664	Thoracoscopy, surgical; with thoracic sympathectomy		X
32665	Thoracoscopy, surgical; with esophagomyotomy (Heller type)		X
32666	Thoracoscopy, surgical; with therapeutic wedge resection (for example mass, nodule), initial unilateral		X
32667	Thoracoscopy, surgical; with therapeutic wedge resection (for example mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)		X
32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)		X
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)		X
32670	Thoracoscopy, surgical; with removal of 2 lobes (bilobectomy)		X
32671	Thoracoscopy, surgical; with removal of lung (pneumonectomy)		X
32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed		X
32673	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
32674	Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)		X
39401	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (e.g., lymphoma), when performed	X	
39402	Mediastinoscopy; with lymph node biopsy(ies) (e.g., lung cancer staging)	X	
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (for example Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed		X
43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	X	
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance		X
43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	X	
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)		X
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)		X
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire		X
43197	Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	X	
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple	X	
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	X	
43201	Esophagoscopy, flexible, transoral diagnostic, with directed submucosal injection(s), any substance		X
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	X	
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices		X
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices		X
43206	Esophagoscopy, flexible, transoral with optical endomicroscopy	X	
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed		X
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection		X
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)		X
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)		X
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)		X
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)		X
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesions(s) by hot biopsy forceps		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		X
43220	Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)		X
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilator(s) over guide wire		X
43227	Esophagoscopy, flexible, transoral; with control of bleeding any method		X
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination	X	
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	X	
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)		X
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
43236	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with directed submucosal injection(s), any substance		X
43237	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with endoscopic ultrasound examination limited to the esophagus	X	
43238	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)	X	
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	X	
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)		X
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter		X
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	X	
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices		X
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices		X
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (for example balloon, bougie)		X
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube		X
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)		X
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire		X
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps		X
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		X
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	X	
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (for example anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)		X
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection		X
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method		X
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease		X
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis	X	
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing (separate procedures)	X	
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	X	
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy		X
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)		X
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts		X
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method		X
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)		X
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	X	
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent		X
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)		X
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct		X
43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed		X
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed		X
43285	Removal of esophageal sphincter augmentation device		X
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon		X
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)		X
44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedures	X	
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	X	
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body		X
44364	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique		X
44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery		X
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X
44369	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique		X
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)		X
44372	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube		X
44373	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunosotomy tube		X
44376	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	X	
44377	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	X	
44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding, (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
44380	Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed(separate procedure)	X	
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation		X
44382	Ileoscopy, through stoma; with biopsy, single or multiple	X	
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre and post-dilation and guide wire passage, when performed)		X
44385	Endoscopic evaluation of small intestinal pouch (for example Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
44386	Endoscopic evaluation of small intestinal pouch (for example Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	X	
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
44389	Colonoscopy through stoma; with biopsy, single or multiple	X	
44390	Colonoscopy through stoma; with removal of foreign body(s)		X
44391	Colonoscopy through stoma; with control of bleeding, any method		X
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps		X
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		X
44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)		X
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)		X
44403	Colonoscopy through stoma; with endoscopic mucosal resection		X
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance		X
44405	Colonoscopy through stoma; with transendoscopic balloon dilation		X
44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	X	
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	X	
44408	Colonoscopy through stoma; with decompression (for pathologic distention) (for example volvulus, megacolon), including placement of decompression tube, when performed		X
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	X	
45303	Proctosigmoidoscopy, rigid; with dilation, (for example, balloon, guide wire, bougie)		X
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	X	
45307	Proctosigmoidoscopy, rigid; with removal of foreign body		X
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp or other lesion by hot biopsy forceps or bipolar cautery		X
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp or other lesion by snare technique		X
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps or other lesions by hot biopsy forceps, bipolar cautery or snare technique		X
45317	Proctosigmoidoscopy, rigid; with control of bleeding, (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
45320	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (for example, laser)		X
45321	Proctosigmoidoscopy, rigid; with decompression of volvulus		X
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)		X
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	X	
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)		X
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps		X
45334	Sigmoidoscopy, flexible; with control of bleeding, any method		X
45335	Sigmoidoscopy, flexible; with direct submucosal injection(s), any substance		X
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (for example volvulus, megacolon),including placement of decompression tube, when performed		X
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique		X
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation		X
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	X	
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	X	
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)		X
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)		X
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection		X
45350	Sigmoidoscopy, flexible; with band ligation(s) (for example hemorrhoids)		X
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
45379	Colonoscopy, flexible, with removal of foreign body(s)		X
45380	Colonoscopy, flexible, with biopsy, single or multiple	X	
45381	Colonoscopy, flexible, with directed submucosal injection(s), any substance		X
45382	Colonoscopy, flexible, with control of bleeding, any method		X
45384	Colonoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps		X
45385	Colonoscopy, flexible, with removal of tumor(s), polyp(s) or other lesion(s) by snare technique		X
45386	Colonoscopy, flexible, with transendoscopic balloon dilation		X
45388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)		X
45390	Colonoscopy, flexible; with endoscopic mucosal resection		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
45391	Colonoscopy, flexible, with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures.	X	
45392	Colonoscopy, flexible, with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures.	X	
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (for example volvulus, megacolon), including placement of decompression tube, when performed		X
45398	Colonoscopy, flexible; with band ligation(s) (for example hemorrhoids)		X
46600	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	X	
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (for example colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	X	
46604	Anoscopy; with dilation, (for example, balloon, guide wire, bougie)		X
46606	Anoscopy; with biopsy, single or multiple	X	
46607	Anoscopy; with high-resolution magnification (HRA) (for example colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	X	
46608	Anoscopy; with removal of foreign body		X
46610	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery		X
46611	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique		X
46612	Anoscopy; with removal of multiple tumors, polyps or other lesions by hot biopsy forceps, bipolar cautery or snare technique		X
46614	Anoscopy; with control of bleeding (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		X
46615	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique		X
47550	Biliary endoscopy, intraoperative (choledochoscopy) (list separately in addition to code for primary procedure)	X	
47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing (separate procedure)	X	
47553	Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple	X	
47554	Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi		X
47555	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent		X
47556	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent		X
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	X	
49321	Laparoscopy, surgical; with biopsy (single or multiple)	X	
49322	Laparoscopy, surgical; with aspiration of cavity or cyst (for example, ovarian cyst) (single or multiple)		X
49323	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity		X
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (for example fiducial markers, dosimeter),		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
	intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)		
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum		X
50551	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service		X
50553	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography; with ureteral catheterization, with or without dilation of ureter		X
50555	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography; with biopsy		X
50557	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
50562	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with resection of tumor		X
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service		X
50572	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter		X
50574	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with biopsy		X
50575	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)		X
50576	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, installation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
50945	Laparoscopy, surgical; ureterolithotomy		X
50947	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement		X
50948	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement		X
50949	Unlisted laparoscopy procedure, ureter		X
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service		X
50953	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter		X
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with biopsy		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
50970	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service		X
50972	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter		X
50974	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with biopsy	X	
50976	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy		X
50980	Ureteral endoscopy with ureterotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus		X
52000	Cystourethroscopy (separate procedure)	X	
52001	Cystourethroscopy with irrigation and evacuation of multiple obstructing clots		X
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service		X
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	X	
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation or duct radiology, exclusive of radiologic service		X
52204	Cystourethroscopy, with biopsy	X	
52250	Cystourethroscopy and radiotracer with or without biopsy or fulguration		X
52282	Cystourethroscopy, with insertion of urethral stent		X
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material		X
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus		X
52351	Cystourethroscopy with ureteroscopy and/or pyeloscopy; diagnostic	X	
52352	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)		X
52353	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)		X
52354	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of lesion		X
52355	Cystourethroscopy with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor		X
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (for example Gibbons or double-J type)		X
52400	Cystourethroscopy with incision, fulguration or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds		X
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts		X
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant		X

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure		X
54690	Laparoscopy, surgical; orchiectomy		X
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis		X
57452	Colposcopy of the cervix including upper/adjacent vagina	X	
57454	Colposcopy of the cervix including upper/adjacent vagina;with biopsy(s) of the cervix and endocervical curettage		X
57455	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix	X	
57456	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage		X
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix	X	
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix		X
58555	Hysteroscopy, diagnostic (separate procedure)		X
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C		X
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)		X
58560	Hysteroscopy, surgical; with division of resection of intrauterine septum (any method)		X
58561	Hysteroscopy, surgical; with removal of leiomyomata		X
58562	Hysteroscopy, surgical; with removal of impacted foreign body		X
58563	Hysteroscopy, surgical; with endometrial ablation (for example endometrial resection, electrosurgical ablation, thermoablation)		X
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants		X
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)		X
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)		X
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera or peritoneal surface by any method		X
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal		X
G0104	Colorectal cancer screening; flexible sigmoidoscopy	X	
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	X	
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	X	
S0601	Screening proctoscopy	X	
C7509	Bronchoscopy, rigid or flexible, diagnostic with cell washing(s) when performed, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed	X	
C7510	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage(s), with computer-assisted image-guided navigation, including fluoroscopic guidance when performed		X
C7511	Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed	X	
C7512	Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with transendoscopic endobronchial ultrasound (EBUS) during	X	

Endoscopy Matrix			
CPT Code	**Description of Endoscopy**	**Diagnostic**	**Therapeutic (Surgical)**
	bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance when performed		
C7541	Diagnostic endoscopic retrograde cholangiopancreatography (ERCP), including collection of specimen(s) by brushing or washing, when performed, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	X	
C7542	Endoscopic retrograde cholangiopancreatography (ERCP) with biopsy, single or multiple, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)	X	
C7543	Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy/papillotomy, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)		X
C7544	Endoscopic retrograde cholangiopancreatography (ERCP) with removal of calculi/debris from biliary/pancreatic duct(s), with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s)		X
C7550	Cystourethroscopy, with biopsy(ies) with adjunctive blue light cystoscopy with fluorescent imaging agent		X
C7554	Cystourethroscopy with adjunctive blue light cystoscopy with fluorescent imaging agent		X
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi		X
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus		X

EQUIPMENT CALIBRATION LOG

EQUIPMENT	DATE	MAINTENANCE BY:

EQUIPMENT TRANSFER LOG FOR STERILIZATION

Date transferred	Description of equipment	Signature of who received delivery

ESTABLISHED CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last | First | Middle

9. Gender ☐ Male ☐ Female	10. Date of birth (mm/dd/yyyy)	11. CCS/GHPP case number

12. Client index number (CIN)	13. Client's Medi-Cal number

Diagnosis

14.
Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10:_____

15. Service Authorization Request for *(Check one)*
☐ a. CCS/GHPP New SAR
☐ b. Authorization extension (If checked, enter authorization number:_____)

Requested Services

16.* **CPT-4/ HCPCS Code/NDC**	17. **Specific Description of Service/Procedure**	18. **From (mm/dd/yy)**	**To (mm/dd/yy)**	19. **Frequency/ Duration**	20. **Units**	21. **Quantity (Pharmacy Only)**

* A specific procedure code/NDC is required in column 16 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

22. Other documentation attached ☐ Yes	23. Enter facility name (where requested services will be performed, if other than office.)

Inpatient Hospital Services

24. Begin date	25. End date	26. Number of days	27. Extension begin date	28. Extension end date	29. Number of extension days

Additional Services Requested from Other Health Care Providers

30. Provider's name	Provider number	Telephone number ( )	Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

31. Provider's name	Provider number	Telephone number ( )	Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

32. Signature of physician/provider or authorized designee	33. Date

INSTRUCTIONS

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Gender: Check the appropriate box.
10. Date of birth: Enter the client's date of birth.
11. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
12. Client index number (CIN): Enter the client's CIN number. If not known, leave blank.
13. Client's Medi-Cal number: Enter the client's Medi-Cal number. If number is not known, leave blank.

Diagnosis

14. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

15. a. CCS/GHPP New SAR: Check if requesting a new authorization for an established CCS/GHPP client.
    b. Authorization extension: Check if requesting an extension of an authorized request. Please enter the authorization number on the line.
16. CPT-4/HCPCS code/NDC: Enter the requested CPT-4, HCPCS code, or NDC code. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
17. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
18. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
19. Frequency/duration: Enter the frequency or duration of the procedures/services being requested.
20. Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
21. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
22. Other documentation attached: Check this box if attaching additional documentation.
23. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

24. Begin date: Enter the date the requested inpatient stay will begin.
25. End date: Enter the date the requested inpatient stay will end.
26. Number of days: Enter the number of days for the requested inpatient stay.
27. Extension begin date: Enter the date the requested extension of authorized inpatient stay will begin.
28. Extension end date: Enter the date the requested extended stay will end.
29. Number of extension days: Enter number of days for the requested extension inpatient stay.

Additional Services Requested from Other Health Care Providers

30. and 31. Provider's name: Enter name of the provider you are referring services to.
    Provider number: Enter the provider's provider number.
    Telephone: Enter provider's telephone number.
    Contact person: Enter the name of the person who can be contacted regarding the request.
    Address: Enter address of the provider.
    Description of services: Enter description of referred services.
    Procedure code: Enter the procedure code for requested service other than ongoing physician services.
    Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
    Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
    Additional information: Include any written instructions/details here.

Signature

32. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
33. Date: Enter the date the request is signed.

Primary Care Provider- Site Review Standards

Purpose: The Facility Site Review Standards provide the instructions, rules, regulations, parameters, and indicators for conducting Facility Site Reviews using the Facility Site Review tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Scoring: Site reviews include on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet review criteria. Critical Elements have a weight of two (2) points each and non-Critical Elements have a weight of one (1) point on the site review tool. Compliance levels include:

1) Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Fail: 79% and below

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 170 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), physician (MD), or physician assistant (PA) is labeled "**RN/NP/CNM/LM/MD/PA".**

Directions: Score full point(s) if review item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for CAPs and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 170 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 170 points.
4) Divide the total points given by 170 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.

Step 2: Add points given for all six (6) sections.

Example: 31 (Access/Safety)
27 (Personnel)
25 (Office Management)
40 (Clinical Services)
13 (Preventive Services)
34 (Infection Control)
170 (POINTS GIVEN)

Step 3: Subtract "N/A" points from 170 total points possible.

170 (Total points possible)
- 5 (N/A points)
165 ("Adjusted" total points possible)

Step 4: Divide total points given by the "adjusted" points, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Points given}}{\text{"Adjusted" total}} \quad \text{or} \quad \frac{140}{165} = 0.8485 \times 100 = \mathbf{85\%}$$

Criteria	I. Access/Safety Standards
A. Site is accessible and useable by individuals with physical disabilities.	**Sites must have the following safety accommodations for physically disabled persons:** **<u>Americans with Disabilities Act (ADA) Regulations</u>:** • Site must meet city, county, and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. • All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992.[1] • Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs.[2] **I.A.1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.** **<u>Parking</u>:** • Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances. • Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place. • If the provider has no control over availability of accessible parking within lot or nearby street spaces for persons with disabilities, the provider must have a plan in place for making program services available to persons with physical disabilities. **I.A.2) Pedestrian ramps have a level landing at the top and bottom of the ramp.** **<u>Ramps</u>:** • A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. • Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Ramps must be a minimum of 36-inches wide. Some areas require wider ramps.

[1] Title 28, Code of Federal Regulations (CFR), section 35.151. The CFR is searchable at: https://www.ecfr.gov/search.
[2] 28 CFR section 36.402.

Criteria	I. Access/Safety Standards
	• All edges must be protected to keep anyone from slipping off. • All ramps shall have a level top and bottom landings that are 5 feet long. • Ramps must have handrails on both sides if length is longer than 6 feet. **I.A.3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.** **<u>Exit Doors</u>:** • All entrances and exterior and interior exit doors, regardless of the occupant load shall be made accessible to persons with disabilities. • Exam room and exit doorways have a minimum opening of 32 inches with the door open at 90 degrees that will allow for passage of wheelchairs. • Door hardware = operable with a single effort without requiring ability to grasp hardware. • Effort to operate doors = a maximum pressure of 5 pounds at interior doors. • Door hardware height = 30” – 44” above floor. • Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. • Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **I.A.4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.** **<u>Elevators</u>:** • If there is no elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **I.A.5) Clear floor space for wheelchair in waiting area and exam room.** **<u>Clear Floor Space</u>:** • Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. • A minimum clear space of 60-inch diameter or square area is needed to turn a wheelchair. **<u>Sanitary Facilities</u>:** **I.A.6) Wheelchair accessible restroom facilities.** • A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close.

Criteria	I. Access/Safety Standards
	• Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. • If wheelchair-accessible restrooms are not available within the office site, reasonable alternative accommodation are provided such as a wheelchair-accessible restroom located within the building. Other reasonable alternatives may include, but is not limited to, urinal, bedpan, or bedside commode in a private area. **IA.7) Wheelchair accessible handwashing facilities or reasonable alternative.** • Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. • If wheelchair-accessible handwashing facilities are not available within the office site, reasonable alternative accommodation are provided such as sanitizers and wheelchair-accessible restroom located within the building. **Note:** • A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible.[3] • Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible.[4] • Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. • Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. • Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site-specific alternatives to provide services.[5] • Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site.

[3] 28 CFR sections 35.149 – 35.150.
[4] Title 24, California Code of Regulations (CCR), sections 2-419, California Administrative Code, the State Building Code. CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[5] Title II-5.2000 of the ADA Technical Assistance Manual, available at: https://www.ada.gov/taman2.html.

Criteria	I. Access/Safety Standards
	Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
B. Site environment is maintained in a clean and sanitary condition.	**I.B.1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.** • The physical appearance of floors/carpets, walls, furniture, patient areas, and restrooms are clean and well maintained. **I.B.2) Restrooms are clean and contain appropriate sanitary supplies.** • Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. • Environmental safety includes the "housekeeping" or hygienic condition of the site. • Clean means unsoiled, neat, tidy, and uncluttered. • "Well maintained" means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	**<u>Ordinances</u>:** • Sites must meet city, county, and state fire safety and prevention ordinances. • Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **There is evidence staff has received safety training and/or has safety information available on the following:** **I.C.1) Fire safety and prevention.** **I.C.2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).** **<u>Emergency Action Plans</u>:** • Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. • Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information.[6]

[6] 29 CFR section 1910.38

Criteria	I. Access/Safety Standards
	I.C.3) Lighting is adequate in all areas to ensure safety. **Illumination:** Lighting is adequate in-patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. **I.C.4) (CE) Exit doors and aisles are unobstructed and egress (escape) accessible.** **Access Aisle:** • Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. • The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route but may be reduced to a minimum of 32 inches at a doorway. • Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other type of emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords (including taped cords) or other items are not placed on or across walkway areas. **I.C.5) Exit doors are clearly marked with "Exit" signs.** **Exits:** Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.[7] **I.C.6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.** **Evacuation Routes**: • Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.[8] **I.C.7) Electrical cords and outlets are in good working condition.** **Electrical Safety:** • Electrical cords are in good working condition with no exposed wires, frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling, or under doors or floor coverings.

[7] 29 CFR 1910.37
[8] 29 CFR 1910.33-39, 19 CCR 3.09 (a) (1) (B).

Criteria	I. Access/Safety Standards
	• Extension cords are not used as a substitute for permanent wiring. • All electrical outlets have an intact wall faceplate. • Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. **I.C.8) Fire Fighting Equipment in accessible location.** **Firefighting equipment:** **There is firefighting equipment that must be in accessible locations on site. At least one of the following types of fire safety equipment is on site:** • **Fire Extinguisher:** The employer shall provide portable fire extinguishers and shall mount, locate, and identify them so that they are readily accessible. Fire extinguishers are maintained in a fully charged and operable condition and kept in their designated places at all times except during use.[9] • Smoke Detector with intact batteries. • Automatic Sprinkler System With a 10-inch clearance between sprinkler heads and stored materials. **I.C.9) An employee alarm system.** **Employee Alarm System:** • Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them.[10] OSHA: For those employers with 10 or fewer employees in a workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system. **Note:** Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.

[9] 29 CFR 1910.157
[10] 29 CFR 1910.37

Criteria	I. Access/Safety Standards
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. **RN/NP/CNM/LM/MD/PA**	**I.D. 1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.** **Site Specific Emergency Procedures:** • Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). • There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. • When the physician or non-physician medical practitioner (NPMP) is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. • Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. **I.D.2) Emergency equipment is stored together in easily accessible location and is ready to be used.** **Emergency Medical Equipment:** During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: ○ Establish and maintain a patent/open airway. ○ Manage emergency medical conditions. Emergency equipment and medication, appropriate to patient population served, are available in an accessible location and ready for use. • An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. • For emergency “Crash” cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. • Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. https://www.aafp.org/afp/2007/0601/p1679.html

Criteria	I. Access/Safety Standards
	I.D. 3) Emergency phone number contacts are posted, updated annually and as changes occur. **<u>Emergency Phone Number list</u>:** Posted in an accessible and prominent location(s) and includes: ○ Local emergency response services (e.g., 911 for fire, police/sheriff, ambulance). ○ Emergency contacts (e.g., responsible managers, supervisors). ○ Appropriate State, County, City, and local agencies (e.g., local poison control number). The list should be dated, and telephone numbers updated annually and as changes occur. **Emergency medical equipment appropriate to practice/patient population is available on site:** **<u>I.D. 4) (CE) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag</u>:** Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment with various sizes of airway devices appropriate to patient population within the practice and examples of oxygen delivery systems include: ○ Wall oxygen delivery system ○ Portable oxygen tank ○ Portable oxygen concentrator (POC) All oxygen delivery systems must be able to be regulated up to 6 liters of oxygen per minute, maintained for a minimum of 15 minutes. This flow rate establishes a minimum total oxygen delivery capacity of 90 liters for these devices:[11] ○ Nasal cannula or mask ○ Bulb syringe ○ Ambu bag as appropriate to patient population served. Mask should be replaced when they no longer make a solid seal.

[11] See the Food and Drug Administration (FDA) guidelines for oxygen generators and oxygen equipment for emergency use, available at: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/review-guidelines-oxygen-generators-and-oxygen-equipment-emergency-use

	○ Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. ○ Oxygen tubing does not need be connected to oxygen tank, but must be kept in close proximity to tank. Oropharyngeal airways are no longer required. **I.D.5) (CE) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia:** Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing, and pulmonary edema. Per the American Academy of Family Practice (AAFP), the minimum equipment to manage emergency anaphylactic reaction, asthma exacerbation, chest pain, opioid overdose, and hypoglycemia, based on the patient population served, shall include: ○ Epinephrine 1mg/mL (injectable) ○ Diphenhydramine 25 mg (oral) or 50 mg/ml (injectable) ○ Naloxone[12] ○ Chewable aspirin 81 mg[13] ○ Nitroglycerin spray/tablet[14] ○ Bronchodilator medication (solution for nebulizer or metered dose inhaler) ○ Glucose (any type of glucose containing at least 15 grams) ○ Appropriate sizes of ESIP needles/syringes[15] and alcohol wipes • The typical adult strength to address cardiac emergencies is 325 mg (four doses of 81 mg chewable aspirin or one dose of 325 non-enteric coated aspirin). • If the site is seeing adults, the reviewer shall assess whether the appropriate number of chewable aspirin tablets of 81 mg is available (at least four tablets). **I.D.6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.** • There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). • Package inserts are not acceptable as dosage charts. • All emergency medications in the emergency kit/ crash cart must have dosage charts. Score should be either a **Yes or No only**

[12] In 2018, the U.S. Surgeon General issued an advisory emphasizing the importance of health care professionals having naloxone (an opioid antagonist) on hand and being trained in how to use it. The U.S. Surgeon General's advisory is available at: https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html. Also see the FDA's approval of Narcan to reverse opioid overdose: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/narcan-naloxone-nasal-spray-approved-reverse-opioid-overdose, and articles regarding overdose preparedness for ambulatory clinics, available at: https://www.aafp.org/fpm/2021/0100/p17.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5753997/.

[13] See the American Heart Association's article on Aspirin and Heart Disease, available at: https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/aspirin-and-heart-disease.

[14] Pediatric offices only serving patients under 18 years old are not required to keep Nitroglycerin in their emergency kit. According to the FDA, "The safety and effectiveness of nitroglycerin in pediatric patients (under 18 years old) have not been established." Also see page 8 of an article on Nitrostat, available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021134s007lbl.pdf.

[15] If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control Standards.

Criteria	I. Access/Safety Standards
	I.D.7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly. Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s). **I.D.8) Replace/re-stock emergency medication, equipment, and supplies immediately after use.** A receipt or documentation showing medication is ordered is acceptable for any medication shortage. **Note:** An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy 2) serious impairment to bodily functions 3) serious dysfunction of any bodily organ or part "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.
E. Medical and lab equipment used for patient care is properly maintained. **RN/NP/CNM/LM/MD/PA**	**I.E.1) Medical equipment is clean.** **Medical and Laboratory Equipment:** All equipment used to measure or assess patient health status/condition is clean. **I.E.2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.** **Documentation:** • There is documented evidence that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. • Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

Criteria	I. Access/Safety Standards
	• All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment or is serviced annually by a qualified technician. • Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. **Note:** The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemocues, and audiometers.

Criteria	II. Personnel Standards		
A.1. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Certified Radiological Technologist (CRT)	CRT Certificate.	California Department of Public Health (CDPH), Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Midwife (LM)	Licensed Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate DEA Registration	Medical Board of CA DEA
	Physicians' Assistant/ Associate (PA)	PA License DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA DEA
	Radiological Technician	Limited Permit	CDPH, Radiologic Health Branch

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Standards</th></tr>
<tr><td rowspan="4"></td><td>Registered Dietitian (RD)</td><td>RD Registration Card</td><td>Commission on Dietetic Registration</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td colspan="3">II.A.1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.
<u>Note</u>: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</td></tr>
<tr><td rowspan="2">A.2. All required professional licenses and certifications, issued from the appropriate licensing/certification agency, are current.</td><td colspan="2"><u>Note</u>:
Effective June 27, 2010, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:[16]

NOTICE
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov.</td><td><u>Note</u>:
Effective August 11, 2011, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Board , and includes the following:[17]

NOTIFICATION TO CONSUMERS
Physician Assistants are licensed and regulated by the Physician Assistant Board
(916) 561-8780
www.pab.ca.gov</td></tr>
<tr><td colspan="3">II.A.2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Board.

The notice to consumers above shall be provided by one of the following methods:</td></tr>
</table>

[16] 16 CCR 1355.4, as mandated by Business and Professions Code (BPC) section 138.
[17] 16 CCR 1399.547, as mandated by BPC section 138.

Criteria	II. Personnel Standards
	○ Prominently posted sign that includes a QR code in an area visible to patients in at least 48-pt Arial font. ○ A written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Board). ○ A statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in at least 14-pt font.
B. Health care personnel are properly identified.	**II.B.1) Health care personnel wear identification badges/tags printed with name and title.** • Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. • It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. **Note:** • In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference themselves, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. • "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under Business and Professions Code (Sections 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the nametag requirement for the individual safety or therapeutic concerns.
C. Site personnel are qualified and trained for assigned responsibilities. **RN/NP/CNM/LM/MD/PA**	**Unlicensed Personnel:** Medical assistants (MAs) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon, or podiatrist in a medical office or clinic setting. • "Supervision" means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA.

Criteria	II. Personnel Standards
	• Per Business and Professions Code Section 2069 (a) (1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at their discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. • The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site. **II.C.1) Documentation of education/training for non-licensed medical personnel is maintained on site.** • Training may be administered under a licensed physician; or under an RN, LVN, NP, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: • Diploma or certification from an accredited training program/school, or • Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. • For facilities that have pediatric patients (under 21 years old) obtain evidence of completed training (valid for 4 years) in: o Audiometric screening o Vision screening o Anthropometric measurements, including obtaining Body Mass Index (BMI) percentile o Dental screening and fluoride varnish application **• C.2) (CE) Only qualified/trained personnel retrieve, prepare or administer medications.** Medication administration by an MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. • **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.**

Criteria	II. Personnel Standards
	• Unlicensed staff (e.g. MAs) have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. • To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. **Note:** • **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** [18] • MAs may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. • The supervising physician must specifically authorize all medications administered by an MA. "Authorization" means a specific written or standing order prepared by the supervising physician. **II.C.3) Site has a procedure in place for confirming correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration.** • To help reduce the risk of medication errors, staff shall follow procedures for confirming the correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration. **II.C.4) Only qualified/trained personnel operate medical equipment.** **Medical Equipment:** • Provider and/or staff can demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment but at any given time, a staff must be prepared to operate equipment that is not routinely needed by every patient such as patient lifts and accessible scales. Health care personnel at the site must demonstrate that they can turn on the oxygen tank and tell when an oxygen tank needs to be replaced and/or refilled.

[18] 16 CCR 1366.3(a) (1), also see information from the Medical Board of California on Medical Assistants, available at: https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/Medical-Assistants.aspx. https://www.mbc.ca.gov/FAQs/?cat=Licensees&topic=Medical%20Assistants

Criteria	II. Personnel Standards
	• For facilities that see pediatric patients (under 21 years old), the facility staff responsible for conducting hands on preventive screening, specifically: audiometric screening, vision screening, anthropometric measurements, including obtaining Body Mass Index (BMI) percentile, dental screening and fluoride varnish application, must demonstrate competency and appropriate application of these screenings/services. o Reviewers may interview site personnel regarding the appropriate use of equipment and/or request demonstrated use of equipment, as appropriate. o Reviewers may utilize CHDP Health Assessment Guidelines for ▪ Audiometric screening ▪ Vision screening ▪ Anthropometric measurements, including obtaining Body Mass Index (BMI) percentile ▪ Dental screening and fluoride varnish application ▪ https://www.dhcs.ca.gov/services/chdp/Pages/HAG.aspx **Note:** • Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. • Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on site. • Family members and personal care assistants, whether paid or unpaid, are not "unlicensed personnel" or otherwise captured within the scope of this tool.
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. **RN/NP/CNM/LM/MD/PA**	**II.D.1) Standardized Procedures provided for NPs and/or CNMs.** • The scope of practice for NPs and CNMs is clearly defined including the delegation of the supervision of MAs when supervising physician is off premises. • Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Practice Agreement and Supervision Physician's Responsibility documentation are present on site. • Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice.

Criteria	II. Personnel Standards
	NPs: • NPs are prepared through education and experience to provide primary care and to perform advanced procedures. • The extent of required supervision must be specified in the Standardized Procedures. • Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. • Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. **CNM:** • The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. • The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges. **Note:** CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. **II.D.2) A Practice Agreement defines the scope of services provided by PAs and Supervisory Guidelines define the method of supervision by the Supervising Physician.** **PA:** • Practice Agreement: a) Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. b) The delegation of the supervision of MAs when supervising physician is off premises. c) An original or copy must be readily accessible at all practice sites in which the PA works.

Criteria	II. Personnel Standards
	d) Failure to maintain a Practice Agreement is a violation of the PA Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. • Supervising Physician's Responsibility for Supervision of PAs' Practice Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: o Emergency transport of patients and back-up procedures (e.g., can call 911, name of hospital to transport patient included in Practice Agreement) for when the supervising physician is not on the premises. **<u>Note</u>:** • A Delegation of Services Agreement (DSA) in effect prior to January 1, 2020, shall be updated to meet the current requirements.[19] • DSAs that still reflect components that are no longer required by BPC section 3502.3 should be enforced since the DSA is the currently established agreement between the PA and the supervising physician. • The reviewer should assess the site's process for compliance with the DSA. • Any deficiency shall result in a CAP requesting the site to adhere to the DSA components or establish a new Practice Agreement. **II.D.3) Standardized Procedures, Practice Agreements, and Supervisory Guidelines are revised, updated, and signed by the supervising physician and NPMP when changes in scope of services occur.** • Standardized Procedures, Practice Agreements shall undergo periodic review, with signed, dated revisions completed at each change in scope of work by supervising physician. • Frequency of the review to identify changes in scope of service shall be specified in writing. **II.D.4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.** **DEA:**

[19] BPC 3502.3

Criteria	II. Personnel Standards
	Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number.

E. Non-physician medical practitioners (NPMP) are supervised according to established standards. **RN/NP/CNM/LM/MD/PA**	**The designated supervising physician(s) on site:**
	
	II.E.1) Ratio to number of NPMPs does not exceed established ratios in any combination.
	NPMPs:
	• The supervising physician holds ultimate responsibility for the practice of each supervised NPMP.
	• The maximum number of NPMPs who may be supervised by a single primary care physician (PCP) is limited to the following at any given time/shift in any of their locations:[20]
	  ○ 4 NPs with furnishing license (there is no limit to the number of NPs the physician may supervise if the NP does not hold a furnishing license);
	  ○ 4 CNMs; and
	  ○ 4 PAs.
	
	This ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within these stated limits.
	
	Physician Assistant Board (PAB) is at https://www.pab.ca.gov/ or the PAB office at 916-561-8780.
	
	II.E.2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.
	Supervising Physician:
	• "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA.
	• Supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.

[20] BPC 3516(b), Welfare and Institutions Code (WIC) section 14132.966

Criteria	II. Personnel Standards
	II.E.3) Evidence of NPMP supervision. **<u>Evidence of NPMP Supervision:</u>** • Standardized Procedures for NP or CNM should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.[21] • Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work. • Evidence of supervision of NPMP(s) are verifiable through on-site observation of supervisory processes, documentation, or supervisor/NPMP's knowledge of the process.
F. Site personnel receive safety training. **RN/NP/CNM/LM/MD/PA**	**II.F. There is evidence that site staff has received training on the following:** **1) Infection Control/Universal Precautions (annually)** **2) Bloodborne Pathogens Exposure Prevention (annually)** **3) Biohazardous Waste Handling (annually)** Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***<u>at least annually</u>***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: o Universal/standard precautions o Use of personal protective equipment o Accessible copy of Bloodborne Pathogens Standard o Work practice controls/exposure prevention o Modes of transmitting bloodborne pathogens o Epidemiology/symptoms of HBV and HIV o Recognition of activities with exposure element o Handling and labeling of biohazardous waste(s) o Hepatitis B vaccination protocol and requirements o Explanation of emergency procedures o Post exposure reporting/evaluation/follow-up procedures o Decontamination of equipment/work areas o Site's written bloodborne pathogen exposure plan o Opportunity for discussion/questions

[21] BPC 2834

Criteria	II. Personnel Standards
	Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include: o Informal in-services o New staff orientation o External training courses o Educational curriculum o Participation lists, etc. Training documentation must contain: 1) Employee's name 2) Job titles 3) Training date(s) 4) Type of training 5) Contents of training session 6) Names/qualifications of trainers Records must be kept for three (3) years. **Note:** Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or OPIM receive training as required by the Bloodborne Pathogens Standard.[22]
G. Site personnel receive training on member rights. **RN/NP/CNM/LM/MD/PA**	**II.G. There is evidence that site staff has received information and/or training on the following:** **II.G.1) Patient Confidentiality** • Site personnel have received information and/or training about patient confidentiality and must be prepared to provide information on how patient confidentiality is protected at the site.

[22] 8 CCR 5193

Criteria	II. Personnel Standards
	• Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written patient confidentiality information on site and explain how to use information. **II.G.2) Informed Consent, including Human Sterilization** • Site personnel have received information and/or training on informed consent, including human sterilization. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written informed consent, including human sterilization information on site and explain how to use information. **II.G.3) Prior Authorization Requests** • Site personnel have received information and/or training on prior authorization requests. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written prior authorization requests information on site and explain how to use information. **II.G.4) II.F.4) Grievance/Complaint Procedure** • Site personnel have received information and/or training on grievance/complaint procedure. Staff must be prepared to provide information to patient when requested. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written grievance/complaint procedures information on site and explain how to use information. **II.G.5) Child/Elder/Domestic Violence Abuse**

Criteria	II. Personnel Standards
	Abuse Reporting: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** • Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. • Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspected" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). • Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment, which makes him/her a mandated reporter, must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision.[23] **II.G.6) Sensitive Services/Minors' Rights** • Site personnel have received information and/or training on sensitive services/minors' rights. Sensitive Services include family planning, pregnancy, sexually transmitted infections, etc. • PCP sites must have basic information on sensitive services that are appropriate to their practice office and be prepared to provide information to patients when needed. • Minor's Rights: California Family Code provides that a minor may, without parental consent, receive a number of sensitive services including outpatient mental health treatment and counseling for children 12 years and older. **II.G.7) Health Plan Referral Process/Procedures/Resources**

[23] Penal Code section 11166.5

Criteria	II. Personnel Standards
	• Site personnel have received information and/or training on health plan referral process/procedures/resources. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written health plan referral process/procedures/resources information on site and explain how to use information. **II.G.8) Cultural and Linguistic Training** • Site personnel have received information and/or training on cultural and linguistic appropriate services. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written cultural and linguistic information on site and explain how to use information. Cultural and Linguistic Training- Culturally and Linguistically Appropriate Services (CLAS) mandates are Federal requirements for all recipients of Federal funds.[24] **II.G.9) Disability Rights and Provider Obligations** • Site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act • Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings. **https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf** **https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf** **https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf**

[24] See the National Standards on CLAS, available at: https://www.health.pa.gov/topics/Documents/Health%20Equity/CLAS%20Standards%20FactSheet.pdf.

Criteria	III. Office Management Standards
A. Physician coverage is available 24 hours a day, 7 days a week.	**III.A.1) Clinic office hours are posted or readily available upon request.** Current clinic office hours are posted within the office or readily available upon request. **III.A.2) Provider office hour schedules are available to staff.** **III.A.3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff and members after-hours.** Current site-specific resource information is available to site personnel and members about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. **III.A.4) Contact information for off-site physician(s) is available at all times during office hours.** When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **III.A.5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.** **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There are sufficient health care personnel to provide timely, appropriate health Care services. **RN/NP/CNM/LM/MD/PA**	**III.B.1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.** • In addition to the physician, only appropriately licensed medical personnel such as a CNM, LM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls.

Criteria	III. Office Management Standards
	• The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act does not permit the LVN to perform triage independently.[25] • The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. • The LVN may not perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. • Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician.[26] **Note:** Telephone triage is the system for managing telephone calls during ***and*** after office hours. **III.B.2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.** • Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls. **III.B.3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.** • Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.
C. Health care services are readily available. **RN/NP/CNM/LM/MD/PA**	**III.C.1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.** **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: o Urgent Care: 48 hours o Access to the first Prenatal Visit: 10 business days o Non-urgent (Routine) Care: 10 business days

[26] 16 CCR 1366(b)

Criteria	III. Office Management Standards
	III.C.2) Patients are notified of scheduled routine and/or preventive screening appointments. • The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care, and emergency care. • Systems, practices, and procedures used for making services readily available to patients will vary from site to site. **III.C.3) There is a process in place verifying follow-up on missed and canceled appointments.** • An organized system must be evident (in use) for scheduling appointments appropriately, notifying, and reminding members of scheduled appointments, and following up on missed or canceled appointments. • Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	**III.D.1) Interpreter services are made available in identified threshold languages specified for location of site.** • Sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. **III.D.2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.** • Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. • Reviewer should ask for a written policy which includes the languages spoken by bilingual providers and staff. **Note:** https://www.lep.gov; 22 CCR 51309.5 • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.

Criteria	III. Office Management Standards
	• Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member's circumstances. Minors, under 18 years old, accompanying members shall not be used as interpreters. • The Affordable Care Act of 2010, Section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record. Sign language interpreter services may be utilized for medically necessary health care services and related services such as: o Obtaining medical history and health assessments o Obtaining informed consents and permission for treatments o Medical procedures o Providing instructions regarding medications o Explaining diagnoses o Treatment and prognoses of an illness o Providing mental health assessment o Therapy or counseling
E. Procedures for timely referral/ consultative services are established on site. **RN/NP/CNM/LM/MD/PA**	**Office practice procedures allow timely provision and tracking of:** **III.E.1) Processing internal and external referrals, consultant reports, and diagnostic test results.** • An organized, timely referral system is evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. • Referral informational resources are readily available for use by site personnel. • Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end Systems, practices, and procedures used for handling referrals will vary from site-to-site.

Criteria	III. Office Management Standards
	III.E.2 (CE) Physician Review and follow-up of referral/consultation reports and diagnostic test results. • There is a documented process of the practitioner review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps. • Practitioner review is evidenced by date and signature/initials on the report of the reviewing practitioner.
F. Member grievance/ complaint processes are established on site.	**III.F.1) Phone number(s) for filing grievances/complaints are located on site.** • At least one telephone number for filing grievances is posted on site or is readily available upon request. **III.F.2) Complaint forms and a copy of the grievance procedure are available on site.** • Complaint forms and a copy of the grievance procedure are readily available on site and can be provided to members promptly upon request. • Includes The Department of Managed Health Care Help Center 1-888-466-2219 and Ombudsman 1-888-452-8609. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.
G. Medical records are available for the practitioner at each scheduled patient encounter.	**III.G.1) Medical records are readily retrievable for scheduled patient encounters.** • The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters.

Criteria	III. Office Management Standards
	III.G.2) Medical documents are filed in a timely manner to ensure availability for patient encounters. • Medical records are filed in a timely manner that allows for ease of accessibility within the facility or in an appropriate health record storage facility if stored off-premises.[27]
H. Confidentiality of personal medical information is protected according to State and federal guidelines. **RN/NP/CNM/LM/MD/PA**	**III.H.1) Exam rooms and dressing areas safeguard patients' right to privacy.** **Privacy:** • Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. • Practices are in place to safeguard patient privacy. • Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **III.H.2) Procedures are followed to maintain the confidentiality of personal patient information.** **Confidentiality:** • Personnel follows site policy/procedures for maintaining confidentiality of individual patient information. • Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas (this includes unattended electronic devices, patient registration sign-in sheets with more than one unique patient identifier). • There must be a confidentiality agreement between the provider and the cleaning service agency/persons if the medical records are kept in an open space and/or are unsecured. **Electronic Records:** • Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems.

[27] 22 CCR 75055

Criteria	III. Office Management Standards
	• Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. • Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **III.H. 3) Medical record release procedures are compliant with State and federal guidelines.** **Record Release:** • Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. • The release terms, such as to whom records are released and for what purposes, and the expiration date of the consent to medical record release should also be described. • This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.[28] **III.H.4) Storage and transmittal of medical records preserves confidentiality and security.** **Storage and transmittal:** • Health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall confidentially and securely keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. • FAX cover sheet shall have confidentiality statement. **III.H.5) Medical records are retained for a minimum of 10 years.** **Record Retention:** • Records required to be kept and maintained under this section (including minors under 18 years old) shall be retained by the provider for a period of 10 years from the final date of the contract

[28] 45 CFR 164.524

Criteria	III. Office Management Standards
	period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with 42 CFR 438.3(u).[29]

[29] WIC 14124.1

Criteria	IV. Clinical Services - Pharmaceutical Standards
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, disposition, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times.[30] The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access.[31] • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs.[32] **IV.A.2) Drugs, drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.** • All drugs (including sample and over the counter), medication supplies, hazardous substances and prescription pads are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic.[33] (CA B&P Code, 4051.3) • A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. (42 CFR 482.13-CMS Manual System; 42 CFR Part 482.25) • Keys to the locked storage area are available only to staff authorized by the physician to have access.[34] (16 CCR, Chapter 2, Division 3, Section 1356.32) • During business hours, the lockable space may remain unlocked ONLY if there is no access to

[30] BPC 4172
[31] 16 CCR 1356.3
[32] 22 CCR 75032 and 75033
[33] BPC 4051.3
[34] 16 CCR 1356.32

Criteria	IV. Clinical Services - Pharmaceutical Standards
	this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over the counter), medication supplies, prescription pads and hazardous substances must be securely locked. **IV.A.3) Controlled drugs are stored in a locked space accessible only to authorized personnel.** **<u>Controlled substances</u>**: • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel.[35] **IV.A.4) A dose-by-dose controlled substance distribution log is maintained.** • Written records are maintained of controlled substances inventory list(s) that includes: 1) Provider's DEA number 2) Name of medication 3) Original quantity of drug 4) Dose 5) Date 6) Name of patient receiving drug 7) Name of authorized person dispensing drug and 8) Number of remaining doses • Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. • Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.[36] **IV.A.5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.** • A list of drugs available for use in the clinic shall be maintained. Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives American Society of hospital

[35] 21 CFR 1301.75
[36] 21 CFR 1301.72

Criteria	IV. Clinical Services - Pharmaceutical Standards
	pharmacist (ASHP) Guidelines: Minimum Standard for pharmaceutical services in ambulatory care).[37] • Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs. **Note:** During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must ***always remain*** in the immediate area. At all other times, drugs, medication supplies, and hazardous substances must be securely locked. Controlled substances are ***always locked***.
B. Drugs are handled safely and stored appropriately. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan (CAP). **IV.B.1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.** **Drug Preparation:** Drugs shall be drawn up in a designated clean medication preparation area that is not adjacent to potential sources of contamination, including sinks or other water sources. The drug preparation area should be cleaned and disinfected on a regular basis. CDC guidelines for drug preparation and safety: https://www.cdc.gov/injectionsafety/providers/provider_faqs_med-prep.html **IV.B.2) Drugs for external use are stored separately from drugs for internal use.** **Storage:** • Drugs shall be separated by route of administration, especially ophthalmic and otic preparations. • Vaccines and other drugs should be stored separately from food, lab specimens, human specimens, cleaning supplies, and other items that may potentially cause contamination.

[37] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.

Criteria	IV. Clinical Services - Pharmaceutical Standards

	• The Center for Disease Control (CDC) recommends avoiding storing other medications and biological products such as lab specimens/human specimens in a vaccine storage unit.
	
	IV.B.3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.
	• Storing food, other medications, and biological products with vaccines put vaccines at risk for temperature fluctuation, excessive light exposure, administration errors, and contamination.
	  ○ If food, other medications and biological products must be stored in the same refrigerator with vaccines, they must be in the sealed containers and stored below vaccines on the different shelves.
	• Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected.[38]
	• Room temperature where drugs are stored does not exceed 30ºC (86ºF).[39]
	• A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions.[40]
	• A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth or rendered injurious to health.
	• Drugs that are unused are considered by the Environmental Protection Agency (EPA) to be toxic wastes and must be disposed in accordance with 40 CFR, part 261.
	
	American College of Physician guidelines state sound management procedures include:
	  ○ Routinely checking for expiration dates.
	  ○ Keeping medicines off the floor.
	  ○ Labeling the sample medicines or writing prescribing information directly on the sample package.
	  ○ Keeping a log of sample medicines given. In case of a recall, keeping a log allows to track down a patient to whom the recalled drug had been prescribed.
	  ○ When a medication sample is given to a patient, the name and strength of the medication, instructions for use and the quantity or duration of therapy is always documented in the patient's chart.

[38] 21 CFR 211.142
[39] 22 CCR 75037(d)
[40] Title 21, United States Code (USC), section 351. USC is searchable at: https://uscode.house.gov/search/criteria.shtml.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	ASHP guidelines for minimum standard for pharmaceutical services in ambulatory care: ○ Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives. ○ Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs.[41] **Immunobiologics:**[42] • Sites should have a written Vaccine Management Plan for routine and emergency vaccine management (required for Vaccines for Children (VFC) providers). • Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. • Diluent does not need refrigeration if vaccine is administered right after diluent is added. • Vaccines are not stored in the doors, floors, vegetable bins, or under or near cooling vents of a refrigerator or freezer. **IV.B.4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).** **Refrigerator:** Vaccines are kept in a refrigerator **maintained at 2-8ºC or 36-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, recombinant Zoster, or any combinations of these listed vaccines.[43] **IV.B. 5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).**

[41] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.
[42] See the FDA's webpage on Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines.
[43] See the CDC Vaccine Recommendation and Guidelines of the Advisory Committee on Immunization Practices, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are always protected from light. o MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. o Never freeze vaccine diluents. **IV.B. 6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.** CDC recommends for both temporary and long-term storage refrigerators and freezers using: o Purpose-built units designed to either refrigerate or freeze (can be compact, under-the counter style or large units). o Stand-alone household units. o Units dedicated to storage of biologics. Measures should be in place to ensure that vaccine storage units are not accidentally physically disconnected from the power supply, such as “Do Not Disconnect” labels and not plugging units into surge protectors with an on/off switch. **Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances.[44]** **IV.B. 7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.** Refrigerator and freezer temperatures are documented at least once a day (required twice daily for VFC providers). CDC recommends use of a continuous temperature monitoring device (digital data loggers). o Digital data loggers (DDL) should have a minimum accuracy of +/- 1°F (0.5°C) o Equipped with buffered probe o Active temperature display outside of the unit o Capacity for continuous monitoring and recording where the data can be routinely downloaded o Calibrated at least every 2 years, to monitor vaccine storage unit temperatures

[44] See the CDC Vaccine & Immunization webpage, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	At least one back-up device should be readily available for emergency vaccine transport or when primary DDL is sent in for calibration. **IV.B. 8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.** • A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is required. www.cdc.gov; https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/impact-severe-weather-conditions-biological-products • Site personnel must be able to verbalize the procedures in the plan used to promptly respond to OUT OF RANGE TEMPERATURES. • Quarantine vaccines until guidance is obtained. • Action is taken when temperatures are identified to be outside of the recommended range. • Contacting VFC (http://eziz.org/vfc/overview/) or manufacturer are acceptable procedures. • For VFC providers, follow program requirements for documentation and reporting. Consultation with CDC is available when necessary.[45] www.cdc.gov **IV.B. 9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.** • As these items may potentially cause contamination to verify that drugs are stored separately from test reagents, germicides, disinfectants, and other household substances. **IV.B.10) Hazardous substances are appropriately labeled.** **IV.B.11) Site has method(s) in place for drug and hazardous substance disposal.** **Hazardous Substances Labeling and Disposal**: • Safety practices are followed in accordance with current/updated CAL-OSHA standards and 29 CFR 1910.1030.

[45] See the CDC General Best Practice Guidelines for Immunization: Best Practices Guidance of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf, the FDA Questions about Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines, and the CDC webpage on Vaccines and Immunizations, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) only if the hazardous material or residues of the material remain in the container. • Containers for biohazard waste shall comply with United States Department of Transportation requirements when prepared for transport offsite from the facility. • A hazardous waste transporter transporting medical waste shall maintain a completed tracking document and provide a copy of that document to the medical waste generator (clinic, etc.). All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) Identity of hazardous substance 2) Description of hazard warning: can be words, pictures, symbols 3) Date of preparation or transfer **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the workplace. A hazardous substance is any substance that is a physical or health hazard.
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.C.1) There are no expired drugs on site.** **Expiration Date:** • The manufacturer's expiration date must appear on the labeling of all drugs and formulas. • All prescription drugs not bearing the expiration date are deemed to have expired. • If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unreconstituted drug. • Expired drugs may not be distributed or dispensed. • Per CDC – Medication Vials should be discarded whenever sterility is compromised or questionable.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Per CDC "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial". • Per VFC "For multi-dose vials that do not require reconstitution, doses that remain after withdrawal of a dose can be administered until the expiration date printed on the vial unless otherwise specified by the manufacturer (Polio, meningococcal polysaccharide vaccine (MPSV4), PPSV, TIV, IPV, and yellow fever that are available in multi-dose vials)".[46] Both CDC and VFC recommend to follow the manufacturer's product information. **IV.C.2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.** • Site has a procedure to check expiration date of all drugs (including vaccines and samples) and infant and therapeutic formula AT LEAST monthly. **IV.C.3) All stored and dispensed prescription drugs are appropriately labeled.** **Prescription Labeling**: • Labels shall be carefully preserved, and all medications shall be stored in their original containers. • Each prescription medication dispensed is in a container that is not cracked, soiled, or without secure closures.[47] • Each commercial container of a controlled substance shall have printed on the label the symbol designating the schedule in which such controlled substance is listed. • Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. • California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record.[48]

[46] See the CDC Frequently Asked Questions regarding Multi-dose vials, available at: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
[47] 22 CCR 75037(A)
[48] BPC 4170 and 4171

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Drug Distribution: • Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • In order to prevent inadvertent exposure to out-of-range temperatures, vaccines should never be re-distributed beyond the manufacturer/distributer-to-clinic distribution chain unless during an emergency. • In the event of necessary vaccine transport (emergency/power outage), vaccines must be packaged following CDC recommendations and include temperature monitoring devices during transport (approval is required for VFC providers prior to any vaccine transfer). **IV.C.4) (CE) Only lawfully authorized persons dispense drugs to patients.** **Drug Dispensing:** • Drug dispensing complies with all applicable State and federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist, or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. • Personnel such as MAs, office managers, and receptionists do not dispense drugs. • Drugs are not offered for sale, charged or billed to Medi-Cal members.[49] • A record of all drugs and formulas dispensed shall be entered in the patient's medical record. **Drug Administration:** • Basic safe practices for medication/vaccine administration, assess and document: 1) Patient's identity 2) Correct medication 3) Correct dose 4) Correct route 5) Appropriate time CMS Manual System;[50] • Proper preparation is critical for maintaining the integrity of the vaccine during transfer from the vial to the syringe.

[49] BPC 4193
[50] 42 CFR 482.23(c)

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Personnel can demonstrate or verbally explain procedure(s) used on site to confirm correct patient, medication/vaccine, dosage and route and vaccine are prepared and drawn only prior to administration. • Proper vaccine administration is critical to ensure that vaccination is safe and effective. • CDC recommends that all health care personnel who administer vaccines receive comprehensive, competency-based training on vaccine administration policies and procedures before administering vaccines. • Comprehensive, skills-based training should be integrated into existing staff education programs such as new staff orientation and annual education requirements. **IV.C.5) Drugs and Vaccines are prepared and drawn only prior to administration.** ACIP discourages the routine practice of providers' prefilling syringes. • Vaccines have a similar appearance after being drawn into a syringe, prefilling may result in administration errors. • Unused, provider prefilled syringes must be discarded if not used within the same day that they are filled. • Unused syringes that are prefilled by the manufacturer and activated (i.e., syringe cap removed, or needle attached) should be discarded at the end of the clinic day. In certain circumstances in which a single vaccine type is being used (e.g., in preparation for a community influenza vaccination campaign), filling a small number (10 or fewer) of syringes may be considered (*5*). The doses should be administered as soon as possible after filling, by the same person who filled the syringes. (**IV.C.6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.** **Vaccine Immunization Statements**:

[51] See the CDC's Vaccine Recommendations and Guidelines of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/generalrecs/administration.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. • Health care providers must present and offer a VIS to patients prior to any vaccine.[52] As of 2009, CDC allows providers to present a current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also offer a copy each time.[53] • The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. • Federal law allows up to 6 months for a new VIS to be used. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at: http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. VFC contains current VIS and provider notifications at: http://www.eziz.org/ **IV.C.7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.** **Pharmacy:** • If a pharmacy is located on site and owned by the clinic, the license issued by the CA State Board of Pharmacy must be present on site. • Every pharmacy that dispenses a controlled substance must be registered with the DEA and be licensed by the CA State Board of Pharmacy. • A licensed pharmacist monitors drug distribution and policies and procedures for medication dispensing and storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice. **IV.C.8) Site utilizes California Immunization Registry (CAIR) or the most current version.**

[52] 42 USC 300aa-26(D)(2)
[53] See the CDC's Facts about VIS, which is available at: https://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Immunization Registry Utilization: Scoring must be No or Yes. • DHCS requires documentation of immunizations in the California CAIR or the local registry. • If the clinic does not offer vaccines administration, the site staff shall be able to utilize the registry to access the member's immunization record. Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry (is) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws. DHCS Contract; CDC Recommendations at: www.cdc.gov/vaccines.

Criteria	IV. Clinical Services – Laboratory Review
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	**IV.D.1) Laboratory test procedures are performed according to current site-specific CLIA certificate.** **CLIA Certificates**: • All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. • Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. **Note:** Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address. 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. 4) A multi-site CLIA waiver can be used at all affiliated locations. A copy of the CLIA waiver must be at each individual location with the address of the main location on the waiver. A copy of the CLIA application must be reviewed by the CSR to verify the locations included for old and new locations. The CLIA Certificate on site includes one of the following: ○ Certificate of Waiver: Site can perform only exempt waived tests ○ Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or NPMPs can perform PPM procedures and waived tests

Criteria	IV. Clinical Services – Laboratory Review
	○ Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey ○ Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements ○ Certificate of Accreditation: Lab is accredited by an accreditation organization approved by CMS **Waived Tests**: • If only waived tests are performed, site has a current CLIA Certificate of Waiver. • There are no specific CLIA regulations regarding the performance of waived tests. • Site personnel are expected to follow the test manufacturer's instructions. • Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. **Moderate and High Complexity Tests:** Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. **IV.D.2) Testing personnel performing clinical lab procedures have been trained.** **Personnel Training:** • Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. • Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. • Site personnel that perform CLIA waived tests have access to and can follow test manufacturer's instructions. • When requested, site personnel can provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.

Criteria	IV. Clinical Services – Laboratory Review
	• The required training and certification are established by legislation for personnel performing moderate and high complexity tests.[54] Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **IV.D.3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.** **IV.D.4) Lab test supplies are not expired.** Lab supplies are disposed of by manufacturer's expiration date. **IV.D.5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.** **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.cms.gov or www.fda.gov includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 or LFSrecep@cdph.ca.gov for CLIA certification, laboratory license, or personnel questions.**

[54] BPC 1200-1213

Criteria	IV. Clinical Services – Radiology Review
E. Site meets CDPH Radiological inspection and safety regulations	**IV.E.1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.** **<u>CDPH Radiologic Health Branch (RHB) Inspection Report</u>**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. Acceptable documentation is: o Inspection Report and Proof of Registration, ***or*** o Inspection Report and Proof of Registration *and* Short Form Sign-off sheet, ***or*** o Inspection Report and Proof of Registration *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB The Radiologic Inspection Report and Proof of Registration (receipt of payment or cancelled check), issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents are issued to the site: o "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. o "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more violations that are serious. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "status of documents on site, proceed to score all items 1-9.** **The following documents are posted on site:** **IV.E.2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.** **IV.E.3) "Radiation Safety Operating Procedures" posted in highly visible location.** **IV.E.4) "Notice to Employees Poster" posted in highly visible location.** **IV.E.5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.** **IV.E.6) Physician Supervisor/Operator certificate posted and within current expiration date.**

Criteria	IV. Clinical Services – Radiology Review
	IV.E.7) Technologist certificate posted and within current expiration date. **The following radiological protective equipment is present on site:** **IV.E.8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.** **IV.E.9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.** **Radiological Equipment:** Equipment inspection, based on a "priority" rating system, is established by legislation. https://blink.ucsd.edu/_files/safety-tab/rad/Title-17-CCR.pdf • Mammography equipment is inspected annually, and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.[55] • High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. • Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment uses, and likelihood of radiation exposure. If reviewer is uncertain about the "status of equipment inspection, call the RHB. **Radiology Personnel:** • All certificates/licenses are posted and show expiration dates. • If there are many technicians, a list of names, license numbers, and expiration dates may be substituted. • The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. • The "Limited Permit" restricts the technician to one of the ten-(10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry.

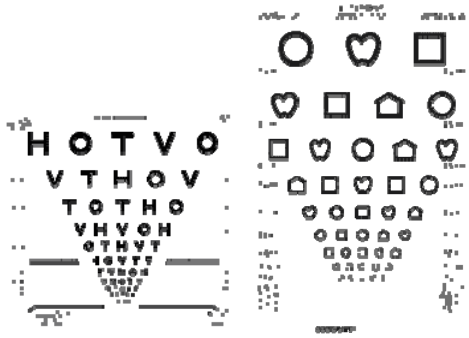
[55] 21 CFR 900

Criteria	IV. Clinical Services – Radiology Review
	Note: • Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. • RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. • Dexascanners manufacturer guidelines do not require gonadal shielding or lead aprons due to very low radiation output, and potential for the shield to obscure the area being scanned, possibly rendering the scan non-diagnostic. With the focused beam, operators do not need aprons, the amount of exposure of "scattered" beams to an operator seated near the scanner is about the same level as that found in the natural environment. A traditional x-ray machine used for bone density testing, is not a dexascanner, and *may* require shielding/apron. **Note:** The RHB of the Food, Drug, and Radiation Safety Division of CDPH enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH RHB at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at https://www.cdph.ca.gov/rhb

Criteria	V. Preventive Services Standards
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**Examination equipment, appropriate for primary care services, is available on site:** **V.A.1) Exam tables and lights are in good repair.** **<u>Examination Table and Lights</u>:** • Lights and exam tables shall be in good repair. “Good repair” means clean and well maintained in proper working order. • Examination tables must have a protective barrier such as paper which is changed between patients, to cover the exam surface. **V.A.2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese, thigh).** **V.A.3) Thermometer with a numeric reading.** **V.A.4) Basic exam equipment: in addition to items mentioned above, offices should have the following:** o Percussion hammer o Tongue blades o Patient gowns **V.A.5) Scales: Standing balance beam and infant scales.** **<u>Scales:</u>** • Infant scales are marked and accurate to increments of one (1) ounce or less and have a capacity of at least 35 pounds. • Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less and have a capacity of at least 300 pounds. • Balance beam scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. • Electronic or digital scales have automatic zeroing and lock-in weight features. • Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use as, over time, the spring counterbalance mechanism loses its accuracy.

Criteria	V. Preventive Services Standards
	V.A.6) Measuring devices for stature (height/length) measurement and head circumference measurement. **Measuring Devices:** Equipment on site for measuring stature (length/height) and head circumference includes: ○ Rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface. ○ Vertical to the wall-mounted standing measurement surface. ○ Flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. ○ Moveable, non-flexible footboard at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. ○ A non-stretchable tape measuring device marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference (re-usable measuring device must be appropriately cleaned in between use). **V.A.7) Eye charts (literate and illiterate) and occluder for vision testing.** **Vision Testing:**[56] • Site has both literate (e.g., Snellen) and illiterate eye charts • The current preferred optotypes (figures or letters of different sizes) for patients who cannot distinguish letters are the LEA or HOTV symbols (see figures below)

[56] See the Procedures for the Evaluation of the Visual System by Pediatricians, available at: https://pediatrics.aappublications.org/content/137/1/e20153597. Also see the American Association for Pediatric Ophthalmology and Strabismus Vision Screening Committee's Pediatric Screening Guidance during the COVID-19 Pandemic, available at: https://aapos.org/education/allied-health/covid.

Criteria	V. Preventive Services Standards
	 • Wall mounted eye charts should be height adjustable and positioned at the eye-level of the patient • Examiners shall stand their patients with their heels to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere. “Heel” lines are aligned with center of eye chart at 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. • Eye charts are in an area with adequate lighting and at height(s) appropriate to use • Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. **V.A.8) Ophthalmoscope.** Ophthalmoscope is in good working condition. **V.A.9) Otoscope with adult and pediatric ear speculums.** Otoscope with multi-size ear speculums appropriate to the population served. **V.A.10) A pure tone, air conduction audiometer is located in a quiet location for testing.**

Criteria	V. Preventive Services Standards

	Hearing Testing:[57]
	• The pure tone audiometer must have the minimum ability to:
	  ○ Produce intensities between 0 to 80 dB
	  ○ Have a headset with right and left earphones
	  ○ Be operated manually
	  ○ Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz
	• Offices that provide pediatric preventive services should have a pure tone; air conduction audiometer available, audiometric testing is required at preventive health visits starting at 4 years of age.
	• PCP offices (such as Family Practitioners or General Practitioners) that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review.

B. Health education services are available to Plan members.	**Health Education Services:** Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. **Health education materials and Plan-specific resource information are:** **V.B.1) Readily accessible on site or are made available upon request.** **V.B.2) Applicable to the practice and population served on site.** **V.B.3) Available in threshold languages identified for county and/or area of site location.** **Health Education Materials:**

[57] See the American Speech-Language-Hearing Association's guidance on Audiograms, available at: https://www.asha.org/public/hearing/audiogram/.

Criteria	V. Preventive Services Standards
	• Must be available in the appropriate threshold languages and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. • Must be available in accessible format which may include written information, audio and/or videotapes, computerized programs, and visual presentation aids for people with disabilities. • Should include general topics for health educational material such as: Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • Must meet the Medi-Cal Managed Care readability and suitability requirements for educational material distributed to Medi-Cal members.[58] **Plan-Specific Referral Information:** Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. ○ For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. ○ Although a site may not stock informing materials in each threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. ○ Interpreter services are provided in all identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

[58] See All Plan Letter (APL) 18-016, "Readability and Suitability of Written Health Education Materials". APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Criteria	VI. Infection Control Standards
A. Infection control procedures for Standard/Universal precautions are followed. 🗺 🗁 **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **Hand Washing Facilities:**[59] • Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air-drying machines. • Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. • Staff can demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. • On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available.[60] **VI.A.1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.** **Soap or Antiseptic Hand Cleaner:** Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. ○ Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). ○ Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). ○ Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

[59] See the World Health Organization's Hand Hygiene guidelines, available at: https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/hand-hygiene-why-how-and-when-brochure.pdf?sfvrsn=dc8a0810_2

[60] 29 CFR 1919.1030

Criteria	VI. Infection Control Standards
	VI.A.2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms. **Waste Disposal Container:**[61] • Contaminated wastes (e.g. dental drapes, band-aids, sanitary napkins, soiled disposable diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. • Closed containers are not required for regular, solid waste trash containers. **VI.A.3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.** **Isolation Procedures**:[62] • Personnel can demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. • If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. • Isolation procedures may vary from site to site. **Note:** • Infection Control standards are practiced on site to minimize risk of disease transmission. • Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. • Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. • "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

[61] HSC 118275-118320. Also see the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.

[62] See the CDC's Guidelines for Isolation Precautions, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 🗣 🗁 **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. **VI.B.1) (CE) Personal Protective Equipment for Standard Precautions is readily available for staff use.** **Personal Protective Equipment (PPE):** PPE must be readily available.[63] PPE for protection against bloodborne pathogen hazards is available on site and must include: 1) Gloves 2) Water repellent clothing barrier/gown 3) Face/eye protection (e.g., goggles/face shield) 4) Respiratory infection protection (e.g., mask) PPE does not include general work clothes (e.g., uniforms, cloth lab coats) that will permit liquid to soak through. • The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. • Proper storage often requires a dry and clean place that is not subject to temperature extremes. **VI.B.2) (CE) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.** **Blood and Other Potentially Infectious Materials (OPIM):** • OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. • Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. • Double bagging is required only if leakage is possible.

[63] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	Labels: • A warning label is affixed to red-bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. • The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red orange with contrasting lettering/symbols) is part of, or affixed to, the container. • Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". • Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. • Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. **VI.B.3) (CE) Needlestick safety precautions are practiced on site.** **Needlestick Safety:**[64] • Contaminated sharps are discarded immediately. • Sharps containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. • Sharps are not bent, removed from a syringe, or recapped. Recapping, bending, or removing contaminated needles is permissible only if there is no feasible alternative or if such actions are required for a specific medical procedure. If recapping, bending, or removal is necessary, employers must ensure that workers use either a mechanical device or a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA.[65] • Security of portable containers in patient care areas is always maintained.

[64] See the OSHA Needlestick Safety Frequently Asked Questions, available at: , and the OSHA Standards for Bloodborne Pathogens, available at: https://www.osha.gov/bloodborne-pathogens https://www.hercenter.org/rmw/osha-bps.php.

[65] 8 CCR 5193

Criteria	VI. Infection Control Standards
	• Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. • Containers are not overfilled past the manufacturer's designated fill line, or more than ¾ full. • Supply of containers on hand is adequate to ensure routine change-out when filled. **VI.B.4) All sharp injury incidents are documented.** **Sharps Injury Documentation**:[66] • Site has a method in place to document sharps injuries. • The Sharps Injury Log must contain, at a minimum, information about the injury, the type and brand of device involved in the injury (if known), the department or work area where the exposure occurred, and an explanation of how the incident occurred. • The incident must be recorded in the log within 14 business days of the date the incident is reported to the employer and maintained in such a manner to protect the confidentiality of the injured employee (e.g., removal of personal identifiers) and follow-up care is documented within 14 days of injury incident. • Sites with 10 or fewer employees are exempt from OSHA recordkeeping requirements and are exempt from recording and maintaining a Sharps Injury Log, however, it is recommended to have a method in place to document sharps injuries regardless of the number of employees. **Regulated Waste Storage:** Regulated wastes include: ○ **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation. ○ **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. **VI.B.5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.**

[66] See 8 CCR 5193, and the National Institute for Occupational Safety and Health's guidance on Preventing Needlesticks and Sharps Injuries, available at: https://www.cdc.gov/niosh/topics/bbp/sharps.html.

Criteria	VI. Infection Control Standards
	VI.B.6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.[67] • Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* and placed in red biohazardous bags with Biohazard label and stored in a closed container that is not accessible to unauthorized persons. • If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" and CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS". See HSC Sections 117915-117946, 49 CFR, Section 173.6; Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016. **VI.B.7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.** **Contaminated Laundry:** • Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. • Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label. • Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. • Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for staff. • Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.

[67] HSC 117600-118360, 29 CFR 1910.1030, CDC Guidelines for Isolating Precautions: Preventing Transmission of Infection Agents in Healthcare Settings, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
	VI.B.8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds). **Medical Waste Disposal:** California adopted statutes into HSC affecting medical waste transporters in October 1993.[68] • Only medical waste transporters listed with CDPH can transport medical waste. • All medical waste transporters must carry paperwork issued by CDPH in each vehicle while transporting medical waste. • Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter. • Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). However, a medical waste-tracking document that includes the name of the person transporting, number of waste containers (e.g., three sharps containers, or five biohazard bags), types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. For the CDPH list of current medical waste transporters, visit: https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/Haulist_012921.pdf For information on the United States Postal Service mailability standards for medical waste (including sharps) refer to the Domestic Mail Manual, section 601.10.17: https://pe.usps.com/Archive/HTML/DMMArchive20100607/601.htm CDPH Medical Waste Management Program: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx CDPH Medical Waste Management Program Transporter Checklist: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8660.pdf CDPH Medical Waste Transporter Annual Verification: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8668.pdf

[68] HSC 117600-11836

Criteria	VI. Infection Control Standards
	CDPH Medical Waste Transfer Stations and Offsite Treatment Facilities: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/Transfer-and-Treatment.aspx CDPH Medical Waste Transporters Data Submission Protocol: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8666.pdf Department of Toxic Substances Control-Managing Hazardous Waste Transporters Registration https://dtsc.ca.gov/transporters/ ***Note:** Contaminated wastes include materials soiled with blood during their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags but can be discarded as solid waste in regular trash receptacle.
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.C.1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.** **Routine Decontamination:** ○ Contaminated work surfaces are decontaminated with an appropriate disinfectant.[69] ○ Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. ○ Staff can identify cleaning and disinfection of surfaces and equipment, the disinfectant used and responsible personnel in between patients use. **VI.C.2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.** **The written schedule for cleaning and decontamination of the work site as follows:** ○ **Area cleaned/decontaminated**

[69] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	○ **Frequency of cleaning/decontamination** ○ **Employee responsible for determining and implementing the written schedule** All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below: ○ Location within the facility ○ Type of surface or equipment to be treated ○ Type of soil or contamination present ○ Tasks or procedures being performed in the area Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when: ○ Surfaces become overtly contaminated. ○ There is a spill of blood or OPIM. ○ Procedures are completed. ○ At the end of the work shift if the surface may have become contaminated since the last cleaning. **Spill Procedure:** Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). **Disinfectant solutions used on site are:** **VI.C.3) Approved by the Environmental Protection Agency (EPA).** **VI.C.4) Effective in killing HIV/HBV/TB.** **VI.C.5) Follow manufacturer instructions.** **Disinfectant Products:** ○ Products used for decontamination have a current EPA-approved status. ○ Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. ○ Decontamination products are used according to manufacturer's guidelines for decontamination and contact times.

Criteria	VI. Infection Control Standards
	<u>10% Bleach Solution</u>: o 10% bleach solution that is EPA registered and effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). o Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). o Surface is air-dried or allowed appropriate time (stated on label) before drying. o Manufacturer's directions, *specific* to every bleach product, are followed carefully. **<u>Note</u>:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.[70] Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at 29 CFR 1910.1030.
D. Reusable medical instruments are properly sterilized after each use. **RN/NP/CNM/LM/MD/PA**	**<u>Deficiencies</u>:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.D.1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.** If site uses an autoclave or cold chemical solution to achieve sterilization and/or high level disinfection (HLD) of instruments/equipment, site shall have specific policy/procedures or manufacturer's instructions addressing instrument/equipment pre-treatment, cleaning and preparation, the management of chemical solutions, autoclave loading and operation, safety guidelines and precautions, and other required processes, which are available to staff to follow. **Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:** **VI.D.2) Cleaning reusable instruments/equipment prior to sterilization.** **Cleaning Prior to Sterilization:**

[70] 8 CCR 5193. Also see CalOSHA's Best Practices Approach for Reducing Bloodborne Pathogen Exposure, available at:

https://www.dir.ca.gov/dosh/dosh_publications/BBPBest1.pdf.

Criteria	VI. Infection Control Standards
	• Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris. **Cold chemical sterilization/high level disinfection:** **VI.D.3a) (CE) Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.** • Personnel can demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Product efficacy tests (i.e. test strips) shall be performed according to manufacturer's guidelines. **Cold Chemical Sterilization/High Level disinfection:** • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterilization and or high-level disinfection exposure times and solution expiration date and time are available to staff. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff. **VI.D.3b) Confirmation from manufacturer item(s) is/are heat sensitive.** • Per CDC,[71] the use of liquid chemical germicides to sterilize instruments ("cold sterilization") are limited. Sterility is not verified or assured with cold chemical sterilization. The first choice is always heat sterilization. The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item". • The use of a liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.

[71] See the CDC Guidelines for Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf. Also see the CDC's Guidelines on other sterilization methods, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/other-methods.html.

Criteria	VI. Infection Control Standards
	VI.D.3c) (CE) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions in the event of a cold chemical sterilant spill. Cold Chemical Sterilants Spillage: The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop MSDS for each chemical or mixture of chemicals.[72, 73] ○ Employers must have the data sheets for cold chemical sterilants readily available to employees who work with the products to which they could be exposed. ○ Staff should attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site. ○ Personnel are familiar with and can recognize signs and symptoms of exposure to cold chemical sterilants used on site. ○ Staff must be aware of the procedures for clean up in the event of spillage. ○ Staff can demonstrate or verbally explain procedure(s) used on site for chemical spill cleanup. ○ If personnel are unable to demonstrate or explain site-specific chemical spill cleanup procedures *and* cannot locate written chemical spill cleanup procedure instructions, site is considered deficient. ○ Cleanup procedures may vary from site to site depending on the cold chemical sterilants used. ○ The appropriate PPE for cold chemical sterilants clean up must be readily available. National Institute for Occupational Safety and Health (NIOSH) with the Centers for Disease Control and Prevention. Environmental Health and Safety guidelines for disinfectants and sterilization methods. MSDS for cold chemical sterilants. The American National Standard (ANSI)/Advancing Safety in Medical Technology (AAMI) ST58:2013. Control Methods and Work Practices: are in place to prevent or reduce exposure to the cold chemical sterilants. Cold chemical sterilants have toxic properties and are hazardous.

[72] 29 CFR 1910.1200, 1915.99, 1917.28, 1918.90, 1926.59, and 1928.21.
[73] See CDC guidelines on sterilizing heat sensitive dental instruments, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/healthcare-equipment.html l/ 29 CFR 1910.1030(d)(3)(i), 29 CFR 1910.1030(d)(3)(ii), 29 CFR 1910.1030(d)(4)(ii)(A), 29 CFR 1910.1030(d)(4)(iii)(B), 29 CFR 1910.132, 29 CFR 1910.134. See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/index.html.

Criteria	VI. Infection Control Standards
	• Cold chemical sterilants must be used strictly in accordance with the manufacturer's directions. Always consult the manufacturer for safety precautions and MSDS information. • The appropriate PPE must be used to avoid inhalation or skin contact exposure to during the cold chemical sterilization/high level disinfection process. Examples of cold chemical sterilants include: o Glutaraldehyde (Cidex) o Peracetic acid o Hydrogen peroxide-based solutions Glutaraldehyde is a common cold chemical sterilants. Exposure to glutaraldehyde can cause the following health effects: throat and lung irritation, breathing difficulty, nose irritation, nosebleed, burning eyes and conjunctivitis, rash, hives, headaches, and nausea. Exposure to glutaraldehyde may be prevented or reduced by using the following control methods and work practices: o Use local exhaust ventilation. o Keep glutaraldehyde baths under a fume hood where possible.[74] o Avoid skin contact (use appropriate PPE-gloves and aprons made of nitrile or butyl rubber wear goggles and face shields). o Use only enough sterilants to perform the required sterilization procedure. o Seal or cover all containers holding the sterilants. o Attend training classes. **Autoclave/Steam Sterilization:** **VI.D.4a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.** • Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. • Written operating procedures for autoclave are available on site to staff. • Documentation of sterilization loads include date, time and duration of run cycle, temperature, steam pressure, and operator of each run.

[74] For more information on glutaraldehyde exposure and safety tips, refer to the CDC guidance, available at: https://www.cdc.gov/niosh/docs/2001-115/default.html.

Criteria	VI. Infection Control Standards
	• If instruments/equipment are transported off-site for sterilization, equipment handling, and transport procedures are available on site to staff. • Documentation of instruments and personnel transporting must be maintained. **VI.D.4 b) Autoclave maintenance per manufacturer's guidelines.** **Autoclave Maintenance:** Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: o Mechanical problems o Inspection dates o Results/outcome of routine servicing o Calibration o Repairs, etc. **Note:** If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. **VI.D.4c) (CE) Spore testing of autoclave/steam sterilizer with documented results (at least monthly).** **Spore Testing:** • Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. • Documentation of biological spore testing includes: o Date o Results o Types of spore test used o Person performing/documenting test results • Written procedures for performing routine spore testing are available on site to staff **Note: Documentation of monthly spore testing must be maintained onsite even for sterilization that is performed offsite.**

Criteria	VI. Infection Control Standards
	VI.D.4.d) (CE) Management of positive mechanical, chemical, and biological indicators of the sterilization process. **Autoclave/Steam Sterilization Mechanical, Chemical, and Biological Indicators:[75]** • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Per CDC, the autoclave/steam sterilization procedure should be monitored routinely by using a combination of: o Mechanical Indicator: monitor sterilization process with a daily assessment of cycle time and temperature by examining the temperature record chart and an assessment of pressure via the pressure gauge (e.g., graphs, gauges, printouts) o Chemical Indicator: are usually either heat-or chemical-sensitive inks that change color when one or more sterilization parameters (e.g., steam-time, temperature, and/or saturated steam; ETO-time, temperature, relative humidity and/or ETO concentration) are present. o Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items o Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s). • Written procedures for for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: o Report problem o Repair autoclave o Retrieve all instruments sterilized since last negative spore test o Re-test autoclave o Re-sterilize retrieved instruments • Biologic spore test products vary and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile.

See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

Criteria	VI. Infection Control Standards

	VI.D.4.e) Sterilized packages are labeled with sterilization date and load identification information.
	<u>Package and storage of sterilized items</u>:
	• Following the sterilization process, medical and surgical devices must be handled using aseptic technique in order to prevent contamination.
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Sterilized package labels include:
	  ○ Date of sterilization
	  ○ Load run identification information
	  ○ Initials of staff member
	  ○ General contents (e.g. suture set) each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site
	
	VI.D.4.f) Storage of sterilized packages.
	<u>Storage of sterilized packages</u>:[76]
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Maintenance of sterility is event related, not time related.
	• Sterilized items are considered sterile until use, unless an event causes contamination.
	• Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area.
	• Site has a process for routine evaluation of sterilized packages.

[76] See the CDC Summary of Recommendations regarding Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html, and the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf.

California Department of Health Care Services **January 1, 2024**
Managed Care Quality and Monitoring Division

Primary Care Provider- Site Review Tool

Date: _____ **Health Plan Name or Code:** _____ **IPA:** _____

Last Review Date: _____ **Site ID:** _____ **Site NPI:** _____

Reviewer name/title: _____ **Provider Address:** _____

Reviewer name/title: _____ **City and Zip Code:** _____

Reviewer name/title: _____ **Phone:** _____ **Fax:** _____ **Current Fire Clearance:** _____

Contact person/title: _____

No. of staff on site: _____ **Physician** _____ **NP** _____ **CNM** _____ **LM** _____ **PA** _____ **RN** _____ **LVN** _____ **MA** _____ **Clerical** _____ **other**

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic Type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ JC _____ CHDP _____ NCQA _____ CPSP _____ None _____ PCMH _____ Other_____	_____ Family Practice _____ Internal Medicine _____ Pediatrics _____ OB/GYN _____General Practice _____ Specialist)	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Solo _____ Medical Group _____ Staff/Teaching _____ Other _____ (type)

Site Scores

	Total Points Poss.	Points Given	No Points	N/As	CE*
I. Access/Safety	**31**				
II. Personnel	**27**				
III. Office Management	**25**				
IV. Clinical Services	**40**				
V. Preventive Services	**13**				
VI. Infection Control	**34**				
Totals	**170**				

*CE = Critical Elements. Indicate any CEs for easy reference to generate a CAP.

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 170 total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

170 - _____ = _____
N/A Points — Adjusted Points

_____ ÷ _____ = _____ X 100 = _____%
Points Given — Total / Adjusted Points — Decimal Compliance Score — Rate

Compliance Rate

_____ **Exempted Pass: 90% or above** (without deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control)

_____ **Conditional Pass: 80-89%, or 90% and above** with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control

_____ **Fail: 79% and Below**

_____ CAP Required

_____ Other follow-up

Next Site Review Due: _____

I. Access/Safety Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. Title 24, California Code of Regulations (CCR) (CA Building Standards Code); Title 28 Code of Federal Regulations (CFR) §35 (American Disabilities Act of 1990, Title II, Title III) All facilities designed, altered, or constructed after January 26, 1992, for the use of public entity must be readily accessible and usable by persons with disabilities. Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	1)	1)	1)	1	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	2)	2)	2)	1	
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	3)	3)	3)	1	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	4)	4)	4)	1	
5) Clear floor space for wheelchair in waiting area and exam room.	5)	5)	5)	1	
6) Wheelchair accessible restroom facilities.	6)	6)	6)	1	
7) Wheelchair accessible handwashing facilities or reasonable alternative.	7)	7)	7)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 28 CCR §1300.80; 22 CCR §75062					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	1)	1)	1)	1	
2) Restrooms are clean and contain appropriate sanitary supplies.	2)	2)	2)	1	
C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220, §2299-2989; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.37, §1910.38, §1910.157, §1910.301, §1926.34					
There is evidence staff has received safety training and/or has safety information available on the following:					
1) Fire safety and prevention.	1)	1)	1)	1	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	2)	2)	2)	1	
3) Lighting is adequate in all areas to ensure safety.	3)	3)	3)	1	
4) <u>Exit doors and aisles are unobstructed and egress (escape) accessible.</u>	**4)**	**4)**	**4)**	**2**	
5) Exit doors are clearly marked with “Exit” signs.	5)	5)	5)	1	
6) Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location at all elevators, stairs and exits.	6)	6)	6)	1	
7) Electrical cords and outlets are in good working condition.	7)	7)	7)	1	
8) Fire Fighting Equipment in accessible location	8)	8)	8)	1	
9) An employee alarm system.	9)	9)	9)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/ MD/PA only

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 8 CCR §3220; 22 CCR §51056, §53216, §75031; 28 CCR §1300.67, §1300.80; American Academy of Family Practice (AAFP)					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1)	1)	1)	1	
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	2)	2)	2)	1	
3) Emergency phone number contacts are posted, updated annually, and as changes occur.	3)	3)	3)	1	
Emergency medical equipment appropriate to practice/patient population is available on site:					
4) **Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.**	**4)**	**4)**	**4)**	**2**	
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.	**5)**	**5)**	**5)**	**2**	
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	6)	6)	6)	1	
There is a process in place on site to:					
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	7)	7)	7)	1	
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	8)	8)	8)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
E. Medical and lab equipment used for patient care is properly maintained. 28 CCR §1300.80; 21 CFR §800-1299; 22 CCR §75062; §53230					
1) Medical equipment is clean.	1)	1)	1)	1	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	2)	2)	2)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria	Yes	No	N/A	Wt.	Site Score
A. Professional health care personnel have current California licenses and certifications. CA Business & Professional Code (BPC) §2050, §2099.5, §2506, §2725, §2746, §2835, §3500, §4110; CCR, Title 16, §1355.4, §1399.547					
1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	1)	1)	1)	1	
2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	2)	2)	2)	1	
B. Health care personnel are properly identified. BPC §680					
1) Health care personnel wear identification badges/tags printed with name and title.	1)	1)	1)	1	
C. Site personnel are qualified and trained for assigned responsibilities. BPC §2069; 16 CCR §1366 - 1366.4					
1) Documentation of education/training for non-licensed medical personnel is maintained on site.	1)	1)	1)	1	
2) Only qualified/trained personnel retrieve, prepare, or administer medications.	**2)**	**2)**	**2)**	**2**	
3) Site has a procedure in place for confirming correct patient/medication/vaccine dosage and route prior to administration.	3)	3)	3)	1	
4) Only qualified/trained personnel operate medical equipment.	4)	4)	4)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474; BPC §2725, §2746.5, §2746.51, §2836.1					
1) Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	1)	1)	1)	1	
2) A Practice Agreement defines the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines define the method of supervision by the Supervising Physician.	2)	2)	2)	1	
3) Standardized Procedures, Practice Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.	3)	3)	3)	1	
4) Each NPMP that prescribes controlled substances has a valid Drug Enforcement Administration Registration Number.	4)	4)	4)	1	
E. NPMPs are supervised according to established standards. BPC §3516(b); Welfare and Institutions Code (WIC) 14132.966; 16 CCR §1379; §1399.545					
The designated supervising physician(s) on site: 1) Ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 NPs b) 1:4 CNMs c) 1:4 PAs	1)	1)	1)	1	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	2)	2)	2)	1	
3) Evidence of NPMP supervision.	3)	3)	3)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
F. Site personnel receive safety training annually 8 CCR §5193; CA Health and Safety Code (HSC) §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030, 8 CCR §3342					
There is evidence that site staff has received **annual** training on the following: 1) Infection Control/Universal Precautions (annually)	1)	1)	1)	1	
2) Blood Borne Pathogens Exposure Prevention (annually)	2)	2)	2)	1	
3) Biohazardous Waste Handling (annually)	3)	3)	3)	1	
G. Site personnel receive training on member rights. 22 CCR §51009, §51305.1, §53452, §53858; 28 CCR §1300.68; 42 CFR §438.206 (6); 42 CFR §438.224; 42 CFR §438.10 (g); HSC 124260, 1374.16; CA Penal Code §11164, §1166.5, §11168, Family Code 6920, 6924, 6930; National Youth law					
There is evidence that site staff has received training on the following:					
1) Patient confidentiality	1)	1)	1)	1	
2) Informed Consent, including human sterilization	2)	2)	2)	1	
3) Prior Authorization requests	3)	3)	3)	1	
4) Grievance/Complaint Procedure	4)	4)	4)	1	
5) Child/Elder/Domestic Violence Abuse	5)	5)	5)	1	
6) Sensitive Services/Minors' Rights	6)	6)	6)	1	
7) Health Plan referral process/procedures/resources	7)	7)	7)	1	
8) Cultural and linguistics	8)	8)	8)	1	
9) Disability Rights and Provider Obligations	9)	9)	9)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

III. Office Management Criteria	Yes	No	N/A	Wt.	Site Score
A. Physician coverage is available 24 hours a day, 7 days a week. 22 CCR §56500, §53855					
The following are maintained current on site:					
1) Clinic office hours are posted or readily available upon request.	1)	1)	1)	1	
2) Provider office hour schedules are available to staff.	2)	2)	2)	1	
3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.	3)	3)	3)	1	
4) Contact information for off-site physician(s) is available at all times during office hours.	4)	4)	4)	1	
5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.	5)	5)	5)	1	
B. There are sufficient health care personnel to provide timely, appropriate health care services. 22 CCR §53855; 28 CCR §1300.67.1, §1300.80					
1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.	1)	1)	1)	1	
2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.	2)	2)	2)	1	
3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.	3)	3)	3)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Health care services are readily available. 22 CCR §56000(2); 28 CCR §1300.67.2.2					
1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.	1)	1)	1)	1	
2) Patients are notified of scheduled routine and/or preventive screening appointments.	2)	2)	2)	1	
3) There is a process in place verifying follow-up on missed and canceled appointments.	3)	3)	3)	1	
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1)	1)	1)	1	
2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	2)	2)	2)	1	
E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67, §1300.80					
Office practice procedures allow timely provision and tracking of:					
1) Processing internal and external referrals, consultant reports, and diagnostic test results.	1)	1)	1)	1	
2) **Physician Review and follow-up of referral/consultation reports and diagnostic test results.**	**2)**	**2)**	**2)**	**2**	
F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260					
1) Phone number(s) for filing grievances/complaints are located on site.	1)	1)	1)	1	
2) Complaint forms and a copy of the grievance procedure are available on site.	2)	2)	2)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	1)	1)	1)	1	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	2)	2)	2)	1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines.					
1) Exam rooms and dressing areas safeguard patients' right to privacy.	1)	1)	1)	1	
2) Procedures are followed to maintain the confidentiality of personal patient information.	2)	2)	2)	1	
3) Medical record release procedures are compliant with State and federal guidelines.	3)	3)	3)	1	
4) Storage and transmittal of medical records preserves confidentiality and security.	4)	4)	4)	1	
5) Medical records are retained for a minimum of 10 years.	5)	5)	5)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

IV. Clinical Services: Pharmaceutical Services Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. BPC §4172; 22 CCR §75032, §75033, §75037(a-g), §75039; 21 CFR §1301.72, §1301.75, §1301.76, §1302; 16 CCR §1356.3; HSC §11053-11058					
1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	1)	1)	1)	1	
2) Prescription drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances, and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	2)	2)	2)	1	
3) Controlled drugs are stored in a locked space accessible only to authorized personnel.	3)	3)	3)	1	
4) A dose-by-dose controlled substance distribution log is maintained.	4)	4)	4)	1	
5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.	5)	5)	5)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

IV. Clinical Services: Pharmaceutical Services Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351; HSC §117600-118360; 40 CFR, part 261; Current CDC Recommendations					
1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.	1)	1)	1)	1	
2) Drugs for external use are stored separately from drugs for internal use.	2)	2)	2)	1	
3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	3)	3)	3)	1	
4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).	4)	4)	4)	1	
5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).	5)	5)	5)	1	
6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.	6)	6)	6)	1	
7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.	7)	7)	7)	1	
8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.	8)	8)	8)	1	
9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.	9)	9)	9)	1	
10) Hazardous substances are appropriately labeled.	10)	10)	10)	1	
11) Site has method(s) in place for drug and hazardous substance disposal.	11)	11)	11)	1	

Comments: (Write comments for all "No" (0 points) and "N/A" scores.)

RN/NP/CNM/LM/MD/PA only

IV. Clinical Services: Pharmaceutical Services Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. BPC §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26; CDC Recommendations; DHCS Contract; All Plan Letter 18-004; BPC §4000 et seq (Pharmacy Law); §4170; HSC §11000-11651 (Uniform Controlled Substances Act)					
1) There are no expired drugs on site.	1)	1)	1)	1	
2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	2)	2)	2)	1	
3) All stored and dispensed prescription drugs are appropriately labeled.	3)	3)	3)	1	
4) **Only lawfully authorized persons dispense drugs to patients.**	**4)**	**4)**	**4)**	**2**	
5) **Drugs and Vaccines are prepared and drawn only prior to administration.**	**5)**	**5)**	**5)**	**2**	
6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	6)	6)	6)	1	
7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	7)	7)	7)	1	
8) Site utilizes California Immunization Registry (CAIR) or the most current version.	8)	8)	8)	1	

Comments: (Write comments for all "No" (0 points) and "N/A" scores.)

IV. Clinical Services: Laboratory Services Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 22 CCR §51211.2, §51137.2; BPC §1200-1214, §1229, §1220; 42 USC 263a; Public Law 100-578; www.cms.gov; www.fda.gov					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate.	1)	1)	1)	1	
2) Testing personnel performing clinical lab procedures have been trained.	2)	2)	2)	1	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	3)	3)	3)	1	
4) Lab test supplies are not expired.	4)	4)	4)	1	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	5)	5)	5)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

IV. Clinical Services: Radiology Services Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30110, §30111, §30255, §30305, §30404, §30405; https://www.cdph.ca.gov/rhb or (916) 327-5106					
1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.	1)	1)	1)	1	
The following documents are <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.	2)	2)	2)	1	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	3)	3)	3)	1	
4) "Notice to Employees Poster" posted in highly visible location.	4)	4)	4)	1	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.	5)	5)	5)	1	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date.	6)	6)	6)	1	
7) Technologist certificate posted *and* within current expiration date.	7)	7)	7)	1	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	8)	8)	8)	1	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	9)	9)	9)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

V. Preventive Services	Yes	No	N/A	Wt.	Site Score
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. 22 CCR §53851; 28 CCR §1300.67					
Examination equipment, appropriate for primary care services, is available on site:					
1) Exam tables and lights are in good repair.	1)	1)	1)	1	
2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh).	2)	2)	2)	1	
3) Thermometer with a numeric reading**.**	3)	3)	3)	1	
4) Basic exam equipment: percussion hammer, tongue blades, patient gowns.	4)	4)	4)	1	
5) Scales: standing balance beam and infant scales.	5)	5)	5)	1	
6) Measuring devices for stature (height/length) measurement and head circumference measurement.	6)	6)	6)	1	
7) Eye charts (literate and illiterate) and occluder for vision testing.	7)	7)	7)	1	
8) Ophthalmoscope.	8)	8)	8)	1	
9) Otoscope with multi-size ear speculums appropriate to the population served.	9)	9)	9)	1	
10) A pure tone, air conduction audiometer is located in a quiet location for testing.	10)	10)	10)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

V. Preventive Services: Health Education Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67 Health education materials and Plan-specific resource information are: 1) Readily accessible on site or are made available upon request.	1)	1)	1)	1	
2) Applicable to the practice and population served on site.	2)	2)	2)	1	
3) Available in threshold languages identified for county and/or area of site location.	3)	3)	3)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1)	1)	1)	1	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms.	2)	2)	2)	1	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	3)	3)	3)	1	
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); HSC, §117600-118360 (CA Medical Waste Management Act, 1997, updated January 2017); 29 CFR §1910.1030; 49 CCR §173.6; 49 CFR, Section 173.6; CDC Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016; 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings.					
1) **Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.**	**1)**	**1)**	**1)**	**2**	
2) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.	**2)**	**2)**	**2)**	**2**	
3) **Needlestick safety precautions are practiced on site.**	**3)**	**3)**	**3)**	**2**	
4) All sharp injury incidents are documented.	4)	4)	4)	1	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)	5)	5)	1	
6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	6)	6)	6)	1	
7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	7)	7)	7)	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds).	8)	8)	8)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; HSC §118275					
1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	1)	1)	1)	1	
2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	2)	2)	2)	1	
Disinfectant solutions used on site are: 3) Approved by the Environmental Protection Agency (EPA).	3)	3)	3)	1	
4) Effective in killing HIV/HBV/TB.	4)	4)	4)	1	
5) Follow manufacturer instructions.	5)	5)	5)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
D.Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856; CDC guideline for disinfection and sterilization; Food and Drug Administration: Reprocessing medical equipment in health care setting.					
1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.	1)	1)	1)	1	
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures: 2) Cleaning reusable instruments/equipment prior to sterilization.	2)	2)	2)	1	
3) Cold chemical sterilization/high level disinfection: **a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.**	**3a)**	**3a)**	**3a)**	**2**	
b) Confirmation from manufacturer item(s) is/are heat sensitive.	3b)	3b)	3b)	1	
c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.	**3c)**	**3c)**	**3c)**	**2**	
4) Autoclave/steam sterilization. a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.	4a)	4a)	4a)	1	
b) Autoclave maintenance per manufacturer's guidelines.	4b)	4b)	4b)	1	
c) **Spore testing of autoclave/steam sterilizer with documented results (at least monthly).**	**4c)**	**4c)**	**4c)**	**2**	
d) **Management of positive mechanical, chemical, and biological indicators of the sterilization process.**	**4d)**	**4d)**	**4d)**	**2**	
e) Sterilized packages are labeled with sterilization date and load identification information.	4e)	4e)	4e)	1	
f) Storage of sterilized packages.	4f)	4f)	4f)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

PCP:	Page 1 of 2
SECTION: Access/Safety	
POLICY AND PROCEDURE: Fire Safety and Prevention and Emergency Non-Medical Procedures	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Site shall be maintained in a manner that provides a safe environment for all patients, visitors and personnel. Site shall meet all city, county and state fire safety and prevention ordinances. Site staff shall receive training and information on fire safety & prevention and emergency non-medical procedures.

PROCEDURE:

I. SAFE ENVIRONMENT

A. The provider/designee will ensure the following fire and safety precautions:
   1. Lighting is adequate in all areas.
   2. Exit doors and aisles are unobstructed and egress (escape) accessible.
   3. Exit doors are clearly marked with “Exit” signs.
   4. Clearly diagramed “Evacuation Routes” for emergencies are posted in visible locations.
   5. Electrical cords and outlets are in good working condition.
   6. At least one type of fire fighting/protection equipment is accessible at all times.
   7. Employee Alarm system

B. Staff will be responsible to correct any “unsafe” situation, and/or report the situation to the provider/designee who will make/arrange for correction.

II. INFORMATION AND TRAINING

A. Fire Safety & Prevention and non-medical emergency information will be available on site. Staff will be informed of the location of the information and how to use the information. Staff training on fire safety & prevention and emergency non-medical procedures will be verifiable and may be part of staff education documented in:
   - Informal or formal staff trainings
   - New staff orientation
   - External training courses
   - Employee Alarm System –

B. Training topics will include:
    1. Fire safety and prevention procedures including:
        a. Evacuation routes and exits for the exam rooms, office suite and building.
        b. Evacuation procedures.
        c. Location of fire alarms, extinguishers, sprinklers and smoke detectors.
        d. Emergency phone numbers.
        e. Work place violence procedures including emergency numbers.
        f. Emergency alarm system
            1. Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them. (29 CFR 1910. 37) OSHA: For those employers with 10 or fewer employees in a particular workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system.

ATTACHMENTS: Workplace Violence Protocol (Resource)
Emergency Earthquake Plan (Resource)
Emergency Fire Plan (Resource)
Site Evacuation Plan (Sample)

Freezer Temperature Log

MONTH & YEAR	FREEZER LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
Example	8:00 a.m.	NN		-26.1	-29.1	-23.8	
	4:00 p.m.	NN	✔	-23.6	-26.2	-14.3	12345
1	a.m.						
	p.m.						
2	a.m.						
	p.m.						
3	a.m.						
	p.m.						
4	a.m.						
	p.m.						
5	a.m.						
	p.m.						
6	a.m.						
	p.m.						
7	a.m.						
	p.m.						
8	a.m.						
	p.m.						
9	a.m.						
	p.m.						
10	a.m.						
	p.m.						
11	a.m.						
	p.m.						
12	a.m.						
	p.m.						
13	a.m.						
	p.m.						
14	a.m.						
	p.m.						
15	a.m.						
	p.m.						

Notes: _____

Instructions

Keep freezer in OK range.

Check temperatures twice a day.

1. Fill out month, year, freezer ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/freezer ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name: _____

Signature: _____
Date: ___/___/___
Staff Na mes and Initials: _____

Freezer Temperature Log

MONTH & YEAR	FREEZER LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
16	a.m.						
	p.m.						
17	a.m.						
	p.m.						
18	a.m.						
	p.m.						
19	a.m.						
	p.m.						
20	a.m.						
	p.m.						
21	a.m.						
	p.m.						
22	a.m.						
	p.m.						
23	a.m.						
	p.m.						
24	a.m.						
	p.m.						
25	a.m.						
	p.m.						
26	a.m.						
	p.m.						
27	a.m.						
	p.m.						
28	a.m.						
	p.m.						
29	a.m.						
	p.m.						
30	a.m.						
	p.m.						
31	a.m.						
	p.m.						

Notes: _____

Instructions

Keep freezer in OK range.

Check temperatures twice a day.

1. Fill out month, year, freezer ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/freezer ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name: _____

Signature: _____
Date: ___/___/___
Staff Na mes and Initials: _____

Freezer Temperature Log

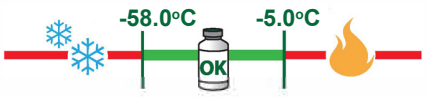
MONTH & YEAR	FREEZER LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
Example	8:00 a.m.	NN		-10.3	-20.2	-9.1	
	4:00 p.m.	NN	✔	2.4	-9.0	-6.2	12345
1	a.m.						
	p.m.						
2	a.m.						
	p.m.						
3	a.m.						
	p.m.						
4	a.m.						
	p.m.						
5	a.m.						
	p.m.						
6	a.m.						
	p.m.						
7	a.m.						
	p.m.						
8	a.m.						
	p.m.						
9	a.m.						
	p.m.						
10	a.m.						
	p.m.						
11	a.m.						
	p.m.						
12	a.m.						
	p.m.						
13	a.m.						
	p.m.						
14	a.m.						
	p.m.						
15	a.m.						
	p.m.						

Notes: _____

Instructions

Keep freezer in OK range.



Check temperatures twice a day.

1. Fill out month, year, freezer ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/freezer ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name: _____

Signature: _____
Date: ___/___/___
Staff Na mes and Initials: _____

_____

_____

VFC

CALIFORNIA 1-877-243-8832

Keep all VFC temperature logs and data files for three years.

F° Freezer Temperature Log

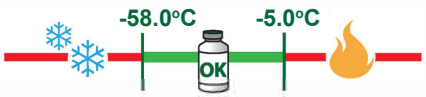
MONTH & YEAR	FREEZER LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
16	a.m.						
	p.m.						
17	a.m.						
	p.m.						
18	a.m.						
	p.m.						
19	a.m.						
	p.m.						
20	a.m.						
	p.m.						
21	a.m.						
	p.m.						
22	a.m.						
	p.m.						
23	a.m.						
	p.m.						
24	a.m.						
	p.m.						
25	a.m.						
	p.m.						
26	a.m.						
	p.m.						
27	a.m.						
	p.m.						
28	a.m.						
	p.m.						
29	a.m.						
	p.m.						
30	a.m.						
	p.m.						
31	a.m.						
	p.m.						

Notes: _____

Instructions

Keep freezer in OK range.



Check temperatures twice a day.

1. Fill out month, year, freezer ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/freezer ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name: _____

Signature: _____
Date: ___/___/___
Staff Na mes and Initials: _____

_____

_____

VFC _____

Health Education Materials for CalViva Health Members

Providers may fax requests to 800-628-2704, or email the completed form to Healtheducationdept@healthnet.com. For questions, call 800-804-6074.

Provider information – please print clearly		
Provider/clinic/organization name:	Contact name:	
Address:		
County:	Phone:	Email:

- 50 copies of materials will be sent for each topic ordered. A maximum of 5 topics may be ordered each month.
- Please allow 4–6 weeks for processing and delivery. For larger orders, call 800-804-6074.

Select requested topics and languages

Topics	Language(s)[1]	Topics	Language(s)[1]
Adverse Childhood Experiences (ACEs)		Mental health	
Asthma		Migraine headaches	
Breast cancer screening		Nutrition	
Breastfeeding basics		Pain control	
CalViva Health's Health Education Programs		Pregnancy	
Cervical cancer screening		Preventive screening guidelines	
Chronic obstructive pulmonary disease (COPD)		Respiratory infection (RSV)	
Cold – self care		Smoking cessation tips	
Dementia		Staying Healthy Assessment (SHA) forms[2]	
Dental – tips for healthy teeth		Stress management	
Diabetes – tips to control diabetes		Substance abuse	
Exercise		Tension headaches	
Flu		Tuberculosis	
Heart health		Urinary tract infections (UTI)	
Hypertension		Vertigo – staying safe	
Lead poisoning		Weight control	
Low back pain		Well child care	

List any additional topic that you need	Language(s)[1]

[1]All topics are available in English and Spanish. Some topics are also available in Hmong. Alternative formats may be available upon request.

[2]Staying Healthy Assessment (SHA) forms: One complete set of SHA forms will be sent for each language ordered. Forms can also be downloaded at www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx.

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

21-655/FRM369354EH01w (10/21)

Health Education Materials for Health Net Medi-Cal and Dental Members

Providers may fax requests to 800-628-2704, or email the completed form to Healtheducationdept@healthnet.com. For questions, call 800-804-6074.

Provider information – please print clearly		
Provider/clinic/organization name:	Contact name:	
Address:		
County:	Phone:	Email:

- 50 copies of materials will be sent for each topic ordered. A maximum of 5 topics may be ordered each month.
- Please allow 4–6 weeks for processing and delivery. For larger orders, call 800-804-6074.

Select requested topics and languages

Topics	Language(s)[1]	Topics	Language(s)[1]
Adverse Childhood Experiences (ACEs)		Low back pain	
Asthma		Lung disease	
Breast cancer screening		Mental health	
Breastfeeding basics		Migraine headaches	
Bipolar disorder		Nutrition	
Birth control: The Pill		Pain control	
Carotid artery disease (CAD)		Pregnancy	
Cervical cancer screening		Preventive screening guidelines	
Chronic obstructive pulmonary disease (COPD)		Respiratory infection (RSV)	
Cold – self care		Schizophrenia	
Dementia		Smoking cessation tips	
Dental – tips for healthy teeth		Staying Healthy Assessment (SHA) forms[2]	
Depression		Stress management	
Diabetes – tips to control diabetes		Substance abuse	
Exercise		Tension headaches	
Flu		Trauma brain injury	
Health Net's Health Education Programs		Tuberculosis	
Heart failure		Urinary tract infections (UTI)	
Heart health		Vertigo – staying safe	
Hypertension		Weight control	
Kidney failure		Well child care	
Lead poisoning			

List any additional topic that you need	Language(s)[1]

[1]All topics are available in English and Spanish. Some topics are also available in Arabic (Ar), Armenian (Am), Khmer (K), Farsi (F) , Hmong (H), Chinese (C), Korean (Ko), Vietnamese (V), Russian (R), and Tagalog (T). Alternative formats may be available upon request.

[2]Staying Healthy Assessment (SHA) forms: One complete set of SHA forms will be sent for each language ordered. Forms can also be downloaded at www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx.

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21-654/FRM367461EH01w (10/21)

HEALTH PLAN INTERPRETER LINES (Medi-Cal)

Aetna	**800-525-3148**	**Health Plan of San Mateo**	**800-750-4776**
Alameda Alliance For Health	**866-948-4149**	**IEHP**	**800-440-4347**
Anthem Blue Cross	**888-285-7801 (LA)** **800-407-4627**	**Kern Family Health Care**	**800-391-2000**
CalViva Health	**888-893-1569**	**L.A. Care Health Plan**	**888-930-3031**
Care1st Health Plan	**800-605-2556**	**Molina Healthcare**	**888-665-4621**
Caremore	**888-350-3447**	**Partnership Health Plan of California**	**800-863-4155**
CCAH	**855-469-5222**	**Positive Healthcare**	**866-874-3972**
Cigna Healthcare	**800-806-2059**	**San Francisco Health Plan**	**800-288-5555**
Community Health Group	**800-224-7766 (MCL)** **888-244-4430 (CMC)**	**Santa Clara Family Health Plan**	**800-260-2055 (MCL)** **800-723-4795 (CMC)**
Community Health Plan	**800-475-5550**	**Scan Health Plan**	**800-559-3500**
Community Health Plan of Imperial Valley	**833-236-4141** **TTY - 711**	**Scripps Health Plan**	**844-337-3700**
Gold Coast Health Plan	**888-301-1228**	**Sharp Health Plan**	**800-359-2002**
Health Net	**800-675-6110 (MCL)** **855-464-3571 (CMCLA)** **855-464-3572 (CMCSD)**	**United Healthcare**	**866-270-8785**
Health Plan of San Joaquin	**888-896-7526**	**Western Health Advantage**	**888-563-2250**

HEARING: Using 25 db ☑ = Normal ☒ = Abnormal						
	1000	2000	3000	4000	5000	6000
Right						
Left						

VISION: ☐ With ☐ Without Glasses

Right Eye: _____ / _____ Left Eye: _____ / _____

Both Eyes: _____ / _____

HEARING: Using 25 db ☑ = Normal ☒ = Abnormal						
	1000	2000	3000	4000	5000	6000
Right						
Left						

VISION: ☐ With ☐ Without Glasses

Right Eye: _____ / _____ Left Eye: _____ / _____

Both Eyes: _____ / _____

HEARING: Using 25 db ☑ = Normal ☒ = Abnormal						
	1000	2000	3000	4000	5000	6000
Right						
Left						

VISION: ☐ With ☐ Without Glasses

Right Eye: _____ / _____ Left Eye: _____ / _____

Both Eyes: _____ / _____

HEPATITIS B VACCINATION DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Signature of Employee Date

High-Risk Pregnancy Referral Form

For provider use only.

Please complete this form for all CalViva Health members with high-risk pregnancies within 7 days of identification. Fax form to secure fax line at (866) 878-0034. For questions, call (559) 447-6122.

SECTION A: Patient Information

Today's date (MM/DD/YY): _____ID card #/CIN #: _____Date of birth (MM/DD/YY): _____

Last name: _____First name: _____Telephone #: _____

Street address: _____City: _____State: _____ZIP code: _____

Date of last menstrual period: _____Anticipated delivery hospital:_____ Due date (MM/DD/YY): _____

Preferred language spoken: ☐ English ☐ Spanish ☐ Other: _____

Race/ethnicity: ☐ Hispanic/Latino ☐ African American ☐ Asian/Pacific Islander ☐ White ☐ Native American ☐ Other:_____

SECTION B: OB Provider Information

Last name: _____ First name: _____

Street address: _____ Suite #: _____ City: _____ State: _____ ZIP code: _____

Telephone #: _____Tax ID: _____Provider license #: _____

SECTION C: Current Medications

List all current medications:

☐ Prenatal vitamins ☐ Insulin/diabetic medication ☐ Blood pressure medication:_____

☐ Narcotics ☐ Antidepressant/anti-anxiety ☐ Other: _____

SECTION D: Identified Risk

Medical:

☐ Asthma ☐ Currently receiving 17-p injections ☐ Current placental problems

☐ Diabetes ☐ Gestational diabetes ☐ Previous preterm birth (<37 weeks)

☐ Advanced maternal age (>35 years) ☐ Genetic disorder ☐ Previous high-risk pregnancy

☐ History of poor pregnancy outcome ☐ Multifetal pregnancies ☐ Pregnancy-induced hypertension

☐ Stillbirth ☐ Multiple miscarriages ☐ LBW or VLBW

☐ Medications that may affect fetal outcome ☐ Teen pregnancy (<17 years) ☐ Other: _____

Substance Abuse:

☐ Alcohol How many drinks per day?_____ ☐ Tobacco/cigarettes Packs per day? _____

☐ Prescription medications used Name of medication:_____ How often? _____

☐ Street drugs ☐ Marijuana ☐ Other What drug(s)?_____ How often? _____

List any other medical/psychological problems not included above or other issues that may place member at risk:

_____

SECTION E: Referrals Made by OB Office or CPSP Program (indicate location or name of the program)

☐ WIC ☐ Case management_____ ☐ Health plan:_____ ☐ Nutrition counseling_____

☐ Prenatal/parenting/childbirth classes_____ ☐ Glucose monitor with nutritional counseling _____

☐ Smoking cessation_____ ☐ Substance abuse treatment_____ ☐ Psychosocial services_____

Provider comments or suggestions:

_____

_____

Signature and Title: _____ **Date:**_____

To be completed by internal case manager:

DATE CM OPENED: _____ **DATE DELIVERED:** _____ **DATE CM CLOSED:** _____

Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL | health net

High-Risk Pregnancy Referral Form

For provider use only.

Please complete this form for all Community Health Plan of Imperial Valley members with high-risk pregnancies within 7 days of identification. Fax form to secure fax line at 866-581-0540. Questions, email CASHP.ACM.CMA@healthnet.com.

SECTION A: Patient Information

Today's date (MM/DD/YY): _____ID card #/CIN #: _____Date of birth (MM/DD/YY): _____

Last name: _____First name: _____ Phone #:_____

Street address: _____City: _____State: _____ZIP Code:_____

Date of last menstrual period: _____Anticipated delivery hospital:_____ Due date (MM/DD/YY): _____

Preferred language spoken: ☐ English ☐ Spanish ☐ Other: _____

Race/ethnicity: ☐ Hispanic/Latino ☐ African American ☐ Asian/Pacific Islander ☐ White ☐ Native American ☐ Other:_____

SECTION B: OB Provider Information

Last name: _____ First name: _____

Street address: _____ Suite #: _____ City: _____ State:_____ ZIP Code: _____

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SECTION C: Current Medications

List all current medications:

☐ Prenatal vitamins ☐ Insulin/diabetic medication ☐ Blood pressure medication:_____

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SECTION D: Identified Risk

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☐ History of poor pregnancy outcome ☐ Multifetal pregnancies ☐ Pregnancy-induced hypertension

☐ Stillbirth ☐ Multiple miscarriages ☐ LBW or VLBW

☐ Medications that may affect fetal outcome ☐ Teen pregnancy (<17 years) ☐ Other: _____

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_____

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☐ Smoking cessation_____ ☐ Substance abuse treatment_____ ☐ Psychosocial services_____

Provider comments or suggestions:

_____

_____

Signature and Title: _____ **Date:**_____

To be completed by internal case manager:

DATE CM OPENED: _____ DATE DELIVERED: _____ DATE CM CLOSED: _____

High-Risk Pregnancy Referral Form

For provider use only.

Please complete this form for all Health Net members with high-risk pregnancies within 7 days of identification. Fax form to secure fax line at (866) 878-0034. For questions, call (559) 447-6122.

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Today's date (MM/DD/YY): _____ID card #/CIN #: _____Date of birth (MM/DD/YY): _____

Last name: _____First name: _____Telephone #: _____

Street address: _____City: _____State: _____ZIP code: _____

Date of last menstrual period: _____Anticipated delivery hospital:_____ Due date (MM/DD/YY): _____

Preferred language spoken: ☐ English ☐ Spanish ☐ Other: _____

Race/ethnicity: ☐ Hispanic/Latino ☐ African American ☐ Asian/Pacific Islander ☐ White ☐ Native American ☐ Other:_____

SECTION B: OB Provider Information

Last name: _____ First name: _____

Street address: _____ Suite #: _____ City: _____ State: _____ ZIP code: _____

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SECTION C: Current Medications

List all current medications:

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☐ Stillbirth ☐ Multiple miscarriages ☐ LBW or VLBW

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List any other medical/psychological problems not included above or other issues that may place member at risk:

_____

SECTION E: Referrals Made by OB Office or CPSP Program (indicate location or name of the program)

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☐ Prenatal/parenting/childbirth classes_____ ☐ Glucose monitor with nutritional counseling _____

☐ Smoking cessation_____ ☐ Substance abuse treatment_____ ☐ Psychosocial services_____

Provider comments or suggestions:

_____

_____

Signature and Title: _____ **Date:**_____

To be completed by internal case manager:

DATE CM OPENED: _____ DATE DELIVERED: _____ DATE CM CLOSED: _____

Hospice Services Documentation Guide

Submission Requirements and Documentation Overview

To initiate hospice services, the following certifications and documents must be submitted to Health Net within **five (5) calendar days** of the hospice election date. If completed documentation is not received within this timeframe, services will not be covered from the hospice admission date until all required materials are submitted.

Submission information:

- **Outpatient**: Send completed documentation via encrypted email to HospiceCTIforms@centene.com.
- **Inpatient**: Follow the Medi-Cal Provider Operations Manual > *Requesting Prior Authorization or Coordinating a PCP Referral* at https://bit.ly/HN-MCL-Prior-Authorizations. Attach all required documentation to your request.

Required Documentation by Benefit Period

Submit the following within 5 calendar days of hospice certification and election for:	
Initial 90-day benefit period	1. **Certificate of Terminal Illness (CTI),** completed from written certification statements from the hospice medical director and/or attending physician (if applicable) confirming a terminal illness with a life expectancy of six months or less (copy of oral is acceptable). 2. Medi-Cal Hospice Program Election Notice signed by the member and provider. 3. **Initial Care Plan**, which outlines the hospice services the member will receive. 4. **Transfer Summary, Discharge Summary** and/or prior **revocation of hospice elections** form(s), as applicable. 5. **Written prescription** (required for inpatient).
Second 90-day benefit period	1. **Recertification CTI.** 2. **Original CTI** (from initial 90-day period). 3. Medi-Cal Hospice Program Election Notice signed by the member and provider. 4. **Transfer Summary, Discharge Summary** and/or prior **revocation of hospice elections** form(s), as applicable.
Subsequent 60-day benefit periods	1. **Recertification CTI.** 2. **Original CTI** (from initial 90-day period). 3. Medi-Cal Hospice Program Election Notice signed by the member and provider. 4. **Face-to-Face Encounter Documentation**: Certification from a hospice physician or nurse practitioner must be performed within no more than thirty (30) calendar days before the start of each 60-day benefit period. 5. **Transfer Summary, Discharge Summary** and/or prior **revocation of hospice elections** form(s), as applicable.
Hospice revocation, discharge, or transfer	1. Revocation of hospice election form. 2. Discharge Summary and/or Transfer Summary.

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Certification and Documentation Summary

Documentation	Description	Submit within 5 calendar days	Inpatient	Outpatient

Certification of terminal illness (CTI)	Hospice care requires written certification from the attending physician and/or hospice medical director confirming a terminal illness with a life expectancy of six months or less.
	
	A physician certification must contain the qualifying clause, "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course."
	
	Neither Health Net nor its delegated PPGs may deny hospice care to a Medi-Cal member certified as terminally ill.
	
	Each certification period needs to be authorized by the provider and consists of:
	• Two 90-day periods.
	  ○ **Initial 90 days**: For the initial 90-day benefit period, the hospice provider must obtain written certification statements from the hospice medical director and/or attending physician (if applicable).
	• Followed by unlimited number of 60-day benefit periods.
	  ○ The hospice provider must obtain separate written certification of terminal illness for each hospice benefit period.
		X	**X**	**X**

Discharge summary	Indication that member is being discharged from hospice services. Required when applicable.		**X**	**X**
Face-to-face encounter documentation	Certification from the hospice medical director, designee, or hospice team physician must be supplied when the member is continuing care for **greater than three benefit periods**	**X**	**X**	**X**
Initial care plan	The initial plan of care is a required document that outlines the hospice services a member will receive.		**X**	**X**
Medi-Cal Hospice Program Election Notice	The *Medi-Cal Hospice Program Election Notice* must be signed by the member and provider.	**X**	**X**	**X**

Certification and Documentation Summary, *continued*

Documentation	Description	Submit within 5 calendar days	Inpatient	Outpatient
Prior authorization	Prior authorization is required for inpatient care only. Follow the standard prior authorization processes. Attach all required documentation to the prior authorization request.		**X**	
Request for Single Case Agreement	Out-of-network (OON) coverage will only be available when medically necessary services are not available in-network and a request for SCA is submitted.		**X**	**X**
Revocation of hospice election	Signed form by member and/or members representative indicating they are discontinuing hospice services. Required when applicable.	**X**	**X**	**X**
Transfer summary	Transfer of hospice services between agencies. Required when applicable.		**X**	**X**
Written prescription	Includes justification for general inpatient care and must be signed by the member's attending physician.		**X**	

Hospice Services Documentation Guide

Submission Requirements and Documentation Overview

To initiate hospice services, the following certifications and documents must be submitted to Health Net*, on behalf of CalViva Health, within **five (5) calendar days** of the hospice election date. If completed documentation is not received within this timeframe, services will not be covered from the hospice admission date until all required materials are submitted.

Submission information:

- **Outpatient**: Send completed documentation via encrypted email to HospiceCTIforms@centene.com.
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Second 90-day benefit period	1. **Recertification CTI.** 2. **Original CTI** (from initial 90-day period). 3. **Medi-Cal Hospice Program Election Notice** signed by the member and provider. 4. **Transfer Summary, Discharge Summary** and/or prior revocation of hospice elections form(s), as applicable.
Subsequent 60-day benefit periods	1. **Recertification CTI.** 2. **Original CTI** (from initial 90-day period). 3. **Medi-Cal Hospice Program Election Notice** signed by the member and provider. 4. **Face-to-Face Encounter Documentation**: Certification from a hospice physician or nurse practitioner must be performed within no more than thirty (30) calendar days before the start of each 60-day benefit period. 5. **Transfer Summary, Discharge Summary** and/or prior revocation of hospice elections form(s), as applicable.
Hospice revocation, discharge, or transfer	1. Revocation of hospice election form. 2. Discharge Summary and/or Transfer Summary.

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Certification and Documentation Summary

Documentation	Description	Submit within 5 calendar days	Inpatient	Outpatient

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	A physician certification must contain the qualifying clause, "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course."
	
	Neither Health Net nor its delegated PPGs may deny hospice care to a Medi-Cal member certified as terminally ill.
	
	Each certification period needs to be authorized by the provider and consists of:
	• Two 90-day periods.
	  ○ **Initial 90 days**: For the initial 90-day benefit period, the hospice provider must obtain written certification statements from the hospice medical director and/or attending physician (if applicable).
	• Followed by unlimited number of 60-day benefit periods.
	  ○ The hospice provider must obtain separate written certification of terminal illness for each hospice benefit period.
		X	**X**	**X**

Discharge summary	Indication that member is being discharged from hospice services. Required when applicable.		**X**	**X**
Face-to-face encounter documentation	Certification from the hospice medical director, designee, or hospice team physician must be supplied when the member is continuing care for **greater than three benefit periods**	**X**	**X**	**X**
Initial care plan	The initial plan of care is a required document that outlines the hospice services a member will receive.		**X**	**X**
Medi-Cal hospice program election notice	The *Medi-Cal Hospice Program Election Notice* must be signed by the member and provider.	**X**	**X**	**X**

Certification and Documentation Summary, *continued*

Documentation	Description	Submit within 5 calendar days	Inpatient	Outpatient
Prior authorization	Prior authorization is required for inpatient care only. Follow the standard prior authorization processes. Attach all required documentation to the prior authorization request.		**X**	
Request for single case agreement	Out-of-network (OON) coverage will only be available when medically necessary services are not available in-network and a request for SCA is submitted.		**X**	**X**
Revocation of hospice election	Signed form by member and/or members representative indicating they are discontinuing hospice services. Required when applicable.	**X**	**X**	**X**
Transfer summary	Transfer of hospice services between agencies. Required when applicable.		**X**	**X**
Written prescription	Includes justification for general inpatient care and must be signed by the member's attending physician.		**X**	

Hospice Services Documentation Guide

Submission Requirements and Documentation Overview

To initiate hospice services, the following certifications and documents must be submitted to Health Net*, on behalf of Community Health Plan of Imperial Valley, within **five (5) calendar days** of the hospice election date. If completed documentation is not received within this timeframe, services will not be covered from the hospice admission date until all required materials are submitted.

Submission information:

- **Outpatient**: Send completed documentation via encrypted email to HospiceCTIforms@centene.com.
- **Inpatient**: Follow the Medi-Cal Provider Operations Manual > *Requesting Prior Authorization or Coordinating a PCP Referral* at https://bit.ly/HN-MCL-Prior-Authorizations. Attach all required documentation to your request.

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Second 90-day benefit period	1. **Recertification CTI.** 2. **Original CTI** (from initial 90-day period). 3. **Medi-Cal Hospice Program Election Notice** signed by the member and provider. 4. **Transfer Summary, Discharge Summary** and/or prior **revocation of hospice elections** form(s), as applicable.
Subsequent 60-day benefit periods	1. **Recertification CTI.** 2. **Original CTI** (from initial 90-day period). 3. **Medi-Cal Hospice Program Election Notice** signed by the member and provider. 4. **Face-to-Face Encounter Documentation**: Certification from a hospice physician or nurse practitioner must be performed within no more than thirty (30) calendar days before the start of each 60-day benefit period. 5. **Transfer Summary, Discharge Summary** and/or prior **revocation of hospice elections** form(s), as applicable.
Hospice revocation, discharge, or transfer	1. Revocation of hospice election form. 2. Discharge Summary and/or Transfer Summary.

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified

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Certification and Documentation Summary

Documentation	Description	Submit within 5 calendar days	Inpatient	Outpatient

Certification of terminal illness (CTI)	Hospice care requires written certification from the attending physician and/or hospice medical director confirming a terminal illness with a life expectancy of six months or less.
	
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	  ○ **Initial 90 days**: For the initial 90-day benefit period, the hospice provider must obtain written certification statements from the hospice medical director and/or attending physician (if applicable).
	• Followed by unlimited number of 60-day benefit periods.
	  ○ The hospice provider must obtain separate written certification of terminal illness for each hospice benefit period.
		X	**X**	**X**

Discharge summary	Indication that member is being discharged from hospice services. Required when applicable.		**X**	**X**
Face-to-face encounter documentation	Certification from the hospice medical director, designee, or hospice team physician must be supplied when the member is continuing care for **greater than three benefit periods**	**X**	**X**	**X**
Initial care plan	The initial plan of care is a required document that outlines the hospice services a member will receive.		**X**	**X**
Medi-Cal hospice program election notice	The *Medi-Cal Hospice Program Election Notice* must be signed by the member and provider.	**X**	**X**	**X**

Certification and Documentation Summary, *continued*

Documentation	Description	Submit within 5 calendar days	Inpatient	Outpatient
Prior authorization	Prior authorization is required for inpatient care only. Follow the standard prior authorization processes. Attach all required documentation to the prior authorization request.		**X**	
Request for single case agreement	Out-of-network (OON) coverage will only be available when medically necessary services are not available in-network and a request for SCA is submitted.		**X**	**X**
Revocation of hospice election	Signed form by member and/or members representative indicating they are discontinuing hospice services. Required when applicable.	**X**	**X**	**X**
Transfer summary	Transfer of hospice services between agencies. Required when applicable.		**X**	**X**
Written prescription	Includes justification for general inpatient care and must be signed by the member's attending physician.		**X**	

HYSTERECTOMY - INFORMED CONSENT

This is to certify that I, _____, have been advised by my
(name of patient)
physician or his or her designee, _____, that the
(name of physician/designee)
hysterectomy which will be performed on me will render me permanently sterile and incapable of having children. I have been informed of my rights to consultation by a second physician prior to having this operation.

_____ _____
Patient Signature Date

_____ _____
Patient Representative (if any) Date

Prepare in triplicate: copy to patient; copy to patient records; copy to physician billing form.

CalViva HEALTH

Name FIRST MI LASTNAME

CIN # XXXXXXXXX

Physician Group and PCP
PPG Name
PCP or Clinic Name
Street Address
City State Zip + 4
PCP PHONE: X-XXX-XXX-XXXX

Effective date with PCP: MM/DD/YY
Office Copay: $0

Issue Date MM/DD/YY
Enrollment Date MM/DD/YY

CalViva Health only covers medical and hospital services provided or authorized by your Participating Physician Group (PPG).

To change your PPG or Primary Care Provider (PCP), call CalViva Health Member Services at 1-888-893-1569 / TTY: 711 or visit www.calvivahealth.org

Rx BIN 022659 RxPCN 6334225

CalViva Health Member Services is available 24 hours a day, 7 days a week

Member Services & Mental Health Benefits	1-888-893-1569 (TTY: 711)
Nurse Advice Line	1-888-893-1569 (TTY: 711)
Website	www.calvivahealth.org
24/7 Video Doctor Appointment	www. teladoc.com

If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital.

See your PCP for non-emergency health needs like colds, minor infections or illnesses, or treatment for ongoing health needs. Do not go to the emergency room for routine health care.

Providers Call for Eligibility and Authorization: **1-888-893-1569** Option 2 for eligibility verification.
Non-contracted hospitals requesting prior authorization for post-stabilization care: 1-800-995-7890, option 2
Medi-Cal Rx Help Line: **1-800-977-2273**
Out of area/Emergency Providers Call 1-888-893-1569 for authorization.

Prior Authorization: Primary Care Physician referral in advance is required for most non-emergency services by contracting providers. Emergency services are covered by CalViva Health without prior authorization and at no cost to the members. Emergency services rendered to the member by non-CalViva Health providers are reimbursable by CalViva Health without prior authorization.

This card is for identification only. It does not verify eligibility.

Mail all claims to: PO Box 9020, Farmington, MO 63640-9020.

CalViva HEALTH

SAMPLE SAMPLE

CIN #: [XXXXXXXXXXXX]
Card Issue Date: [MM/DD/YYYY]
Effective Date: [MM/DD/YYYY]

Member: [Member Full Name]

calvivahealth.org

PPG: [Health Care Partners of Los Angeles]
PCP/Clinic Name: [Dr. Marin Short]
Street Address
City State Zip + 4
PCP Phone Number: [1-XXX-XXX-XXXX]
Effective Date with PCP: [MM/DD/YYYY]
Office Copay: $0

This card is for identification only.
It does not verify eligibility.

RXBIN: [022659]
RXPCN: [6334225]

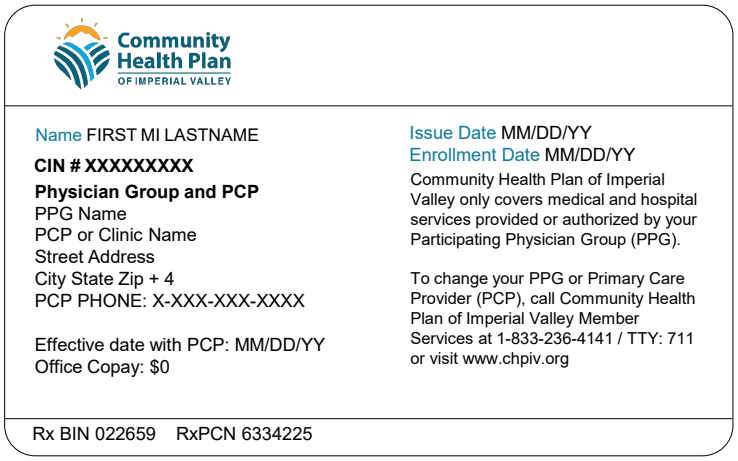
www.calvivahealth.org

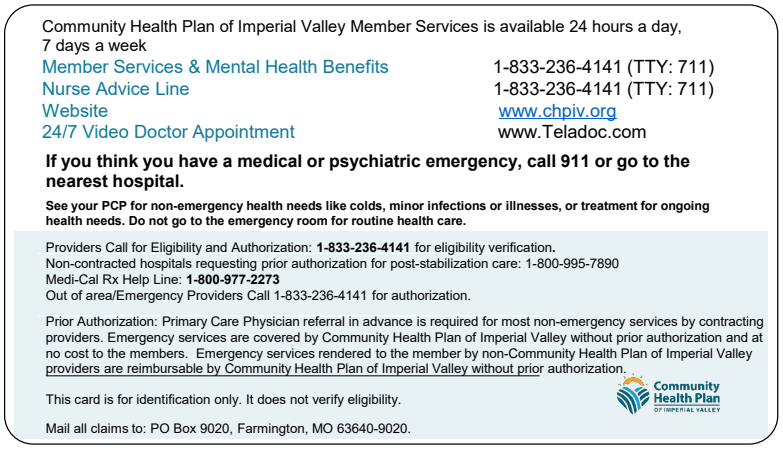
Member & Provider Services	[1-888-893-1569] (TTY: 711)
Behavioral Health Benefits	[1-888-893-1569] (TTY: 711)
24/7 Nurse Advice Line	[1-888-893-1569] (TTY: 711)
24/7 Virtual Doctor Appointment	www.teladoc.com
Medi-Cal Dental	[1-800-735-2922] (TTY: 711)
Inpatient Admits	[1-800-995-7890, option 2] (TTY: 711)
Medi-Cal RX	[1-800-977-2273] (TTY: 711)

Medical Claims:
PO Box 9040 Farmington, MO 63640-9040

Prior Authorization: Primary Care Physician referral in advance is required for most non-emergency services by contracting providers. Emergency services rendered by both contracted and non-contracted providers are covered at no cost to the member and reimbursable by CalViva Health without prior authorization.

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room.





Your Community Health Plan of Imperial Valley ID Card

This is your Community Health Plan of Imperial Valley identification card. Please check that your name, doctor (PCP) and physician group (PPG) are correct. If you find a mistake, call Community Health Plan of Imperial Valley Member Services. The phone number is listed on your ID card.

Carry this ID card with you at all times. Show it to your provider when you receive services. See Evidence of Coverage, included with your welcome packet, for a description of your benefits.

Please destroy old ID cards.

More Services

Your new telehealth service provider is Teladoc. Teladoc gives you 24/7 access to U.S. board-certified doctors. You can access them with ease – either through the web, your phone or through the Teladoc app. Get the care you need in minutes from the comfort of home or at work. Or, get care even while traveling!

Community Health Plan
OF IMPERIAL VALLEY | MEDI-CAL

CIN #: [XXXXXXXXXXXX]
Card Issue Date: [MM/DD/YYYY]
Effective Date: [MM/DD/YYYY]

Member: [Member Full Name]

chpiv.org

PPG: [Health Care Partners of Los Angeles]
PCP/Clinic Name: [Dr. Marin Short]
Street Address
City State Zip + 4
PCP Phone Number: [1-XXX-XXX-XXXX]
Effective Date with PCP: [MM/DD/YYYY]
Office Copay: $0

This card is for identification only.
It does not verify eligibility.

RXBIN: [022659]
RXPCN: [6334225]

www.chpiv.org

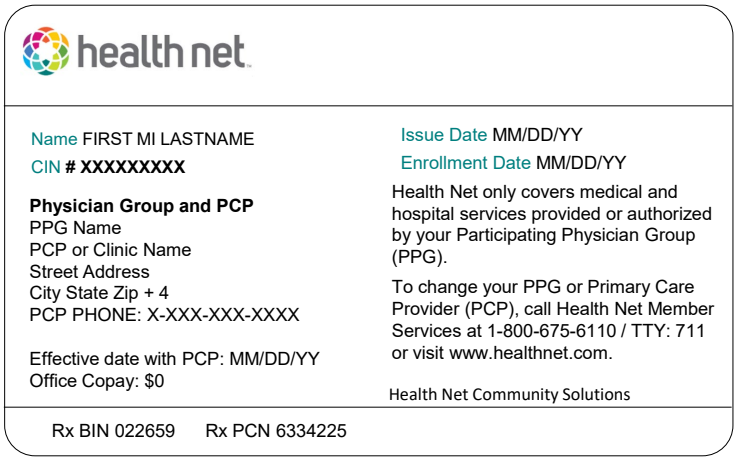
Member Services	[1-833-236-4141] (TTY: 711)
Behavioral Health Benefits	[1-833-236-4141] (TTY: 711)
24/7 Nurse Advice Line	[1-833-236-4141] (TTY: 711)
24/7 Virtual Doctor Appointment	www.teladoc.com
Provider Services	[1-833-236-4141] (TTY: 711)
Inpatient Admits	[1-800-995-7890] (TTY: 711)
Medi-Cal RX	[1-800-977-2273] (TTY: 711)

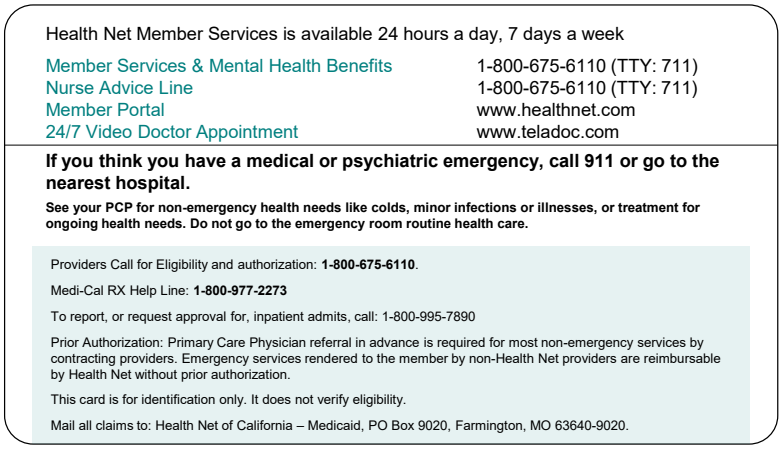
Medical Claims:
PO Box 9040 Farmington, MO 63640-9040

Community Health Plan
OF IMPERIAL VALLEY | MEDI-CAL

Prior Authorization: Primary Care Physician referral in advance is required for most non-emergency services by contracting providers. Emergency services rendered by both contracted and non-contracted providers are covered at no cost to the member and reimbursable by Community Health Plan of Imperial Valley without prior authorization.

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room.





Your Health Net ID Card

This is your Health Net identification card. Please check that your name, doctor (PCP), and physician group (PPG) are correct. If you find a mistake, call Health Net Member Services. The phone number is listed on your ID card.

Carry this ID card with you at all times. Show it to your provider when you receive services. See your Evidence of Coverage, included with your welcome packet, for a description of your benefits.

Please destroy old ID cards.

health net

CIN #: [XXXXXXXXXXXX]
Card Issue Date: [MM/DD/YYYY]
Effective Date: [MM/DD/YYYY]

Member: [Member Full Name]

healthnet.com

PPG: [Health Care Partners of Los Angeles]
PCP/Clinic Name: [Dr. Marin Short]
Street Address
City State Zip + 4
PCP Phone Number: [1-XXX-XXX-XXXX]
Effective Date with PCP: [MM/DD/YYYY]
Office Copay: $0

This card is for identification only.
It does not verify eligibility.

Health Net Community Solutions, Inc.

RXBIN: [022659]
RXPCN: [6334225]

www.healthnet.com

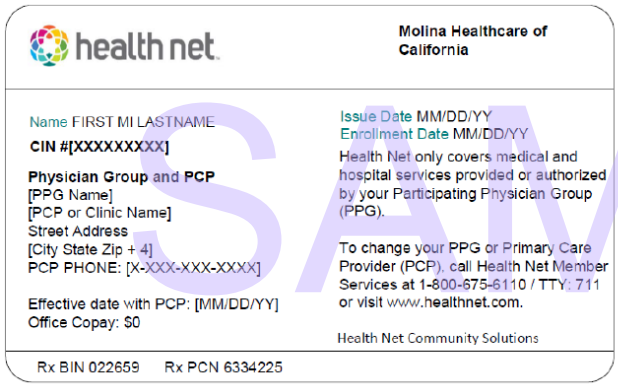
Member Services	1-800-675-6110 (TTY: 711)
Behavioral Health Benefits	1-800-675-6110 (TTY: 711)
24/7 Nurse Advice Line	1-800-675-6110 (TTY: 711)
24/7 Virtual Doctor Appointment	www.teladoc.com
Provider Services	1-800-675-6110 (TTY: 711)
Inpatient Admits	1-800-995-7890 (TTY: 711)
Medi-Cal RX	1-800-977-2273 (TTY: 711)

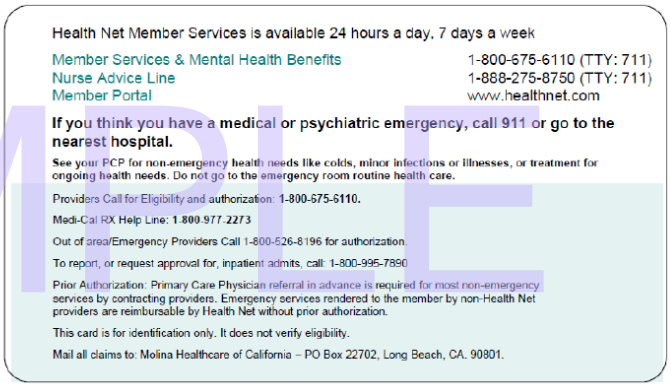
Medical Claims: Health Net Claims
PO Box 9040 Farmington, MO 63640-9040

health net

Prior Authorization: Primary Care Physician referral in advance is required for most non-emergency services by contracting providers. Emergency services rendered by both contracted and non-contracted providers are covered at no cost to the member and reimbursable by Health Net without prior authorization.

FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room.


health net
Molina Healthcare of California
Name FIRST MI LASTNAME
CIN #[XXXXXXXXX]
Physician Group and PCP
[PPG Name]
[PCP or Clinic Name]
Street Address
[City State Zip + 4]
PCP PHONE: [X-XXX-XXX-XXXX]
Effective date with PCP: [MM/DD/YY]
Office Copay: $0
Issue Date MM/DD/YY
Enrollment Date MM/DD/YY
Health Net only covers medical and hospital services provided or authorized by your Participating Physician Group (PPG).
To change your PPG or Primary Care Provider (PCP), call Health Net Member Services at 1-800-675-6110 / TTY: 711 or visit www.healthnet.com.
Health Net Community Solutions
Rx BIN 022659
Rx PCN 6334225


Health Net Member Services is available 24 hours a day, 7 days a week
Member Services & Mental Health Benefits 1-800-675-6110 (TTY: 711)
Nurse Advice Line 1-888-275-8750 (TTY: 711)
Member Portal www.healthnet.com
If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital.
See your PCP for non-emergency health needs like colds, minor infections or illnesses, or treatment for ongoing health needs. Do not go to the emergency room routine health care.
Providers Call for Eligibility and authorization: 1-800-675-6110.
Medi-Cal Rx Help Line: 1-800-977-2273
Out of area/Emergency Providers Call 1-800-526-8196 for authorization.
To report, or request approval for, inpatient admits, call: 1-800-995-7890
Prior Authorization: Primary Care Physician referral in advance is required for most non-emergency services by contracting providers. Emergency services rendered to the member by non-Health Net providers are reimbursable by Health Net without prior authorization.
This card is for identification only. It does not verify eligibility.
Mail all claims to: Molina Healthcare of California – PO Box 22702, Long Beach, CA. 90801.

SAMPLE

Individualized Care Plan (ICP)

Purpose:

To address client's problems/risks/concerns identified during prenatal visits, Prenatal Combined Assessment/Reassessment and/or Postpartum Assessment.

Definition:

The ICP is a document developed by a comprehensive perinatal practitioner(s) in conjunction with the client. The plan includes four components: obstetrical, nutritional, health education, and psychosocial. Each component includes identification of risk conditions, prioritization of needs, proposed intervention(s) including methods, timeframe, outcome goal, proposed referrals, and each health discipline's responsibilities based on the results of the assessments.

Procedure:

Client Information:

Patient:

Write in the client's complete name following the format of first name, middle initial and last name.

Gravida:

Write in the number of times the patient became pregnant including this one. All pregnancies should be counted regardless of whether they resulted in a live birth or not.

Para:

Write in the number of previous deliveries resulting in infants weighing 500 grams or more or having a gestational age of 20 weeks or more whether alive or dead at delivery. A multiple fetal pregnancy (twins, triplets, etc.) counts as only one delivery.

EDC:

Estimated Date of Confinement (EDC) or the due date is the calculated birthdate of the infant using the first day of the patient's last menstrual period. Charts
(Appendix 1) or "OB wheels" can be used for the calculation. Write in the month/day/year.

Provider Name:

Write in the name of the physician or certified nurse midwife in charge of the patients overall OB care.

Case Coordinator:

Write in the full name and title. Example: Susie Doe, CPHW

Column 1

Date:

Write in the date when the problem is identified whether at the initial assessment, reassessment, or a follow-up visit.

Strengths Identified:

Write in any of the patient's strengths that can help change the particular problem(s) or issue(s) identified at this visit. Appendix 2 lists some examples of strengths.

Column 2

Identified Problem/Risk/Concern:

Write in all problems, risks, and concerns related to obstetrical, health education, nutrition, and psychosocial issues. This box should include concerns that the patient wants addressed at this visit as well as issues identified by the CPSP Support Services staff. Number the problems if more than one is being addressed at this visit. List all risk conditions that require follow-up by the support services and medical staff. **Do not** include issues that have been adequately addressed with interventions noted in the Prenatal Combined Assessment/Reassessment Tool itself. Use all the space you need to adequately document the problem/risk/concern. If more than one row is needed, rewrite date and use "same as above" for the strengths identified on column 1. Refer to Appendix 3 for a sample list of obstetrical, health education, nutrition, and psychosocial problem/risk/concern(s).

Column 3

Teaching/Counseling/Referral(s)

Write in all specific actions being performed to remedy the problem/ risk/ concern(s). Make sure the patient agrees with proposed interventions. These actions are based on advice, counseling, resources, and referrals provided by the staff to the patient. If patient is unwilling to follow the plan provided, document your efforts. The referrals to other professionals (RD, SW, etc.) or programs (smoking cessation program, alcohol/drug services, male involvement program, etc.) should be made in accordance with practice protocols or provider recommendation. Use short sentences and do not rewrite the problem. When writing the intervention for the corresponding problem, continue using the same number previously assigned in column 2.

Column 4 & 5

Follow-up/Reassessment Date - Outcome/Plan

Write in the date at the top of the box. Restate the problem with the respective number assigned in column 2. At the follow -up antepartum visit/reassessment, record patient's progress towards resolving the problem. Recheck the previous plan and comment on results obtained. If goals were not achieved, modify the plan and record new interventions. If the problem continues past column 5, rewrite it on an additional care plan sheet. If problem/ risk/concern (s) has been resolved, write a short note and then "resolved." A sample of an Individualized Care Plan is as follows:

Date: 11/13/96 **Strengths Identified**: Motivated Enjoys reading Adequate food Adequate support system Likes to learn	**Identified Problem /Risk/ Concern** 1. Iron deficiency anemia 2. Excessive weight gain	**Teaching/ Counseling/ Referral** 1. Iron supplements prescribed by the provider to be taken 3 times/day with Vit. C rich food/juice. 2. a. Handouts given per protocol b. Low fat foods choices and low fat cooking techniques discussed	**Follow-up Reassessment Date-Outcome/Plan** 12/01/96 1. Iron deficiency anemia: pt took medication for one week and stopped because of severe constipation. a. Provider prescribed a different iron supplement b. Pt was advised to increase fiber and fluid intake	**Follow-up Reassessment Date-Outcome/Plan** 12/23/96 1. Iron deficiency anemia: pt is taking iron supplement as prescribed. a. Handouts on Iron rich foods given
Date: 11/13/96 **Strengths Identified**: Same as above		2. c. Assessment of food frequency utilizing Perinatal Food Frequency Questionnaire d. Counseled to reduce the intake of fruit juices. Documented on Perinatal Food Frequency Questionnaire	12/01/96 2. Excessive weight gain: pt followed all recommendations resolved	
Date: 1/13/97 **Strengths Identified**: Same as above Interested in participating in group classes	1. Iron deficiency anemia 3. Exposure to second hand smoking	1. a. Referred to nutrition group classes 3. a. Techniques for reducing exposure discussed b. Techniques to communicate with family member discussed	1/30/97 1. Iron deficiency anemia: normal blood tests results-resolved 3. Exposure to second hand smoking: pt was unsuccessful in stopping family member from smoking. a. Referred to provider for "prescription" for family member not to smoke around client b. Handouts per protocols	2/28/97 3. Exposure to second hand smoking: the family member moved out of the house - resolved

Appendix 2

Sample Strengths List

Ability to comprehend and make decisions
Ability to cope
Adequate food
Adequate shelter/ clothing
Adequate transportation
Emotionally stable
Employed
Experience/knowledge of delivery
Experience/knowledge of infant care
Experience/knowledge of parenting
Experience/knowledge of pregnancy
Financially stable
Positive compliance
Positive self-esteem
High School Education
Interest/willingness to participate in individual/group classes
Motivated
Refrigerator/stove
Support system
Thinking of the future
Wanted/accepted/planned pregnancy

Appendix 3

Sample of Problem List

Obstetrical

Anemia/hemoglobinopathy
Blood problems
Cardiovascular disorders
Chronic renal disease
Diabetes Type 1
Diabetes Type 2
Dysplasia/GYN malignancy
Gastrointestinal disorders
Genetic risk
Gestational diabetes
Hepatitis
History of abnormal infant
History of C-Section/Uterine Surgery
History of DES exposure
History of gestational diabetes (insulin/diet controlled)
History of hospitalization(s)
History of Incompetent Cervix
History of less than 2500 gram infant
History of more than 4000 gram infant
History of neonatal death
History of preterm birth (less than 36 weeks)
History of stillbirth
HIV risk
Hypertension/chronic
Hypo/hyperthyroid
Kidney problems
Multiple gestation
Pregnancy induced hypertension
Pregnancy interval less than a year
Psychological illness
Pulmonary disease /TB
Rh hemolytic disease
Seizure disorders
STD
Uterine problems
Vaginal bleeding

Nutrition

Abnormal glucose
Anemia
Currently breast feeding
Eating disorders
Excessive wt. Gain during pregnancy
High caffeine consumption
High parity
Hypovolemia
Inadequate wt. Gain during pregnancy
Less than 3 years since first menses
Low income
Moderately overweight (more than 120% desirable wt.)
Previous obstetrical complications
Short interpregnancy interval
Substance use
Underweight (less than 90% desirable wt.)
Very overweight (more than 135% desirable wt.)

Health Education

Age less than 17 or greater than 35 years of age
Cardiovascular problems
Conflict scheduling class times
Diabetes
Economic and housing problems
Extreme anxiety or emotional problems
Low education level
Failed Appointments
Family problems/Abuse
HIV risk status
Inability to read or write or low reading level
Inability to reach decisions or comprehension difficulties
Inadequate nutritional status
Lack of social support structure
Late initiation of prenatal care
Low motivation or interest
Little or no experience with U.S. health care
Negative attitude about pregnancy
Noncompliance with medical advice
Occupational risk
Past negative experience with U.S. health care
Physical disabilities
Preterm labor
Primigravida or multi-gravida with five or more
Substance use
Transportation

Psychosocial

Eating disorders
Excessive difficulty in coping with crisis interfering with self care
Excessive worries/fears regarding body image
Excessive worries/fears related to fetus
Extreme difficulty or resistance to comply with medical recommendations
Fear of dying during labor
Fears of inability to parent
Frequent complaints for which no diagnosis can be found
History or current indication of domestic violence
Lack of resources (financial, transportation, food, clothing, shelter)
Pregnancy complicated by detection of fetal anomaly
Previous pregnancy loss
Previous psychological history of depression, suicide, psychosis
Rejection or denial of pregnancy
Relationship problems or absence of a support person
Severe emotional problems
Unrealistic positive or negative feelings about pregnancy/motherhood/parenthood

Provider Communications

HEALTH INDUSTRY COLLABORATION EFFORT

HICE

Simplifying Healthcare Administration

Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

On behalf of the ICE Cultural and Linguistic Workgroup,

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SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is

1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

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[1] Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations**- *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion**- *asks about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identifies your patient's language needs including health literacy levels. Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment –** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as "*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*"

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

✓ Use simple words and avoid jargon. ✓ Never use acronyms. ✓ Avoid technical language (if possible). ✓ Repeat important information – a patient's logic may be different from yours. ✓ Ask patients to repeat back to you important information. ✓ Ask open-ended questions. ✓ Use medically trained interpreters familiar with cultural nuances.	✓ Give information in small chunks. ✓ Articulate words. ✓ "Read" written instructions out load. ✓ Speak slowly (don't shout). ✓ Use body language to support what you are saying. ✓ Draw pictures, use posters, models or physical demonstrations. ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

Use **Ask Me 3®**[2]. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

INTERVIEW QUESTIONS

Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.*

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.*

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?*

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.*

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

EFFECTIVE COMMUNICATION

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

AUXILIARY AIDS AND SERVICES

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key.
For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

COMPANIONS

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the ADA, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	**These are some options we can provide for you…..**
Am blind or have vision impairments that keep me from reading	- Large print materials - Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped https://www.loc.gov/nls/pdf/application.pdf - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older- People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:
The KEY to Patient Engagement

Where do I start?
Check out the Q&A below to learn more...

Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:
- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

Go: *pull it all together, implement, evaluate, plan for the future*

What language service needs should I begin to identify?

Keep it simple and write down:
- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!
- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!
- Review resources and identify those most useful for your office

Go!
- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies. and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit http://ddtp.cpuc.ca.gov/homepage.aspx

Teletype Device

Relay Operator

Cell or Landline Phone

SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B

RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent
- answers to your questions
- Member may have trouble communicating in English or you may have a
- very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

"*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

OR

"*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

"*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak…." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

TIPS FOR WORKING WITH INTERPRETERS

TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

When the interpreter comes onto the line let the interpreter know the following: **

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.**

ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **

- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
  Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

1) Identify the languages spoken by your patients, and
2) Identify the language services available to meet these needs

For example:

Language spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in person interpreter

Identify the language capability of your staff (See Employee Language Skills Self-Assessment)
• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency
• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. ***IF you use a minor, document the reason a minor was used.***

<u>Identify services available</u> do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry Collaboration Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic العربية
أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Armenian Հայերեն
Նշեք, թե որ լեզվով եք խոսում: Թարգմանիչ կկանչենք: Թարգմանչի ծառայությունները տրամադրվում են անվճար:

Bengali বাংলা
আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বোভাষীকে ডাকা হবে। দ্বোভাষী আপনি নিখরচায় পাবেন।

Cambodian (Khmer) ខ្មែរ (កម្ពុជា)
សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។

Chinese (Cantonese) 廣東話
請指認您的語言，以便為您提供免費的口譯服務。

Chinese (Mandarin) 普通话
请指认您的语言，以便为您提供免费的口译服务。

Farsi (Persian) فارسي
زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

Greek Ελληνικά
Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.

Hindi हिंदी
अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।

Hmong Hmoob
Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Japanese 日本語
あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean 한국어
귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.

Portuguese Português
Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi ਪੰਜਾਬੀ
ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Russian Русский
Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Samoan Fa`asamoa
Fa`asino lau gagana. Ole a vala`au se fa`amatala`upu. Ua saunia se fa`amatala`upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Español
Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai ไทย
ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย

Tongan Tongan Lea Faka-Tonga
Tuhu`i mai ho`o lea fakafonua. `E ui ha fakatonulea. `Oki ta`etotongi kia `a e fakatonulea.

Urdu اردو
اپنی زبان پر اشارہ کریں- ایک ترجمان کو بلاجائے گا- ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا-

Vietnamese Tiếng Việt
Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

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COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中文	*Chinese*	歡迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieâït	*Vietnamese*	Phòng vệ sinh
中文	*Chinese*	洗手間

Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**

Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Cl
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Courtesy statements	***Frases de cortesía***	***Từ ngữ lịch sự***	
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Patient may say….	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	病
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

Patient may say…	*El paciente puede decir…*	*Bệnh nhân có thể nói...*	*病人可能會說...*
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？

Point to a sentence **Señale una frase** **Xin chỉ vào câu** **指向句子**

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員可能會問或說。。。*
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	
Point to a sentence	Señale una frase	Xin chỉ vào câu	

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員*
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現*

Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**

Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kr
Point to a sentence	**Señale una frase**	**Lonje dwèt ou s**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Ko***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an ka*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè dokè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	ske mwen ka gen yon entèprèt?

Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab di oubyen mande...**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka ѐ pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon enѐprѐt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon enѐprѐt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Krey
Point to a sentence	Señale una frase	Lonje dwèt ou sou
Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **po**
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou
Now, fill out these forms, please	*Ahora, por favor conteste estas formas.*	*Kounye a, ekri enfimasyon yo ma*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.
Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ **Department/Job Title:** _____

_____

Work Days: **Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun** **Work Hours (Please Specify):** _____

_____

Directions: (1) List any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language

Language	**Dialect, region, or country**	**Fluency: see attached key (Circle)**			**I would like to use my language skills to speak with patients (Circle)**	**I would like to use my reading language skills to communicate with patients (Circle)**	**I would like to use my language skills to write patient communications (Circle)**
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?

SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: http://minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities…

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit https://www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website https://www.thinkculturalhealth.hhs.gov , sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, http://minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, http://minorityhealth.hhs.gov
- Think Cultural Health, https://www.thinkculturalhealth.hhs.gov

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
Confidentiality Preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020[2], LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.

Visit glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit glaad.org for additional resources on how to fairly and accurately report on transgender people

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- **GLMA cultural competence webinar series**
- **Providing Enhanced Resources Cultural Competency Training**
- **LGBT Health Resources**
- **Equal Employment Opportunity Commission** for your local EEOC field office
- **Creating an LGBT Friendly Practice**
- **LGBT Training Curricula for Behavioral Health and Primary Care Practitioners**
- **Preventing Discrimination**
- **Bullying Policies & Laws**

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
    - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
    - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
    - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.

- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand,	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
Beliefs About Drug Addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

		what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **Note: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.1

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Other federal and state legislation protecting the right to "equal care" outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued "Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.
The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity
  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier

an obstacle, impediment, obstruction, boundary, or separation.

Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication

the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

Disability

any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity

an avoidable and unfair difference in health status between segments of the population.

Health Literacy

the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation
: In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
: one who translates orally for parties conversing in different languages.

Language
: the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
: is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
: Anything intended to aid memory.

Race
: the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
: an asset valuable commodity or service.

Service
: help or assistance.

Speech
: the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
: a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
: a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
: an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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Guidance to Comply with New Interpreter Quality Standards
Requirements on the use of Bilingual/Multilingual Staff as Interpreters

Summary of Requirements and Documentation		
Requirement	**Potential Evidence**	**Provider Office to Note Documentation of Qualification**
Office has a documented policy to offer interpreter support to LEP patients	☐ Local office written policy; or ☐ Local office policy that defers and adheres to the policy distributed by medical group Note: Policy includes documentation of patient language needs in medical record	Written policy available for viewing by an auditor Policy title:
Adheres to generally accepted interpreter ethics principles, including client confidentiality	Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at: http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf	Signed attestations are available. ☐ Yes ☐ No
Has *demonstrated* proficiency in speaking and understanding both spoken English and at least one other spoken language	☐ Formal assessment of proficiency; or ☐ Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology	☐ Formal assessment of proficiency; or Annual performance evaluations document ☐ Ability to interpret effectively, ☐ Ability to interpret accurately, ☐ Ability to interpret impartially, ☐ Ability to interpret receptively and expressly, ☐ Ability to interpret to and from English and another language using any **necessary specialized vocabulary terminology and phraseology** Note: see NCIHC Interpreter Code of Ethics for description of above.	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D. **http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf**		

Language Proficiency Assessment Resources

The bilingual assessment vendors included on this list are suggestions that providers might consider if they choose to use a bilingual assessment vendor to help ensure that they are using qualified bilingual staff to provide patient care, as these organizations have self-attested that they meet the required criteria. However, that should not be considered an endorsement for any language service vendor by ICE. The ICE C&L Team has not in the past and does not now endorse any language service vendors.

Language Proficiency Assessment Resources						
		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Berkeley Language Institute (BLI) Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).	http://www.berkeleylanguageinstitute.com/index.html 1-510-655-9469 Marci Valdivieso marci@berkeleylanguageinstitute.com	**8 languages offered**: Arabic, Chinese (Mandarin, Cantonese, and Taishanese/ Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese	Yes	• Professional language assessments for interpreters, translators, & bilingual speakers • Language Proficiency Oral Assessment – ideal for current & pre-employment bilingual employees • Language Proficiency Written Assessment • Medical Staff Oral Assessment • Healthcare Interpreter Assessments	Evaluators are experienced linguists that have: • At least five years interpreter & translator experience • Have shown an aptitude to be language evaluators. • They are generally certified by/with the National Board or CCHI if the language pair is an option, or • They are otherwise assessed and trained prior to being given evaluation assignments	Cost will vary depending on language pair and type of assessment $115 - $190/ person
Culture Advantage Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.	https://cultureadvantage.org/ 1-316-217-0198 Marlene Obermeyer, MA, RN director@cultureadvantage.org	**10 languages offered**: Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese	Yes All medical specialties offered in the professional program	• Bilingual Staff Medical Interpreting Skills Assessment (MISA) • Specialty-specific Medical Interpreting Skills Assessment	• Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair	Cost will vary $200 /MISA $250 - $950 for Online Courses
ISI Language Solutions ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations.	https://isilanguagesolutions.com/industries/healthcare/ 1-818-753-9181 John Lopez john@isitrans.com Christina Xu Christina@isitrans.com	**22 languages offered**: Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese	No	• Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole ○ Language Proficiency Assessment ○ Building Cultural Competency Workshop ○ Medical Terminology Workshop ○ Medical Interpreting Ethics and Protocol Workshop	Professional Linguists • Certification or Accreditation from American Translators Association (ATA) or equivalent organization • Degree in Translation or foreign equivalent • Subject-Matter expertise in the field of Life Sciences • Extensive experience in translation and linguistics	Must contact for costs Cost example: • Flat rate/ test - $80

To report any updates to this document, i.e., an organization that should no longer be included, or an organization that meets the criteria and should be included on this document, please contact: Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Language Line Academy (LLA) Our professional testing and training ensures the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.	https://www.langualeline.com/ 1-844-552-8378 Ana Catalina Arguedas Fernández lla@languageline.com	**1 language offered**: Spanish	Yes Pediatrics Mental Health OB/Gyn Ophthalmology Gastroenterology Oncology Cardiology Pharmacy	• Healthcare Bilingual Fluency assessment for clinicians and medical staff • Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour • Interpreter Readiness Assessment • Interpreter Skills Test	LLA testers have a variety of qualifications, including: • M.A., Translation & Interpretation • Years of medical interpreting experience • External interpreter certification credentials	Cost will vary $145 - $160/ test Volume discounts available
Language Testing International (LTI) In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests.	https://www.languagetesting.com/ 1-800-486-8444 Marketing/ Scheduling Team Diane ext. 123 Dina ext. 127 info@languagetesting.com	**100+ languages offered**, most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish View complete list of languages online	Offers general testing/ proficiency assessments Does not specifically assess proficiency for healthcare interpretation or translation services	• Oral Proficiency Interview 15 – 30 minute telephonic interview • Oral Proficiency Interview – Computer 20 – 40 minute on-demand, internet or phone-delivered proficiency test • Writing Proficiency Test via the web 20 – 80 minutes • Listening Proficiency Test 50 – 125 minutes • Reading Proficiency Test 50 – 125 minutes	LTI strictly uses • Certified ACTFL testers and raters Ensuring quality and validity of tests	Contact for costs Package options available for some languages Cost examples: • $100 - $200/ person for phone survey • $159 for web based proctoring
MasterWord For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.	https://www.masterword.com/ 1-866-716-4999 masterword@masterword.com	**250+ languages offered** for interpreting and translation **Contact for languages offered for proficiency assessments**	Not specified Offers On Demand training & Webinars for Healthcare, includes: • Maternal Fetal Medicine • Cardiology • Mental Health • Oncology • Emergency	• Language Proficiency Assessment: 60 minutes Contact for languages • Health Care Interpreter Assessment (HCIA®): 32 min. / 45 min. –oral / written Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.	Assessments based on formats of CCHI & NBCMI national certification exams	On Demand Assessments: $105 - $155

To report any updates to this document, i.e., an organization that should no longer be included, or an organization that meets the criteria and should be included on this document, please contact:
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COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).

We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials:
email Ivy Diaz at ivy.diaz@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

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Provider Communications

HEALTH INDUSTRY
COLLABORATION EFFORT

HICE

Simplifying Healthcare Administration

Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

On behalf of the ICE Cultural and Linguistic Workgroup,

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SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is

1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

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[1] Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations**- *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion**- *asks about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identifies your patient's language needs including health literacy levels. Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment –** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as "*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*"

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

✓ Use simple words and avoid jargon. ✓ Never use acronyms. ✓ Avoid technical language (if possible). ✓ Repeat important information – a patient's logic may be different from yours. ✓ Ask patients to repeat back to you important information. ✓ Ask open-ended questions. ✓ Use medically trained interpreters familiar with cultural nuances.	✓ Give information in small chunks. ✓ Articulate words. ✓ "Read" written instructions out load. ✓ Speak slowly (don't shout). ✓ Use body language to support what you are saying. ✓ Draw pictures, use posters, models or physical demonstrations. ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

Use **Ask Me 3®**[2]. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

INTERVIEW QUESTIONS

Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.*

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.*

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?*

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.*

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

EFFECTIVE COMMUNICATION

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

AUXILIARY AIDS AND SERVICES

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key.
For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

COMPANIONS

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the ADA, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	**These are some options we can provide for you…..**
Am blind or have vision impairments that keep me from reading	- Large print materials - Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped https://www.loc.gov/nls/pdf/application.pdf - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older- People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:
The KEY to Patient Engagement

Where do I start?
Check out the Q&A below to learn more...

Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:
- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

Go: *pull it all together, implement, evaluate, plan for the future*

What language service needs should I begin to identify?

Keep it simple and write down:
- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!
- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!
- Review resources and identify those most useful for your office

Go!
- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies. and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit http://ddtp.cpuc.ca.gov/homepage.aspx

Teletype Device

Relay Operator

Cell or Landline Phone

SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B

RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent
- answers to your questions
- Member may have trouble communicating in English or you may have a
- very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

"*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

OR

"*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

"*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak…." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

TIPS FOR WORKING WITH INTERPRETERS

TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

When the interpreter comes onto the line let the interpreter know the following: **

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.**

ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **

- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
  Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

1) Identify the languages spoken by your patients, and
2) Identify the language services available to meet these needs

For example:

Language spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in person interpreter

Identify the language capability of your staff (See Employee Language Skills Self-Assessment)
• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency
• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. ***IF you use a minor, document the reason a minor was used.***

<u>Identify services available</u> do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry Collaboration Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic العربية
أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Armenian Հայերեն
Նշեք, թե որ լեզվով եք խոսում: Թարգմանիչ կկանչենք: Թարգմանչի ծառայությունները տրամադրվում են անվճար:

Bengali বাংলা
আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বোভাষীকে ডাকা হবে। দ্বোভাষী আপনি নিখরচায় পাবেন।

Cambodian (Khmer) ខ្មែរ (កម្ពុជា)
សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។

Chinese (Cantonese) 廣東話
請指認您的語言，以便為您提供免費的口譯服務。

Chinese (Mandarin) 普通话
请指认您的语言，以便为您提供免费的口译服务。

Farsi (Persian) فارسي
زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

Greek Ελληνικά
Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.

Hindi हिंदी
अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।

Hmong Hmoob
Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Japanese 日本語
あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean 한국어
귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.

Portuguese Português
Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi ਪੰਜਾਬੀ
ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Russian Русский
Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Samoan Fa`asamoa
Fa`asino lau gagana. Ole a vala`au se fa`amatala`upu. Ua saunia se fa`amatala`upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Español
Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai ไทย
ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย

Tongan Tongan Lea Faka-Tonga
Tuhu`i mai ho`o lea fakafonua. `E ui ha fakatonulea. `Oki ta`etotongi kia `a e fakatonulea.

Urdu اردو
اپنی زبان پر اشارہ کریں- ایک ترجمان کو بلاجائے گا- ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا-

Vietnamese Tiếng Việt
Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

Provided courtesy of Industry Collaboration Effort and LanguageLine Solutions.

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COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中文	*Chinese*	歡迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieâït	*Vietnamese*	Phòng vệ sinh
中文	*Chinese*	洗手間

Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**

Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Cl
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Courtesy statements	***Frases de cortesía***	***Từ ngữ lịch sự***	
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Patient may say….	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	病
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

Patient may say…	*El paciente puede decir…*	*Bệnh nhân có thể nói...*	*病人可能會說...*
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？

Point to a sentence **Señale una frase** **Xin chỉ vào câu** **指向句子**

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員可能會問或說。。。*
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	
Point to a sentence	Señale una frase	Xin chỉ vào câu	

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員*
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現*

Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**

Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kr
Point to a sentence	**Señale una frase**	**Lonje dwèt ou s**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Ko***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an ka*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè dokè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	ske mwen ka gen yon entèprèt?

Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab di oubyen mande...**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka ѐ pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon enѐprѐt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon enѐprѐt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Krey
Point to a sentence	Señale una frase	Lonje dwèt ou sou
Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **po**
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou
Now, fill out these forms, please	*Ahora, por favor conteste estas formas.*	*Kounye a, ekri enfimasyon yo ma*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.
Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ **Department/Job Title:** _____

_____

Work Days: **Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun** **Work Hours (Please Specify):** _____

_____

Directions: (1) List any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language

Language	**Dialect, region, or country**	**Fluency: see attached key (Circle)**			**I would like to use my language skills to speak with patients (Circle)**	**I would like to use my reading language skills to communicate with patients (Circle)**	**I would like to use my language skills to write patient communications (Circle)**
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?

SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: http://minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities…

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit https://www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website https://www.thinkculturalhealth.hhs.gov , sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, http://minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, http://minorityhealth.hhs.gov
- Think Cultural Health, https://www.thinkculturalhealth.hhs.gov

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
Confidentiality Preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020[2], LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.

Visit glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit glaad.org for additional resources on how to fairly and accurately report on transgender people

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- **GLMA cultural competence webinar series**
- **Providing Enhanced Resources Cultural Competency Training**
- **LGBT Health Resources**
- **Equal Employment Opportunity Commission** for your local EEOC field office
- **Creating an LGBT Friendly Practice**
- **LGBT Training Curricula for Behavioral Health and Primary Care Practitioners**
- **Preventing Discrimination**
- **Bullying Policies & Laws**

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
    - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
    - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
    - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.

- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand,	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
Beliefs About Drug Addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

		what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **Note: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.1

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Other federal and state legislation protecting the right to "equal care" outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued "Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.
The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity
  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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www.whitehouse.gov/omb/fedreg_race-ethnicity

www.who.int.healthsystems/topics/equity

CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier

an obstacle, impediment, obstruction, boundary, or separation.

Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication

the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

Disability

any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity

an avoidable and unfair difference in health status between segments of the population.

Health Literacy

the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation
: In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
: one who translates orally for parties conversing in different languages.

Language
: the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
: is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
: Anything intended to aid memory.

Race
: the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
: an asset valuable commodity or service.

Service
: help or assistance.

Speech
: the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
: a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
: a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
: an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL

health net

Provider Communications

HEALTH INDUSTRY COLLABORATION EFFORT

HICE

Simplifying Healthcare Administration

Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

On behalf of the ICE Cultural and Linguistic Workgroup,

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SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is

1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

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[1] Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations**- *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion**- *asks about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identifies your patient's language needs including health literacy levels. Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment –** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as "*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*"

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

✓ Use simple words and avoid jargon. ✓ Never use acronyms. ✓ Avoid technical language (if possible). ✓ Repeat important information – a patient's logic may be different from yours. ✓ Ask patients to repeat back to you important information. ✓ Ask open-ended questions. ✓ Use medically trained interpreters familiar with cultural nuances.	✓ Give information in small chunks. ✓ Articulate words. ✓ "Read" written instructions out load. ✓ Speak slowly (don't shout). ✓ Use body language to support what you are saying. ✓ Draw pictures, use posters, models or physical demonstrations. ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

Use **Ask Me 3®[2]**. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

INTERVIEW QUESTIONS

Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.*

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.*

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?*

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.*

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

EFFECTIVE COMMUNICATION

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

AUXILIARY AIDS AND SERVICES

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key.
For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

COMPANIONS

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the ADA, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	**These are some options we can provide for you…..**
Am blind or have vision impairments that keep me from reading	- Large print materials - Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped https://www.loc.gov/nls/pdf/application.pdf - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older- People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:
The KEY to Patient Engagement

Where do I start?
Check out the Q&A below to learn more...

Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:
- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

Go: *pull it all together, implement, evaluate, plan for the future*

What language service needs should I begin to identify?

Keep it simple and write down:
- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!
- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!
- Review resources and identify those most useful for your office

Go!
- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies. and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit http://ddtp.cpuc.ca.gov/homepage.aspx

Teletype Device

Relay Operator

Cell or Landline Phone

SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B

RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent
- answers to your questions
- Member may have trouble communicating in English or you may have a
- very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

"*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

OR

"*May I put you on hold? I am going to connect us with an interpreter*." (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

"*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak…." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

TIPS FOR WORKING WITH INTERPRETERS

TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

When the interpreter comes onto the line let the interpreter know the following: **

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.**

ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **

- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
  Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

1) Identify the languages spoken by your patients, and
2) Identify the language services available to meet these needs

For example:

Language spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in person interpreter

Identify the language capability of your staff (See Employee Language Skills Self-Assessment)
• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency
• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. ***IF you use a minor, document the reason a minor was used.***

<u>Identify services available</u> do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry Collaboration Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic العربية
أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Armenian Հայերեն
Նշեք, թե որ լեզվով եք խոսում: Թարգմանիչ կկանչենք: Թարգմանչի ծառայությունները տրամադրվում են անվճար:

Bengali বাংলা
আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বোভাষীকে ডাকা হবে। দ্বোভাষী আপনি নিখরচায় পাবেন।

Cambodian (Khmer) ខ្មែរ (កម្ពុជា)
សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។

Chinese (Cantonese) 廣東話
請指認您的語言，以便為您提供免費的口譯服務。

Chinese (Mandarin) 普通话
请指认您的语言，以便为您提供免费的口译服务。

Farsi (Persian) فارسي
زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

Greek Ελληνικά
Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.

Hindi हिंदी
अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।

Hmong Hmoob
Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Japanese 日本語
あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean 한국어
귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.

Portuguese Português
Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi ਪੰਜਾਬੀ
ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Russian Русский
Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Samoan Fa`asamoa
Fa`asino lau gagana. Ole a vala`au se fa`amatala`upu. Ua saunia se fa`amatala`upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Español
Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai ไทย
ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย

Tongan Tongan Lea Faka-Tonga
Tuhu`i mai ho`o lea fakafonua. `E ui ha fakatonulea. `Oki ta`etotongi kia `a e fakatonulea.

Urdu اردو
اپنی زبان پر اشارہ کریں- ایک ترجمان کو بلاجائے گا- ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا-

Vietnamese Tiếng Việt
Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

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COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中文	*Chinese*	歡迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieâït	*Vietnamese*	Phòng vệ sinh
中文	*Chinese*	洗手間

Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**

Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Cl
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Courtesy statements	***Frases de cortesía***	***Từ ngữ lịch sự***	
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Patient may say….	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	病
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

Patient may say…	*El paciente puede decir…*	*Bệnh nhân có thể nói...*	*病人可能會說...*
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？

Point to a sentence **Señale una frase** **Xin chỉ vào câu** **指向句子**

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員可能會問或說。。。*
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Staff may ask or say…	***El personal del médico le puede decir…***	***Nhân viên có thể hỏi hoặc nói..***	***職員***
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現*

Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**

Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kr
Point to a sentence	**Señale una frase**	**Lonje dwèt ou s**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Ko***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an ka*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè dokè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	ske mwen ka gen yon entèprèt?

Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab di oubyen mande...**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka ѐ pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon enѐprѐt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon enѐprѐt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Krey
Point to a sentence	Señale una frase	Lonje dwèt ou sou
Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **po**
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou
Now, fill out these forms, please	*Ahora, por favor conteste estas formas.*	*Kounye a, ekri enfimasyon yo ma*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.
Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ **Department/Job Title:** _____

_____

Work Days: **Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun** **Work Hours (Please Specify):** _____

_____

Directions: (1) List any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language

Language	**Dialect, region, or country**	**Fluency: see attached key (Circle)**			**I would like to use my language skills to speak with patients (Circle)**	**I would like to use my reading language skills to communicate with patients (Circle)**	**I would like to use my language skills to write patient communications (Circle)**
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?

SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: http://minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities…

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit https://www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website https://www.thinkculturalhealth.hhs.gov , sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, http://minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, http://minorityhealth.hhs.gov
- Think Cultural Health, https://www.thinkculturalhealth.hhs.gov

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
Confidentiality Preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020[2], LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.

Visit glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit glaad.org for additional resources on how to fairly and accurately report on transgender people

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- **GLMA cultural competence webinar series**
- **Providing Enhanced Resources Cultural Competency Training**
- **LGBT Health Resources**
- **Equal Employment Opportunity Commission** for your local EEOC field office
- **Creating an LGBT Friendly Practice**
- **LGBT Training Curricula for Behavioral Health and Primary Care Practitioners**
- **Preventing Discrimination**
- **Bullying Policies & Laws**

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
    - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
    - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
    - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.

- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand,	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
Beliefs About Drug Addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

		what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **Note: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.1

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Other federal and state legislation protecting the right to "equal care" outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued "Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.
The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity
  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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www.whitehouse.gov/omb/fedreg_race-ethnicity

www.who.int.healthsystems/topics/equity

CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier

an obstacle, impediment, obstruction, boundary, or separation.

Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication

the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture
: shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Demographics
: of or related to the study of changes that occur in the large groups of people over a period of time.

Disability
: any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination
: the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse
: of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

Engagement
: in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity
: ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities
: is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity
: an avoidable and unfair difference in health status between segments of the population.

Health Literacy
: the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation
: In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
: one who translates orally for parties conversing in different languages.

Language
: the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
: is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
: Anything intended to aid memory.

Race
: the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
: an asset valuable commodity or service.

Service
: help or assistance.

Speech
: the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
: a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
: a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
: an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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Guidance to Comply with New Interpreter Quality Standards
Requirements on the use of Bilingual/Multilingual Staff as Interpreters

Summary of Requirements and Documentation		
Requirement	**Potential Evidence**	**Provider Office to Note Documentation of Qualification**
Office has a documented policy to offer interpreter support to LEP patients	☐ Local office written policy; or ☐ Local office policy that defers and adheres to the policy distributed by medical group Note: Policy includes documentation of patient language needs in medical record	Written policy available for viewing by an auditor Policy title:
Adheres to generally accepted interpreter ethics principles, including client confidentiality	Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at: http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf	Signed attestations are available. ☐ Yes ☐ No
Has *demonstrated* proficiency in speaking and understanding both spoken English and at least one other spoken language	☐ Formal assessment of proficiency; or ☐ Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology	☐ Formal assessment of proficiency; or Annual performance evaluations document ☐ Ability to interpret effectively, ☐ Ability to interpret accurately, ☐ Ability to interpret impartially, ☐ Ability to interpret receptively and expressly, ☐ Ability to interpret to and from English and another language using any **necessary specialized vocabulary terminology and phraseology** Note: see NCIHC Interpreter Code of Ethics for description of above.	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D. **http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf**		

Language Proficiency Assessment Resources

The bilingual assessment vendors included on this list are suggestions that providers might consider if they choose to use a bilingual assessment vendor to help ensure that they are using qualified bilingual staff to provide patient care, as these organizations have self-attested that they meet the required criteria. However, that should not be considered an endorsement for any language service vendor by ICE. The ICE C&L Team has not in the past and does not now endorse any language service vendors.

Language Proficiency Assessment Resources						
		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Berkeley Language Institute (BLI) Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).	http://www.berkeleylanguageinstitute.com/index.html 1-510-655-9469 Marci Valdivieso marci@berkeleylanguageinstitute.com	**8 languages offered**: Arabic, Chinese (Mandarin, Cantonese, and Taishanese/ Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese	Yes	• Professional language assessments for interpreters, translators, & bilingual speakers • Language Proficiency Oral Assessment – ideal for current & pre-employment bilingual employees • Language Proficiency Written Assessment • Medical Staff Oral Assessment • Healthcare Interpreter Assessments	Evaluators are experienced linguists that have: • At least five years interpreter & translator experience • Have shown an aptitude to be language evaluators. • They are generally certified by/with the National Board or CCHI if the language pair is an option, or • They are otherwise assessed and trained prior to being given evaluation assignments	Cost will vary depending on language pair and type of assessment $115 - $190/ person
Culture Advantage Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.	https://cultureadvantage.org/ 1-316-217-0198 Marlene Obermeyer, MA, RN director@cultureadvantage.org	**10 languages offered**: Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese	Yes All medical specialties offered in the professional program	• Bilingual Staff Medical Interpreting Skills Assessment (MISA) • Specialty-specific Medical Interpreting Skills Assessment	• Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair	Cost will vary $200 /MISA $250 - $950 for Online Courses
ISI Language Solutions ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations.	https://isilanguagesolutions.com/industries/healthcare/ 1-818-753-9181 John Lopez john@isitrans.com Christina Xu Christina@isitrans.com	**22 languages offered**: Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese	No	• Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole ○ Language Proficiency Assessment ○ Building Cultural Competency Workshop ○ Medical Terminology Workshop ○ Medical Interpreting Ethics and Protocol Workshop	Professional Linguists • Certification or Accreditation from American Translators Association (ATA) or equivalent organization • Degree in Translation or foreign equivalent • Subject-Matter expertise in the field of Life Sciences • Extensive experience in translation and linguistics	Must contact for costs Cost example: • Flat rate/ test - $80

To report any updates to this document, i.e., an organization that should no longer be included, or an organization that meets the criteria and should be included on this document, please contact: Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Language Line Academy (LLA) Our professional testing and training ensures the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.	https://www.langualeline.com/ 1-844-552-8378 Ana Catalina Arguedas Fernández lla@languageline.com	**1 language offered**: Spanish	Yes Pediatrics Mental Health OB/Gyn Ophthalmology Gastroenterology Oncology Cardiology Pharmacy	• Healthcare Bilingual Fluency assessment for clinicians and medical staff • Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour • Interpreter Readiness Assessment • Interpreter Skills Test	LLA testers have a variety of qualifications, including: • M.A., Translation & Interpretation • Years of medical interpreting experience • External interpreter certification credentials	Cost will vary $145 - $160/ test Volume discounts available
Language Testing International (LTI) In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests.	https://www.languagetesting.com/ 1-800-486-8444 Marketing/ Scheduling Team Diane ext. 123 Dina ext. 127 info@languagetesting.com	**100+ languages offered**, most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish View complete list of languages online	Offers general testing/ proficiency assessments Does not specifically assess proficiency for healthcare interpretation or translation services	• Oral Proficiency Interview 15 – 30 minute telephonic interview • Oral Proficiency Interview – Computer 20 – 40 minute on-demand, internet or phone-delivered proficiency test • Writing Proficiency Test via the web 20 – 80 minutes • Listening Proficiency Test 50 – 125 minutes • Reading Proficiency Test 50 – 125 minutes	LTI strictly uses • Certified ACTFL testers and raters Ensuring quality and validity of tests	Contact for costs Package options available for some languages Cost examples: • $100 - $200/ person for phone survey • $159 for web based proctoring
MasterWord For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.	https://www.masterword.com/ 1-866-716-4999 masterword@masterword.com	**250+ languages offered** for interpreting and translation **Contact for languages offered for proficiency assessments**	Not specified Offers On Demand training & Webinars for Healthcare, includes: • Maternal Fetal Medicine • Cardiology • Mental Health • Oncology • Emergency	• Language Proficiency Assessment: 60 minutes Contact for languages • Health Care Interpreter Assessment (HCIA®): 32 min. / 45 min. –oral / written Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.	Assessments based on formats of CCHI & NBCMI national certification exams	On Demand Assessments: $105 - $155

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COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).

We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials:
email Ivy Diaz at ivy.diaz@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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PCP:	
SECTION: Personnel	
POLICY AND PROCEDURE: Informed Consent and Human Sterilization Consent	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Site personnel receive training and/or information on member rights that include informed consent and human sterilization consent.

PROCEDURE:

1. **Written Member Rights** should be available at the office site. Staff should be able to locate the written Member Rights list and explain how to use the information.

2. Staff trainings regarding member rights may be part of office staff education documented in:
   - Informal or formal in-services
   - New staff orientation
   - External training courses

3. Topics included in the trainings must include:
   a. Informed Consent for Human Sterilization

   Patients shall be informed about any proposed treatment or procedure that includes medically significant risks, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment. Documentation of this discussion and the signed consent shall be written and included in the member's medical record.

   Note: patient rights incorporate the requirements of the Joint Commission on Accreditation of Healthcare Organizations, Title 22, California Code of Regulations, Section 70707 and Medicare Conditions of Participation.

   Requirements include be are not limited to:

   - Conducted by physician or physician designee.
   - Offered booklet published by the DHCS and copy of consent form must be given to the member.
   - Provided answers to any question the member may have.

- Inform the member, that they may refuse or withhold consent to procedure at any time before the sterilization.

- Describe fully the available alternatives of family planning and birth control.
- Advise that the sterilization procedure is considered irreversible.
- Explain fully the description of discomforts and risks and benefits of the procedure.
- Utilize the PM330 sterilization consent form.
  Forms may be downloaded (English and Spanish) from the following Medi-Cal web site:
  http://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q2055	ABECMA	Idecabtagene vicleucel, suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0287	ABELCET	Amphotericin B lipid complex	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0400	ABILIFY	Aripiprazole, intramuscular, 0.25 mg	THERAPEUTIC INJ	
J0402	ABILIFY ASIMTUFII	Aripiprazole IM ER Susp Prefilled Syringe	THERAPEUTIC INJ	
J0401	ABILIFY MAINTENA	Apriprazole 300mg, IM injection	THERAPEUTIC INJ	
J9258	ABRAXANE	Paclitaxel Protein-Bound Particles for Injectable Suspension (albumin-bound). Mfg.Teva	THERAPEUTIC INJ	CHEMOTHERAPY*
J9264	ABRAXANE	Paclitaxel protein-bound particles, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5132	ABRILADA	Injection, adalimumab-afzb , biosimilar, 10 mg- 0069-0347-02; 40mg 0069-0319-01.	THERAPEUTIC INJ	
Q5132	ABRILADA	Injection, adalimumab-afzb , biosimilar, 20, 40mg - 00069-0333-02; 00069-0325-01; 00069-0325-02; 00069-0328-02; 00025-0325-02 ; 00025-0328-02; 00025-0333-02; 00025-0325-01	SELF-INJECTABLE	
90678	ABRYSVO	Respiratory Syncytial Virus Vaccine solution for intramuscular injection	THERAPEUTIC INJ	IMMUNIZATION
J0137	Acetaminophen	Injection, acetaminophen (Hikma) not therapeutically equivalent to J0131, 10 mg	THERAPEUTIC INJ	
J0134	Acetaminophen 10mg/ml solution	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to J0131, 10 mg	THERAPEUTIC INJ	
J0136	Acetaminophen 10mg/ml solution	Injection, acetaminophen (b braun) not therapeutically equivalent to j0131, 10 mg	THERAPEUTIC INJ	
J1120	ACETAZOLAMIDE SODIUM	Acetazolamide sodium injection	THERAPEUTIC INJ	
J0132	ACETYLCYSTEINE INJ	Acetylcysteine injection, 10 mg	THERAPEUTIC INJ	
J3262	ACTEMRA 162mg/0.9ml Syringe (50242-0138-01)	Tocilizumab, 1 mg	SELF-INJECTABLE	
J3262	ACTEMRA INJECTION (50242-0136-01, 50242-0137-01)	Tocilizumab 200mg, 400mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0801	ACTHAR HP	Injection, corticotropin (acthar gel), up to 40 units	THERAPEUTIC INJ	
J0802	ACTHAR HP	Corticotropin injection, 40 MG	THERAPEUTIC INJ	
90648	ACTHIB	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0795	ACTHREL	Corticorelin Ovine Triflutal	THERAPEUTIC INJ	
J9216	ACTIMMUNE	Interferon gamma 1-b 3 miillion units	SELF-INJECTABLE	CHEMO ADJUNCT*
J2997	ACTIVASE	Alteplase recombinant, 1mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0133	ACYCLOVIR SODIUM	Acyclovir, 5 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90715	ADACEL	Tdap vaccine, > 7 yrs, IM	THERAPEUTIC INJ	IMMUNIZATION
J2504	ADAGEN	Pegademase bovine, 25 IU	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0791	ADAKVEO	Crizanlizumab-tmca IV Solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	ADBRY	Tralokinumab-ldrm injection, for subcutaneous use	SELF-INJECTABLE	
J9042	ADCETRIS	Brentuximab vedotin Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0153	ADENOCARD	Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds)	THERAPEUTIC INJ	
C9399, J3490	ADLYXIN	Lixisenatide Solution	SELF-INJECTABLE	
J0171	ADRENALIN	Adrenalin (epinephrine) inject	THERAPEUTIC INJ	
J9000	ADRIAMYCIN	Doxorubicin hcl 10 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9190	ADRUCIL	Fluorouracil injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9029	ADSTILADRIN	Nadofaragene firadenovec-vncg) suspension, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J7192	ADVATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7207	ADYNOVATE	Antihemophilic Factor (Recombinant), PEGylated, is a human antihemophilic factor	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7171	ADZYNMA	Adamts13 recombinant-krhn	THERAPEUTIC INJ	
90685	AFLURIA Peds Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90688	AFLURIA Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7210	AFSTYLA	Injection, factor VIII, antihemophilic factor,recombinant	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3246	AGGRASTAT	Tirofiban HCl, 0.25 mg	THERAPEUTIC INJ	
Q2034	AGRIFLU	Influenza virus vaccine, split virus, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5150	AHZANTIVE®	Injection, aflibercept-mrbb, biosimilar to Eylea 1 mg	THERAPEUTIC INJ	
J3590	AIMOVIG	Erenumab-aooe injection, for subcutaneous use	SELF-INJECTABLE	
J3031	AJOVY	Fremanezumab-vfrm	SELF-INJECTABLE	
J0190	AKINETON	Biperiden lactate, per 5 mg	THERAPEUTIC INJ	
J3490	AKOVAZ	Ephedrine sulfate injection, USP for intravenous use	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1454	AKYNZEO	Fosnetupitant and palonsetron) for injection, for intravenous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1931	ALDURAZYME	Laronidase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0216	Alfentanil	Injection, alfentanil hydrochloride, 500 micrograms	THERAPEUTIC INJ	
J9215	ALFERON N	Interferon alfa-N3 (human leukocyte derived), 250,000 IU inj	SELF-INJECTABLE	CHEMO ADJUNCT*
J7173	ALHEMO	Concizumab-mtci SC injection	SELF-INJECTABLE	
J9305	ALIMTA	Pemetrexed, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9057	ALIQOPA	Copanlisib for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9245	ALKERAN	Melphalan hydrochl 50 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0206	Allopurinol	Injection, allopurinol sodium, 1 mg	THERAPEUTIC INJ	
J2469	ALOXI	Palonosetron HCl, 25 mcg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7190	ALPHANATE	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7186	ALPHANATE VWF	Von Willebrand Factor complex, human, ristocetin coFactor (not otherwise specified), per I.U.	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7193	ALPHANINE SD	Factor IX (antihemophilic Factor, purified, non-recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7201	ALPROLIX	Coagulation Factor IX (Recombinant), Fc Fusion Protein], Lyophilized Powder for Solution for Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0270	Alprostadil 500	Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct physician supervision, not for use when drug is self-administered)	THERAPEUTIC INJ	
J7214	ALTUVIIIO™	Antihemophilic factor (recombinant) DNA-derived, Factor VIII concentrate, lyophilized powder for solution, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1552	ALYGLO™	Immune globulin (human)-stwk IV SOLN 10 GM/100ML	THERAPEUTIC INJ	
Q1256	ALYMSYS®	Bevacizumab-maly injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0289	AMBISOME	Amphotericin B liposome inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2920	A-METHAPRED	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	A-METHAPRED	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0215	AMEVIVE	Alefacept	THERAPEUTIC INJ	
J0281	AMICAR	Aminocaproic acid	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0278	AMIKACIN SULF INJ USP 1GRAM/4ML FLIPTOP VIAL	Injection, amikacin sulfate, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0280	AMINOPHYLLINE	Aminophyllin 250 MG inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0282	AMIODARONE HCL	Amiodarone hcl	THERAPEUTIC INJ	
C9399, J3490	AMJEVITA	Adalimumab-atto injection for subcutaneous use	SELF-INJECTABLE	
J1426	AMONDYS 45	Casimersen injection, for intravenous use	THERAPEUTIC INJ	
J3470	AMPHADASE 150 UNIT/ML SOLN	Hyaluronidase, up to 150 units	THERAPEUTIC INJ	
J0285	AMPHOCIN	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0288	AMPHOTEC	Ampho b cholesteryl sulfate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0285	AMPHOTERICIN B	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0290	AMPICILLIN SODIUM	Ampicillin 500 MG inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0295	AMPICILLIN-SULBACTAM	Ampicillin sodium per 1.5 gm	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	AMTAGVI	Lifileucel IV Susp 72,000,000,000 Cells	THERAPEUTIC INJ	CHEMOTHERAPY*
J0225	AMVUTTRA	Vutrisiran injection, for subcutaneous use	THERAPEUTIC INJ	
J0300	AMYTAL SODIUM	Amobarbital 125 MG inj	THERAPEUTIC INJ	
J0716	ANASCORP	Centruroides immune f(ab)2, up to 120 milligrams	THERAPEUTIC INJ	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	THERAPEUTIC INJ	
J0690	ANCEF	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	ANDEMBRY®	Garadacimab-gxii) injection, SC	SELF-INJECTABLE	
J7169	ANDEXXA	Coagulation factor Xa (recombinant), inactivated-zhzo) Lyophilized Powder for Solution For Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0330	ANECTINE	Succinycholine chloride inj	THERAPEUTIC INJ	
J0583	ANGIOMAX	Bivalirudin, 1mg	THERAPEUTIC INJ	
J1738	ANJESO	Meloxicam injection, for intravenous use	THERAPEUTIC INJ	
J9028	ANKTIVA	Nogapendekin alfa inbakicept-pmln solution, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
90581	ANTHRAX VACCINE	Anthrax vaccine, sc	THERAPEUTIC INJ	IMMUNIZATION
J1451	ANTIZOL	Fomepizole, 15 mg	THERAPEUTIC INJ	
J1260	ANZEMET	Dolasetron mesylate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2277	APHEXDA	Motixafortide for injection, for subcutaneous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0364	APOKYN	Apomorphine hydrochloride, 1mg	SELF-INJECTABLE	
C9145	APONVIE	Injection, aprepitant, 1 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0739	APRETUDE	Cabotegravir extended-release injectable suspension), for intramuscular use	THERAPEUTIC INJ	
J3430	AQUA-MEPHYTON	Vitamin K phytonadione inj	THERAPEUTIC INJ	
J0256	ARALAST	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0390	ARALEN	Injection, chloroquine hydrochloride, up to 250 mg	THERAPEUTIC INJ	
J0380	ARAMINE	Metaraminol bitartrate	THERAPEUTIC INJ	
J0881	ARANESP	Darbepoetin alfa, 1 microgram (non-ESRD use)	SELF-INJECTABLE	CHEMO ADJUNCT*
J0882	ARANESP	Darbepoetin alfa, 1 microgram (for ESRD on dialysis	SELF-INJECTABLE	CHEMO ADJUNCT*
J2793	ARCALYST	Rilonacept Injection 220 mg Solr	SELF-INJECTABLE	
90679	AREXVY	Respiratory Syncytial Virus Vaccine, Adjuvanted	THERAPEUTIC INJ	IMMUNIZATION
J0883	ARGATROBAN	Injection, argatroban, 1 mg (for non-ESRD use)	THERAPEUTIC INJ	
J0884	ARGATROBAN	Injection, argatroban, 1 mg (for ESRD on dialysis)	THERAPEUTIC INJ	
J0891	ARGATROBAN	Injection, argatroban (accord), not therapeutically equivalent to j0883, 1 mg (for non-esrd use)	THERAPEUTIC INJ	
J0892	ARGATROBAN	Injection, argatroban (accord), not therapeutically equivalent to j0884, 1 mg (for esrd on dialysis)	THERAPEUTIC INJ	
J0898	ARGATROBAN	Injection, argatroban (AuroMedics), not therapeutically equivalent to J0883, 1 mg (for non-ESRD use)	THERAPEUTIC INJ	
J0899	ARGATROBAN	Injection, argatroban (AuroMedics), not therapeutically equivalent to J0884, 1 mg (for ESRD on dialysis)	THERAPEUTIC INJ	
J1944	ARISTADA	Aripprazole lauroxilextended release suspension	THERAPEUTIC INJ	
J1943	ARISTADA INITIO	Aripiprazole lauroxil extended-release injectable suspension	THERAPEUTIC INJ	
J3302	ARISTOCORT FORTE	Triamcinolone diacetate inj	THERAPEUTIC INJ	
J1652	ARIXTRA	Fondaparinux sodium, 0.5 mg	SELF-INJECTABLE	
J9261	ARRANON 5 MG/ML SOLN	Nelarabine, 50 Mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0391	ARTESUNATE	Artesunate 110MG Solution Reconstituted	THERAPEUTIC INJ	
J9302	ARZERRA	Ofatumumab	THERAPEUTIC INJ	CHEMOTHERAPY*
J1554	ASCENIV	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid),	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399, J3490	ASCLERA	Polidocanol Injection	THERAPEUTIC INJ	
J9118	ASPARLAS	Calaspargase pegol-mknl, 10 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J2275	ASTRAMORPH	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7504	ATGAM	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2060	ATIVAN	Lorazepam injection	THERAPEUTIC INJ	
J0461	ATROPINE SULFATE	Atropine sulfate injection	THERAPEUTIC INJ	
J0462	ATROPINE SULFATE	Injection, atropine sulfate, not therapeutically equivalent to j0461, 0.01 mg	THERAPEUTIC INJ	
90705	ATTENUVAX	Measles vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9220	AUCATZYL®	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
TBD	AUDENZ™	Influenza A (H5N1) Tiss-Cult Subunit Adjuvanted IM Emulsion	THERAPEUTIC INJ	IMMUNIZATION
C9257	AVASTIN	Bevacizumab, 0.25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9035	AVASTIN	Bevacizumab injection, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3145	AVEED	Testosterone undecanoate 250 mg/ml	THERAPEUTIC INJ	
J2280	AVELOX	Moxifloxacin 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1826	AVONEX	Interferon beta-1A, 11 mcg for intramuscular use (See also J1825)	SELF-INJECTABLE	
Q3027	AVONEX	Interferon beta-1a, 33 mcg	SELF-INJECTABLE	
Q5121	AVSOLA®	Injection, infliximab-axxq, biosimilar, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	AVTOZMA®	Tocilizumab-anoh, IV, Biosimiar to Actemra	THERAPEUTIC INJ	
Q5156	AVTOZMA®	Injection, tocilizumab-anoh , biosimilar to Actemra, 1 mg	SELF-INJECTABLE	
J0714	AVYCAZ	Ceftazidime-avibactam Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	AVZIVI®	Bevacizumab-tnjn	THERAPEUTIC INJ	CHEMOTHERAPY*
J9292	AXTLE™	Injection, pemetrexed (avyxa), not therapeutically equivalent to j9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
S0073	AZACTAM	Aztreonam, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7501	AZATHIOPRINE SODIUM	Azathioprine parenteral	THERAPEUTIC INJ	TRANSPLANT*
J0172	AZMIRO™	Injection, testosterone cypionate , 1 mg	THERAPEUTIC INJ	
J0457	Aztreonam	Injection, aztreonam, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90288	BabyBIG®	Botulism immune globulin, human, for intravenous use	THERAPEUTIC INJ	
J0475	BACLOFEN	Baclofen 10 MG injection	THERAPEUTIC INJ	
J2700	BACTOCILL IN DEXTROSE	Oxacillin sodium injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2865	BACTRIM®	Injection, sulfamethoxazole 5 mg and trimethoprim 1 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0470	BAL IN OIL	Dimecaprol injection	THERAPEUTIC INJ	
J1412	BALFAXAR®	Injection, prothrombin complex concentrate (human), per IU of Factor IX activity	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0184	BARHEMSYS	Amisulpride (antiemetic) IV soln 10 mg/4ml	THERAPEUTIC INJ	
J9023	BAVENCIO	Avelumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
C9462	BAXDELA	Delafloxacin for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0222	BEBTELOVIMAB	BEBTELOVIMAB IV SOLN 175 MG/2ML	THERAPEUTIC INJ	
J7194	BEBULIN VH	Factor IX, complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9032	BELEODAQ	Belinostat Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9036	BELRAPZO	Bendamustine hydrochloride injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1200	BENADRYL	Diphenhydramine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9058	Bendamustine	Injection, bendamustine HCl (Apotex), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9059	Bendamustine	Injection, bendamustine HCl (Baxter), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9034	BENDEKA	Bendamustine HCl Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7195	BENEFIX	Factor IX (antihemophilic Factor, recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3590	BENLYSTA®	Injection, belimumab, 200MG/ML Solution Prefilled Syringe	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	BENLYSTA®	Injection, belimumab, 200MG/ML Solution Auto-injector	SELF-INJECTABLE	
J0500	BENTYL	Dicyclomine injection	THERAPEUTIC INJ	
J0179	BEOVU	Brolucizumab-dbll, 1 mg Injection	THERAPEUTIC INJ	
J1414	BEQVEZ	Fidanacogene elaparvovec-dzkt injection, for intravenous infusion	THERAPEUTIC INJ	
J0597	BERINERT	C1 Esterase Inhibitor (Human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9229	BESPONSA	Inotuzumab ozogamicin for IV soln	THERAPEUTIC INJ	CHEMOTHERAPY*
C9999	BESREMI	Ropeginterferon alfa-2b-njft) injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1830	BETASERON	Interferon beta-1b / .25 MG	SELF-INJECTABLE	
90620	BEXSERO	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90380	BEYFORTUS	Nirsevimab-alip IM Soln Prefilled Syringe 100 MG/ML	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90381	BEYFORTUS	Nirsevimab-alip IM Soln Prefilled Syringe 50 MG/ML	THERAPEUTIC INJ	
J0558	BICILLIN C-R (25000)	Penicillin G benzathine and penicillin G procaine, 25,000U	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Injection, penicillin g benzathine, 100,000 units	THERAPEUTIC INJ	
J9050	BICNU	Carmustine, 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9174	BIEZRAY™	Injection, docetaxel , 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	BILDYOS®	Denosumab-nxxp injection, for subcutaneous use biosimilar to Prolia	THERAPEUTIC INJ	
J3590	BILPREVDA®	Denosumab-nxxp injection, for subcutaneous use Biosimilar to Exgeva	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	BIMZELX	Bimekizumab-bkzx	SELF-INJECTABLE	
J0582	BIVALIRUDIN	Injection, bivalirudin (endo), not therapeutically equivalent to j0583, 1 mg	THERAPEUTIC INJ	
J1556	BIVIGAM	Immune Globulin Intravenous (Human), 10% liquid	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9382	BIZENGRI®	Zenocutuzumab-zbco injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5152	BKEMV	Injection, eculizumab-aeeb , biosimilar to Soliris, 2 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9040	BLENOXANE	Bleomycin sulfate injection, 15 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9037	BLENREP	Belantamab mafodotin-blmf for iv soln 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9999	BLENREP®	Belantamab Mafodotin-blmf For IV Soln 70 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9040	BLEOMYCIN SULFATE	Bleomycin sulfate injection, 15 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9039	BLINCYTO	Blinatumomab for Injection, IV	THERAPEUTIC INJ	CHEMOTHERAPY*
J9220	BLUDIGO®	Injection, indigotindisulfonate sodium, 1 mg	THERAPEUTIC INJ	
Q5158	BOMYNTRA®	Denosumab 120mg/1.7ml, Injection, for subcutaneous use (Biosimilar to Xgeva)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1740	BONIVA	Ibandronate sodium Injection, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	BONSITY®	Teriparatide, injection, SC	SELF-INJECTABLE	
90715	BOOSTRIX	Tdap vaccine	THERAPEUTIC INJ	IMMUNIZATION
J9046	Bortezomib	Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9048	Bortezomib	Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9049	Bortezomib	Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9051	Bortezomib	Inj, bortezomib (maia)	THERAPEUTIC INJ	CHEMOTHERAPY*
J9054	BORUZU	Injection, bortezomib, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0585	BOTOX	OnabotulinumtoxinA, 1 unit	THERAPEUTIC INJ	
90288	BOTULISM	Botulism immune globulin, human, IV	THERAPEUTIC INJ	
90287	Botulism Antitoxin Heptavalent	Botulinum antitoxin, equine, any route	THERAPEUTIC INJ	
J3490	BREKIYA®	Dihydroergotamine Mesylate Soln Auto-inj 1 MG/ML	SELF-INJECTABLE	
J3105	BRETHINE	Terbutaline sulfate inj	THERAPEUTIC INJ	
Q2054	BREYANZI	Lisocabtagene maraleucel suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	BRIDION®	Sugammadex Injection, for intravenous use Initial U.S.	THERAPEUTIC INJ	
J0567	BRINEURA®	Cerliponase alfa for intraventricular use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2329	BRIUMVI™	Ublituximab-xiiy	THERAPEUTIC INJ	
C9399, J3490	BRIVIACT	Brivaracetam injection, for intravenous use, CV-	THERAPEUTIC INJ	
J0577	BRIXADI® WEEKLY	Injection, buprenorphine extended-release , less than or equal to 7 days of therapy	THERAPEUTIC INJ	
J0578	BRIXADI™	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	THERAPEUTIC INJ	
J0945	BROMPHENIRAMINE MALEATE	Brompheniramine maleate inj	THERAPEUTIC INJ	
J1939	BUMETANIDE	Injection, bumetanide, 0.5 mg	THERAPEUTIC INJ	
J0665	Bupivicaine	Injection, bupivicaine, not otherwise specified, 0.5 mg	THERAPEUTIC INJ	
S0020	Bupivicaine	Bupivicaine hydro	THERAPEUTIC INJ	
J0592	BUPRENEX	Buprenorphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0594	BUSULFEX 6 MG/ML	injection, busulfan, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0595	BUTORPHANOL TARTRATE	Butorphanol tartrate 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	BYDUREON	Exenatide extended release	SELF-INJECTABLE	
J3490	BYDUREON BCise	Exenatide extended release injectable suspension 2 mg	SELF-INJECTABLE	
J3490	BYETTA	Exenatide Injection	SELF-INJECTABLE	
J2249	BYFAVO	Injection, remimazolam, 1 mg	THERAPEUTIC INJ	
Q5124	BYOOVIZ	Ranibizumab-nuna Intravitreal Injection	THERAPEUTIC INJ	
J0741	CABENUVA	Injection, cabotegravir and rilpivirine, 2mg/3mg	THERAPEUTIC INJ	HIV/AIDS
C9047	CABLIVI	Caplacizumab-yhdp	SELF-INJECTABLE	
J0706	CAFCIT	Caffeine citrate injection, 5 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0636	CALCIJEX	Calcitriol per 0.1 mcg	THERAPEUTIC INJ	
S0161	CALCITROL	Calcitrol, 0.25 mg	THERAPEUTIC INJ	
J0618	Calcium Chloride	Injection, calcium chloride, 2 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0600	CALCIUM DISODIUM VERSENATE	Edetate calcium disodium inj	THERAPEUTIC INJ	
J0610	CALCIUM GLUCONATE	Calcium gluconate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0611	Calcium gluconate	Injection, calcium gluconate (wg critical care), per 10 ml	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0612	Calcium gluconate	Injection, calcium gluconate (Fresenius Kabi), per 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0613	Calcium gluconate	Injection, calcium gluconate (WG Critical Care), per 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1741	CALDOLOR	Injection, ibuprofen, 100 mg	THERAPEUTIC INJ	
J0620	CALPHOSAN	Calcium glycer & lact/10 ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1952	CAMCEVI	Leuprolide injectable, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9010	CAMPATH	Alemtuzumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9206	CAMPTOSAR	Irinotecan injection, 20mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0637	CANCIDAS	Caspofungin acetate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90684	CAPVAXIVE™	Pneumococcal 21-valent Conjugate Vaccine Injection, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0670	CARBOCAINE	Mepivacaine HCL/10 ml	THERAPEUTIC INJ	
J9045	CARBOPLATIN	Carboplatin injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0675	CARBOPROST	Injection, carboprost tromethamine, 0.1 mg	THERAPEUTIC INJ	
J1566	CARIMUNE NF	Immune globulin, intravenous, lyophilized (eg powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9052	Carmustine	Injection, carmustine (Accord), not therapeutically equivalent to J9050, 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1955	CARNITOR	Levocarnitine per 1 gm	THERAPEUTIC INJ	
Q2056	CARVYKTI	Ciltacabtagene autoleucel suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3392	CASGEVY™	Exagamglogene autotemcel, suspension for intravenous infusion	THERAPEUTIC INJ	
J2997	CATHFLO ACTIVASE	Alteplase recombinant, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0270	CAVERJECT	Alprostadil for injection	SELF-INJECTABLE	
J0710	CEFADYL	Cephapirin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0688	CEFAZOLIN	Injection, cefazolin sodium (Hikma), not therapeutically equivalent to J0690, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0689	Cefazolin sodium	Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0690	CEFAZOLIN SODIUM	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0701	Cefepime	Injection, cefepime HCl (Baxter), not therapeutically equivalent to Maxipime, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0703	Cefepime	Injection, cefepime HCl (B. Braun), not therapeutically equivalent to Maxipime, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0783	Cefepime	Cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg J0703 Injection	THERAPEUTIC INJ	
J0715	CEFIZOX	Ceftizoxime sodium / 500 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0715	CEFIZOX IN D5W	Ceftizoxime sodium / 500 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0021	CEFOPERAZONE	Cefoperazone sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0698	CEFOTAXIME SODIUM	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0525	CEFOTETAN	Cefotetan disodium,10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0694	CEFOXITIN SODIUM	Cefoxitin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0713	CEFTAZIDIME	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0697	CEFUROXIME SODIUM	Injection, sterile cefuroxime sodium, per 750 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0697	CEFUROXIME-DEXTROSE	Sterile cefuroxime injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0702	CELESTONE SOLUSPAN	Betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7599	CELLCEPT 500MG	Immunosuppressive drug, not otherwise classified	THERAPEUTIC INJ	TRANSPLANT*
J2724	CEPROTIN	Protein C concentrate, intravenous, human, 10 IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0713	CEPTAZ	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2009	CEREBYX	Fosphenytoin, 50 mg phenytoin equivalent	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0205	CEREDASE	Alglucerase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1786	CEREZYME	Imiglucerase, per unit	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9150	CERUBIDINE	Daunorubicin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90650	CERVARIX	Human Papillomavirus Bivalent (Types 16 and 18) Vaccine, Recombinant	THERAPEUTIC INJ	IMMUNIZATION
J3490	CETROTIDE	Cetrorelix acetate for inj kit 0.25 mg	SELF-INJECTABLE	INFERTILITY
J0720	CHLORAMPHENICOL SOD SUCCINATE	Chloramphenicol sodium inject	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0720	CHLOROMYCETIN	Chloramphenicol sodium inject	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2401	Chloroprocaine	Chloroprocaine hydrochloride, per 1 mg	THERAPEUTIC INJ	
J3230	CHLORPROMAZINE HCL	Chlorpromazine hcl injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0725	CHORIONIC GONADOTROPIN	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
Q5128	CIMERLI™	Injection, ranibizumab-eqrn , biosimilar, 0.1 mg	THERAPEUTIC INJ	
J0717	CIMZIA® Prefilled Syr KIT 200MG NDC 50474-710-81; 50474-710-79	Certolizumab, 200 mg/mL solution in a single-dose prefilled syringe	SELF-INJECTABLE	
J0717	CIMZIA® Vial NDC 50474-700-62	Certolizumab, 200 mg lyophilized powder in a single-dose vial	THERAPEUTIC INJ	
J2786	CINQAIR	Reslizumab	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0598	CINRYZE	Injection, C-1 esterase inhibitor (human), 10 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0185	CINVANTI	Aprepitant, Injection, 1 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0744	CIPRO	Ciprofloxacin for intravenous infusion, 200 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0744	CIPRO IN D5W	Ciprofloxacin for intravenous infusion, 200 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9060	CISPLATIN	Cisplatin 10 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9060	CISPLATIN	Cisplatin 50 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9065	CLADRIBINE	Cladribine per 1 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0698	CLAFORAN	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0698	CLAFORAN IN D5W	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0077	CLEOCIN	Clindamycin phosphate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9248	CLEVIPREX®	Clevidipine butyrate, 1 mg	THERAPEUTIC INJ	
J0736	Clindamycin	Injection, clindamycin phosphate, 300 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0737	Clindamycin	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to J0736, 300 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9027	CLOLAR	Clofarabine injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J2402	CLOROTEKAL®	Chloroprocaine hydrochloride injection, for intrathecal use	THERAPEUTIC INJ	
J7175	COAGADEX	Injection, factor X, (human), 1 IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0745	CODEINE PHOSPHATE	Injection, codeine phosphate, per 30 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0515	COGENTIN	Injection, benztropine mesylate, per 1 mg	THERAPEUTIC INJ	
J0760	COLCHICINE	Colchicine injection	THERAPEUTIC INJ	
J0770	COLISTIMETHATE SODIUM	Injection, colistimethate sodium, up to 150 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9286	COLUMVI™	Glofitamab-gxbm injection for intravenous (IV) infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0770	COLY-MYCIN M	Colistimethate sodium inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
91320	COMERNATY® 2024-25	Covid-19 Vaccine, mRNA, 24-25 Formula	THERAPEUTIC INJ	IMMUNIZATION
J0780	COMPAZINE	Prochlorperazine, up to 10 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q5158	CONEXXENCE®	Denosumab-bnht injection, for subcutaneous use (biosimilar to Prolia)	THERAPEUTIC INJ	
J1595	COPAXONE	Glatiramer acetate	SELF-INJECTABLE	
J0282	CORDARONE IV	Amiodarone hcl	THERAPEUTIC INJ	
J7180	CORIFACT	Factor XIII Concentrate	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0834	CORTROSYN	Cosyntropin per 0.25 MG	THERAPEUTIC INJ	
J1742	CORVERT	Ibutilide fumarate injection	THERAPEUTIC INJ	
J1448	COSELA	Trilaciclib for injection, for intravenous	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3247	COSENTYX	Injection, secukinumab, IV, 1 mg	SELF-INJECTABLE	
J3590	COSENTYX® IV	Secukinumab IV Soln 125 Mg/5ml	THERAPEUTIC INJ	
J3590	COSENTYX® UNOREADY®	Secukinumab Subcutaneous Soln Auto-Injector 300 Mg/2ml	SELF-INJECTABLE	
J9120	COSMEGEN	Dactinomycin, 0.5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0834	Cosyntropin 0.25 MG (generic)	Cosyntropin, not otherwise specified, 0.25 mg	THERAPEUTIC INJ	
J2650	COTOLONE	Prednisolone acetate inj	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1833	CRESEMBA	Isavuconazonium sulfate Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0840	CROFAB	Injection, crotalidae polyvalent immune fab (Ovine), up to 1 gram	THERAPEUTIC INJ	
J0584	CRYSVITA	Burosumab-twza injection, for subcutaneous use	THERAPEUTIC INJ	
J0878	CUBICIN	Daptomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	CUROSURF	Poractant alfa intratracheal suspension	THERAPEUTIC INJ	
J1551	CUTAQUIG	Immune Globulin Subcutaneous (Human) - hipp	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1555	CUVITRU	Immune Globulin Subcutaneous 20% Solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3420	CYANOCOBALAMIN	Vitamin B-12 cyanocobalamin, up to 1000mcg	THERAPEUTIC INJ	
C9087	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (AuroMedics), 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9072	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (Dr. Reddy's), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9074	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (sandoz), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9074	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (sandoz), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9091	CYCLOPHOSPHAMIDE	Cyclophosphamide 1.0 grm inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9092	CYCLOPHOSPHAMIDE	Cyclophosphamide 2.0 grm inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9071	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (auromedics), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9073	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (ingenus), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9074	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (Sandoz), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9075	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, 5 mg, Not otherwise specified	THERAPEUTIC INJ	CHEMOTHERAPY*
J9075	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, 5 mg, Not otherwise specified	THERAPEUTIC INJ	CHEMOTHERAPY*
J9075	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, not otherwise specified, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9076	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (baxter), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7516	CYCLOSPORINE	Cyclosporine, parenteral, 250mg	THERAPEUTIC INJ	TRANSPLANT*
J3290	CYKOLKAPRON®	Injection, tranexamic acid, 5 mg	THERAPEUTIC INJ	
J3590	CYLTEZO	Adalimumab-adbm injection, for subcutaneous use	SELF-INJECTABLE	
J9308	CYRAMZA	Ramucirumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9100	CYTARABINE	Cytarabine hcl 100 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9110	CYTARABINE	Cytarabine, 500mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5143	CYTELZO	Adalimumab-adbm; Low Conc., interchangeable for Humira	SELF-INJECTABLE	
90291	CYTOGAM	Injection, cytomegalovirus, immune globulin intravenous (human), CMV-IgIV intravenous, human, per vial	THERAPEUTIC INJ	
J0850	CYTOGAM	Injection, cytomegalovirus, immune globulin intravenous (human), CMV-IgIV intravenous, human, per vial	THERAPEUTIC INJ	
J1570	CYTOVENE	Ganciclovir sodium injection	THERAPEUTIC INJ	HIV/AIDS
J9090	CYTOXAN	Cyclophosphamide 500 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1110	D.H.E. 45	Dihydroergotamine mesyltate	SELF-INJECTABLE	
J9130	DACARBAZINE	Dacarbazine 100 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9140	DACARBAZINE	Dacarbazine 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0894	DACOGEN	Decitabine for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0875	DALVANCE	Dalbavancin hcl for iv soln 500 mg	THERAPEUTIC INJ	
J9348	DANYELZA	Naxitamab-gqgk 40MG/10ML Solution Injection, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90700	DAPTACEL	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J0873	DAPTOMYCIN	Injection, daptomycin, not therapeutically equivalent to J0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0874	DAPTOMYCIN	Inj, daptomycin (baxter), not therapeutically equivalent to J0878	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0877	Daptomycin	Daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0878	Daptomycin	Injection, daptomycin (hospira), not therapeutically equivalent to J0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0872	Daptomycin for Injection (room temperature)	Injection, daptomycin, unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg, Xellia	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9145	DARZALEX	Daratumumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9144	DARZALEX FASPRO	Injection, daratumumab 10 mg and hyaluronidase-fihj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9011	DATROWAY®	Datopotamab deruxtecan-dlnk, IV	THERAPEUTIC INJ	CHEMOTHERAPY*
J9150	DAUNORUBICIN HCL	Daunorubicin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9151	DAUNOXOME	Daunorubicin citrate liposomal formulation, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	DAWNZERA™	Donidalorsen sodium subcutaneous soln auto-inj 80 mg/0.8ml	SELF-INJECTABLE	
J0589	DAXXIFY	DaxibotulinumtoxinA-lanm for injection, for intramuscular use	THERAPEUTIC INJ	
J2597	DDAVP	Desmopressin acetate, per 1 mcg	THERAPEUTIC INJ	
90714	DECAVAC	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0893	Decitabine	Injection, decitabine (Sun Pharma) not therapeutically equivalent to J0894, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0893	Decitabine	Injection, decitabine (sun pharma), not therapeutically equivalent to J0894,	THERAPEUTIC INJ	CHEMOTHERAPY*
J0911	DEFENCATH®	Heparin-Taurolidine Lock Flush Soln	THERAPEUTIC INJ	
J0895	DEFEROXAMINE MESYLATE	Deferoxamine mesylate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	DEFITELIO	Defibrotide sodium injection, for intravenous use	THERAPEUTIC INJ	
J1094	DEKASOL LA	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3265	DEMADEX	Torsemide 10 mg/ml	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2175	DEMEROL	Meperidine hydrochlide /100 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9098	DEPOCYT	Cytarabine liposome, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1000	DEPO-ESTRADIOL	Depo-estradiol cypionate injection	THERAPEUTIC INJ	
J3490	DEPO-PROVERA 150 MG	Medroxyprogesterone contraceptive injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1053	DEPO-PROVERA 400 MG	Medroxyprogesterone injection 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1050	DEPO-SUBQ PROVERA 104®	Medroxyprogesterone acetate Injection	THERAPEUTIC INJ	
J1071	DEPO-TESTOSTERONE	Testosterone cypionate, 1mg	THERAPEUTIC INJ	TRANSGENDER HORMONES
J0895	DESFERAL	Deferoxamine mesylate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2597	DESMOPRESSIN ACETATE	Desmopressin acetate	THERAPEUTIC INJ	
J1094	DEXAMETHASONE ACETATE	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	DEXASONE L.A.	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1750	DEXFERRUM	Iron dextran, 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1190	DEXRAZOXANE	Dexrazoxane hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
C9048	DEXTENZA	Dexamethasone Ophthalmic Insert.	THERAPEUTIC INJ	
J7100	DEXTRAN 40 IN D5W	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	DEXTRAN 40 IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7110	DEXTRAN 75 IN D5W	Dextran 75 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7110	DEXTRAN 75 IN NACL	Dextran 75 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7060	DEXTROSE	5% Dextrose/water	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7070	DEXTROSE	Infusion, D5W, 1000 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7121	DEXTROSE in LACTATED RINGERS 5%	5% dextrose in lactated ringer's, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S5010	DEXTROSE-NaCL 5 – 0.45% SOLUTION	5% dextrose and 0.45% normal saline, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9034	DEXYCU	Dexamethasone intraocular suspension	THERAPEUTIC INJ	
J3360	DIAZEPAM	Diazepam, up to 5 mg	THERAPEUTIC INJ	
J0500	DICYCLOMINE HCL	Dicyclomine injection	THERAPEUTIC INJ	
J1450	DIFLUCAN IN SODIUM CHLORIDE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1162	DIGIBIND	Digoxin immune fab (ovine)	THERAPEUTIC INJ	
J1162	DIGIFAB	Digoxin immune fab (ovine)	THERAPEUTIC INJ	
J1160	DIGOXIN	Digoxin injection	THERAPEUTIC INJ	
J1110	DIHYDROERGOTAMINE MESYLATE	Dihydroergotamine mesyltate	SELF-INJECTABLE	
J1170	DILAUDID	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0092	DILAUDID	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1163	Diltiazem	Injection, diltiazem HCl, 0.5 mg	THERAPEUTIC INJ	
J1240	DIMENHYDRINATE	Dimenhydrinate injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1200	DIPHENHYDRAMINE HCL	Diphenhydramine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
90719	DIPHTHERIA TOXOID	Diphtheria toxoid, IM	THERAPEUTIC INJ	IMMUNIZATION
90702	DIPHTHERIA-TETANUS TOXOIDS	DT vaccine < 7 yrs, IM	THERAPEUTIC INJ	IMMUNIZATION
90718	DIPHTHERIA-TETANUS TOXOIDS	Td vaccine > 7, IM	THERAPEUTIC INJ	IMMUNIZATION
J2704	DIPRIVAN	Propofol, 10 mg	THERAPEUTIC INJ	
90296	DIPTHERIA ANTITOXIN	Diptheria antitoxin, equine any route	THERAPEUTIC INJ	
J1245	DIPYRIDAMOLE INJECTION	Dipyridamole injection	THERAPEUTIC INJ	
J1205	DIURIL IV	Chlorothiazide sodium, per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1250	DOBUTAMINE HCL	Dobutamine HCL 250 mg	THERAPEUTIC INJ	
J9172	Docetaxel	Injection, docetaxel (Ingenus), not therapeutically equivalent to J9171, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1265	DOPAMINE HCL	Dopamine hcl, 40 mg injection	THERAPEUTIC INJ	
J1265	DOPAMINE HCL 200MG IN 5% DEXTROSE	Dopamine injection	THERAPEUTIC INJ	
J1265	DOPAMINE HCL 800MG IN 5% DEXTROSE	Dopamine injection	THERAPEUTIC INJ	
J1265	DOPAMINE IN D5W	Dopamine injection	THERAPEUTIC INJ	
J1267	DORIBAX	Doripenem, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2050	DOXIL	Doxorubicin hydrochloride, liposomal, Doxil, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1271	DOXY 100	Doxycycline Hyclate, 1mg	THERAPEUTIC INJ	
J1790	DROPERIDOL	Droperidol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90723	PEDIARIX	Diphtheria, tetanus toxoids, acellular pertussia vaccine, hepatitis B and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9130	DTIC-DOME	Dacarbazine 100 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590, C9399	DUPIXENT	Dupilumab injection, for subcutaneous use	SELF-INJECTABLE	
J0735	DURACLON	Clonidine hydrochloride	THERAPEUTIC INJ	
J2270	DURAMORPH	Morphine sulfate, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2274	DURAMORPH	Morphine sulfate, preservative-free for epidural or intrathecal use, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	DURAMORPH	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7318	DUROLANE	Sodium hyaluronic, for single intra-articular injection 60mg/3ml	THERAPEUTIC INJ	
J7351	DURYSTA	Injection, bimatoprost, intracameral implant, 1 microgram	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1130	DYLOJECT	Diclofenac sodium, 0.5 mg, Injection	THERAPEUTIC INJ	
J0586	DYSPORT	AbobotulinumtoxinA, 5 units	THERAPEUTIC INJ	
J3590	EBGLYSS™	Lebrikizumab-lbkz Subcutaneous Soln Auto-inject 250 MG/2ML	SELF-INJECTABLE	
J3520	EDETATE DISODIUM	Edetate disodium /150 mg	THERAPEUTIC INJ	
J0270	EDEX	Injection, alprostadil, 1.25 mcg	SELF-INJECTABLE	
J3590, C9399	EGRIFTA SV	Tesamorelin acetate for inj 2 mg	SELF-INJECTABLE	HIV/AIDS
J9063	ELAHERE	Injection, mirvetuximab soravtansine-gynx, 1 mg , for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1743	ELAPRASE	Idursulfase,1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1320	ELAVIL	Amitriptyline injection	THERAPEUTIC INJ	
J3060	ELELYSO	Taliglucerase alfa Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1413	ELEVIDYS	Delandistrogene moxeparvovec-rokl suspension, for intravenous infusion	THERAPEUTIC INJ	
J2508	ELFABRIO®	Pegunigalsidase alfa-iwxj injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9217	ELIGARD	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	ELIGARD	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J9218	ELIGARD®	Leuprolide acetate) for injectable suspension, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2783	ELITEK	Rasburicase, 0.5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9178	ELLENCE	Epirubicin hcl, 2 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9175	ELLIOTTS B	Elliotts b solution per ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J7205	ELOCTATE	Antihemophilic Factor (Recombinant), Fc Fussion Protein], Lyophilized Powder for Solution For Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9263	ELOXATIN	Oxaliplatin	THERAPEUTIC INJ	CHEMOTHERAPY*
J1323	ELREXFIO	Injection, elranatamab-bcmm, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9020	ELSPAR	Asparaginase injection, 10,000 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9269	ELZONRIS	Tagraxofusp-erzs injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0458	EMBLAVEO™	Aztreonam and avibactam injection, IV	THERAPEUTIC INJ	
J1453	EMEND 115 MG SOLR	Fosaprepitant, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	EMGALITY	Galcanezumab-gnlm	SELF-INJECTABLE	
J0350	EMINASE	Anistreplase 30 u	THERAPEUTIC INJ	
C9151	EMPAVELI	Pegcetacoplan subcutaneous Solution 1080 mg/20ml	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7799	EMPAVELI	Pegcetacoplan injection, for subcutaneous use NDC 73606-0010-01	SELF-INJECTABLE	
J9176	EMPLICITI	Elotuzumab for Intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J9999	EMRELIS™	Telisotuzumab vedotin-tllv for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1438	ENBREL	Etanercept injection	SELF-INJECTABLE	
J3402	ENCELTO™	Revakinagene Taroretcel-lwey Intravitreal Implant 200,000 CELLS	THERAPEUTIC INJ	
90382	ENFLONSIA™	Clesrovimab-cfor injection, for intramuscular use	THERAPEUTIC INJ	
90740	ENGERIX-B	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90746	ENGERIX-B	Hepatitis B vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90744	ENGERIX-B 10 MCG/0.5ML INJ	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90747	ENGERIX-B 20 MCG/ML INJ	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9358	ENHERTU	Fam-trastuzumab deruxtecan-nxki for IV Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J1302	ENJAYMO	Sutimlimab-jome) injection, for intravenous use	THERAPEUTIC INJ	
J3590	ENSPRYNG	Satralizumab-mwge for subcutaneous use	SELF-INJECTABLE	
J3590	ENTYVIO	Vedolizumab for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3380	ENTYVIO (SubQ)	Vedolizumab soln **pen-injector** 108 MG/0.68ML 64764-0108-20; 64764-0108-21	SELF-INJECTABLE	
Q5149	ENZEEVU	Injection, aflibercept-abzv, biosimilar to Eylea, 1 mg	THERAPEUTIC INJ	
J3490	EPHEDRINE	Ephedrine sulfate inj 50 mg/ml	THERAPEUTIC INJ	
J0166	Epinephrine	Injection, epinephrine (belcher) not therapeutically equivalent to j0171, 0.1 mg	THERAPEUTIC INJ	
J0165	Epinephrine	Injection, epinephrine, not otherwise specified, 0.1 mg	THERAPEUTIC INJ	
J0167	Epinephrine	Injection, epinephrine (hospira), not therapeutically equivalent to J0165, 0.1 mg	THERAPEUTIC INJ	
J0168	Epinephrine	Injection, epinephrine (international medication systems), not therapeutically equivalent to J0165, 0.1 mg	SELF-INJECTABLE	
J0163	Epinephrine	Injection, epinephrine in sodium chloride (endo), 0.1 mg	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0164	Epinephrine	Injection, epinephrine in sodium chloride (baxter), 0.1 mg	THERAPEUTIC INJ	
J0169	EPINEPHRINE HCL	Adrenalin epinephrine inject	THERAPEUTIC INJ	
J3490	EPIPEN	Epinephrine hcl injection device 1:1000	SELF-INJECTABLE	
J3490	EPIPEN JR	Epinephrine hcl injection device 1:1000	SELF-INJECTABLE	
J9231	EPKINLY	Epcoritamab-bysp injection for subcutaneous (SC) use.	SELF-INJECTABLE	CHEMO ADJUNCT*
J0885	EPOGEN	Epoetin alfa, (for non-ESRD use), 1000 units	SELF-INJECTABLE	
Q4081	EPOGEN	Epoetin Alfa, 100 Units (For ESRD On Dialysis) (For Renal Dialysis Facilities And Hospital Use)	SELF-INJECTABLE	
Q5151	EPYSQLI	Injection, eculizumab-aa, biosimilar to Soliris, 2 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0348	ERAXIS 50 MG	Anadulafungin injection	THERAPEUTIC INJ	
J9055	ERBITUX	Cetuximab injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	ERELZI	Etanercept-szzs injection, for subcutaneous	SELF-INJECTABLE	
J1330	ERGONOVINE MALEATE	Ergonovine maleate injection	THERAPEUTIC INJ	
J9019	ERWINAZE	Asparaginase Erwinia chrysanthemi Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1364	ERYTHROCIN	Erythromycin lactobionate 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1364	ERYTHROMYCIN LACTOBIONATE	Erythromycin lactobionate 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2428	ERZOFRI	Injection, paliperidone palmitate extended release, 1 mg	THERAPEUTIC INJ	
J1805	Esmolol	Injection, esmolol HCl, 10 mg	THERAPEUTIC INJ	
J1806	Esmolol	Injection, esmolol HCl (WG Critical Care) not therapeutically equivalent to J1805, 10 mg	THERAPEUTIC INJ	
J1370	Esomeprazole Sodium	Injection, esomeprazole sodium, 1 mg	THERAPEUTIC INJ	
J7204	ESPEROCT	Antihemophilic factor (recombinant), glycopegylated-exei is a coagulation Factor VIII concentrate indicated for use in adults and children with hemophilia A	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1380	ESTRADIOL VALERATE 10 MG/ML	Estradiol valerate injection, Up to 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
J1430	ETHAMOLIN	Ethanolamine oleate 100 mg	THERAPEUTIC INJ	
J0207	ETHYOL	Amifostine	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9181	ETOPOPHOS	Etoposide 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7323	EUFLEXXA	Sodium Hyaluronate injection	THERAPEUTIC INJ	
J3111	EVENITY	Romosozumab-aqqg injection, for subcutaneous use	THERAPEUTIC INJ	
J1305	EVKEEZA	Evinacumab-dgnb injection, for intravenous	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9246	EVOMELA	Melphalan	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399/J3490	EVZIO	Naloxone hydrochloride injection Auto-Injector	SELF-INJECTABLE	
J1428	EXONDYS 51	Eteplirsen IV Soln 100 MG/2ML	THERAPEUTIC INJ	
J0666	EXPAREL®	Injection, bupivacaine liposome, 1 mg	THERAPEUTIC INJ	
J1830	EXTAVIA	Interferon beta-1b	SELF-INJECTABLE	
J0178	EYLEA	Injection, aflibercept, 1 mg	THERAPEUTIC INJ	
J0177	EYLEA HD	Aflibercept Injection 8 mg/0.07ml	THERAPEUTIC INJ	
J0180	FABRAZYME	Agalsidase beta injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0517	FASENRA	Benralizumab, for subcutaneous use	THERAPEUTIC INJ	
J0517	FASENRA PEN	Benralizumab subcutaneous soln auto-injector 30 mg/ml	SELF-INJECTABLE	
J9395	FASLODEX	Fulvestrant	THERAPEUTIC INJ	CHEMOTHERAPY*
J7198	FEIBA VH IMMUNO (ANTI-INHIBITOR COAGULANT COMPLEX)	Anti-inhibitor, coagulant complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1951	FENSOLVI	Leuprolide acetate for injectable suspension,	THERAPEUTIC INJ	
J3010	FENTANYL CITRATE	Fentanyl citrate injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0138	FERAHEME INJECTION	Ferumoxytol 1 mg, for iron deefiency anemia, non-ESRD use	THERAPEUTIC INJ	
Q0139	FERAHEME INJECTION	Ferumoxytol 1 mg, for iron deefiency anemia, for ESRD on dialysis	THERAPEUTIC INJ	
J2916	FERRLECIT	Na ferric gluconate complex	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0693	FETROJA	Injection, cefiderocol, 5 mg	THERAPEUTIC INJ	
J0699	FETROJA	Injection, cefiderocol, 10 mg	THERAPEUTIC INJ	
J7177	FIBRYGA®	Fibrinogen Concentrate (Human) For IV Soln 2 GM	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1744	FIRAZYR	Icatibant	SELF-INJECTABLE	
J9155	FIRMAGON	Degarelix, 1 mg for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
S0030	FLAGYL	Metronidazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1572	FLEBOGAMMA	Immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1325	FLOLAN	Epoprostenol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0155	FLOLAN STREILE DILUENT	Sterile diluent for epoprostenol, 50 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0034	FLOXIN	Ofloxacin, 400 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9200	FLOXURIDINE	Floxuridine injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90694	FLUAD® Quadrivalent	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90686	FLUARIX® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90673	FLUBLOK	Influenza Virus Vacc Recombinant HA PF Soln Pref Syr 0.5 Ml, 2024-25	THERAPEUTIC INJ	IMMUNIZATION
90682	FLUBLOK® QUAD INJ 2022-23	nfluenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90661	FLUCELVAX PF	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90674	FLUCELVAX QUADRIVALENT 2022-2023	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1450	FLUCONAZOLE IN DEXTROSE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1450	FLUCONAZOLE IN SODIUM CHLORIDE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9185	FLUDARA	Fludarabine phosphate injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9185	FLUDARABINE PHOSPHATE	Fludarabine phosphate injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90686	FLULAVAL Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9190	FLUOROURACIL	Fluorouracil injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2679	FLUPHENAZINE	Injection, fluphenazine HCl, 1.25 mg	THERAPEUTIC INJ	
J2680	FLUPHENAZINE DECANOATE	Fluphenazine decanoate 25 mg	THERAPEUTIC INJ	
Q2037	FLUVIRIN	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90656	FLUZONE 2024-2025	Influenza Virus Vaccine Split PF Susp	THERAPEUTIC INJ	IMMUNIZATION
90657	FLUZONE 2024-2025	Influenza Virus Vaccine Split IM Susp 6-35 Months, IM, 0.25 ML	THERAPEUTIC INJ	IMMUNIZATION
90658	FLUZONE 2024-2025	Influenza Virus Vaccine Split Im Susp Age 3 Years Old & Over IM, 0.5 ML	THERAPEUTIC INJ	IMMUNIZATION

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90662	FLUZONE HIGH DOSE	Influenza Virus Vac Split High-Dose PF Susp	THERAPEUTIC INJ	IMMUNIZATION
90662	FLUZONE High-Dose Quadrivalent	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular	THERAPEUTIC INJ	IMMUNIZATION
90685	FLUZONE Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90687	FLUZONE Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90688	FLUZONE Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1434	FOCINVEZ	Injection, fosaprepitant, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1808	FOLIC ACID	Injection, folic acid, 0.1 mg	THERAPEUTIC INJ	
S0128	FOLLISTIM AQ	Follitropin beta, 75 IU	SELF-INJECTABLE	INFERTILITY
J9307	FOLOTYN	Pralatrexate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0713	FORTAZ	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0713	FORTAZ IN D5W	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3110	FORTEO	Teriparatide, 10 mcg	SELF-INJECTABLE	
J3490	FORZINITY™	Elamipretide Hcl Subcutaneous Soln 280 Mg/3.5ml	SELF-INJECTABLE	
J1456	Fosaprepitant	Injection, fosaprepitant (Teva), not therapeutically equivalent to J1453, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1455	FOSCAVIR	Foscarnet sodium injection	THERAPEUTIC INJ	HIV/AIDS
J1645	FRAGMIN	Dalteparin sodium, per 2,500 IU	SELF-INJECTABLE	
J9072	FRINDOVYX	Injection, cyclophosphamide, (Avyxa), 5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9200	FUDR	Floxuridine injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5108	FULPHILA	Pegfilgrastim-jmdb biosimilar	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5108	FULPHILA	Pegfilgrastim-jmdb, biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J9393	FULVESTRANT	Injection, fulvestrant (Teva) not therapeutically equivalent to J9395, 25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9394	FULVESTRANT	Injection, fulvestrant (Fresenius Kabi) not therapeutically equivalent to J9395, 25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9395	FULVESTRANT	Fulvestrant inj, 25 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0285	FUNGIZONE	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1941	FUROSCIX	Injection, furosemide 20 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1940	FUROSEMIDE	Furosemide injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0641	FUSILEV	Levoleucovorin calcium, 0.5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1324	FUZEON	Enfuvirtide, 1 mg	SELF-INJECTABLE	HIV/AIDS
J9331	FYARRO	Sirolimus protein-bound particles for IV	THERAPEUTIC INJ	CHEMOTHERAPY*
Q1530	FYLNETRA	Pegfilgrastim-pbbk injection, for subcutaneous use	THERAPEUTIC INJ	
J0475	GABLOFEN	Baclofen inj	THERAPEUTIC INJ	
J1560	GAMA**STAN** 15-18%	Gamma globulin, intramuscular, over 10 cc (always use for any amount injected over 10cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	GAMA**STAN** 1 cc	Gamma globulin, intramuscular, 1 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9210	GAMIFANT	Emapalumab-lzsg injection, for intravenous use	THERAPEUTIC INJ	
J1569	GAMMAGARD LIQUID	Immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1566	GAMMAGARD S/D	Immune globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561	GAMMAKED	Injection, immune globulin, intravenous, non-lyophilized, e.g. liquid	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1557	GAMMAPLEX	Immune Globulin Intravenous (human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561	GAMUNEX-C	Immune globulin, (Gamunex/Gamunex-C/Gammaked	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561-JB	GAMUNEX-C	Immune Globulin Injection (human) 10% Caprylate/chromatography purified - Subcutaneous	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1574	Ganciclovir	Injection, ganciclovir sodium (Exela) not therapeutically equivalent to J1570, 500 mg	THERAPEUTIC INJ	HIV/AIDS
S0132	GANIRELIX	Ganirelix acetate 250 mcg	SELF-INJECTABLE	INFERTILITY
J1457	GANITE	Gallium nitrate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
90649	GARDASIL	Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (Gardasil is only indicated in males and females from 9 through 26 years of age)	THERAPEUTIC INJ	IMMUNIZATION
90651	GARDASIL 9	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use (Gardasil 9 is only indicated for females from 9 through 26 years of age and males from 9 through 15 years of age)	THERAPEUTIC INJ	IMMUNIZATION
J3490/C9399	GATTEX 5 MG KIT	Teduglutide [rDNA origin], for Injection, for subcutaneous use	SELF-INJECTABLE	
J9301	GAZYVA	Obinutuzumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7326	GEL-ONE	Hyaluronan or derivative, Gel-One, for intra-articular injection	THERAPEUTIC INJ	
J7328	GEL-SYN	Hyaluronan or derivative for intra-articular injection, 0.1 mg	THERAPEUTIC INJ	
J9196	Gemcitabine	Injection, gemcitabine hydrochloride (Accord), not therapeutically equivalent to J9201, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9201	GEMZAR	Gemcitabine HCl, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0395	GENESA	Arbutamine hcl injection	THERAPEUTIC INJ	
J2941	GENOTROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J1580	GENTAMICIN SULFATE	Gentamicin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	GENTRAN 40 IN D5W	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	GENTRAN 40 IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7320	GENVISC 850	Hyaluronan or derivative, for intra-articular injection	THERAPEUTIC INJ	
J3486	GEODON	Ziprasidone mesylate	THERAPEUTIC INJ	
J3490	GIAPREZA	Angiotensin II Injection for Intravenous Infusion	THERAPEUTIC INJ	
J0223	GIVLAARI	Givosiran injection, for Subcutaneous use	THERAPEUTIC INJ	
J0257	GLASSIA	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1595	GLATOPA	Glatiramer acetate, 20 mg	SELF-INJECTABLE	
J1610	GLUCAGEN	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1610	GLUCAGON	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1611	GLUCAGON	Injection, glucagon HCl (Fresenius Kabi), not therapeutically equivalent to J1610, per 1 mg	SELF-INJECTABLE	
J1610	GLUCAGON EMERGENCY	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1598	GLYCOPYRROL	Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to J1596, 0.1 mg	THERAPEUTIC INJ	
J1596	Glycopyrrolate	Injection, glycopyrrolate, 0.1 mg	THERAPEUTIC INJ	
J1600	GOLD SODIUM THIOMALATE	Gold sodium thiomaleate injection	THERAPEUTIC INJ	
S0126	GONAL-F	Follitropin alfa 75 iu	SELF-INJECTABLE	INFERTILITY
J0614	GRAFAPEX™	Treosulfan for injection, for intravenous use	THERAPEUTIC INJ	
J1447	GRANIX	tbo-filgrastim, 1 microgram	SELF-INJECTABLE	CHEMO ADJUNCT*
J1447	GRANIX	tbo-filgrastim, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J1610	GVOKE	Glucagon hydrochloride, per 1 mg	SELF-INJECTABLE	
J1612	GVOKE®	Injection, glucagon, 0.01 mg	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1610	GVOKE®	Glucagon hydrochloride, per 1 mg	SELF-INJECTABLE	
J0599	HAEGARDA	C1 esterase inhibitor (human) for subcutaneous inj	SELF-INJECTABLE	
J9179	HALAVEN	Eribulin mesylate Injecton	THERAPEUTIC INJ	CHEMOTHERAPY*
J1630	HALDOL	Haloperidol injection	THERAPEUTIC INJ	
J1631	HALDOL DECANOATE	Haloperidol decanoate injection	THERAPEUTIC INJ	
J1630	HALOPERIDOL LACTATE	Haloperidol injection	THERAPEUTIC INJ	
90632	HAVRIX	Hepatitis A vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90633	HAVRIX	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90371	H-BIG	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
J1270	HECTOROL	Doxercalciferol	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7192	HELIXATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1411	HEMGENIX®	Etranacogene dezaparvovec-drlb) suspension, for intravenous infusion	THERAPEUTIC INJ	
J7170	HEMLIBRA	Emicizumab-kxwh injection, for subcutaneous use	SELF-INJECTABLE	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7190	HEMOFIL M	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90748	HEP B/HIB VACCINE	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use (Price is per 0.5 mL dose)	THERAPEUTIC INJ	IMMUNIZATION
J1642	HEP FLUSH-10	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1571	HEPAGAM B - IM	Hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 mL (see J1573 for IV use)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1573	HEPAGAM B - IV	Hepatitis B immune globulin (Hepagam B), intravenous, 0.5 mL (see J1571 for IM use)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1643	HEPARIN	Injection, heparin sodium (Pfizer), not therapeutically equivalent to J1644, per 1000 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN (PORCINE) IN D5W	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN (PORCINE) IN NACL	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN (PORCINE) IN NACL	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN (PORCINE) LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN COMBINATION	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1644	HEPARIN SODIUM (BOVINE)	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM (PORCINE)	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN SODIUM FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM IN NACL	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN SODIUM LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90739	HEPLISAV-B	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1642	HEP-LOCK	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEP-LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEP-LOCK PF	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9248	HEPZATO KIT™	Melphalan for Intrarterial-arterial Solution 59Mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9355	HERCEPTIN	Trastuzumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9355	HERCEPTIN HYLECTA™	Trastuzumab, excludes biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5146	HERCESSI®	Injection, trastuzumab-strf , biosimilar to Herceptin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5113	HERZUMA	Trastuzumab-pkrb, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90646	HIB VACCINE, PRP-D	Hib Vaccine, Prp-D, IM	THERAPEUTIC INJ	IMMUNIZATION
90648	HIBERIX	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1559	HIZENTRA	Immune Globulin Subcutanenous (human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5140	HULIO	Injection, adalimumab-fkjp, biosimilar to Humira, 1 mg	SELF-INJECTABLE	
90281	HUMAN IG, IM	Immune Globulin (IG), human, for intramuscular use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90283	HUMAN IG, IV	Immune Globulin (IGIV), human, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90284	HUMAN IG, SUB Q	Immune globulin (IGIV), human, for use in subcutaneous infusions, 100 mg, each	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7187	HUMATE-P	Von Willebrand Factor complex, human, ristocetin coFactor, per IU, VWF:RCO	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2941	HUMATROPE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J0135	HUMIRA	Adalimumab injection	SELF-INJECTABLE	
J7321	HYALGAN	Hyaluronan or derivative,for intra-articular injection, per dose	THERAPEUTIC INJ	
J9351	HYCAMTIN	Topotecan, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0360	HYDRALAZINE HCL	Hydralazine hcl injection	THERAPEUTIC INJ	
J1700	HYDROCORTISONE ACETATE	Hydrocortisone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1710	HYDROCORTONE	Hydrocortisone sodium ph injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1170	HYDROMORPHONE HCL	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3425	HYDROXO-COBOLAMINE	Injection, hydroxocobalamin, 10 mcg	THERAPEUTIC INJ	
J1729	HYDROXYprogesterone Caproate	HYDROXYprogesterone Caproate 1.25 GM/5ML SOLN	THERAPEUTIC INJ	
J3410	HYDROXYZINE HCL	Hydroxyzine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3473	HYLENEX	Hyaluronidase, recombinant, 1 USP unit	THERAPEUTIC INJ	
J7322	HYMOVIS	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
J7172	HYMPAVZI™	Injection, marstacimab-hncq, 0.5 mg	SELF-INJECTABLE	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90371	HYPERHEP B®	Hepatitis B immune globulin (HBIg), human, for intramuscular use	THERAPEUTIC INJ	
90375	HYPERRAB	Rabies Immune Globulin (RIg), human, for intramuscular and/or subcutaneous use	THERAPEUTIC INJ	
J1730	HYPERSTAT	Diazoxide injection	THERAPEUTIC INJ	
J1575	HYQVIA 10 GM/100ML KIT	Immune Globulin Infusion 10% [human] with recombinant human hyaluronidase	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5144	IDACIO®	Adalimumab-aacf	SELF-INJECTABLE	
J9211	IDAMYCIN PFS	Idarubicin hcl injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9211	IDARUBICIN	Idarubicin hcl injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7202	IDELVION	Coagulation Factor IX (Recombinant), Albumin Fusion Protein (rIX-FP), a recombinant human blood coagulation factor	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7355	iDose TR	Injection, travoprost, intracameral implant, 1 microgram	THERAPEUTIC INJ	
J9208	IFEX	Ifosfomide injection, 1 gram	THERAPEUTIC INJ	CHEMOTHERAPY*
J9208	IFOSFAMIDE	Ifosfomide injection, 1 gram	THERAPEUTIC INJ	CHEMOTHERAPY*
J2403	IHEEZO	Chloroprocaine Hcl Ophth Gel 3%	THERAPEUTIC INJ	
J0638	ILARIS INJECTION	Canakinumab 180 mg	THERAPEUTIC INJ	
J3245	ILUMYA	Tildrakizumab-asmn 100 mg/ml injection, for subcutaneous use	THERAPEUTIC INJ	
J7313	ILUVIEN	fluocinolone acetonide, intravitreal implant, 0.01 mg	THERAPEUTIC INJ	
J3590	IMAAVY™	Nipocalimab-Aahu IV Soln	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	IMCIVREE	Setmelanotide injection, for subcutaneous use	SELF-INJECTABLE	
J9026	IMDELLTRA	Tarlatamab-dlle for injection, for intravenous use	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9173	IMFINZI	Durvalumab soln for IV infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3030	IMITREX	Sumatriptan, succinate	SELF-INJECTABLE	
J3030	IMITREX STATDOSE	Sumatriptan, succinate	SELF-INJECTABLE	
J9347	IMJUDO	Tremelimumab-actl soln for IV infusion 25 mg/1.25ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9325	IMLYGIC	Talimogene laherparepvec, 1 million plaque forming units (PFU)	THERAPEUTIC INJ	CHEMOTHERAPY*
J2373	IMMPHENTIV	Injection, phenylephrine hydrochloride , 20 micrograms	THERAPEUTIC INJ	
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 2cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 3cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 4cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 5cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 6cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 7cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 8cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 9cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 10cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1560	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, over 10cc (always use for any amount injected over 10cc and place number of units)(1cc = 1 unit)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90376	IMOGAM RABIES-HT	Rabies IG, heat treated	THERAPEUTIC INJ	
90675	IMOVAX RABIES	Rabies vaccine, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7307	IMPLANON	Etonogestrel (Contraceptive) Implant System, Including Implants And Supplies	THERAPEUTIC INJ	
Q5098	IMULDOSA™	Injection, ustekinumab-srlf, (biosimilar for Stelara), 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5098	IMULDOSA™	Injection, ustekinumab-srlf, for self-injection (biosimilar for Stelara), 1 mg	SELF-INJECTABLE	
J7501	IMURAN	Azathioprine parenteral	THERAPEUTIC INJ	TRANSPLANT
J1790	INAPSINE	Droperidol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2170	INCRELEX	Mecasermin [rDNA origin] Injection	SELF-INJECTABLE	GROWTH HORMONE
J1800	INDERAL	Propranolol injection	THERAPEUTIC INJ	
90700	INFANRIX	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J1750	INFED	Iron dextran 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q5103	INFLECTRA	Infliximab, biosimilar, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90654	INFLUENZA VACCINE	Influenza virus vaccine, split virus, preservative free, for intradermal use	THERAPEUTIC INJ	IMMUNIZATION
J9198	INFUGEM	Gemcitabine in sodium chloride injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2270	INFUMORPH 200	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2271	INFUMORPH 200	Morphine SO4 injection 100mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	INFUMORPH 200	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	INFUMORPH 500	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1439	INJECTAFER	Ferric carboxymaltose Injection	THERAPEUTIC INJ	
J1327	INTEGRILIN	Eptifibatide injection	THERAPEUTIC INJ	
J1335	INVANZ	Ertapenem injection, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2426	INVEGA HAFYERA™	Paliperidone palmitate inj, 1 MG	THERAPEUTIC INJ	
J2426	INVEGA SUSTENNA	Paliperidone palmitate	THERAPEUTIC INJ	
J3490	INVEGA TRINZA	Paliperidone palmitate extended release injectable	THERAPEUTIC INJ	
J1750	IRON DEXTRAN COMPLEX	Iron dextran, 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1834	Isoniazid	Injection, isoniazid, 1 mg	THERAPEUTIC INJ	
J9315	ISTODAX	Romidepsin, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9249	IVRA™	Melphalan HCl IV Soln 90 MG/ML (Base Equiv)	THERAPEUTIC INJ	IMMUNIZATION
J9207	IXEMPRA KIT	Ixabepilone, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90738	IXIARO SUSPENSION	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5109	IXIFI	Infliximab-qbtx, biosimilar, 10 mg	THERAPEUTIC INJ	
J7213	IXINITY	Coagulation factor IX (recombinant)] Lyophilized Powder for Solution for Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2782	IZERVAY	Avacincaptad Pegol Intravitreal Soln 2 MG/0.1ML (20 MG/ML)	THERAPEUTIC INJ	
J9281	JELMYTO	Mitomycin pyelocalyceal instillation, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9272	JEMPERLI	Dostarlimab-gxly	THERAPEUTIC INJ	CHEMOTHERAPY*
J7316	JETREA	Ocriplasmin Intravitreal Injection, 2.5 mg/mL	THERAPEUTIC INJ	
90735	JE-VAX	Japanese Encephalitis Virus Vaccine Inactivated	THERAPEUTIC INJ	IMMUNIZATION
J9043	JEVTANA	Cabazitaxel Injection 60 MG/1.5ML SOLN	THERAPEUTIC INJ	CHEMOTHERAPY*
J7208	JIVI	Antihemophilic factor (recombinant), PEGylated-aucl] lyophilized powder for solution, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3590	JOBEVNE™	Bevacizumab-nwgd. Biosimilar to Avastin	THERAPEUTIC INJ	
Q5136	JUBBONTI®	Denosumab-Bbdz Inj Soln Prefilled Syringe (biosimilar to Prolia)	THERAPEUTIC INJ	
90611	JYNNEOS	Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use	THERAPEUTIC INJ	IMMUNIZATION
J9354	KADCYLA	Ado-trastuzumab emtansine for iv soln 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1290	KALBITOR	Ecallantide	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1840	KANAMYCIN SULFATE	Kanamycin sulfate 500 MG injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1850	KANAMYCIN SULFATE	Kanamycin sulfate 75 MG injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5117	KANJINTI	Trastuzumab-anns,10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2480	KANUMA	Sebelipase alfa injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7168	KCENTRA	Prothrombin Complex Concentrate (Human)) for Intravenous Use	THERAPEUTIC INJ	
J3590	KEBILIDI	Eladocagene exuparvovec-tneq intraputaminal infusion	THERAPEUTIC INJ	
90377	KEDRAB®	Rabies immune globulin, heat- and solvent/detergent-treated (RIg-HT S/D), human, for intramuscular and/or subcutaneous use	THERAPEUTIC INJ	
J0690	KEFZOL	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3301	KENALOG	Triamcinolone acetonide injection, 10 mg	THERAPEUTIC INJ	
C9460	KENGREAL	Cangrelor Injection	THERAPEUTIC INJ	
J2425	KEPIVANCE	Palifermin injectionection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1953	KEPPRA	Levetiracetam, 500 mg/5 mL injection	THERAPEUTIC INJ	
J1953	KEPPRA 500 MG/5ML SOLN	Levetiracetam, 10 mg	THERAPEUTIC INJ	
J3590	KESIMPTA	Ofatumumab soln auto-injector 20 mg/0.4ml	SELF-INJECTABLE	
J3490	KETAMINE	Ketamine hcl Injection	THERAPEUTIC INJ	
J1885	KETOROLAC TROMETHAMINE	Ketorolac tromethamine injection	THERAPEUTIC INJ	
J3590	KEVZARA	Sarilumab subcutaneous soln prefilled syringe	SELF-INJECTABLE	
J9271	KEYTRUDA	Pembrolizumab for injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399	KEYTRUDA QLEX™	Pembrolizumab-Berahyaluron-pmph Inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J0642	KHAPZORY	Levoleucovorin for IV soln	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9274	KIMMTRAK	Tebentafusp-tebn IV soln 100 mcg/0.5m	THERAPEUTIC INJ	CHEMOTHERAPY*
J2046	KIMYRSA	Oritavancin Diphosphate For IV Soln 1200 Mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3590	KINERET	Anakinra subcutaneous injection 100 mg/0.67ml	SELF-INJECTABLE	
90696	KINRIX SUSP	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0175	KISUNLA	Injection, donanemab-azbt, 2 mg	THERAPEUTIC INJ	
J7190	KOATE-DVI	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7192	KOGENATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0879	KORSUVA	Difelikefalin injection, for intravenous use	THERAPEUTIC INJ	
J7211	KOVALTRY	Antihemophilic Factor (Recombinant), is a recombinant,human DNA sequence derived, full length Factor VIII concentrate	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2507	KRYSTEXXA	Pegloticase	THERAPEUTIC INJ	
J0591	KYBELLA	Injection, deoxycholic acid, 1 mg	THERAPEUTIC INJ	
Q2042	KYMRIAH	Tisagenlecleucel, up to 250 million car-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J9047	KYPROLIS	Carfilzomib Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1626	KYTRIL	Granisetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
S0091	KYTRIL	Granisetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1920	Labetalol	Injection, labetalol HCl, 5 mg	THERAPEUTIC INJ	
J1921	Labetalol	Injection, labetalol HCl (Hikma) not therapeutically equivalent to J1820, 5 mg	THERAPEUTIC INJ	
J7120	LACTATED RINGER'S	Ringers lactate infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0217	LAMZEDE	Velmanase alfa-tycv) for injection, for intravenous use	THERAPEUTIC INJ	
J1160	LANOXIN	Digoxin injection	THERAPEUTIC INJ	
J1932	Lanreotide 1 mg (Cipla)	Lanreotide acetate, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9285	LARTRUVO	Injection, olaratumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0202	LEMTRADA	Alemtuzumab Injection for Intravenous Infusion	THERAPEUTIC INJ	
J0174	LEQEMBI	Injection, lecanemab-irmb, 1 mg	THERAPEUTIC INJ	
J3490	LEQEMBI® IQLK™	Lecanemab-irmb soln auto-inj 360 mg/1.8ml	SELF-INJECTABLE	
J1306	LEQVIO	Inclisiran injection, for subcutaneous use	THERAPEUTIC INJ	
J0640	LEUCOVORIN CALCIUM	Leucovorin calcium injection	SELF-INJECTABLE	CHEMO ADJUNCT*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2820	LEUKINE	Sargramostim injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9218	LEUPROLIDE ACETATE	Leuprolide acetate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1954	Leuprolide acetate for depot	Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9065	LEUSTATIN	Cladribine per 1 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J1956	LEVAQUIN	Levofloxacin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1955	LEVOCARNITINE	Levocarnitine per 1 gm	THERAPEUTIC INJ	
J1960	LEVO-DROMORAN	Levorphanol tartrate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0650	Levothyroxine	Injection, levothyroxine sodium, not otherwise specified, 10 mcg	THERAPEUTIC INJ	
J0651	Levothyroxine	Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to J0650, 10 mcg	THERAPEUTIC INJ	
J0652	Levothyroxine	Injection, levothyroxine sodium (hikma), not therapeutically equivalent to J0650, 10 mcg	THERAPEUTIC INJ	
J3490	Levothyroxine Injection, 200 mcg	Levothyroxine	THERAPEUTIC INJ	
J3490	Levothyroxine Injection, 500 mcg	Levothyroxine	THERAPEUTIC INJ	
J1980	LEVSIN	Hyoscyamine sulfate injection	THERAPEUTIC INJ	
J1990	LIBRIUM	Chlordiazepoxide injection	THERAPEUTIC INJ	
J9119	LIBTAYO	Cemiplimab-Rwlc IV Soln	THERAPEUTIC INJ	CHEMOTHERAPY*
J2001	LIDOCAINE IN D5W	Lidocaine injection	THERAPEUTIC INJ	
J2010	LINCOCIN	Lincomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2021	LINEZOLID	Injection, linezolid (Hospira) not therapeutically equivalent to J2020, 200 mg	THERAPEUTIC INJ	
J0476	LIORESAL	Baclofen intrathecal	THERAPEUTIC INJ	
J7100	LMD IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3263	LOQTORZI®	Toripalimab-tpzi IV solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J2060	LORAZEPAM	Lorazepam injection	THERAPEUTIC INJ	
J1650	LOVENOX	Enoxaparin sodium, 10 mg	SELF-INJECTABLE	
J2778	LUCENTIS 0.5 MG/0.05ML SOLN	Ranibizumab, 0.5 Mg	THERAPEUTIC INJ	
J2560	LUMINAL	Phenobarbital sodium injection	THERAPEUTIC INJ	
J0221	LUMIZYME	Alglucosidase alfa	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9313	LUMOXITI	Moxetumomab pasudotox-tdfk for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9350	LUNSUMIO™	Mosunetuzumab-axgb) injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
C9399, J3490	LUPANETA PACK	Leuprolide acetate for depot suspension; norethindrone acetate tablets	THERAPEUTIC INJ	
J9218	LUPRON	Leuprolide acetate injection Kit 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1950	LUPRON DEPOT	Leuprolide acetate 3.75 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	LUPRON DEPOT	Leuprolide acetate suspension 7.5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	LUPRON DEPOT-PED	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	LUSEDRA	Fospropofol disodium Injection	THERAPEUTIC INJ	
A9607	LUTATHERA®	lutetium Lu 177 dotatate) injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1954	LUTRATE DEPOT	Injection, leuprolide acetate for depot suspension, 7.5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3398	LUXTURNA	Voretigene neparvovec-rzyl	THERAPEUTIC INJ	
J3394	LYFGENIA	Lovotibeglogene autotemcel suspension for intravenous infusion	THERAPEUTIC INJ	
90665	LYME DISEASE VACCINE	Lyme disease vaccine, adult dosage, IM	THERAPEUTIC INJ	IMMUNIZATION
J9161	LYMPHIR	Denileukin diftitox-cxdl	THERAPEUTIC INJ	CHEMOTHERAPY*
J3391	LYNMELDY	Atidarsagene autotemcel IV SUSP	THERAPEUTIC INJ	
J9999	LYNOZYFIC™	Linvoseltamab-gcpt injection, for intravenous use	THERAPEUTIC INJ	
J3475	MAGNESIUM SULFATE	Magnesium sulfate	THERAPEUTIC INJ	
J2151	Mannitol	Injection, mannitol, 250 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9353	MARGENZA	Injection, margetuximab-cmkb, 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0692	MAXIPIME	Injection, cefepime hydrochloride, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90708	MEASLES-RUBELLA VACCINE	Measles-Rubella Vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J1051	MEDROXYPROGESTERONE MICRO	Medroxyprogesterone injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0694	MEFOXIN IN DEXTROSE	Cefoxitin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9249	Melphalan Hydrochloride	Injection, melphalan (apotex), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90644	MENHIBRIX	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
S0122	MENOPUR	Menotropins 75 iu	THERAPEUTIC INJ	INFERTILITY
90619	MENQUADFI™	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90734	MENVEO	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D), or CRM197 carrier (MenACWY-CRM), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J2180	MEPERGAN	Meperidine/promethazine injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2175	MEPERIDINE HCL	Meperidine hydrochl /100 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3397	MEPSEVII™	Vestronidase alpha-vjbk	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2184	MEROPENEM	Injection, meropenem (B. Braun) not therapeutically equivalent to J2185, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2183	MERREM	injection, meropenem (wg critical care), not therapeutically equivalent to J2185, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2185	MERREM	Meropenem 100MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90706	MERUVAX II	Rubella vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9209	MESNA	Mesna injection, 200mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9209	MESNEX	Mesna injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1230	METHADONE HCL	Methadone HCl, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2210	METHERGINE	Methylergonovin maleate injection	THERAPEUTIC INJ	
J2800	METHOCARBAMOL	Methocarbamol injection	THERAPEUTIC INJ	
J9255	METHOTREXATE	Injection, methotrexate (Accord), not therapeutically equivalent to J9250 and J9260, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE POWDER 1GM IN 50ML SD VIAL (P.F.)	Methotrexate sodium injection, 25mg/ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE POWDER 1GM IN 50ML SD VIAL (P.F.)	Methotrexate sodium injection, 25mg/ml (Not for Chemotherapy)	SELF-INJECTABLE	
J9250	METHOTREXATE SODIUM	Methotrexate sodium injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE SODIUM	Methotrexate sodium injection	THERAPEUTIC INJ	
J9250	METHOTREXATE SODIUM LPF	Methotrexate sodium injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0210	METHYLDOPATE HCL	Methyldopate hcl injection	THERAPEUTIC INJ	
J1020	METHYLPRED 20	Methylprednisolone 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	METHYLPRED 40	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1040	METHYLPREDNISOLONE ACETATE	Methylprednisolone 80 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	METHYLPREDNISOLONE ACETATE USP	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2920	METHYLPREDNISOLONE SODIUM SUCC	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	METHYLPREDNISOLONE SODIUM SUCC	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2765	METOCLOPRAMIDE HCL	Metoclopramide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0616	Metoprolol	Injection, metoprolol tartrate, 1 mg	THERAPEUTIC INJ	
J1836	Metronidazole	Injection, metronidazole, 10 mg	THERAPEUTIC INJ	
J0630	MIACALCIN	Calcitonin salmon injection	SELF-INJECTABLE	
J2246	MICAFUNGIN	Injection, micafungin in sodium (Baxter), not therapeutically equivalent to J2248, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2247	MICAFUNGIN	Injection, micafungin sodium (Par Pharm) not therapeutically equivalent to J2248, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2251	MIDAZOLAM	Injection, midazolam HCl (WG Critical Care) not therapeutically equivalent to J2250, per 1 mg	THERAPEUTIC INJ	
J2250	MIDAZOLAM HCL	Midazolam hydrochloride	THERAPEUTIC INJ	
J2260	MILRINONE IN DEXTROSE	Milrinone lactate Per 5 MG	THERAPEUTIC INJ	
J2260	MILRINONE LACTATE	Milrinone lactate Per 5 MG	SELF-INJECTABLE	
J2265	MINOCIN	Minocycline hydrochloride Injection 1 mg	SELF-INJECTABLE	
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	SELF-INJECTABLE	
J0888	MIRCERA	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	SELF-INJECTABLE	CHEMO ADJUNCT*
J9270	MITHRACIN	Plicamycin, 2.5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MITOMYCIN	Mitomycin 5 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9291	MITOMYCIN	Mitomycin 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9293	Mitoxantrone	Mitoxantrone Hcl Inj Conc 20 Mg/10ml (2 Mg/ml)	THERAPEUTIC INJ	
90707	M-M-R II	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	THERAPEUTIC INJ	IMMUNIZATION
91323	mNEXSPIKE®	COVID-19 Vaccine, mRNA injection, IM	THERAPEUTIC INJ	IMMUNIZATION
J9349	MONJUVI	Tafasitamab-cxix For IV Soln 200 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J7190	MONOCLATE-P	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1437	MONOFERRIC	Injection ferric derisomaltose 10 mg	THERAPEUTIC INJ	
J7193	MONONINE	Factor IX (antihemophilic Factor, purified, non-recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7327	MONOVISC	High Molecular Weight Hyaluronan	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2270	MORPHINE SULFATE	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2271	MORPHINE SULFATE	Morphine SO4 injection 100mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2272	MORPHINE SULFATE	Injection, morphine sulfate (Fresenius Kabi) not therapeutically equivalent to J2270, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2274	MORPHINE SULFATE	Morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	MORPHINE SULFATE (PF)	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	MOUNJARO	Tirzepatide Injection, for subcutaneous use	SELF-INJECTABLE	
J2281	MOXIFLOXACIN	Injection, moxifloxacin (Fresenius Kabi) not therapeutically equivalent to J2280, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2562	MOZOBIL 24 MG/1.2ML SOLN	Plerixafor injection	THERAPEUTIC INJ	
90683	MRESVIA™	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90704	MUMPSVAX	Mumps vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9230	MUSTARGEN	Mechlorethamine hydrochloride, (nitrogen mustard), 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MUTAMYCIN	Mitomycin 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5107	MVASI	Bevacizumab-awwb	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	MYALEPT	Metreleptin for injection	SELF-INJECTABLE	
J2248	MYCAMINE	Micafungin sodium for Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9203	MYLOTARG	Gemtuzumab ozogamicin, 0.1 mg 4.5 MG SOLR	THERAPEUTIC INJ	CHEMOTHERAPY*
J0587	MYOBLOC	RimabotulinumtoxinB, 100 units	THERAPEUTIC INJ	
J1600	MYOCHRYSINE	Gold sodium thiomaleate injection	THERAPEUTIC INJ	
J0220	MYOZYME 10 MG	Injection, alglucosidase alfa, 10 mg, not otherwise specified	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90371	NABI-HB	Hepatitis B immune globulin (HBIg), human, for intramuscular use	THERAPEUTIC INJ	
J2290	NAFCILLIN	Injection, nafcillin sodium, 20 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1458	NAGLAZYME 1MG/ML	Galsulfase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2300	NALBUPHINE HCL	Nalbuphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	NALMEFENE	Nalmefene hcl inj 1 mg/ml	THERAPEUTIC INJ	
J2322	NANDROLONE DECANOATE	Nandrolone decanoate 200 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2795	NAROPIN	Ropivacaine hcl injection	THERAPEUTIC INJ	
J9390	NAVELBINE	Vinorelbine tartrate, per 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2515	NEMBUTAL	Pentobarbital sodium inj, 50 mg	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3590	NEMLUVIO	Nemolizumab-ilto 30MG Auto-injector	SELF-INJECTABLE	
J2710	NEOSTIGMINE METHYLSULFATE	Neostigmine methylslate injection	THERAPEUTIC INJ	
J2370	NEO-SYNEPHRINE	Phenylephrine hcl injection	THERAPEUTIC INJ	
J2506	NEULASTA	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Self-Injectable)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2506	NEULASTA	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Therapeutic Inj)	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J2506	NEULASTA ONPRO KIT	6 mg/0.6 mL Pegfilgrastim in a single-dose prefilled syringe co-packaged with the on-body injector (OBI)	SELF-INJECTABLE	CHEMO ADJUNCT*
J1442	NEUPOGEN	Filgrastim 480 mcg injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1442	NEUPOGEN	Filgrastim (G-CSF), excludes biosimilars, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J3420	NEURO B-12 FORTE S	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3420	NEURO B-12 S	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3305	NEUTREXIN	Trimetrexate glucoronate	THERAPEUTIC INJ	
J1370	NEXIUM® I.V. 20 MG SOLR	Esomeprazole injection	THERAPEUTIC INJ	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies	THERAPEUTIC INJ	
J0283	NEXTERONE	Injection, amiodarone hydrochloride, 30 mg	THERAPEUTIC INJ	
J0219	NEXVIAZYME	Avalglucosidase alfa-ngpt	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	NGENLA	Somatrogon-ghla injection, for subcutaneous use	SELF-INJECTABLE	
J2404	Nicardipine	Injection, nicardipine, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9038	NIKTIMVO	Axatilimab-csfr	THERAPEUTIC INJ	
J9268	NIPENT	Pentostatin, per 10mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0211	NITHIODOTE	Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg	THERAPEUTIC INJ	
J2305	Nitroglycerin	Injection, nitroglycerin, 5 mg	THERAPEUTIC INJ	
Q5110	NIVESTYM	Filgrastim-aafi soln prefilled syringe 300 mcg or 480mcg	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5110	NIVESTYM	Filgrastim-aafi, biosimilar, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J2941	NORDITROPIN	Somatropin, 1 mg	THERAPEUTIC INJ	
J2360	NORFLEX	Orphenadrine injection	SELF-INJECTABLE	
90371	NOVAPLUS NABI-HB	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0725	NOVAREL	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J7182	NOVOEIGHT	Factor VIII, antihemophilic factor, recombinant per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7189	NOVOSEVEN	Factor VIIa (antihemophilic Factor, recombinant), per 1 microgram	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
C9399, J3490	NOXAFIL	Posaconazole Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2802	NPLATE	Romiplostim, 10 micrograms	THERAPEUTIC INJ	
J2300	NUBAIN	Nalbuphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2182	NUCALA Vial	Mepolizumab for injection	THERAPEUTIC INJ	
J2182	NUCALA AUT0-INJECTOR, PREFILLED SYRINGE	Injection, mepolizumab, 1 mg Auto-injector 00173-0892-01; pfs. 00173-0892-42; 00173-0904-42	SELF-INJECTABLE	
J1809	NULIBRY®	Injection, fosdenopterin, 0.1 mg	THERAPEUTIC INJ	
J0485	NULOJIX	Belatacept, 1 mg injection	THERAPEUTIC INJ	
C9143	NUMBRINO™	Cocaine hydrochloride nasal solution , 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2410	NUMORPHAN	Oxymorphone hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2941	NUTROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2941	NUTROPIN AQ	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2941	NUTROPIN DEPOT	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
91304	NUVAXOVID™	COVID-19 vaccine, adjuvanted	THERAPEUTIC INJ	IMMUNIZATION
J7209	NUWIQ	Factor VIII (antihemophilic factor, recombinant) 1 I.U.	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0121	NUZYRA	Injection, omadacycline, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5148	NYPOZI	Filgrastim-txid Soln, Biosimilar to Neupogen	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5122	NYVEPRIA	Pegfilgrastim-apgf	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5122	NYVEPRIA	Pegfilgrastim-apgf	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7188	OBIZUR	Antihemophilic Factor (Recombinant), Porcine Sequence IV Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2350	OCREVUS	Ocrelizumab injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2351	OCREVUS ZUNOVO	Ocrelizumab hyaluronidase-ocsq	THERAPEUTIC INJ	
J1568	OCTAGAM	Immune Globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0131	OFIRMEV	Injection, acetaminophen, not otherwise specified,10 mg	THERAPEUTIC INJ	
Q5114	OGIVRI	Trastuzumab-dkst, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
C9101	OLINVYK	Oliceridine injection, for intravenous use	THERAPEUTIC INJ	
J3490	OMIDRIA	Phenylephrine and ketorolac injection 1% / 0.3%	THERAPEUTIC INJ	
J3590	OMISIRGE	Omidubicel-onlv Suspension for IV Infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5154	OMLYCLO®	Injection, omalizumab-igec, biosimilar, 5 mg	THERAPEUTIC INJ	
J2941	OMNITROPE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2267	OMVOH	Mirikizumab-mrkz I**ntravenous** injection 00002-7575-01	THERAPEUTIC INJ	
J3590	OMVOH SubQ	Mirikizumab-mrkz **subcutaneous** injection 00002-8011-01; 00002-8011-27	SELF-INJECTABLE	
J0364	ONAPGO™	Apomorphine Hcl Soln Cartridge	THERAPEUTIC INJ	
J9266	ONCASPAR	Pegaspargase, per single dose vial	THERAPEUTIC INJ	CHEMOTHERAPY*
J9205	ONIVYDE	Irinotecan liposome injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0222	ONPATTRO	Patisiran lipid complex injection, for intravenous use	THERAPEUTIC INJ	
J9160	ONTAK	Denileukin diftitox, 300 mcg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5112	ONTRUZANT	Trastuzumab-dttb, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9299	OPDIVO	Nivolumab, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9289	OPDIVO QVANTIG	Nivolumab and hyaluronidase-nvhy) injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9298	OPDUALA	Nivolumab and relatlimab-rmbw) injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5153	OPUVIZ™	Aflibercept-yszy injection, for intravitreal use (biosimilar to EYLEA)	SELF-INJECTABLE	
J2407	ORBACTIV	Oritavancin diphosphate for IV soln 400 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0129	ORENCIA	Abatacept Inj, 10 mg	THERAPEUTIC INJ	
J0129	ORENCIA IV	Abatacept, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2360	ORPHENADRINE CITRATE	Orphenadrine injection	THERAPEUTIC INJ	
J7505	ORTHOCLONE OKT3	Muromonab-cd3, parenteral, 5 mg	THERAPEUTIC INJ	TRANSPLANT
J7324	ORTHOVISC	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL)	THERAPEUTIC INJ	
J3590	OSENVELT®	denosumab-bmwo injection, SC biosimilar to Xgeva	THERAPEUTIC INJ	
Q5159	OSPOMYV™	Injection, denosumab-dssb (ospomyv-xbryk), biosimilar to Prolia, 1 mg	THERAPEUTIC INJ	
C9399, J3490	OTREXUP	Methotrexate Injection	SELF-INJECTABLE	
Q9999	OTULFI™	Ustekinumab-aauz Soln Prefilled Syringe 45 MG/0.5ML. (Biosimilar to Stelara)	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q9999	OTULFI™	Ustekinumab-aauz Soln Prefilled Syringe 90 MG/ML. Biosimilar to Stelara	SELF-INJECTABLE	
Q9999	OTULFI™	Injection, ustekinumab-aauz, biosimilar to Stelara, 1 mg, IV	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	OVIDREL	Chorionic gonadotropin 250 MCG/0.5ML INJ	SELF-INJECTABLE	INFERTILITY
J2700	OXACILLIN SODIUM	Oxacillin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0224	OXLUMO	Injection, lumasiran, 0.5 mg	THERAPEUTIC INJ	
J2590	OXYTOCIN	Oxytocin injection	THERAPEUTIC INJ	
C9399, J3490	OZEMPIC	SemaglutIde Soln, injection, for subcutaneous use	SELF-INJECTABLE	
J1096	OZURDEX	Dexamethasone intravitreal Implant	THERAPEUTIC INJ	
J9264	PACLITAXEL	Paclitaxel protein-bound particles, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9267	PACLitaxel	Paclitaxel, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9259	Paclitaxel	Injection, paclitaxel protein-bound particles (American Regent) not therapeutically equivalent to J9264, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9258	Paclitaxel protein-bound particles	Injection, paclitaxel protein-bound particles (Teva), not therapeutically equivalent to J9264, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9177	PADCEV	Enfortumab vedotin-ejfv) for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2468	Palonosetron	Injection, palonosetron hydrochloride (avyxa), not therapeutically equivalent to J2469, 25 micrograms	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590, C9399	PALYNZIQ	Pegvaliase-pqpz injection, for subcutaneous use	SELF-INJECTABLE	
J2430	PAMIDRONATE DISODIUM	Pamidronate disodium /30 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1566	PANGLOBULIN NF	Immune Globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1640	PANHEMATIN	Hemin, 1 mg	THERAPEUTIC INJ	
J1576	PANZYGA	Immune globulin intravenous, human - ifas 10% Liquid Preparation	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2440	PAPAVERINE HCL	Papaverine hcl injection	THERAPEUTIC INJ	
J3590	PAPZIMEOS™	Zopapogene imadenovec-drba	THERAPEUTIC INJ	
J9045	PARAPLATIN	Carboplatin injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0606	PARSABIV	Injection, etelcalcetide, 0.1 mg for intravenous use	THERAPEUTIC INJ	
Q5147	PAVBLU	Aflibercept-ayyh intravitreal inj 2 mg/0.05ml	THERAPEUTIC INJ	
90647	PEDVAX HIB	Haemophilus influenzae type b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
S0145	PEGASYS	Pegylated interferon alfa-2a, 180 mcg per mL	SELF-INJECTABLE	
J9294	Pemetrexed	Injection, pemetrexed (Hospira), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9296	Pemetrexed	Injection, pemetrexed (Accord), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9297	Pemetrexed	Injection, pemetrexed (Sandoz), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9314	PEMETREXED	Injection, pemetrexed (Teva) not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9292	Pemetrexed	Injection, pemetrexed, not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9304	PEMFEXY	Pemetrexed IV soln 500 mg/20ml	THERAPEUTIC INJ	CHEMOTHERAPY*
Q0224	PEMGARDA	Pemivibart IV soln 500 mg/4ml (125 mg/ml)	THERAPEUTIC INJ	
J9324	PEMRYDI RTU	Injection, pemetrexed, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90623	PENBRAYA	Meningococcal ACYW (Tet Conj)-Mening B (Rcmb) Vacc For Inj	THERAPEUTIC INJ	IMMUNIZATION
J2540	PENICILLIN G POT IN DEXTROSE	Penicillin G potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2540	PENICILLIN G POTASSIUM	Penicillin G potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2510	PENICILLIN G PROCAINE	Penicillin g procaine injection	THERAPEUTIC INJ	
90624	PENMENVY®	Meningococcal Groups A, B, C, W, and Y Vaccine injection, IM	THERAPEUTIC INJ	IMMUNIZATION
J9999	Penpulimab-kcqx	Penpulimab-kcqx injection, for intravenous use	THERAPEUTIC INJ	
90698	PENTACEL	Diphtheria, tetanus toxoids, acecllular pertussis vaccine, Haemophilius influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular useTaP - Hib - IPV), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
S0080	PENTAM 300 MG SOLUTION	Pentamidine isethionateper 300 mg	THERAPEUTIC INJ	
J2513	PENTASPAN 10%	Pentastarch 10% solution	THERAPEUTIC INJ	
J1308	PEPCID	Famotidine, 20 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9306	PERJETA	Pertuzumab Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J2798	PERSERIS	Risperidone for extended-release injectable suspension	THERAPEUTIC INJ	
91319	PFIZER-BIONTECH COVID-19 VACCINE/5-11Y	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
91318	Pfizer Covid-19 Vac-tris 6m-4y	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J2540	PFIZERPEN-G	Penicillin g potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2550	PHENERGAN	Promethazine hcl injection	THERAPEUTIC INJ	
J2560	PHENOBARBITAL SODIUM	Phenobarbital sodium injection	THERAPEUTIC INJ	
J2760	PHENTOLAMINE MESYLATE	Phentolamine mesylate injection	THERAPEUTIC INJ	
J2372	Phenylephrine	Injection, phenylephrine HCl (Biorphen), 20 mcg	THERAPEUTIC INJ	
J2370	PHENYLEPHRINE HCL	Phenylephrine hcl injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1165	PHENYTOIN SODIUM	Phenytoin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399	PHESGO	Pertuzumab-trastuz-hyaluron-zzxf inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9600	PHOTOFRIN	Porfimer sodium, 75 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3430	PHYTONADIONE	Vitamin K phytonadione injection	THERAPEUTIC INJ	
J1307	PIASKY	Crovalimab-akkz injection, for intravenous or subcutaneous	THERAPEUTIC INJ	
S0081	PIPERACILLIN	Piperacillin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2590	PITOCIN	Oxytocin injection	THERAPEUTIC INJ	
90727	PLAGUE VACCINE	Plague Vaccine, IM	THERAPEUTIC INJ	IMMUNIZATION
J9060	PLATINOL AQ	Cisplatin 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9062	PLATINOL AQ	Cisplatin 50 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	PLEGRIDY	Peginterferon beta-1a soln pen-inj	SELF-INJECTABLE	
90732	PNEUMOVAX 23	Pneumococcal polysaccharide vaccine, 23 valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9309	POLIVY	Polatuzumab vedotin-piiq for Intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0670	POLOCAINE	Mepivacaine HCL 10 ml	THERAPEUTIC INJ	
J0670	POLOCAINE-MPF	Mepivacaine HCL/10 ml	THERAPEUTIC INJ	
J1566	POLYGAM S/D	Immune Globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1203	POMBILITI®	Cipaglucosidase alfa-atga for IV solution	THERAPEUTIC INJ	
J9295	PORTRAZZA	Necitumumab IV Soln 800 Mg/50ml (16 Mg/Ml)	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
C9144	POSIMIR	Injection, bupivacaine, 1 mg	THERAPEUTIC INJ	
J3480	POTASSIUM CHLORIDE	Potassium chloride	THERAPEUTIC INJ	
S5012	POTASSIUM CHLORIDE in DEXTROSE SOLUTION	5% dextrose with potassium chloride, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9204	POTELIGEO	Mogamulizumab-kpkc injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	PRALUENT	Alirocumab Injection, for subcutaneous use	SELF-INJECTABLE	
C9399	PRAXBIND	Idarucizumab injection, for intravenous use	THERAPEUTIC INJ	
J3490	PRECEDEX	Dexmedetomidine hcl inj 200 mcg/2ml	THERAPEUTIC INJ	
J2650	PREDACORT 50	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2650	PRED-JECT-50	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2650	PREDNISOLONE ACETATE	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0725	PREGNYL	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J1410	PREMARIN	Estrogen conjugate 25 MG	THERAPEUTIC INJ	
S0195	PREVNAR 16 MCG/0.5ML SUSP	Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years to nine years of age who have not previously received the vaccine	THERAPEUTIC INJ	IMMUNIZATION
90677	PREVNAR 20	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3490	PREVYMIS	Letermovir injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2278	PRIALT	Ziconotide injection	THERAPEUTIC INJ	
J2260	PRIMACOR	Milrinone lactate / 5 MG	THERAPEUTIC INJ	
J2260	PRIMACOR IN DEXTROSE	Milrinone lactate / 5 MG	THERAPEUTIC INJ	
J0743	PRIMAXIN IV	Cilastatin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2670	PRISCOLINE	Totazoline hcl injection	THERAPEUTIC INJ	
J1459	PRIVIGEN	Immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg (Privigen)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0570	PROBUPHINE IMPLANT KIT	Buprenorphine hcl subdermal implant 74.2 mg	THERAPEUTIC INJ	
J2690	PROCAINAMIDE HCL	Procainamide hcl injection	THERAPEUTIC INJ	
J0780	PROCHLORPERAZINE EDISYLATE	Prochlorperazine, up to 10 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0885	PROCRIT	Epoetin alfa, (for non-ESRD use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
Q4081	PROCRIT	Epoetin Alfa, 100 Units (For ESRD On Dialysis) (For Renal Dialysis Facilities And Hospital Use)	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7194	PROFILNINE SD	Factor IX, complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2675	PROGESTERONE	Progesterone per 50 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7525	PROGRAF	Tacrolimus injection	THERAPEUTIC INJ	TRANSPLANT
J0256	PROLASTIN	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9015	PROLEUKIN	Aldesleukin, per single use vial	THERAPEUTIC INJ	CHEMOTHERAPY*
J0897	PROLIA	Denosumab 60MG/ML	THERAPEUTIC INJ	
J2950	PROMAZINE HCL	Promazine hcl injection	THERAPEUTIC INJ	
J2550	PROMETH-50	Promethazine hcl injection	THERAPEUTIC INJ	
J2550	PROMETHAZINE HCL	Promethazine hcl injection	THERAPEUTIC INJ	
J7401	PROPEL	Mometasone furoate sinus implant, 10 micrograms	THERAPEUTIC INJ	
J1800	PROPRANOLOL HCL	Propranolol injection	THERAPEUTIC INJ	
90710	PROQUAD	Measles, Mumps, Rubella and Varicella (Oka/Merck) Virus Vaccine Live	THERAPEUTIC INJ	IMMUNIZATION
J0270	PROSTIN VR 500 MCG	Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct physician supervision, not for use when drug is self-administered)	THERAPEUTIC INJ	
J2720	PROTAMINE SULFATE	Protamine sulfate/10 MG	THERAPEUTIC INJ	
J3490	PROTONIX	Pantoprazole sodium, 40 mg	THERAPEUTIC INJ	
J2730	PROTOPAM CHLORIDE	Pralidoxime chloride injection	THERAPEUTIC INJ	
Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3415	PYRIDOXINE HCL	Pyridoxine hcl 100 mg	THERAPEUTIC INJ	
J3590	PYZCHIVA	Ustekinumab-ttwe is biosimilar* to STELARA	SELF-INJECTABLE	
Q9997	PYZCHIVA®	USTEKINUMAB-TTWE IV SOLN 130 MG/26ML	THERAPEUTIC INJ	
Q9996	PYZCHIVA®	Ustekinumab-ttwe Subcutaneous Soln 45 MG/0.5ML Biosimilara to Stelara	SELF-INJECTABLE	
J1304	QALSODY	Tofersen Intrathecal Soln 100 MG/15ML (6.7 MG/ML)	THERAPEUTIC INJ	
J3490	QFITLIA™	Fitusiran injection, for subcutaneous use	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90696	QUADRACEL	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0330	QUELICIN	Succinycholine chloride injection	THERAPEUTIC INJ	
J1201	QUZYTTIR	Cetirizine hydrochloride injection, for intravenous use	THERAPEUTIC INJ	
90675	RABAVERT	Rabies vaccine, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	IMMUNIZATION
J1301	RADICAVA	Edaravone injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2026	RADIESSE	Calcium hydroxylapatite Implant	THERAPEUTIC INJ	
J2780	RANITIDINE	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2547	RAPIBLYK™	Landiolol HCl For IV Soln 280 MG	THERAPEUTIC INJ	
J2547	RAPIVAB	Peramivir Injection	THERAPEUTIC INJ	
C9399, J3490	RASUVO	Methotrexate Injection	SELF-INJECTABLE	
Q3028	REBIF	Interferon beta-1a injection	SELF-INJECTABLE	
J7203	REBINYN	Coagulation Factor IX (Recombinant), GlycoPEGylated lyophilized powder for solution for intravenous injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0896	REBLOZYL	Luspatercept-aamt for Subcutaneous inj	THERAPEUTIC INJ	
J0742	RECARBRIO	Imipenem, cilastatin, and relebactam for injection, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3489	RECLAST	Zoledronic acid 1 mg Injection (Reclast)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7192	RECOMBINATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90743	RECOMBIVAX HB 10MCG/0.5ML	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use 10MCG/ML= one dose)	THERAPEUTIC INJ	IMMUNIZATION
90746	RECOMBIVAX HB 10MCG/ML	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use, 10MCG/ML	THERAPEUTIC INJ	IMMUNIZATION
90740	RECOMBIVAX HB 40MCG/ML	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90744	RECOMBIVAX HB 5MCG/0.5ML	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use, 5MCG/0.5ML= one dose)	THERAPEUTIC INJ	IMMUNIZATION
90746	RECOMBIVAX HB 5MCG/0.5ML	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use, 10MCG/ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7192	REFACTO	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1945	REFLUDAN	Lepirudin	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0243	REGEN-COV	Injection, casirivimab and imdevimab, 2400 mg	THERAPEUTIC INJ	
J2765	REGLAN	Metoclopramide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
Q5125	RELEUKO	Filgrastim-ayow inj soln 300 mcg/ml	SELF-INJECTABLE	CHEMO ADJUNCT*
J2212	RELISTOR	Methylnaltrexone bromide injection	SELF-INJECTABLE	
J1745	REMICADE	Infliximab, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3285	REMODULIN	Treprostinil injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2004	RENACIDIN	Bladder calculi irrig sol	THERAPEUTIC INJ	
Q5104	RENFLEXIS	Infliximab-abda for Injection, for Intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0130	REOPRO	Injection abciximab, 10 mg	THERAPEUTIC INJ	
C9399, J3590	REPATHA	Evolocumab subcutaneous soln	SELF-INJECTABLE	
Q5105	RETACRIT	Epoetin alfa-epbx, biosimilar, (retacrit) (for esrd on dialysis), 100 units	SELF-INJECTABLE	
Q5106	RETACRIT	Epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
J2993	RETAVASE	Injection, reteplase, 18.1 mg	THERAPEUTIC INJ	
J7311	RETISERT IMPLANT	Fluocinolone acetonide invitreal implant	THERAPEUTIC INJ	
J3485	RETROVIR	Zidovudine IV Soln 10 MG/ML	THERAPEUTIC INJ	HIV/AIDS
J3490	REVATIO	Sildenafil IV Soln 10 MG/12.5ML	THERAPEUTIC INJ	
C9399, J3590	REVCOVI	Elapegademase-lvlr injection, for intramuscular use	THERAPEUTIC INJ	
J3490	REZIPRES	Ephedrine hydrochloride injection for intravenous use	THERAPEUTIC INJ	
J0349	REZZAYO	Rezafungin for injection, for intravenous use	THERAPEUTIC INJ	
90386	RH Ig, IV	Rho(D) Immune Gobulin (RhIgIV), human, for intravenous use (Effective 3/30/06 Price is per 100 IU - previously Price was per 1500 IU) (see also J2790, Q4089	THERAPEUTIC INJ	
J7100	RHEOMACRODEX IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90384	RHO(D) Ig (RHIG)	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	THERAPEUTIC INJ	
J2790	RHOGAM (HUMAN)	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	THERAPEUTIC INJ	
90384	RHOGAM® ULTRA-FILTERED PLUS	Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2791	RHOPHYLAC	Rho d immune globulin injection	THERAPEUTIC INJ	
Q5123	RIABNI	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	THERAPEUTIC INJ	CHEMOTHERAPY*
J7178	RIASTAP	Injection, human fibrinogen concentrate, 1 mg	THERAPEUTIC INJ	
J2804	Rifampin	Injection, rifampin, 1 mg	THERAPEUTIC INJ	
J1212	RIMSO-50	Dimethyl sulfoxide 50% 50 ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2794	RISPERDAL CONSTA	Risperidone 0.5 mg, Injection	THERAPEUTIC INJ	
J9312	RITUXAN	Rituximab,100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9311	RITUXAN HYCELA	Rituximab and hyaluronidase human injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	RIVFLOZA	Nedosiran Sodium Subcutaneous Soln 80 MG/0.5ML	SELF-INJECTABLE	
J7200	RIXUBIS	Factor ix (antihemophilic factor, recombinant)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2800	ROBAXIN	Methocarbamol injection	THERAPEUTIC INJ	
J3490	ROBINUL	Glycopyrrolate 0.2MG/ML	THERAPEUTIC INJ	
J0696	ROCEPHIN	Ceftriaxone sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0696	ROCEPHIN IN DEXTROSE	Ceftriaxone sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1412	ROCKTAVIAN	Valoctocogene roxaparvovec-rvox	THERAPEUTIC INJ	
J1449	ROLVEDON	Eflapegrastim-xnst injection, for subcutaneous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3490	ROMAZICON	Flumazenil IV soln 0.5 mg/5ml	THERAPEUTIC INJ	
J9314	ROMIDEPSIN	Injection romidepsin non-lypohilized 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9318	ROMIDEPSIN	Romidepsin, non-lyophilized, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9319	ROMIDEPSIN	Romidepsin, lyophilized, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0596	RUCONEST	C1 esterase inhibitor (recombinant) for Intravenous Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5119	RUXIENCE	Rituximab-pvvr (Rituxan biosimilar)	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	RYANODEX	Dantrolene sodium for injectable suspension, for intravenous use	THERAPEUTIC INJ	
J9061	RYBREVANT	Amivantamab-vmjw	THERAPEUTIC INJ	CHEMOTHERAPY*
J2801	RYKINDO	Risperidone for extended-release injectable suspension, for intramuscular use	THERAPEUTIC INJ	
J9021	RYLAZE	Asparaginase erwinia chrysanthemi (recombinant)-rywn) injection, for intramuscular use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3402	RYONCIL®	Remestemcel-L-rknd 2 x 3.8 ML Susp for IV Infusion Kit	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2998	RYPLAZIM	Plasminogen, human-tvmh)	THERAPEUTIC INJ	
J9333	RYSTIGGO	Rozanolixizumab-noli injection, for subcutaneous use	THERAPEUTIC INJ	
J0870	RYTELO	Imetelstat sodium for IV soln	THERAPEUTIC INJ	CHEMOTHERAPY*
J9361	RYZNEUTA®	Injection, efbemalenograstim alfa-vuxw, 0.5 mg	THERAPEUTIC INJ	
J2941	SAIZEN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J1744	SAJAZI	Icatibant acetate subcutaneous soln pref syr	SELF-INJECTABLE	
J7131	SALINE BACTERIOSTATIC	Hypertonic Saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7130	SALINE FLUSH	Hypertonic Saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7516	SANDIMMUNE	Cyclosporine, parenteral, 250mg	THERAPEUTIC INJ	TRANSPLANT
J2354	SANDOSTATIN	Octreotide injection, non-depot	SELF-INJECTABLE	CHEMO ADJUNCT*
J2353	SANDOSTATIN LAR DEPOT	Octreotide, depot form for intramuscular injection, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0491	SAPHNELO	Anifrolumab-fnia) injection, for intravenous use	THERAPEUTIC INJ	
J9227	SARCLISA	Isatuximab-irfc iv soln 100 mg/5ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	SAXENDA®	Liraglutide (weight management) soln pen-injector 6 mg/ml	SELF-INJECTABLE	
J3490	SCENESSE	Afamelanotide implant, 1 mg	THERAPEUTIC INJ	
Q2027	SCULPTRA	Poly-L-lactic acid Implant	THERAPEUTIC INJ	
J2850	SECRETIN SYNTHETIC HUMAN INJ	Secretin synthetic human	THERAPEUTIC INJ	
J3590	SELARSDI	ustekinumab-aekn IV Soln 130 MG/26MLis biosimilar* to STELARA®	THERAPEUTIC INJ	
Q9998	SELARSDI	Injection, Ustekinumab-aekn, PREFILLED SYRINGE 45 MG/0.5ML, biosimilar to Stelara	SELF-INJECTABLE	
Q9998	SELARSDI	Ustekinumab-Aekn Soln Prefilled Syringe 90 Mg/Ml, Biosimilar to Stelara	SELF-INJECTABLE	
J2941	SEROSTIM	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J7189	SEVENFACT	Factor VIIa (antihemophilic factor, recombinant)-jncw, 1 mcg	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2561	SEZABY	Phenobarbital injection, for intravenous use	THERAPEUTIC INJ	
90750	SHINGRIX	Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection	THERAPEUTIC INJ	IMMUNIZATION
J3490/C9399	SIGNIFOR	Pasireotide injection, for subcutaneous use	SELF-INJECTABLE	
J2502	SIGNIFOR LAR	Pasireotide Injection	THERAPEUTIC INJ	
C9399, J3490	SILIQ	Brodalumab Injection	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3590	SIMLANDI	Adalimumab-ryvk auto-injector kit 1mg, Biosimilar to Humira	SELF-INJECTABLE	
Q5142	SIMLANDI®	Adalimumab-ryvk Inj (biosimilar to Humira), 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399/J3590	SIMPONI	Golimumab 50 mg / 0.5ml Solution	SELF-INJECTABLE	
J1602	SIMPONI ARIA	Golimumab Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0480	SIMULECT	Basiliximab	THERAPEUTIC INJ	TRANSPLANT
J2805	SINCALIDE	Sincalide injection	THERAPEUTIC INJ	
J7402	SINUVA	Mometasone furoate sinus implant, 10 micrograms	THERAPEUTIC INJ	
J3090	SIVEXTRO	Tedizolid phosphate Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2327	SKYRIZI	Injection, risankizumab-rzaa, intravenous, 600 mg/10 mL (60 mg/mL) in each single-dose vial.. NDC 00074-5015-01	THERAPEUTIC INJ	
J3590	SKYRIZI	Rosankizumab-rzaa injection, for subcutaneous use	SELF-INJECTABLE	
J3590	SKYSONA	Elivaldogene autotemcel IV suspension	THERAPEUTIC INJ	
J3590	SKYTROFA	lonapegsomatropin-tcgd) for injection, for subcutaneous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7030	SODIUM CHLORIDE	Infusion, normal saline solution, 1000 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7040	SODIUM CHLORIDE	Infusion, normal saline solution, sterile (500ml = 1 unit	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7042	SODIUM CHLORIDE	5% dextrose/normal saline	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7050	SODIUM CHLORIDE	Normal saline solution infus	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7130	SODIUM CHLORIDE BACTERIOSTATIC	Hypertonic saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1807	SODIUM EDECRIN®	Injection, ethacrynate sodium, 1 mg	THERAPEUTIC INJ	
J7331	SODIUM HYALURONATE 1%	Sodium Hyaluronate 1% for Intra-articular injection	THERAPEUTIC INJ	
J2590	SODIUM PHOSPHATE	Oxytocin injection	THERAPEUTIC INJ	
J3490	SOGROYA	Somapacitan-beco injection, for subcutaneous use	SELF-INJECTABLE	GROWTH HORMONE
J3490	SOLESTA	Dextranomer-sodium hyaluronate injection	THERAPEUTIC INJ	
J2910	SOLGANAL	Aurothioglucose injeciton	THERAPEUTIC INJ	
C9399, J3490	SOLIQUA	Insulin Glargine-Lixisenatide Solution	SELF-INJECTABLE	
J1299	SOLIRIS	Eculizumab 10 mg/ml Soln	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2920	SOLU-MEDROL	Methylprednisolone sodium succinate, up to 40 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	SOLU-MEDROL	Methlprednisolone sodium succinate, up to 125 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	SOLUREX LA	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1930	SOMATULINE DEPOT	Lanreotide acetate, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	SOMAVERT	Pegvisomant for injection	SELF-INJECTABLE	
J3490	Sotalol	Injection, sotalol hydrochloride, 1 mg	THERAPEUTIC INJ	
J3490	SOTRADECOL	Sodium Tetradecyl Sulfate Injection	THERAPEUTIC INJ	
Q0247	SOTROVIMAB	Sotrovimab 500MG/8ML Solution	THERAPEUTIC INJ	
J1747	SPEVIGO	Injection, spesolimab-sbzo, 1 mg , for intravenous use	THERAPEUTIC INJ	
91322	SPIKEVAX®	COVID-19 vaccine, mrna	THERAPEUTIC INJ	IMMUNIZATION
J2326	SPINRAZA	Nusinersen injection, for intrathecal use -	THERAPEUTIC INJ	
J1835	SPORANOX	Itraconazole injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0595	STADOL NS	Butorphanol tartrate 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90717	STAMARIL	Yellow fever vaccine, live, for subcutaneous use	THERAPEUTIC INJ	IMMUNIZATION
J3590	STARJEMZA™	Ustekinumab-hmny IV Soln 130 MG/26ML (5 MG/ML) (For IV Inf). Biosimilar to Stelara	THERAPEUTIC INJ	
J3590	STARJEMZA™	Ustekinumab-hmny Soln Prefilled Syringe 45 MG/0.5ML. Biosimilar to Stelara	SELF-INJECTABLE	
J3590	STARJEMZA™	Ustekinumab-hmny Subcutaneous Soln 45 MG/0.5ML. Biosimilar to Stelara	SELF-INJECTABLE	
J3590	STARJEMZA™	Ustekinumab-hmny Soln Prefilled Syringe 90 MG/ML. Biosimilar to Stelara	SELF-INJECTABLE	
J3357	STELARA	Usetekinumab	SELF-INJECTABLE	
J3358	STELARA IV	Ustekinumab, for intravenous injection, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5099	STEQEYMA	Injection, Ustekinumab-STBA, biosimilar to Stelara, 1 mg	SELF-INJECTABLE	
J9165	STILPHOSTROL	Diethylstilbestrol injection, 250 mg	THERAPEUTIC INJ	CHEMOTHERAPY
Q5127	STIMUFEND	Injection, pegfilgrastim-fpgk , biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5127	STIMUFEND	Injection, pegfilgrastim-fpgk , biosimilar, 0.5 mg	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5157	STOBOCLO®	denosumab-bmwo injection, SC biosimilar to Prolia	THERAPEUTIC INJ	
C9399, J3590	STRENSIQ	Asfotase alfa subcutaneous injection	SELF-INJECTABLE	
J2995	STREPTASE	Streptokinase /250000 IU	THERAPEUTIC INJ	
J3000	STREPTOMYCIN SULFATE	Streptomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3010	SUBLIMAZE	Fentanyl citrate injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q9991	SUBLOCADE	Buprenorphine extended-release less than or equal to 10	THERAPEUTIC INJ	
Q9992	SUBLOCADE	Buprenorphine extended-release over 100 mg	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0330	SUCCINYLCHOLINE CHLORIDE	Succinycholine chloride injection	THERAPEUTIC INJ	
S0039	SULFAMETHOXAZOLE	Sulfamethoxazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1961	SUNLENCA	Lenacapavir injection, for subcutaneous use	THERAPEUTIC INJ	HIV/AIDS
J7321	SUPARTZ	Sodium hyaluronate injection	THERAPEUTIC INJ	
J9226	SUPPRELIN LA, 50 MG	Histrelin implant	THERAPEUTIC INJ	
J1627	SUSTOL	Granisetron extended-release, 0.1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2779	SUSVIMO	Ranibizumab injection) for intravitreal use (Ocular Implant)	THERAPEUTIC INJ	
J2781	SYFOVRE	Pegcetacoplan injection, for intravitreal use	THERAPEUTIC INJ	
J2860	SYLVANT	Siltuximab for Intravenous infusion	THERAPEUTIC INJ	
J3490	SYMLIN	Pramlintide acetate Injection	SELF-INJECTABLE	
90378	SYNAGIS	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	THERAPEUTIC INJ	
J2770	SYNERCID	Quinupristin/dalfopristin	THERAPEUTIC INJ	
J9262	SYNRIBO	Omacetaxine mepesuccinate for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7325	SYNVISC INJ	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
J7325	SYNVISC-ONE INJ	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
S0023	TAGAMET	Cimetidine hydroc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0593	TAKHZYRO	Landelumab-flyo	SELF-INJECTABLE	
C9399, J3590	TALTZ	Ixekizumab	SELF-INJECTABLE	
J3055	TALVEY	Talquetamab-tgvs injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3070	TALWIN	Pentazocine injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9265	TAXOL	Paclitaxel injection, 30 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9171	TAXOTERE	Docetaxel, 20 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0713	TAZICEF	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2053	TECARTUS	Brexucabtagene Autoleucel Suspension for IV Infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
Q2057	TECELRA	Afamitresgene Autoleucel IV Susp 10,000,000,000 CELLS	THERAPEUTIC INJ	CHEMOTHERAPY*
J9022	TECENTRIQ	Atezolizumab injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9024	TECENTRIQ HYBREZ	Atezolizumab-Hyaluronidase-tqjs Inj 1875-30000 MG-UNIT/15ML	THERAPEUTIC INJ	CHEMOTHERAPY*
J9380	TECVAYLI	Teclistamab-cqyv injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0712	TEFLARO	Ceftaroline fosamil	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	TEGSEDI	Inotersen injection, for subcutaneous use	SELF-INJECTABLE	
J9328	TEMODAR 100 MG SOLR	Temozolomide, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90714	TENIVAC	Tetanus and diphtheria toxoids adsorbed (Td), preserative free, when administered to individuals 7 years or older, for intramuscular usear use	THERAPEUTIC INJ	IMMUNIZATION
J9342	TEPADINA®	Injection, thiotepa, not otherwise specified, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3241	TEPEZZA	Teprotumumab-trbw for IV Infusion	THERAPEUTIC INJ	
J9341	TEPYLUTE®	Thiotepa for IV Soln	THERAPEUTIC INJ	
J3105	TERBUTALINE SULFATE INJECTION USP	Terbutaline sulfate injection	THERAPEUTIC INJ	
J3490	TERLIVAZ	Terlipressin for injection, for intravenous use	THERAPEUTIC INJ	
J2460	TERRAMYCIN	Oxytetracycline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0189	TESTOPEL 75MG PELLET	Testosterone pellet, 75 mg	THERAPEUTIC INJ	
J1072	Testosterone Cypionate	Injection, Testosterone Cypionate 1mg (Azmiro)	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
J1080	TESTOSTERONE CYPIONATE	Testosterone cypionate 200 MG	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
J3121	TESTOSTERONE ENANTHATE	Testosterone enanthate injection, Up to 100mg	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
90389	Tetanus Immune Globulin (TIg), human, IM	Tetanus IG (Tig), human, IM	THERAPEUTIC INJ	
90703	TETANUS TOXOID	Tetanus Toxoid Adsorbed USP	THERAPEUTIC INJ	IMMUNZATION
90718	TETANUS-DIPHTHERIA TOXOIDS TD	Tetanus and diphtheria toxoids (Td) adsorbed	THERAPEUTIC INJ	IMMUNZATION
J0120	TETRACYCLINE	Injection, tetracycline, up to 250 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	TEVIMBRA	Tislelizumab-jsgr injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY
J2356	TEZSPIRE	Tezepelumab-ekko injection, for **SYRINGE** subcutaneous use 55513-0112-01- intended for administration by a healthcare provider.	SELF-INJECTABLE	
J2356	TEZSPIRE	Tezepelumab-ekko injection, subcutaneous Solution **AUTO-INJECTOR** 210 MG/1.91ML 55513-0123-01	THERAPEUTIC INJ	
J2810	THEOPHYLLINE IN D5W	Theophylline per 40 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90586	TheraCys 81 MG/VIAL SUSR	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3411	THIAMINE HCL	Thiamine hcl 100 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9340	THIOTEPA	Thiotepa, 15 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3230	THORAZINE	Chlorpromazine hcl injection	THERAPEUTIC INJ	
J7197	THROMBATE III	Antithrombin III (human), per IU	THERAPEUTIC INJ	
J7511	THYMOGLOBULIN	Antithymocyte globuln rabbit	THERAPEUTIC INJ	
J3240	THYROGEN	Injection,thyrotropin alpha, 0.9 mg, provided in 1.1 mg	THERAPEUTIC INJ	
90585	Tice BCG 50 MG SUSR	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use (Price is per 50 mg)	THERAPEUTIC INJ	
90586	Tice BCG 50 MG SUSR	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9030	Tice BCG 50 MG SUSR	BCG 50MG Suspension Reconstituted J9030 BCG live intravesical instillation, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3250	TIGAN	Trimethobenzamide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3244	TIGCYCLINE	Injection, tigecycline (Accord) not therapeutically equivalent to J3243, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9273	TIVDAK	Tisotumab vedotin-tftv for injection 40 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3101	TNKASE	Tenecteplase injection	THERAPEUTIC INJ	
J3260	TOBRAMYCIN SULFATE	Tobramycin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3260	TOBRAMYCIN SULFATE IN SALINE	Tobramycin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5133	TOFIDENCE	Tocilizumab-bavi, biosimilar, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9181	TOPSAR	Etoposide 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1885	TORADOL IM	Ketorolac tromethamine injection	THERAPEUTIC INJ	
J3280	TORECAN	Thiethylperazine maleate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9330	TORISEL	Temsirolimus, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1190	TOTECT 500 MG SOLR	Dexrazoxane hydrochloride, per 250 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
Q5116	TRAZIMERA	Trastuzumab-qyyp,C1220 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9033	TREANDA 100 MG SOLR	Bendamustine HCl, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3315	TRELSTAR	Triptorelin Pamoate For IM Susp 3.75mg, 11.25mg, 22.5mg	THERAPEUTIC INJ	
J1628	TREMFYA	Guselkumab injection, for subcutaneous use	SELF-INJECTABLE	
J1628	TREMFYA IV	Guselkumab injection, for intravenous use	THERAPEUTIC INJ	
J7181	TRETTEN	Factor XIII (antihemophilic factor, recombinant)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3300	TRIESENCE 40 MG/ML SUSP	Triamcinolone acetonide injectable suspension	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1443	TRIFERIC	Ferric pyrophosphate citrate solution, 0.1 mg of iron	THERAPEUTIC INJ	
J1444	TRIFERIC (For use in dialasate)	Ferric pyrophosphate citrate powder, 0.1 mg of iron	THERAPEUTIC INJ	
J1445	TRIFERIC® AVNU	Ferric pyrophosphate citrate solution 0.1 mg of iron	THERAPEUTIC INJ	
90721	TRIHIBIT PRESERVATIVE FREE	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3310	TRILAFON	Perphenazine injeciton	THERAPEUTIC INJ	
J3250	TRIMETHOBENZAMIDE HCL	Trimethobenzamide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3316	TRIPTODUR	Triptorelin pamoate for IM ER susp 22.5 mg	THERAPEUTIC INJ	
J9017	TRISENOX	Arsenic trioxide, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7329	TRIVISC	Sodium hyaluronate for intra-articular injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3320	TROBICIN	Spectinomycn di-hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9317	TRODELVY	Sacituzumab govitecan-hziy for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1746	TROGARZO	Ibalizumab-uiyk injection, for intravenous use	THERAPEUTIC INJ	
J0200	TROVAN	Alatrofloxacin mesylate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399, J3490	TRULICITY	Dulaglutide injection, for subcutaneous use	SELF-INJECTABLE	
90621	TRUMENBA	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5115	TRUXIMA	Rituximab-abbs	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	TRYNGOLZA	Olezarsen sod Subcutaneous Soln auto-inject 80MG/0.8ML	SELF-INJECTABLE	
90636	TWINRIX	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5135	TYENNE	Tocilizumab-aazg) injection, for intravenous or subcutaneous use.	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3243	TYGACIL 50MG	Tigecycline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	TYMLOS	Abaloparatide injection, for subcutaneous use	SELF-INJECTABLE	
90691	TYPHIM VI	Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90692	TYPHOID VACCINE, H-P	Typhoid Vaccine, H-P, sc/id	THERAPEUTIC INJ	IMMUNIZATION
Q5134	TYRUKO	Injection, natalizumab-sztn , biosimilar, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2323	TYSABRI	Natalizumab 1 mg injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9381	TZIELD	Teplizumab-mzwv IV Soln 2 MG/2ML (1 MG/ML)	THERAPEUTIC INJ	
Q5111	UDENYCA	Pegfilgrastim-CBQV	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5111	UDENYCA	Pegfilgrastim-cbqv, biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5111	UDENYCA ONBODY	Pegfilgrastim-cbqv On Body Injector	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1303	ULTOMIRIS	Ravulizumab-cwvz injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0295	UNASYN 1.5GM	Injection, ampicillin sodium/sulbactam sodium, per 1.5 gm	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1246	UNITUXIN	Injection, Dinutuximab, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9275	UNLOXCYT™	Injection, cosibelimab-ipdl, 2 mg	THERAPEUTIC INJ	
J1823	UPLIZNA	Inebilizumab-cdon injection, for intravenous use	THERAPEUTIC INJ	
J3350	UREAPHIL	Urea injection	THERAPEUTIC INJ	
J0520	URECHOLINE	Bethanechol chloride inject	THERAPEUTIC INJ	
J2679	UZEDY	Risperidone Subcutaneous ER Susp Prefilled Syr 200 MG/0.56ML	THERAPEUTIC INJ	
J2185	VABOMERE	Meropenem and vaborbactam for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2777	VABYSMO	Faricimab-svoa intravitreal inj 6 mg/0.05ml	THERAPEUTIC INJ	
J3360	VALIUM	Diazepam, up to 5 mg	THERAPEUTIC INJ	
J9357	VALSTAR	Valrubicin, intravesical, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3370	VANCOCIN HCL	Vancomycin hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3374	VANCOMYCIN	Injection, vancomycin HCl (Mylan) not therapeutically equivalent to J3370, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3375	Vancomycin	Injection, vancomycin hydrochloride (xellia), not therapeutically equivalent to J3373, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3370	VANCOMYCIN HCL	Vancomycin hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9488	VAPRISOL	Injection, conivaptan hydrochloride, 1 mg	THERAPEUTIC INJ	
90632	VAQTA	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90633	VAQTA	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90396	VARICELLA-ZOSTER IMMUNE GLOB	Varicella-zoster IG, IM	THERAPEUTIC INJ	
C9399, J3490	VARITHENA	Polidocanol injectable foam	THERAPEUTIC INJ	
90716	VARIVAX	Chicken pox vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90396	VARIZIG	Varicella virus vaccine (VAR), live, for subcutaneous use	THERAPEUTIC INJ	
J2598	Vasopressin	Injection, vasopressin, 1 unit	THERAPEUTIC INJ	
J2599	Vasopressin	Injection, vasopressin (American Regent) not therapeutically equivalent to J2598, 1 unit	THERAPEUTIC INJ	
J2601	Vasopressin	Injection, vasopressin (baxter), 1 unit	THERAPEUTIC INJ	
90625	VAXCHORA®	Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use	THERAPEUTIC INJ	IMMUNIZATION
90697	VAXELIS™	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90671	VAXNEUVANCE	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J2371	VAZCULEP	Phenylephrine hydrochloride Injection for intravenous use	THERAPEUTIC INJ	
J9303	VECTIBIX	Panitumumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5129	VEGZELMA	Injection, bevacizumab-adcd biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0248	VEKLURY	Remdesivir, 1 mg	THERAPEUTIC INJ	
J9041	VELCADE	Bortezomib, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1756	VENOFER	Iron sucrose injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9376	VEOPOZ	Pozelimab-bbfg inj soln	THERAPEUTIC INJ	
J2250	VERSED	Midazolam hydrochloride	THERAPEUTIC INJ	
J3465	VFEND IV	Voriconazole 10 mg	SELF-INJECTABLE	HOME HEALTH / INFUSION**
J3095	VIBATIV	Telavancin injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	VICTOZA®	Liraglutide [rDNAorigin] Injection	SELF-INJECTABLE	
J9025	VIDAZA	Azacitidine injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1427	VILTEPSO	Viltolarsen	THERAPEUTIC INJ	
J1322	VIMIZIM	Elosulfase alfa	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90593	VIMKUNYA™	Chikungunya Virus Vac Rcmb VLP IM Susp Pref Syr 40 MCG/0.8ML	THERAPEUTIC INJ	CHEMOTHERAPY*
C9254	VIMPAT INJECTION	Injection, lacosamide, 1 mg	THERAPEUTIC INJ	
J9360	VINBLASTINE SULFATE	Vinblastine sulfate inj 1 mg/ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9370	VINCRISTINE SULFATE	Vincristine sulfate, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9390	VINORELBINE TARTRATE	Vinorelbine tartrate, per 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7333	VISCO-3	Hyaluronan or derivative for intra-articular injection, per dose	THERAPEUTIC INJ	
J3410	VISTARIL	Hydroxyzine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0740	VISTIDE	Cidofovir 375 mg injection	THERAPEUTIC INJ	HIV/AIDS
J3396	VISUDYNE	Verteporfin 0.1 mg injection	THERAPEUTIC INJ	
J3420	VITAMIN B-12	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3430	VITAMIN K	Vitamin K phytonadione injection	THERAPEUTIC INJ	
J3470	VITRASE 200 UNIT/ML SOLN	Hyaluronidase, up to 150 units	THERAPEUTIC INJ	
J3471	VITRASE 200 UNIT/ML SOLN	Hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)	THERAPEUTIC INJ	
J3472	VITRASE 6200 UNIT SOLR	Hyaluronidase, ovine, preservative free, per 1000 USP units	THERAPEUTIC INJ	
J9056	VIVIMUSTA	Injection, bendamustine HCl , 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2315	VIVITROL	Naltrexone, Depot Form, 1 Mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7179	VONVENDI	Von Willebrand factor Recombinant	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
C9293	VORAXAZE	Injection, glucarpidase, 10 units	THERAPEUTIC INJ	
J3490	VOXZOGO	Vosoritide for injection, for subcutaneous	SELF-INJECTABLE	
J3385	VPRIV	Velaglucerase alfa, 100 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7356	VYALEV	Foslevodopa-foscarbidopa Subcutaneous inj	SELF-INJECTABLE	
J3032	VYEPTI	Eptinezumab-jjmr	THERAPEUTIC INJ	
J3490	VYLEESI	Bremelanotide for subcutaneous use	THERAPEUTIC INJ	
J1326	VYLOY®	Zolbetuximab-clzb	THERAPEUTIC INJ	CHEMOTHERAPY*
J1429	VYONDYS 53	Golodirsen IV Solution	THERAPEUTIC INJ	
J9332	VYVGART	Efgartigimod alfa-fcab injection, for intravenous use	THERAPEUTIC INJ	
J9334	VYVGART HYTRULO	Efgartigimod alfa and hyaluronidase-qvfc injection, for subcutaneous use	THERAPEUTIC INJ	
J9153	VYXEOS	Daunorubicin-cytarabine liposome for IV inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	WAINUA	Eplontersen Sodium Subcutaneous Soln Auto-Inj 45 Mg/0.8ml	SELF-INJECTABLE	
J3490	WEGOVY	Semaglutide (weight mngmt) solution	SELF-INJECTABLE	
Q5137	WEZLANA	Injection, ustekinumab-auub, biosimilar, subcutaneous, 1 mg	SELF-INJECTABLE	
Q5138	WEZLANA	Injection, ustekinumab-auub , biosimilar, intravenous, 1 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7183	WILATE SOLUTION	Injection, von Willebrand factor /Coagulation Factor VIII Complex, human	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3590	WINREVAIR	Sotatercept-csrk for subcutaneous soln kit	THERAPEUTIC INJ	
J2792	WINRHO SDF	Rho(D) immune globulin (RhIgIV), human, for intravenous use	THERAPEUTIC INJ	
J2510	WYCILLIN	Penicillin G procaine injection	THERAPEUTIC INJ	
J3490	XACDURO	Sulbactam Sodium & Durlobactam Sodium co-packaged For IV Soln 1-1 GM	THERAPEUTIC INJ	
J1558	XEMBIFY	Immune Globulin Subcutaneous, human-klhw 20%	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0218	XENPOZYME	Injection, olipudase alfa-rpcp, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0588	XEOMIN	IncobotulinumtoxinA	THERAPEUTIC INJ	
J0122	XERAVA	Injection, eravacycline, 1 mg	THERAPEUTIC INJ	
J0897	XGEVA	Denosumab 120mg/ 1.7ml	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0775	XIAFLEX	Collagenase Clostridium Histolyticum Injection	THERAPEUTIC INJ	
J3490	XIFYRML™	Meloxicam injection, IV	THERAPEUTIC INJ	DOFR Class change effective 2/14/08 as a result of FDA and Manufacturers recommendation due to black box warnings Re-reviwed Jan 11, 2022 no change
J3299	XIPERE	triamcinolone acetonide injectable suspension), for suprachoroidal use	THERAPEUTIC INJ	
J2357	XOLAIR (PFS and Auto-injector; all strengths)	Omalizumab, 5 mg	THERAPEUTIC INJ	
J3490	XULTOPHY	Insulin Degludec-Liraglutide Solution	SELF-INJECTABLE	
J2001	XYLOCAINE (CARDIAC)	Lidocaine injection	THERAPEUTIC INJ	
J7185	XYNTHA KIT	Factor VIII (antihemophilic Factor, recombinant), per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3490	XYOSTED	Testosterone enanthate solution auto-injector	SELF-INJECTABLE	
J9228	YERVOY	Ipilimumab Injection, for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5155	YESAFILI™	Injection, aflibercept-jbvf , biosimilar to Eylea, 1 mg	SELF-INJECTABLE	
Q2041	YESCARTA	Axicabtagene ciloleucal, up to 200 Million autologous Anti-CD 19 Car T Cells, including leukapheresis and dose preparation	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5100	YESINTEK	Ustekinumab-kfce, biosimilar to Stelara	SELF-INJECTABLE	
J0738	YEZTUGO®	Injection, lenacapavir (only for use as HIV treatment), 1 mg- Must also use YEZTUGO 300-mg oral tablets.	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90717	YF-VAX	Yellow fever vaccine, live, for subcutaneous use	THERAPEUTIC INJ	IMMUNIZATION
J9352	YONDELIS	Trabectedin for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	YORVIPATH	Palopegteriparatide injection, for subcutaneous use	SELF-INJECTABLE	
J3590	YUFLYMA	Adalimumab-aaty; High Concentration	SELF-INJECTABLE	
J7314	YUTIQ	Fluocinolone acetonide, intravitreal implant, 0.01 mg	THERAPEUTIC INJ	
J9400	ZALTRAP	Ziv-aflibercept Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9320	ZANOSAR	Streptozocin injection, 1 gm	THERAPEUTIC INJ	CHEMOTHERAPY*
J2780	ZANTAC	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2780	ZANTAC IN NACL	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5101	ZARXIO	Filgrastim-sndz injection, biosimilar. 1 microgram	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5101	ZARXIO	Filgrastim-sndz injection, biosimilar. 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J3490	ZEGALOGUE®	Dasiglucagon injection, for subcutaneous use	SELF-INJECTABLE	
J0256	ZEMAIRA	Alpha 1-proteinase inhibitor, human, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3030	ZEMBRACE	Sumatriptan Succinate	SELF-INJECTABLE	
J0291	ZEMDRI	Plazomicin injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2501	ZEMPLAR	Paricalcitol 1 mcg	THERAPEUTIC INJ	
J3490	ZEPBOUND	Tirzepatide (weight mngmt) solution	SELF-INJECTABLE	
J9223	ZEPZELCA	Lurbinectedin for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0695	ZERBAXA	Ceftolozane/tazobactam Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
A9543	ZEVALIN Y-90 3.2 MG/2ML KIT	Yttrium y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	THERAPEUTIC INJ	CHEMOTHERAPY*
J0681	ZEVTERA®	Injection, ceftobiprole medocaril sodium, 3 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0681	ZEVTERA®	Injection, ceftobiprole medocaril sodium, 3 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5120	ZIEXTENZO	Pegfilgrastim-bmez injection, for Subcutaneous use	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5120	ZIEXTENZO	Pegfilgrastim-bmez injection, for Subcutaneous use	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J9174	ZIIHERA®	Zanidatamab-hrii injection IV Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	ZILBRYSQ	Zilucoplan Sodium Subcutaneous Soln Pref Syr 16.6 MG/0.416ML	SELF-INJECTABLE	
J3304	ZILRETTA	Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	THERAPEUTIC INJ	
J2313	ZIMHI™	Injection, naloxone HCl, 1 mg	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAM	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0697	ZINACEF	Cefuroxime injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1190	ZINECARD	Dexrazoxane hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0565	ZINPLAVA	Bezlotoxumab injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5118	ZIRABEV	Bevacizumab-bvzr,10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0456	ZITHROMAX	Azithromycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2405	ZOFRAN	Ondansetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9202	ZOLADEX	Goserelin acetate implant	THERAPEUTIC INJ	CHEMOTHERAPY*
J3399	ZOLGENSMA	Onasemnogene abeparvovec-xioi	THERAPEUTIC INJ	
J3489	ZOMETA	Zoledronic acid 1 mg Injection (Zometa)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2941	ZORBTIVE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2543	ZOSYN	Piperacillin/tazobactam	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1632	ZULRESSO	Brexanolone injection, for intravenous use	THERAPEUTIC INJ	
J3490	ZURNAI™	Nalmefene HCl Soln Auto-injector 1.5 MG/0.5ML (Base Equiv)	SELF-INJECTABLE	
J9999	ZUSDURI™	Mitomycin intravesical instillation	THERAPEUTIC INJ	CHEMOTHERAPY*
J1748	ZYMFENTRA	Infliximab-dyyb injection, for subcutaneous use-CELLTRION USA	SELF-INJECTABLE	
J9359	ZYNLONTA	Loncastuximab tesirine-lpyl) for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0668	ZYNRELEF®	Bupivacaine and meloxicam extended-release solution	THERAPEUTIC INJ	
J3393	ZYNTEGLO	Betibeglogene autotemcel	THERAPEUTIC INJ	
J9345	ZYNYZ	Retifanlimab-dlwr IV Soln 500 MG/20ML (25 MG/ML)	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	ZYPREXA	Olanzapine, 2.5 mg	THERAPEUTIC INJ	
J2358	ZYPREXA RELPREV	Olanzapine Extended Release Injection	THERAPEUTIC INJ	
J2020	ZYVOX	Linezolid 200 mg injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

INPATIENT CALIFORNIA MEDI-CAL PRIOR AUTHORIZATION

Complete and
Fax to: **800-743-1655**

☐ **Standard requests: Determination made as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days after the receipt of request.**

☐ **Urgent requests:** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Last Name, First

*Date of Birth (MMDDYYYY)

*Member ID

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider Address

*Fax

City, State, ZIP

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

Servicing Provider Contact Name

*Servicing NPI

*Servicing TIN

Phone

Servicing Provider/Facility Name Address

Fax

City, State, ZIP

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date OR** Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)

Additional Diagnosis Code (ICD-10)

*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) ☐☐☐

Delivery
779 C-Section Delivery
720 Vaginal Delivery

Inpatient Rehab
427 Rehab

Transplant
992 Transplant

Miscellaneous
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
492 Subacute

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per the Plan policy and procedures. CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL

INPATIENT CALIFORNIA MEDI-CAL PRIOR AUTHORIZATION

health net

Complete and **Fax** to: **800-743-1655**

☐ **Standard requests.** Determination within 7 calendar days of receiving all necessary information.

☐ **Urgent requests:** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Last Name, First

*Date of Birth (MMDDYYYY)

*Member ID

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider Address

*Fax

City, State, ZIP

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

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*Servicing NPI

*Servicing TIN

Phone

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Fax

City, State, ZIP

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Primary Procedure Code* (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date OR** Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

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INPATIENT CALIFORNIA HEALTH NET MEDI-CAL PRIOR AUTHORIZATION

Complete and **Fax** to: **800-743-1655**

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☐ **Urgent requests:** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Last Name, First

*Date of Birth (MMDDYYYY)

*Member ID

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider Address

*Fax

City, State, ZIP

SERVICING PROVIDER / FACILITY INFORMATION

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PCP:	Page 1 of 3
SECTION: Infection Control	
POLICY AND PROCEDURE: Instrument Sterilization	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:

This site will ensure that all reusable medical instruments are properly sterilized after each use.

PROCEDURE:

I. CLEANING PRIOR TO STERILIZATION

A. Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Trained personnel will be able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, according to site-specific policy and/or manufacturer/product label directions.

II. COLD/CHEMICAL STERILIZATION

A. Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written site-specific policy/procedures or Manufacturer's Instructions for cold sterilization are available on site for staff reference. (See FDA Cleared Sterilants and High Level Disinfectant list attached.)

III. AUTOCLAVE/STEAM STERILIZATION

A. The autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff.

IV. AUTOCLAVE MAINTENANCE

A. The autoclave is maintained and serviced according to manufacturer's guidelines. The autoclave is serviced annually by a qualified technician, if the manufacturer's guidelines are not available. A dated sticker indicating the maintenance date will be placed on the autoclave or a service receipt will be kept on file to indicate documentation of mechanical problems, results/outcome of routine servicing, calibration, and repairs.

B. An autoclave log will be kept on file and will include the following:
- date
- time
- duration of run cycle
- temperature
- steam pressure
- load identification information
- operator of each run

V. SPORE TESTING

A. Autoclave spore testing is performed *at least monthly*, unless otherwise stated in the manufacturer's guidelines. Spore testing reports will be maintained on file and will include the following:
- date
- results
- types of spore test used
- person performing/documenting test results

B. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. The following procedures will be followed with a positive spore test:

VI. (REPORT/REPAIR/RETRIEVE/RETEST/RE-STERILIZE)
- ***report*** problem to Office Manager or Doctor
- ***repair*** autoclave
- ***retrieve*** all instruments sterilized since last negative spore test
- ***re-test*** autoclave
- ***re-sterilize*** retrieved instruments

VII. STERILE PACKAGES

A. Storage areas for sterilized packages are maintained clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, drawer).

B. Sterilized package labels include:
   - date of sterilization
   - load run identification information
   - general contents (e.g. suture set)

C. Each item in a sterile package will not be listed on the label if a master list of package contents is available elsewhere on site. It is understood that maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. This site has a process for routine evaluation of sterilized packages.

Guidance to Comply with New Interpreter Quality Standards Requirements on the use of Bilingual/Multilingual Staff as Interpreters

Summary of Requirements and Documentation		
Requirement	**Potential Evidence**	**Provider Office to Note Documentation of Qualification**
Office has a documented policy to offer interpreter support to LEP patients	☐ Local office written policy; or ☐ Local office policy that defers and adheres to the policy distributed by medical group Note: Policy includes documentation of patient language needs in medical record	Written policy available for viewing by an auditor Policy title:
Adheres to generally accepted interpreter ethics principles, including client confidentiality	Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at: http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf	Signed attestations are available. ☐ Yes ☐ No
Has *demonstrated* proficiency in speaking and understanding both spoken English and at least one other spoken language	☐Formal assessment of proficiency; or ☐Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language	☐Yes, assessment results are available for viewing; or ☐Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology	☐Formal assessment of proficiency; or Annual performance evaluations document ☐Ability to interpret effectively, ☐Ability to interpret accurately, ☐Ability to interpret impartially, ☐Ability to interpret receptively and expressly, ☐Ability to interpret to and from English and another language using any **necessary specialized vocabulary terminology and phraseology** Note: see NCIHC Interpreter Code of Ethics for description of above.	☐Yes, assessment results are available for viewing; or ☐Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available

For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D.

http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf

PCP:	
SECTION: Office Management	
POLICY AND PROCEDURE: Interpreter Services	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The site has twenty-four hour access to Interpreter services for non/limited English proficient (LEP) members.

PROCEDURE:

A. Staff will ensure that Interpreter services are made available in identified threshold languages specified for location of site.

B. The PCP will ensure that all personnel providing language interpreter services on site are qualified in medical interpretation.

C. Interpreter skills and capabilities will be documented as follows:

   1. Office has a documented policy to offer interpreter support to LEP patients.
   2. Signed attestation of adherence to generally accepted interpreter ethics principles, including client confidentiality.
   3. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (formal assessment of proficiency; or annual job performance evaluations).
   4. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology (formal assessment of proficiency; or annual job performance evaluations).

D. Staff will document in the medical record any request for, or refusal of language/interpreter services; staff will document primary language for the member. Provider/staff must document in patient's medical record, name or identifier of interpreter used for each visit.

E. The PCP will ensure that 24-hour interpreter services are available for all members either through telephone language services or interpreters on site.

No-Cost Interpreter Services Available 24/7 for Your Patients

YOU AND YOUR PATIENTS CAN ACCESS NO-COST INTERPRETER SERVICES IN OVER 150 LANGUAGES.

Access an interpreter

Physicians and other providers can call the appropriate number below for assistance.

In-person or video interpreter requests

- Request at least five business days in advance during regular business hours.
- Allow 10 business days for sign language interpreter requests.

When asking for an interpreter, tell us:

- The member's Health Net* identification (ID) number
- Appointment date, time and place (or video link and password)
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

To request interpreter services for members, contact the Provider Services Center:

- **Medi-Cal:** 800-675-6110. Press 1 after the voice prompt to bypass a representative and connect directly with an interpreter. Monday through Friday, 8 a.m. to 6 p.m., Pacific time. For after hours, select member option.
- **Individual & Family Plans (Ambetter PPO):** 844-463-8188. Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see page 2 for after hours).
- **Individual & Family Plans (Ambetter HMO):** 888-926-2164. Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see page 2 for after hours).
- **Employer Group HMO, POS and PPO:** 800-641-7761. Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see page 2 for after hours).

(continued)

Phone interpreters in over 150 languages!

Ask for no-cost interpreter services to help you effectively communicate with your patients.

- **After-hours language assistance line for Individual & Family Plans and Employer Group plans:** 800-546-4570. Monday through Friday, 5 p.m. to 8 a.m., Pacific time, weekends and holidays.
- **Behavioral health:** 800-647-7526. Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available after hours).

For office use only. Do NOT post in a patient area.

Phone numbers listed here are for provider use only. Members may contact the number listed on the back of their ID card for member services.

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25-903 (9/25)

No-Cost Interpreter Services Available 24/7 for Your Patients

YOU AND YOUR PATIENTS CAN ACCESS NO-COST INTERPRETER SERVICES IN OVER 150 LANGUAGES. CALL 888-893-1569.

Access an interpreter

Physicians and other providers can call 888-893-1569 (TTY: 711) and press 1, Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available after hours) for assistance.

In-person or video interpreter requests

- Request at least five business days in advance during regular business hours.
- Allow 10 business days for sign language interpreter requests.

When asking for an interpreter, tell us:

- The member's Plan identification (ID) number
- Appointment date, time and place (or video link and password)
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

Members may contact the number listed on the back of their ID card for member services, or 888-893-1569 (TTY: 711). Press 1 after the voice prompt to bypass a representative and connect directly with an interpreter.

(continued)

Phone interpreters in over 150 languages!

Ask for no-cost interpreter services to help you effectively communicate with your patients.

Behavioral health providers can request interpreter services for members by calling 800-647-7526, Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available after hours).

For office use only. Do NOT post in a patient area.

Phone numbers listed here are for provider use only. Members may contact the number listed on the back of their ID card for member services.

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25-902 (9/25)

No-Cost Interpreter Services Available 24/7 for Your Patients

YOU AND YOUR PATIENTS CAN ACCESS NO-COST INTERPRETER SERVICES IN OVER 150 LANGUAGES. CALL 833-236-4141.

Access an interpreter

Physicians and other providers can call 833-236-4141 (TTY: 711) and press 1, Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available after hours) for assistance.

In-person or video interpreter requests

- Request at least five business days in advance during regular business hours.
- Allow 10 business days for sign language interpreter requests.

When asking for an interpreter, tell us:

- The member's Plan identification (ID) number
- Appointment date, time and place (or video link and password)
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

Members may contact the number listed on the back of their ID card for member services, or 833-236-4141 (TTY: 711). Press 1 after the voice prompt to bypass a representative and connect directly with an interpreter.

(continued)

Phone interpreters in over 150 languages!

Ask for no-cost interpreter services to help you effectively communicate with your patients.

Behavioral health providers can request interpreter services for members by calling 800-647-7526, Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available after hours).

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26-209 (2/26)

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

Lao (ພາສາລາວ)
ທ່ານເວົ້າພາສາບໍ? ພວກເຮົາຈະຈັດກຽມນາຍແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Mandarin (中文)
您講中文嗎? 我們將免費為您提供翻譯。

Mixteco
¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

Navajo (Diné bizaad)
Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

Portuguese (Português)
Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

Punjabi (ਪੰਜਾਬੀ)
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

Russian (Русский)
Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

Spanish (Español)
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

Tagalog
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

Thai (ภาษาไทย)
คุณพูดภาษาไทยใช่หรือไม่
เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

Vietnamese (Tiếng Việt)
Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

American Sign Language (ASL)

Please call CalViva Health using the number on the member's ID card or contact 888-893-1569.

For office use only. Do NOT post in a patient area.

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation.

health net

Akorbi
PEOPLE ■ TECHNOLOGY ■ LANGUAGE

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

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American Sign Language (ASL)

Please call Health Net* Provider Services using the number on the Health Net ID card or contact the numbers below:

Medi-Cal (800) 675-6110 | Medicare (800) 929-9224 | Commercial IFP On Exchange (888) 926-2164 | Commercial IFP Off Exchange (877) 857-0701 | Commercial Small Group Off Exchange (800) 361-3366 | Commercial Large Group Off Exchange (800) 641-7761 | Commercial SHOP (Small Group On Exchange) (888) 926-5133

For office use only. Do NOT post in a patient area.

*Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation.

PCP:	
SECTION: Clinical Services	
POLICY AND PROCEDURE: Laboratory Services	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The site will operate in compliance with Clinical Laboratory Improvement Amendment (CLIA) regulations. Therefore, the site shall meet all quality standards to ensure accuracy, reliability and timeliness of patient test results. All lab results are to be communicated to the provider and member in a timely manner.

PROCEDURE:

A. Laboratory test procedures are performed according to current site-specific CLIA certificate.

1. All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease, have a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal.
   - The CLIA Certificate on site includes one of the following:
     a. Certificate of Waiver: Site is able to perform only exempt waived tests, so therefore, has a current CLIA Certificate or Waiver. The current listing of waived tests may be obtained at www.fda.gov/cdrh/clia/testswaived.html.
        - There are no specific CLIA regulations regarding the performance of waived tests. Therefore, site personnel are expected to follow the manufacturer's instructions.
        - Laboratories with Certificates of Waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and/or on a random basis to determine whether only waived tests are being performed.
     b. Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists or mid-level practitioners are able to perform PPM procedures and waived tests.
     c. Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations is determined by survey.
        - For moderate and/or high complexity lab testing, the CLIA regulations list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel and inspections.

d. Certificate of Compliance: Lab has been surveyed and found to be in compliance with all applicable CLIA requirements.
e. Certificate of Accreditation: Lab is accredited by an accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS).

2. CLIA certification/re-certification includes an evaluation every two years (or sooner, if complaint driven) by DHCS of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites.

B. Testing personnel performing clinical lab procedures have been trained.

1. Prior to testing biological specimens, personnel are appropriately trained for the type and complexity of the laboratory services performed. Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately.
2. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions.
3. When requested, site personnel are able to provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.
4. The required training and certification is established by legislation (CA B&P Codes, §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests.

C. Lab supplies are inaccessible to unauthorized persons.

D. Lab test supplies (e.g., vacutainers, culture swabs, test solutions) are not expired. Site has procedure to check expiration date and a method to dispose of expired lab test supplies.

E. The provider will review, initial and date the original copy of each laboratory report, which is then filed in member's medical record.

****For questions regarding CLIA certification, laboratory licensing, and personnel:**
https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments/regulations-federal-register

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

English: If you, or someone you are helping, need language services, call Toll-Free 1-888-893-1569 (TTY: 711). Aids and services for people with disabilities, like documents in braille, accessible PDF and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى المساعدة في الحصول على الخدمات اللغوية، فاتصل بالرقم المجاني 1-888-893-1569 (TTY: 711). المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل، والملفات المنقولة (PDF) التي يمكن الوصول إليها، والطباعة الكبيرة، متوفرة أيضاً. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք անվճար 1-888-893-1569 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ բրեյլով փաստաթղթեր, մատչելի PDF և մեծ տպագրությամբ փաստաթղթեր: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខទូរសព្ទដោយគិតថ្លៃ 1-888-893-1569 (TTY: 711) ។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់មនុស្សពិការ ដូចជា ឯកសារជាអក្សរសម្រាប់មនុស្សពិការ PDF ដែលអាចប្រើសម្រាប់មនុស្សពិការ និងឯកសារព្រឹនអក្សរធំៗ ក៏ត្រូវបានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះមិនមានគិតតម្លៃសម្រាប់អ្នកទេ។

Chinese: 如果您或者您正在帮助的人需要语言服务，请免费致电 1-888-893-1569 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文、无障碍 PDF 和大字版文档。这些服务免费为您提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ رایگان 1-888-893-1569 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل، چاپ درشت و PDF دسترس‌پذیر نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो इस टॉल फ्री नंबर पर कॉल करें 1-888-893-1569 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेले लिपि में दस्तावेज़, सुलभ PDF और बड़े प्रिंट वाले दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau Tus Xov Tooj Hu Dawb 1-888-893-1569 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv su uas cov neeg tsis pom kev siv tau, cov ntaub ntawv PDF uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、トールフリーダイアル1-888-893-1569（TTY: 711）にお問い合わせください。点字、アクセシブルPDF、大活字など、障がいのある方のための補助・サービスもご用意しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면무료 전화 1-888-893-1569 (TTY: 711)번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자, 액세스 가능한 PDF 및 대형 활자 인쇄본)도 제공됩니다.
이 서비스는 무료로 이용하실 수 있습니다.

FLY061957EP00 (06/23)

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທຫາເບີໂທຟຣີ 1-888-893-1569 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບ ຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານແບບບຣາແລ (braille) ສຳລັບຄົນຕາບອດ, ເອກະສານ PDF ທີ່ສາມາດ ເຂົ້າເຖິງໄດ້ສະດວກ ແລະ ເອກະສານພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍ ຄ່າໃດໆ.

Mien: Da'faanh Meih, Fai Heuc Meih Haih Tengx, Oix help Janx-kaeqv waac gong, Heuc Bieqcll-Free 1-888-893-1569 (TTY: 711). Jomc Caux gong Bun Yangh mienh Caux mv fungc, Oix dimc in braille, dongh eix PDF Caux Bunh Fiev , Haih yaac kungx nyei. Deix gong Haih buatc Yietc liuz maiv jaax-zinh Bieqc Meih.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-888-893-1569 (TTY: 711) ‹ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਪਹੁੰਚਯੋਗ PDF ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните на бесплатную линию 1-888-893-1569 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы в специальном формате PDF, напечатанные крупным шрифтом или шрифтом Брайля. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al número gratuito 1-888-893-1569 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille, en letra grande y en archivos PDF accesibles. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng tulong sa mga serbisyo sa wika, tumawag nang Walang Bayad sa 1-888-893-1569 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille, naa-access na PDF at malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทรแบบไม่เสียค่าธรรมเนียม บริการ 1-888-893-1569 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารอักษรเบรลล์, PDF ที่เข้าถึงได้, และเอกสารที่พิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на безкоштовну лінію 1-888-893-1569 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи в спеціальному форматі PDF, надруковані великим шрифтом чи шрифтом Брайля. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi Số miễn phí 1-888-893-1569 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu dạng chữ nổi braille, bản in khổ lớn và PDF có thể tiếp cận được. Quý vị được nhận các dịch vụ này miễn phí.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

If you, or someone you are helping, need language services, call 1-833-236-4141 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic

إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-833-236-4141 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian

Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-833-236-4141 (TTY: 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-833-236-4141 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified)

如果您或者您正在帮助的人需要语言服务，请致电 1-833-236-4141 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional)

如果您或您正在幫助的其他人需要語言服務，請致電 1-833-236-4141 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi

اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-833-236-4141 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi

यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-833-236-4141 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong
Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-833-236-4141 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese
ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-833-236-4141（TTY: 711）。までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean
귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-833-236-4141 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian
ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-833-236-4141 (TTY: 711) ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien
Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-833-236-4141 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-833-236-4141 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian
Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-833-236-4141 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish
Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-833-236-4141 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog
Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-833-236-4141 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai
หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-833-236-4141 (TTY: 711) **นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ**

Ukrainian
Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-833-236-4141 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese
Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-833-236-4141 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

wellcare By health net

Akorbi
PEOPLE ■ TECHNOLOGY ■ LANGUAGE

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

Lao (ພາສາລາວ)
ທ່ານເວົ້າພາສາບໍ? ພວກເຮົາຈະຈັດກຽມນາຍແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Mandarin (中文)
您講中文嗎? 我們將免費為您提供翻譯。

Mixteco
¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

Navajo (Diné bizaad)
Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

Portuguese (Português)
Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

Punjabi (ਪੰਜਾਬੀ)
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

Russian (Русский)
Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

Spanish (Español)
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

Tagalog
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

Thai (ภาษาไทย)
คุณพูดภาษาไทยใช่หรือไม่
เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

Vietnamese (Tiếng Việt)
Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

American Sign Language (ASL)

Please call Provider Services using the number on the member's ID card or contact 800-929-9224.

For office use only. Do NOT post in a patient area.

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INTERPRETERS AVAILABLE

You have access to interpretation services 24/7 at no personal cost to you.
This chart includes languages commonly spoken in your community, additional languages are available.

English: **Do you speak [language]? We will provide an interpreter at no personal cost to you.**

Arabic اللغة العربية	هل تتحدث اللغة العربية؟ سوف نوفر لك مترجمًا فوريًا بدون أي تكلفة عليك.
Armenian Հայերեն	Դուք խոսում է՞ք հայերեն: Մենք կտրամադրենք թարգմանիչ ձեր համարանվճար:
Cambodian ភាសាខ្មែរ	តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។
Cantonese 粵語	您講粵語嗎？我們將免費為您提供翻譯。
Farsi فارسی	فارسی صحبت می کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.
French Français	Parlez-vous français ? Nous vous fournirons gratuitement un interprète.
Greek Ελληνικά	Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.
Hindi हिन्दी	क्या आप हिन्दी बोलते हैं? हम आपके लिए बिना किसी निजी लागत के एक दुभाषिया को उपलब्ध कराएँगे।
Hmong Hmoob	Koj puas yog hais Lus Hmoob? Peb yuav muaj ib tug neeg txhais lus rau koj uas koj tsis tau them nqi.
Japanese 日本語	日本語を話しますか？個人的な負担なしで通訳を提供致します。
Korean 한국어	한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

ເຈົ້າເວົ້າພາສາລາວບໍ? ພວກເຮົາຈະຈັດຜູ້ແປພາສາໃຫ້ໂດຍທີ່ທ່ານບໍ່ຕ້ອງເສຍຄ່າ.	*Lao* ພາສາລາວ
您讲国语吗？我们将免费为您提供翻译。	*Mandarin* 中文
Há ka'aha ní Mixteco? Ku'u kana ntu'u hi'i na ku'u interprete na ka'aha Mixteco takua chinche'é na ní cha me'é ntu ku'u ni chahvina.	*Mixteco* Mixteco
Diné bizaad daats'í bee yáníłti'? Doo bik'é asíníł'áágóó ata' halne'í ná shódeidiilt'eeł.	*Navajo* Diné bizaad
Fala português? Vamos facultar-lhe um intérprete, sem custos para si.	*Portuguese* Português
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।	*Punjabi* ਪੰਜਾਬੀ
Вы говорите по-русски? Мы абсолютно бесплатно предоставим вам переводчика.	*Russian* Русский
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.	*Spanish* Español
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng tagasalin nang wala kang personal na babayaran.	*Tagalog* Tagalog
Quý vị nói được tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.	*Vietnamese* Tiếng Việt
	American Sign Language (ASL)

Please call CalViva Health Member Services

Language Proficiency Assessment Resources

The following resources offer a variety of language proficiency assessment services that can assist your practice in identifying, preparing, and training bi/multi-lingual staff to support language services offered in your practice.

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Berkeley Language Institute (BLI) Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).	http://www.berkeleylanguageinstitute.com/index.html 1-510-655-9469 Marci Valdivieso marci@berkeleylanguageinstitute.com	**8 languages offered**: Arabic, Chinese (Mandarin, Cantonese, and Taishanese/ Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese	Yes	• Professional language assessments for interpreters, translators, & bilingual speakers • Language Proficiency Oral Assessment – ideal for current & pre-employment bilingual employees • Language Proficiency Written Assessment • Medical Staff Oral Assessment • Healthcare Interpreter Assessments	Evaluators are experienced linguists that have: • At least five years interpreter & translator experience • Have shown an aptitude to be language evaluators. • They are generally certified by/with the National Board or CCHI if the language pair is an option, or • They are otherwise assessed and trained prior to being given evaluation assignments.	Cost will vary depending on language pair and type of assessment. $115 - $190/ person
Culture Advantage Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.	https://cultureadvantage.org/ 1-316-217-0198 Marlene Obermeyer, MA, RN director@cultureadvantage.org	**10 languages offered**: Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese	Yes All medical specialties offered in the professional program.	• Bilingual Staff Medical Interpreting Skills Assessment (MISA) • Specialty-specific Medical Interpreting Skills Assessment	• Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair	Cost will vary $200 /MISA $250 - $950 for Online Courses
ISI Language Solutions ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations.	https://isilanguagesolutions.com/industries/healthcare/ 1-818-753-9181 John Lopez john@isitrans.com Christina Xu Christina@isitrans.com	**22 languages offered**: Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese	No	• Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole. ○ Language Proficiency Assessment ○ Building Cultural Competency Workshop ○ Medical Terminology Workshop ○ Medical Interpreting Ethics and Protocol Workshop	Professional Linguists • Certification or Accreditation from American Translators Association (ATA) or equivalent organization • Degree in Translation or foreign equivalent • Subject-Matter expertise in the field of Life Sciences • Extensive experience in translation and linguistics	Must contact for costs Cost example: • Flat rate/ test - $80

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Language Line Academy (LLA) Our professional testing and training ensure the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.	https://www.langualeline.com/ 1-844-552-8378 Ana Catalina Arguedas Fernández lla@languageline.com	**1 language offered**: Spanish	Yes Pediatrics Mental Health OB/Gyn Ophthalmology Gastroenterology Oncology Cardiology Pharmacy	• Healthcare Bilingual Fluency assessment for clinicians and medical staff • Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour. • Interpreter Readiness Assessment • Interpreter Skills Test	LLA testers have a variety of qualifications, including: • M.A., Translation & Interpretation • Years of medical interpreting experience • External interpreter certification credentials	Cost will vary $145 - $160/ test Volume discounts available
Language Testing International (LTI) In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests.	https://www.languagetesting.com/ 1-800-486-8444 Marketing/ Scheduling Team Diane ext. 123 Dina ext. 127 info@languagetesting.com	**100+ languages offered**, most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish View complete list of languages online.	Offers general testing/ proficiency assessments. Does not specifically assess proficiency for healthcare interpretation or translation services.	• Oral Proficiency Interview 15 – 30-minute telephonic interview • Oral Proficiency Interview – Computer 20 – 40 minute on-demand, internet, or phone-delivered proficiency test • Writing Proficiency Test via the web 20 – 80 minutes • Listening Proficiency Test 50 – 125 minutes • Reading Proficiency Test 50 – 125 minutes	LTI strictly uses. • Certified ACTFL testers and raters Ensuring quality and validity of tests	Contact for costs. Package options available for some languages Cost examples: • $100 - $200/ person for phone survey • $159 for web
MasterWord For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.	https://www.masterword.com/ 1-866-716-4999 masterword@masterword.com	**250+ languages offered** for interpreting and translation. **Contact for languages offered for proficiency assessments.**	Not specified Offers On Demand training & Webinars for Healthcare, includes: • Maternal Fetal Medicine • Cardiology • Mental Health • Oncology	• Language Proficiency Assessment: 60 minutes Contact for languages. • Health Care Interpreter Assessment (HCIA®): 32 min. / 45 min. –oral / written Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.	Assessments based on formats of CCHI & NBCMI national certification exams.	On Demand Assessments: $105 - $155

MEDI-CAL LINKAGE / ENROLLMENT
TRACKING LOG FOR INITIAL HEALTH APPOINTMENT

Initials	Patient Name	ID Number	Enrollment / Linkage Date	Phone Number	Date of First Contact	P L	Date of Second Contact.	P L	Date of Third Contact	P L	Appointment Date / Status	K N

Instructions: O Record results of actions taken for scheduling Initial Health Appointment within 120 days of enrollment.

- *Legend* P = Phone L = Letter K = Kept Appointment N = No Show

Long-Term Care Authorization Notification Form

Directions: Complete this form to request inpatient long-term care-related services. Attach the face sheet, Minimum Data Set (MDS), Pre-Admission Screening and Resident Review (PASRR), Treatment Authorization Request (TAR), and any Medicare non-coverage notification to support medical necessity for services. **Fax the completed form and attachments to 855-851-4563**. To check the status of your request, call the Long-Term Care (LTC) Intake Line at 800-453-3033.

Today's date:_____

Member name: _____ Date of birth: _____ Member ID #: _____

Designate type of request by checking appropriate boxes below. Select one:

☐ Routine request (elective)
☐ Urgent request (if care is not received urgently, the member's life/health or ability to regain maximum function could be seriously jeopardized)
☐ New authorization request for new admission
☐ Reauthorization request

Original admission date: _____

Last admission date: _____

Designate service(s) requested by checking appropriate box below:

Date of requested services: _____

Inpatient admission

Is patient readmitted from an acute hospital back to your facility from a bed hold? ☐ Yes ☐ No

If yes, include existing Health Net long-term care authorization number: _____

Date of readmission: _____

☐ LTC subacute custodial services
☐ LTC custodial services
☐ Short-term skilled nursing services

Custodial services that are not included in per diem or covered by any other insurance

☐ Physical, speech or occupation therapy services
☐ Durable medical equipment (DME)
☐ Other: _____

Requesting/ordering provider information		**Servicing provider** (where member will receive services)	
First and last name of requesting provider:	Tax ID/NPI:	Name of hospital/facility or provider of services/product (no abbreviations):	Tax ID/NPI:
Address:		Address:	
City/State/ZIP Code:		City/State/ZIP Code:	
Phone # + ext.	Fax #:	Phone # + ext.	Fax #:
Contact name (**required**):		Contact name :	

Long-Term Care Authorization Notification Form, *continued*

Clinical information		
ICD-10 code(s) (**required**):	Diagnosis description:	Date of onset/injury:
CPT code(s) (**required**):	# of visits	**Describe service requested** (Note: Billed CPT codes not approved may require clinicalreview upon submission of claim and report):

Providers must submit the Face Sheet, MDS, PASRR, TAR, and Medicare non-coverage notification with the authorization notification as applicable.

Hospice services are not a benefit of long-term care. For outpatient hospice services, send documentation via encrypted email to CTIforms@centene.com. For inpatient hospice services, prior authorization is required. For more information on hospice care, access the Provider Library at providerlibrary.healthnetcalifornia.com > select line of business > *Provider Manual* > *Benefits* > *Hospice Care*.

Physician or case manager signature: _____ Contact number: _____

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Long-Term Care Authorization Notification Form

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Today's date:_____

Member name: _____ Date of birth: _____ Member ID #: _____

Designate type of request by checking appropriate boxes below. Select one:

☐ Routine request (elective)
☐ Urgent request (if care is not received urgently, the member's life/health or ability to regain maximum function could be seriously jeopardized)
☐ New authorization request for new admission
☐ Reauthorization request

Original admission date: _____

Last admission date: _____

Designate service(s) requested by checking appropriate box below:

Date of requested services: _____

Inpatient admission

Is patient readmitted from an acute hospital back to your facility from a bed hold? ☐ Yes ☐ No

If yes, include existing Health Net long-term care authorization number: _____

Date of readmission: _____

☐ LTC subacute custodial services
☐ LTC custodial services
☐ Short-term skilled nursing services

Custodial services that are not included in per diem or covered by any other insurance

☐ Physical, speech or occupation therapy services
☐ Durable medical equipment (DME)
☐ Other: _____

Requesting/ordering provider information		**Servicing provider** (where member will receive services)	
First and last name of requesting provider:	Tax ID/NPI:	Name of hospital/facility or provider of services/product (no abbreviations):	Tax ID/NPI:
Address:		Address:	
City/State/ZIP Code:		City/State/ZIP Code:	
Phone # + ext.	Fax #:	Phone # + ext.	Fax #:
Contact name (**required**):		Contact name :	

Long-Term Care Authorization Notification Form, *continued*

Clinical information		
ICD-10 code(s) (**required**):	Diagnosis description:	Date of onset/injury:
CPT code(s) (**required**):	# of visits	**Describe service requested** (Note: Billed CPT codes not approved may require clinicalreview upon submission of claim and report):

Providers must submit the Face Sheet, MDS, PASRR, TAR, and Medicare non-coverage notification with the authorization notification as applicable.

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Physician or case manager signature: _____ Contact number: _____

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED.

Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL | health net

Long-Term Care Authorization Notification Form

Directions: Complete this form to request inpatient long-term care-related services. Attach the face sheet, Minimum Data Set (MDS), Pre-Admission Screening and Resident Review (PASRR), Treatment Authorization Request (TAR), and any Medicare non-coverage notification to support medical necessity for services. **Fax the completed form and attachments to 855-851-4563**. To check the status of your request, call the Long-Term Care (LTC) Intake Line at 800-453-3033.

Today's date:_____

Member name: _____ Date of birth: _____ Member ID #: _____

Designate type of request by checking appropriate boxes below. Select one:

☐ Routine request (elective)
☐ Urgent request (if care is not received urgently, the member's life/health or ability to regain maximum function could be seriously jeopardized)
☐ New authorization request for new admission.
☐ Reauthorization request

Original admission date: _____

Last admission date: _____

Designate service(s) requested by checking appropriate box below:

Date of requested services: _____

Inpatient admission

Is patient readmitted from an acute hospital back to your facility from a bed hold? ☐ Yes ☐ No

If yes, include existing Health Net long-term care authorization number: _____

Date of readmission: _____

☐ LTC subacute custodial services
LTC custodial services
Short-term skilled nursing services

Custodial services that are not included in per diem or covered by any other insurance

☐ Physical, speech or occupation therapy services
☐ Durable medical equipment (DME)
☐ Other: _____

Requesting/ordering provider information		**Servicing provider** (where member will receive services)	
First and last name of requesting provider:	Tax ID/NPI:	Name of hospital/facility or provider of services/product (no abbreviations):	Tax ID/NPI:
Address:		Address:	
City/State/ZIP Code:		City/State/ZIP Code:	
Phone # + ext.	Fax #:	Phone # + ext.	Fax #:
Contact name (**required**):		Contact name:	

Long-Term Care Authorization Notification Form, *continued*

Clinical information		
ICD-10 code(s) (**required**):	Diagnosis description:	Date of onset/injury:
CPT code(s) (**required**):	# of visits	**Describe service requested** (Note: Billed CPT codes not approved may require clinicalreview upon submission of claim and report):

Providers must submit the Face Sheet, MDS, PASRR, TAR, and Medicare non-coverage notification with the authorization notification as applicable.

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Physician or case manager signature: _____ Contact number: _____

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. All rights reserved. CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments.

COUNTY OF LOS ANGELES
Public Health

fax cover sheet

ONE COVER SHEET PER CLIENT - UPPERCASE ONLY

To: Los Angeles County California Children's Services
Fax: (855) 481-6821

Number of Pages: 1
(Including Cover Sheet)

Provider Information

Name:

Organization:

Phone: - -

Return Fax: - -

Client Information

Last Name:

First Name:

Gender:

CCS #:

Date of Birth: - -
(MM/DD/YYYY)

Comments:

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Version 3.1

Marketing Guidelines for Providers Serving CalViva Health Medi-Cal Members

Physicians and other providers are responsible for making sure member-facing materials meet the below guidelines.

Follow these guidelines to create marketing materials, presentations and displays that mention Health Net* or CalViva Health.

You can:	Example
Educate patients about all available plan options and discuss Medi-Cal benefits.	Inform a patient that *"We participate in Medi-Cal and accept [name(s) of accepted insurance plans]."* Help a patient by talking about plan choices for people with Medi-Cal.[1] (Allowed, per California Code of Regulations, Title 22)
List all of the Medi-Cal plans you accept on materials you create.	Display a complete list of all Medi-Cal insurance plans you accept.

You cannot:	Example
Sway a patient's decision to sign up or enroll with any specific Medi-Cal plan in materials.	Inform a patient that *"CalViva Health and/or Health Net is the best plan for people with Medi-Cal."*
Use Health Net and/or CalViva Health's logo or cobrand materials using such logo(s) without the Health Plan's approval.	Create a flyer with the Health Plan's logo on it.
Send materials that mention Health Net or CalViva Health without their approval.	Send a letter to patients advertising a new relationship with the Health Plan.

(continued)

Member-facing materials you create for Medi-Cal patients must be:

- 12-point font or larger.
- At or below a sixth-grade reading level.

Member-facing materials for Calviva Health Medi-Cal patients must include:

- CalViva Health's Notice of Availability.
- CalViva Health's Non-Discrimination Notice.

Can I use the Health Plan logo or mention the Plan in materials?

You cannot use the Health Net logo or mention Health Net's name in materials that are provided to CalViva Health members. You must obtain Health Net and CalViva Health's approval if you wish to use the plan's logo(s) or mention Health Net and/or CalViva Health in patient-facing materials or advertising. For more information, please contact the Health Plan.

What rules apply to the Plan's marketing activities and marketing materials for Medi-Cal recipients?

Department of Health Care Services (DHCS) All Plan Letter (APL) 13-015 (Revised) describes how managed care health plans (MCPs) can market to people eligible for Medi-Cal. Medi-Cal MCPs and their marketing contractors who perform outreach activities to people eligible for Medi-Cal are subject to certain requirements. These include, but are not limited to:

- MCPs are prohibited from conducting door-to-door, cold call and telephone marketing activities for the purposes of enrolling current or potential Medi-Cal beneficiaries.
- All marketing materials, including printed materials, need to be approved in writing by DHCS prior to distribution.
- All marketing materials, presentations and displays need to conform to the cultural and linguistic requirements prescribed in the MCP's health plan contract.

All provider-created marketing materials that mention the Plan and require DHCS review and approval should be forwarded to the Health Plan for submission to DHCS for review and approval as needed.

How can I learn more?

For more information about Medi-Cal marketing guidelines, view All Plan Letter 13-015 (Revised) (PDF) online at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-015.pdf.

For other questions about marketing guidelines, contact CalViva Health at 888-893-1569.

[1]The MCP is required to adhere to the marketing requirements contained in its respective DHCS health plan contract and act in accordance with the marketing requirements contained in Title 22 California Code of Regulations (CCR) 53880 and 53881 and Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411.

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

25-557/FLY1916550EH01w (6/25)

Marketing Guidelines for Providers Serving CHPIV Medi-Cal Members

Physicians and other providers are responsible for making sure member-facing materials meet the below guidelines.

Follow these guidelines to create marketing materials, presentations and displays that mention Health Net* or Community Health Plan of Imperial Valley (CHPIV).

You can:	Example
Educate patients about all available plan options and discuss Medi-Cal benefits.	Inform a patient that *"We participate in Medi-Cal and accept [name(s) of accepted insurance plans]."* Help a patient by talking about plan choices for people with Medi-Cal.[1] (Allowed, per California Code of Regulations, Title 22)
List all of the Medi-Cal plans you accept on materials you create.	Display a complete list of all Medi-Cal insurance plans you accept.

You cannot:	Example
Sway a patient's decision to sign up or enroll with any specific Medi-Cal plan in materials.	Inform a patient that *"CHPIV and/or Health Net is the best plan for people with Medi-Cal."*
Use Health Net and/or CHPIV's logo or cobrand materials using such logo(s) without the Health Plan's approval.	Create a flyer with the Health Plan's logo on it.
Send materials that mention Health Net or CHPIV without their approval.	Send a letter to patients advertising a new relationship with the Health Plan.

(continued)

Member-facing materials you create for Medi-Cal patients must be:

- 12-point font or larger.
- At or below a sixth-grade reading level.

Member-facing materials for CHPIV patients must include:

- CHPIV's Notice of Availability.
- CHPIV's Non-Discrimination Notice.

Can I use the Health Plan logo or mention the Plan in materials?

You cannot use the Health Net logo or mention Health Net's name in materials that are provided to CHPIV members. You must obtain Health Net and CHPIV's approval if you wish to use the Plan's logo(s) or mention Health Net and/or CHPIV in patient-facing materials or advertising. For more information, please contact the Health Plan.

What rules apply to the Plan's marketing activities and marketing materials for Medi-Cal recipients?

Department of Health Care Services (DHCS) All Plan Letter (APL) 13-015 (Revised) describes how managed care health plans (MCPs) can market to people eligible for Medi-Cal. Medi-Cal MCPs and their marketing contractors who perform outreach activities to people eligible for Medi-Cal are subject to certain requirements. These include, but are not limited to:

- MCPs are prohibited from conducting door-to-door, cold call and telephone marketing activities for the purposes of enrolling current or potential Medi-Cal beneficiaries.
- All marketing materials, including printed materials, need to be approved in writing by DHCS prior to distribution.
- All marketing materials, presentations and displays need to conform to the cultural and linguistic requirements prescribed in the MCP's health plan contract.

All provider-created marketing materials that mention the Plan and require DHCS review and approval should be forwarded to the Health Plan for submission to DHCS for review and approval as needed.

How can I learn more?

For more information about Medi-Cal marketing guidelines, view All Plan Letter 13-015 (Revised) (PDF) online at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-015.pdf.

For other questions about marketing guidelines, contact CHPIV at 833-236-4141.

[1]The MCP is required to adhere to the marketing requirements contained in its respective DHCS health plan contract and act in accordance with the marketing requirements contained in Title 22 California Code of Regulations (CCR) 53880 and 53881 and Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411.

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

26-340 FLY1916550EH03w (6/25)

Marketing Guidelines for Providers Serving Medi-Cal Members

Physicians and other providers are responsible for making sure member-facing materials meet the below guidelines.

Follow these guidelines to create marketing materials, presentations and displays that mention Health Net,* its plans or products.

You can:	Example
Educate patients about all available plan options and discuss Medi-Cal benefits.	Inform a patient that *"We participate in Medi-Cal and accept [name(s) of accepted insurance plans]."* Help a patient by talking about plan choices for people with Medi-Cal.[1] (Allowed, per California Code of Regulations, Title 22)
List all of the Medi-Cal plans you accept on materials you create.	Display a complete list of all Medi-Cal insurance plans you accept.

You cannot:	Example
Sway a patient's decision to sign up or enroll with any specific Medi-Cal plan in materials.	Inform a patient that *"Health Net is the best plan for people with Medi-Cal."*
Use the Health Net logo or cobrand materials using Health Net's logo(s) without Health Net's approval.	Create a flyer with the Health Plan's logo on it.
Send materials that mention Health Net without Health Net's approval.	Send a letter to patients advertising a new relationship with the Health Plan.

(continued)

Member-facing materials you create for Medi-Cal patients must be:

- 12-point font or larger.
- At or below a sixth-grade reading level.

Member-facing materials that mention Health Net must include:

- Health Net's Notice of Availability.
- Health Net's Non-Discrimination Notice.

Can I use Health Net's logo or mention Health Net in materials?

You must obtain Health Net's approval if you wish to use Health Net's logo(s) or mention Health Net in patient-facing materials or advertising. For more information, please contact your Health Net Provider Relations representative.

What rules apply to the Plan's marketing activities and marketing materials for Medi-Cal recipients?

Department of Health Care Services (DHCS) All Plan Letter (APL) 13-015 (Revised) describes how managed care health plans (MCPs) can market to people eligible for Medi-Cal. Medi-Cal MCPs and their marketing contractors who perform outreach activities to people eligible for Medi-Cal are subject to certain requirements. These include, but are not limited to:

- MCPs are prohibited from conducting door-to-door, cold call and telephone marketing activities for the purposes of enrolling current or potential Medi-Cal beneficiaries.
- All marketing materials, including printed materials, need to be approved in writing by DHCS prior to distribution.
- All marketing materials, presentations and displays need to conform to the cultural and linguistic requirements prescribed in the MCP's health plan contract.

All provider-created marketing materials that mention the Plan and require DHCS review and approval should be forwarded to the Health Plan for submission to DHCS for review and approval as needed.

How can I learn more?

For more information about Medi-Cal marketing guidelines, view All Plan Letter 13-015 (Revised) (PDF) online at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-015.pdf.

For other questions about marketing guidelines, contact your Provider Relations representative or call the Health Net Medi-Cal Provider Services Center at 800-675-6110.

[1]The MCP is required to adhere to the marketing requirements contained in its respective DHCS health plan contract and act in accordance with the marketing requirements contained in Title 22 California Code of Regulations (CCR) 53880 and 53881 and Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411.

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25-558/FLY1916550EH02w (6/25)

PCP:	Page 1 of 1
SECTION: Access/Safety	
POLICY AND PROCEDURE: Medical and Lab Equipment Maintenance	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Medical and Laboratory equipment used for patient care shall be properly maintained.

PROCEDURE:

I. MAINTENANCE OF MEDICAL EQUIPMENT

A. Operating manuals for medical and lab equipment will be maintained on site.

B. Operating manuals will be the reference for planning routine maintenance schedules for equipment.

C. If operating manuals are not available, an annual cycle for safety/calibration service will be adopted.

D. Documented proof of servicing will be maintained on site and may be in the following form:
   1. A receipt listing all equipment serviced and date of service.
   2. Stickers applied to equipment noting the date of service.
   3. Work orders/receipts for repair of equipment.
   4. A handwritten log with dates and results of calibration (such as for a hemacue).

II. MALFUNCTIONING EQUIPMENT

A. Staff shall inform provider/designee of any equipment found to be malfunctioning or out of service.
   1. Provider/designee will arrange for repair or replacement of malfunctioning equipment.
   2. Documented proof of repair will be maintained on site.

III. QUALIFIED PERSONNEL

A. Qualified staff assigned to operate equipment will be trained on appropriate use and maintenance.

Medical Assistant Certificate

This is to certify that _____has demonstrated and completed on-the-job training as a Medical Assistant under the auspices of the undersigned as follows and in compliance with California Code of regulations, Title 16, Chapter 14, Sections 1366. 1366.1. 1366.1, 1366.3 and 1366.4

*Please **initial** the areas of training:*

____ Preparing patients for and assisting in exams, procedures, positioning, draping, shaving and disinfection treatment sites.

____ Performing, collecting, and recording vital signs including pulse, respiration rate, blood pressure and basic information about the presenting and previous conditions.

____ Performing simple lab and screening tests, customarily performed in a medical office.

____ Non-Invasive collecting and preserving specimens for testing, including urine, sputum, semen, and stool.

____ Assisting patients in ambulation and transfers.

____ Performing ear lavage to remove impacted cerumen.

____ Removing sutures or staples from superficial incisions or lacerations.

____ Applying and removing bandages, dressings, orthopedic appliances, removing casts, splints, and other internal devices.

____ Administering medications orally, sublingually, topically, vaginally, rectally or by providing a single dose to a patient for immediate self-administration. In every instance, prior to administration of medication by the medical assistant, a licensed provider shall verify the correct medication and dosage.

____ Performing electrocardiogram.

____ Other:

_____

_____

Pediatric preventive care screenings for ages 0 to 20 years based on the American Academy of Pediatrics requirements. Training modules are available at the DHCS website: https://www.dhcs.ca.gov/services/chdp/Pages/Training.aspx.

____ Anthropometric Measurements: Collecting and recording patients' data, including head circumference, height, weight, BMI and plotting values on WHO and CDC growth charts.

____ Hearing Screening: Performing audiometric testing, not requiring interpretation by the medical assistant to obtain test results.

____ Vision Screening: Performing visual field testing, simple or automated ophthalmic testing, not requiring interpretation by the medical assistant to obtain test results.

____ Dental Services: Documenting the last oral assessment and fluoride screening. Identify dental home and ensure referral to a dentist is provided at least annually. Apply fluoride varnish under provider's prescription and supervision.

Clinic Name: _____

Provider Name: _____

_____ _____

Provider's Signature Date

Date: _____

To whom it may concern:

This is to certify that _____ has demonstrated and completed On-the-job training as a "MEDICAL ASSISTANT" under the auspices of the undersigned as follows and in compliance with California Code of Regulations, Title 16, Chapter 13, Sections 1366, 1366.1, 1366.2, 1366.3 and 1366.4:

A. Ten clock hours of training in administering injections and performing skin tests.

B. Ten clock hours of training in venipuncture and skin puncture for the purpose of withdrawing blood.

C. Satisfactory performance of at least ten each of intramuscular, subcutaneous, and intra-dermal injections, and ten skin fests, and/or at least ten venipunctures and ten skin punctures.

D. For those only administering medication by inhalation, ten clock hours of training in administering medication by inhalation.

E. Training in A through D above has included instruction and demonstration in:

1. Pertinent anatomy and physiology appropriate to the procedures
2. Choice of equipment
3. Proper techniques including sterile technique
4. Hazards and complications
5. Patient care following treatment or test
6. Emergency procedures
7. California law and regulations for medical assistants

F. Trained and has demonstrated to the satisfaction of instructor, understanding of purposes and techniques of infection control following CDC's "Guidelines for Infection Control in hospital Personnel" (July 1983).

Sincerely Yours,

Provider's Signature _____

Provider's Status_____

Venipuncture, Injection, and Skin Test Certification

This is to certify that _____ has demonstrated and completed on the job training as a "Medical Assistant" here at _____under the auspices of the undersigned as follows and in compliance with business and Professions Code section 20696 and 2070.

A. Ten clock hours of training in venipuncture and skin puncture for the purpose of drawing blood.

B. Ten clock hours of training in administering injections and performing skin tests.

C. Satisfactory performance by the trainee of at least ten of each of the following procedures: intramuscular injections, subcutaneous injections, skin tests, venipunctures and other skin punctures performed in the office

D. Training A through C above, shall include knowledge of the following:

1. Pertinent anatomy and physiology appropriate to the procedure.
2. Choice of equipment
3. Proper technique including sterile technique.
4. Hazards and complications.
5. Post treatment and test patient care
6. Emergency procedure
7. California law and regulations for medical assistants

_____ _____

Physician's Signature Date

Provider Name: _____

Office Address: _____

_____

Office Phone Number: _____

PCP:	
SUBJECT: Office Management	
POLICY AND PROCEDURE: Medical Records	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The medical record shall be maintained to serve the patient/member and healthcare provider in compliance with legal, accrediting and regulatory agency requirements. All member information is regarded as confidential and obtainable only to authorized persons. Medical Records shall be maintained in accordance with medical legal documentation standards including but not limited to health plan operation manual medical record documentation and medical record keeping standards.

PROCEDURE:

I. The provider/designee will ensure that there is a system for the following:
   A. Medical records are available at each encounter and include outpatient, inpatient, referral services, and significant consultations. There must be a separate medical record for each patient

   B. Medical records are accessible within the facility, or an approved health record storage facility on the facility premises.

II. Confidentiality

   A. Staff will ensure that exam rooms and dressing areas safeguard patients' right to privacy.

   B. Staff maintains confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas. Computer monitors should utilize privacy screens, as appropriate, to prevent unauthorized viewing of patient information.

   C. Where applicable, electronic record-keeping system procedures are established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to

ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files.

D. The PCP will ensure that medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release will indicate to whom released and for what purpose. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.

E. Fax forms contain the confidentiality statement

F. The PCP will ensure that medical records are maintained for a minimum of 10 years following patient discharge

III. Documentation

A. Format Section of the Medical Record Documentation Standards

a. Member identification is on each page
b. The medical record includes biographical personal data that is easily located.

c. Emergency contact phone number is noted in medical record.

d. Each member has an organized individual medical record. Hard copy medical records are securely fastened.

e. Member's assigned and/or rendering primary care physician (PCP) is identified.

f. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted

g. Person or entity providing medical interpretation is identified and documented each visit, regardless if done by provider, staff or external vendor. (Note: all forms given in language other than English, must have the English version in member's medical record also)

h. Signed Copy of the Notice of Privacy is included in medical record

B. Documentation Section of the Medical Record Documentation Standards

1. The medication allergies (or no known allergies) are documented in a prominent location.

2. Chronic medical problems and/or significant conditions are consistently documented and can be easily identified.

3. Current continuous medications are consistently documented and can be easily identified.

4. Appropriate consents are present and signed:

    a. Consent for treatment
    b. Release of medical records
    c. Informed Consents are present when any invasive procedure is performed.

5. Advanced Health Care Directive information is offered, and date documented. (Adults, 18 years/older and emancipated minors only). (Note: reviewed every 5 years or as appropriate)

6. All entries are signed, dated and legible.

7. Errors are corrected according to legal medical documentation standards

C. Coordination of Care Section of the Medical Record Documentation Standards

1. History of present illness or reason for visit is documented.

2. Working diagnoses are consistent with findings.

3. Treatment plans are consistent with diagnoses.

4. Instruction for follow up care is documented.

5. Unresolved/continuing problems are addressed in subsequent visit(s)

6. The practitioner instructions for follow-up care, (e.g. when a return office visit is needed), is documented.

7. There is evidence documented of practitioner review of consult/referral reports and diagnostic tests results.

8. There is evidence documented of follow up specialty referrals made and results/reports of diagnostic tests, as appropriate

9. Missed primary care appointments and outreach efforts/follow-up contacts are documented

D. Preventive Care Section of the Medical Record Documentation Standards

1. Pediatric Preventive Care

A. Initial Health Assessment (IHA) includes comprehensive History and Physical that includes Individual Health Education Behavioral Assessment using the DHCS required Staying Healthy Assessment (SHA) tool according to the appropriate age. (see SHA P&P.)

B. Subsequent Comprehensive History and Physical exam completed as age appropriate frequency and SHAs to be reviewed annually and reapplied at age appropriate intervals.

C. Pediatric well visits annually according to AAP guidelines.

1. Alcohol/Drug Misuse: Screening and Behavioral Counselling
2. Anemia Screening
3. Anthropometric measurements
4. Anticipatory guidance
5. Autism Spectrum Disorder Screening
6. Blood Lead Testing
7. Blood Pressure Screening
8. Dental Assessment
    a. Dental home
    b. Flouride supplementation
    c. Flouride varnish
9. Depression Screening
    a. Maternal Depression Screening
10. Developmental Disorder Screening
11. Developmental Surveillance
12. Dyslipidemia Screening
13. Folic acid supplementation
14. Hearing Screening
15. Hepatitis B Screening
16. HIV Screening
17. Intimate Partner Violence Screening
18. Nutrition assessment/Breast Feeding support
19. Obesity Screening
20. Psychosocial/Behavioral Assessment
21. Sexual Activity Assessment
    a. Contraceptive Care
    b. STI screening on all sexually active adolescents, including chlamydia, Gonorrhea, and Syphilis
22. Skin Cancer Behavior Counselling

23. Tobacco Products Use: Screening and Prevention and Cessation Services
24. Tuberculosis Screening
25. Vision Screening

D. Childhood Immunizations

1, Pediatric Immunizations are given according to ACIP guidelines.

2.Vaccine administration documentation (Vaccine administration documentation to include lot number, manufacturer dose, site, VIS publication date)

3.Vaccine Information Statement (VIS) documentation (Vaccine Information Sheet (VIS) given and publication date documented)

2. Adult Preventive Care

A. Initial Health Assessment (IHA) and Comprehensive History and Physical that includes Individual Health Education Behavioral Assessment using the DHCS required Staying Healthy Assessment (SHA) tool according to the appropriate age. (see SHA P&P.)

B. Periodic Health Evaluation according to most recent USPSTF Guidelines

C. Subsequent SHAs to be reviewed annually and reapplied at age-appropriate intervals.

D. Adult Preventive Care Screenings

1. Abdominal Aneurysm Screening
2. Alcohol Misuse: Screening and Behavioral Counseling
3. Breast Cancer Screening
4. Cervical Cancer Screening
5. Colorectal Cancer Screening
6. Depression Screening
7. Diabetic Screening
    a. Comprehensive Diabetic Care
8. Dyslipidemia Screening
9. Folic Acid Supplementation
10. Hepatitis B Screening
11. Hepatitis C Screening
12. High Blood Pressure Screening
13. HIV Screening
14. Intimate Partner Violence Screening
15. Lung Cancer Screening

16. Obesity Screening
17. Osteoporosis Screening
18. Sexually Transmitted Infection (STI) Screening including Chlamydia, Gonorrhea and Syphilis
    a. Sexually Transmitted Infections Counseling
19. Skin cancer Behavioral Counseling
20. Tobacco Use Counseling and Interventions
21. Tuberculosis Screening

E. Adult immunizations

1. Given according to ACIP guidelines.(Flu, tetanus, and/or pneumovax if over age 65 or high risk)
2. Vaccine administration documentation to include lot number, manufacturer dose, site, VIS publication date.
3. Vaccine Information Sheet (VIS) given and publication date documentation

3 OB/CPSP Preventive Criteria

A. Initial Comprehensive Prenatal Assessment (ICA)

1. Initial prenatal visit is completed within 4 weeks of entry into prenatal care.
2. Obstetrical and Medical History
3. Physical Exam
4. Dental Assessment
5. Lab Tests
    a. Bacteriuria Screening
    b. Rh Incompatibility Screening
    c. Diabetes Screening
    d. Hepatitis B Virus Screening
    e. Chlamydia Infection Screening
    f. Syphilis Infection Screening
    g. Gonorrhea Infection Screening

B. First Trimester Comprehensive Assessment

1. Individualized Care Plan
2. Nutrition Assessment
3. Psychosocial Assessment
    a. Maternal Mental Health Screening
    b. Social Needs Assessment
    c. Substance Use/Abuse Assessment
4. Health Education
5. Preeclampsia Screening
6. Intimate Partner Violence Screening

C. Second Trimester Comprehensive Re-assessment
    1. Individualized Care Plan
    2. Nutrition Assessment
    3. Psychosocial Assessment
        a. Maternal Mental Health Screening
        b. Social Needs Assessment
        c. Substance Use/Abuse Assessment
    4. Health Education
    5. Preeclampsia Screening
    6. Intimate Partner Violence Screening

D. Third Trimester Comprehensive Re-assessment
    1. Individualized Care Plan
    2. Nutrition Assessment
    3. Psychosocial Assessment
        a. Maternal Mental Health Screening
        b. Social Needs Assessment
        c. Substance Use/Abuse Assessment
    4. Health Education
    5. Preeclampsia Screening
    6. Intimate Partner Violence Screening
    7. Screening for Strep B
    8. TDAP Immunization

E. Prenatal care visit periodicity according to most recent ACOG Standards

F. Influenza Vaccine

G. Referral to WIC and assessment of Infant Feeding status

H. HIV-related services *offered*

I. AFP/Genetic screening *offered*

J. Family Planning Evaluation

K. Postpartum Comprehensive Assessment (within 21-56 days after delivery)

    1. Individualized Care Plan
    2. Nutrition Assessment
    3. Psychosocial Assessment
        a. Maternal Mental Health/Postpartum Depression Screening
        b. Social Needs Assessment
        c. Substance Use/Abuse Assessment
    4. Health Education
    5. Comprehensive Physical Exam

ADULT HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. _____

Age: _____ Sex: Male Female MR# _____

Immunizations current: Yes No
(See Immunization list below)

TB Risk: Yes No
(Every Periodic Physical Examination)

Advanced Directive discussed: Yes No

Date Discussed: _____

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	18 yrs. and older	Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.			
IHEBA/"Staying Healthy"	18 yrs and Older	Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years.	Record on Staying Healthy Form.		
Check-Up Visit	18 yrs. and older	Every 1-3 years			
	Age > 65	Annually			
Cholesterol	Male, 35 yrs. and older	Every 5 years			
	Female, 45 yrs. and older	Every 5 years			
Diabetes Mellitus Screening	As risk factors indicate	PRN			
Urinalysis	65 yrs. and older	PRN			
Breast Exam	Age > 40 yrs.	Annually			
Mammography	50-74 yrs.	Every 2 years			
Pelvic Exam	19-39 yrs.	Every 1-3 yrs.			
	40 and older	Annually			
Pap Smear	Onset of sexual activity or 21-65 yrs.	Every 1 to 3 yrs. At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.			
Chlamydia	< age 25, all sexually active non-pregnant women > age 25, as risk factors indicate				
Bone Density	65 yrs. and older	At least once			
Vitamin D Deficiency	65 yrs. and older	At clinician's discretion			
TSH Screening	40 yrs. and older	Every 5 years			
Fecal Occult Blood	50-75 yrs., then at clinician's discretion	Annually			
Sigmoidoscopy	50 and older	3-5 yrs.			
	High Risk	PRN			
Colonoscopy	50 and older	Every 10 years			
Prostate Exam	Physician discretion and as clinically indicated	PRN			
PSA	50 and older or as clinically indicated	PRN			
Adult Immunizations					
Tetanus-Diptheria-Pertussis(Tdap) Tetanus-Diphtheria (Td)	18 yrs. and older 18 yrs. and older	1 dose only Every 10 yrs.			
HPV	Females, 18-26 yrs. (HPV2 or HPV4) Males, 18-26 yrs (HPV 4)	3 doses			
Varicella	18 yrs. and older	2 doses if no evidence of immunity			
Zoster	60 yrs. and older	1 dose			
MMR	Born 1957 or after Born before 1957	1-2 doses unless immunity documented Considered immune, unless documentation of immunity required			
Influenza	18 yrs. and older	Annually			
Pneumococcal	18 yrs. and older	1-2 doses, when clinically indicated			
Hepatitis A	18 yrs. and older	2 doses			
Hepatitis B	18 yrs. and older	3 doses			
Meningococcal	18 yrs. and older	1 dose, 2nd dose if high risk			

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
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Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

Advanced Directive Education: Date_____
Refused_____ Yes_____ Initials:_____

LAST NAME: **FIRST NAME:** **MRN#**

PLACE OF SCREENING: **CIRCLE ONE:** ANSI - #____ ISO - #____

AUDIOMETER: **SCORING:** Child responds at 25 dB: Child does not respond at 25 dB: ☐

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To:

Signature & Title of Person Performing Test

HISTORIA MEDICA Y EXAMEN FISICO

MRN # _____

NOMBRE:	ESTADO CIVIL: ❑· S ❑ C ❑ V ❑ D ❑ SEP.	FECHA:
FECHA DE NACIMIENTO:	TEL (CASA):	TEL (TRABAJO):
OCUPACION/EMPLEADOR	Nº del Seg. Soc.:	Nº del SEGURO:

HISTORIA MEDICA FAMILIAR

SI ALGUN PARIENTE SANGUINEO HA TENIDO CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES, PONGA UN CIRCULO ALREDEDOR DEL NUMERO E INDIQUE QUE PARIENTE.

1) ALCOHOLISMO
2) ANEMIA
3) ASMA
4) ARTRITIS
5) SANGRA FACILMENTE
6) CANCER
7) DIABETES
8) EPILEPSIA
9) GLAUCOMA
10) ASMA DEL HENO
11) ENFERMEDAD CARDIACA
12) HIPERTENSION
13) ENFERMEDAD RENAL
14) ENFERMEDAD MENTAL
15) MIGRAÑA
16) OSTEOPOROSIS
17) APOPLEJIA
18) TIROIDES
19)
20)

INTERNACIONES EN HOSPITALES

(sin incluir embarazos)

AÑO — ENFERMEDAD U OPERACION

ALERGIAS

Pasado:

Presente:

ANOTE TODOS LOS MEDICAMENTOS QUE TOMA AHORA: (incluso los que se venden sin receta médica)

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

VACUNA (Fecha de la última)	PRUEBA / EXAMEN (Fecha del último)
Tétano / Difteria	Colesterol
Influenza	Dental
Neumocócica	Vista
Hepatitis	Oído
	Rectal / Excremento
	Sigmoidoscopía
	Prueba cutánea de tuberculosis

HISTORIA MEDICA

Marque con una palomita (✓) e indique la edad en la que tuvo cualquiera de los siguientes síntomas o enfermedades. MARQUE con una equis (X) los problemas actuales.

PROBLEMAS PRINCIPALES 1) _____ 2) _____ 3) _____

❑ Oído disminuido
❑ Zumbido en el oído
❑ Infecciones de oído - *frecuentes*
❑ Mareos
❑ Falla de la vista ❑ Dolor del ojo
❑ Visión doble o borrosa
❑ Infecciones del ojo - *frecuentes*
❑ Sangrado de la nariz - *recurrentes*
❑ Problema del seno
❑ Dolores de garganta - *frecuentes*
❑ Asma del heno / Alergias
❑ Ronquera - *prolongada*
❑ Neumonía / Pleuresía
❑ Bronquitis / Tos crónica
❑ Asma / Jadeo
Falta de aliento:
❑ Haciendo esfuerzo
❑ Estando acostado
❑ Dolor del pecho
❑ Presión sanguínea alta
❑ Soplo cardíaco
❑ Pulso irregular
❑ Palpitaciones
❑ Tobillos hinchados
❑ Desmayos
❑ Dolor de pierna - *caminando*
❑ Venas varicosas / Flebitis
❑ Pérdida del apetito - *reciente*
❑ Dificultad para tragar

❑ Indigestión o acidez estomacal
❑ Ulceras pépticas
❑ Dolor abdominal - *crónico*
❑ Problema de vesícula biliar
❑ Ictericia / Hepatitis
❑ Cambio de hábitos de evacuación intestinal
❑ Diarrea ❑ Estreñimiento
❑ Diverticulosis
❑ Enfermedad de Crohn / Colitis
❑ Excrementos sanguinolentos o alquitranados
❑ Hemorroides
❑ Hernia
❑ Infecciones urinarias - frecuentes
❑ Sangre en la orina
❑ Emisión de orina ❑ Durante la noche más de dos veces
❑ Dolorosa
❑ Pérdida del control
❑ Disminución de la Fuerza/Flujo
❑ Cálculos renales
❑ Enfermedad venérea
❑ Derrame uretral
❑ Fatiga crónica
❑ Pérdida de peso - *reciente*
❑ Anemia
❑ Se magulla fácilmente

❑ Cancer
❑ Diabetes
❑ Enfermedad de tiroides
❑ Convulsiones / Ataques epilépticos
❑ Apoplejía
❑ Temblor / Manos temblantes
❑ Debilidad muscular
❑ Adormecimiento / Sensaciones de hormigueo
❑ Dolores de cabeza - *frecuentes*
❑ Artritis / Reumatismo
❑ Dolor de Espalda - *recurrente*
❑ Fracturas óseas / Lesión de articulaciones
❑ Gota
❑ Osteoporosis
❑ Dolor de pie
❑ Pies fríos y adormecidos
❑ Sarpullido
❑ Ronchas
❑ Psoriasis
❑ Eczema
❑ Sueño - *dificultad*
❑ Nerviosismo
❑ Depresión
❑ Pérdida de la memoria
❑ Mal humor - *excesivo*
❑ Fobias

❑ Enfermedad mental
❑ Varicela
❑ Poliomielitis
❑ Paperas
❑ Sarampión
❑ Rubéola
❑ Fiebre reumática
❑ Escarlatina
❑ Tuberculosis
❑ Herpes
❑ Contacto con sangre o fluidos corporales
❑ Alcohol _____ onzas por semana
❑ Fuma _____ cig. por día
Número de años_____
❑ Café / Té
Nº de tazas por día _____
❑ Directivas con adelanto

HOMBRES - Favor de completar
Fecha del último examen de próstata

❑ Normal ❑ Anormal
Fecha de la última PSA _____

MUJERES - Favor de completar
Flujo Menstrual:
❑ Reg. ❑ Irreg.
❑ Dolor / Cólico
Días de flujo _____
Duraciones del ciclo _____
Fecha del último período _____
❑ Dolor / Sangramiento durante o después del coito
Número de:
Embarazos _____
Abortos provocados _____
Abortos espontáneos _____
Nacimientos con vida _____
Método de control de la natalidad _____
Píldora de control de la natalidad (nombre) _____
❑ Calores súbitos / Menopausia
Fecha del último examen pélvico _____
Fecha de la última prueba de Papanicolaou _____
❑ Normal ❑ Anormal

Fecha del último examen de senos _____
Fecha del último mamograma ____
❑ Normal ❑ Anormal

SINOPSIS **PARA USO DE OFICINA SOLAMENTE:**

Directivas Anticipadas: ❑ Si ❑ No Educativo de Directivas Anticipadas: ❑ Cuestionario "Mantengase Saludable" Fecha:_____

Firma: Dr./Dra.

MEDICATION AND SUMMARY CHART MRN

NAME: **DATE OF BIRTH:** **HT:** **WT:**

ALLERGIES

Pharmacy Name & Telephone #

Patient's (home) Telephone #s: (work)

PROBLEM # START DATE	MEDICATION DOSAGE/FREQ.	REFILL DATES *(record any changes in dosage or frequency)*				STOP DATE OR CONTINUED

CHRONIC PROBLEM LIST

	Date Resolved
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Comprehensive Health Assessment

Under 1 Month Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		
Intake		**Vital Signs**
Allergies		Temp
Height		Pulse
Weight		Resp
Head Circumference		
Birth History	Birth Weight:	Gestation:
Delivery	☐ Vaginal ☐ C-Section	Complications ☐ Yes ☐ No
OB/GYN Provider		
Post-Partum Appointment Date		
Cord	☐ Absent ☐ Present ☐ Redness/swelling ☐ Yellow drainage	
Chronic Problems/Significant Conditions: ☐ See Problem List		
Current Medications/Vitamins: ☐ See Medication List		
Interval History		
Nutrition	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal (2-4 hours) ☐ Abnormal	
Sleeping Position	☐ Supine ☐ Prone ☐ Side	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Childhood hearing impairment	☐ Other:	
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PAPF, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Prone, lifts head briefly	☐ Turns head side to side	☐ Responds to sound
☐ Moro reflex	☐ Blinks at bright light	☐ Keeps hands in a fist

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Palate	Oral mucosa pink, no cleft lip or palate	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Name: DOB:

Assessment

Plan

Referrals

☐ WIC	☐ Audiologist	☐ Optometrist / Ophthalmologist
☐ Maternal Behavioral Health	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ Hep B vaccine	☐ Newborn metabolic screen	☐ Obtain newborn hospital records & hearing screen results
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Colic

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear-facing Infant car seat	☐ Stimulation from hanging objects & bright colors
☐ Call MD for fever	☐ Choking hazards	☐ Family spacing
☐ Family support, social interaction & communication	☐ Never shake baby	☐ Physical growth
☐ Signs of maternal depression	☐ Matches / burns	☐ Stools
☐ Post-Partum Checkup	☐ Violence prevention, gun safety	☐ Sneezing
☐ Hot liquid away from baby	☐ Poison control phone number	☐ Hiccups
☐ Effects of passive smoking	☐ Smoke detector	☐ Bathing
☐ Skin cancer prevention	☐ Hot water temp < 120° F	☐ Circumcision care
☐ Sleeping position	☐ Drowning / tub safety	☐ Cord care

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

1 to 2 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Sleep	☐ Normal ☐ Abnormal		
Sleep Position	☐ Supine ☐ Prone ☐ Side		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Prone, lifts head 45°	☐ Vocalizes (cooing)	☐ Grasps rattle
☐ Kicks	☐ Follows past midline	☐ Smiles responsively (social)

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Present and equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Name: DOB:

Assessment

Plan

Referrals		
☐ WIC	☐ Dietician / Nutritionist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Optometrist / Ophthalmologist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders		
☐ DTaP	☐ IPV	☐ CBC / Basic metabolic panel
☐ Hep B vaccine	☐ PCV	☐ Hct / Hgb
☐ Hib	☐ Rotavirus	☐ ECG ☐ COVID 19 test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)		
Diet, Nutrition & Exercise		
☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Signs of hunger
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear-facing Infant car seat	☐ Childcare plan
☐ Call MD for fever	☐ Choking hazards	☐ Crying
☐ Hot liquid burns	☐ Never shake baby	☐ Family spacing
☐ Signs of maternal depression	☐ Matches / burns	☐ Sibling and family relationships
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Diaper rash	☐ Poison control phone number	☐ Bathing
☐ Skin cancer prevention	☐ Smoke detector	☐ Sleeping position
☐ Crying	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / tub safety	☐ Thumb sucking
Next Appointment		
☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	**Title**	**Date**
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: DOB:

3 to 4 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Sleep	☐ Normal ☐ Abnormal		
Sleep Position	☐ Supine ☐ Prone ☐ Side		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Head steady when sitting	☐ Squeals or coos	☐ Orients to voices
☐ Eyes follow 180°	☐ Rolls form stomach to back	☐ Brings hands together
☐ Grasps rattle	☐ Gums objects	☐ Laughs aloud

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Present and equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐
Subjective / Objective		

Name: DOB:

Assessment

Plan

Referrals

☐ WIC	☐ Dietician / Nutritionist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Optometrist / Ophthalmologist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Influenza vaccine	☐ CBC / Basic metabolic panel
☐ DTaP	☐ IPV	☐ Hct / Hgb
☐ Hep B vaccine (if not up to date)	☐ PCV	☐ PPD skin test ☐ QFT
☐ Hib	☐ Rotavirus	☐ ECG ☐ COVID 19 test
☐ DTaP	☐ IPV	☐ Iron-fortified formula ☐ Iron supplements
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Signs of hunger

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Childcare plan
☐ Signs of maternal depression	☐ Choking hazards	☐ Rolling
☐ Family support, social interaction & communication	☐ Storage of drugs / toxic chemicals	☐ Family spacing
☐ Effects of passive smoking	☐ Matches / burns	☐ Sibling and family relationships
☐ Skin cancer prevention	☐ Violence prevention, gun safety	☐ Physical growth
☐ Sleeping position	☐ Poison control phone number	☐ Reaching for objects
☐ No bottle in bed	☐ Smoke detector	☐ Bathing
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Minor illness care	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: DOB:

5 to 6 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ No head lag when pulled to sitting	☐ Sits briefly alone	☐ Orients to bell
☐ Bears weight on legs	☐ Rolls both ways	☐ Bangs small objects on surface
☐ Reaches for objects	☐ Gums objects	☐ Babbles

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐

Name: DOB:

Neurologic	Alert, no gross sensory or motor deficit ☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ Dentist	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ IPV	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PCV	☐ Hct / Hgb
☐ Hep A vaccine (if high risk)	☐ Rotavirus	☐ PPD skin test ☐ QFT
☐ Hep B vaccine	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Hib	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD	☐ ECG ☐ COVID 19 test
☐ Influenza vaccine	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Introduction to solids	☐ Fortified Infant Cereals	☐ Start solid one at a time
☐ Breastfeeding / formula	☐ No cow's milk	☐ Start feeder cup

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Blocks
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Repetitive games
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Caution with strangers	☐ Poison control phone number	☐ Bathing
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Signs of maternal depression	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: DOB:

7 to 9 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Sleep	☐ Normal ☐ Abnormal		
Sleep Position	☐ Supine ☐ Prone ☐ Side		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder (9 Months)	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Sits without support	☐ Transfers object hand to hand	☐ Looks for toy dropped
☐ Begins to crawl	☐ Rolls over	☐ Says "mama" or "dada"
☐ Pulls to stand	☐ Feeds self, cracker	☐ Scribbles

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals		
☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders		
☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if high risk)	☐ Hct / Hgb
☐ Hep A vaccine (if high risk)	☐ PCV (if not up to date)	☐ Lipid panel (if high risk)
☐ Hep B vaccine	☐ Rotavirus	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD	☐ ECG ☐ COVID 19 test
☐ IPV	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)		
Diet, Nutrition & Exercise		
☐ Introduction to meats & proteins	☐ Fortified Infant Cereals	☐ Mashed table food
☐ Whole grains / iron-rich foods	☐ Finger foods	☐ Start feeder cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Allow to feed self
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Understands "no" but not discipline
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Childcare plan	☐ Poison control phone number	☐ Decreased appetite
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Teething
Next Appointment		
☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

10 to 11 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Pulls self to standing	☐ Walks with help	☐ Drop object in cup
☐ Stands holding on	☐ Plays pat-a-cake	☐ Says "mama" or "dada"
☐ Thumb-finger grasp	☐ Holds cup to drink	☐ Scribbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Name: DOB:

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if high risk)	☐ Hct / Hgb (at 12 months)
☐ Hep A vaccine (if high risk)	☐ PCV (if not up to date)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead (at 12 months)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Introduction to meats & proteins	☐ Weaning breastfeeding	☐ Mashed table food
☐ Whole grains / iron-rich foods	☐ Finger foods	☐ Start feeder cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Allow to feed self
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Looks in mirror
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Caution with strangers	☐ Poison control phone number	☐ Decreased appetite
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: **DOB:**

12 to 15 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 30 min/day) ☐ Active (> 30 min/day)		
Sleep	☐ Regular ☐ Sleep regression ☐ Night time fears		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Walks alone well	☐ Three-word vocabulary	☐ Stacks two-block tower
☐ Stoops and recovers	☐ Plays pat-a-cake	☐ Says "mama" or "dada"
☐ Takes lids off containers	☐ Feeds self	☐ Scribbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP	☐ MMR	☐ Hct / Hgb (at 12 months)
☐ Hep A vaccine	☐ PCV	☐ Lipid panel (if high risk)
☐ Hep B vaccine	☐ Varicella	☐ PPD skin test ☐ QFT
☐ Hib	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Blood Lead (at 12 months)	☐ ECG ☐ COVID 19 test
☐ IPV	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Table food
☐ Whole grains / iron-rich foods	☐ Encourage solids	☐ Using cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing toddler car seat	☐ Feeding self
☐ Routine dental care	☐ Choking hazards	☐ Simple games
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Temper tantrum
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Family play
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Treatment of minor cuts
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

16 to 23 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 30 min/day) ☐ Active (> 30 min/day)	
Sleep	☐ Regular ☐ Sleep regression ☐ Night time fears	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Autism Disorder (18 Months)	☐ ASQ-3, ☐ SWYC, ☐ M-CHAT, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder (18 Months)	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Walks alone fast	☐ 7 to 20-word vocabulary	☐ Stacks three-block tower
☐ Climbs	☐ Names 5 body parts	☐ Says "mama" or "dada"
☐ Kicks a ball	☐ Indicates wants by pointing and pulling	☐ Sips from cup, a little spillage

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open ____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities & grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg length equal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐

Comprehensive Health Assessment

Name: **DOB:**

Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD (PRN through age 4)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Caloric balance
☐ Whole grains / iron-rich foods	☐ Switch to low-fat milk	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Parallel peer play
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

2 Years Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
BMI Value		BMI %	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)	
Sleep Pattern	☐ Regular ☐ Sleep regression ☐ Night time fears	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Autism Disorder	☐ ASQ-3, ☐ SWYC, ☐ M-CHAT, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Runs well, walks up and down	☐ Identifies 5 body parts	☐ Helps around the house
☐ Jumps off the ground with both feet	☐ Plays hide and seek	☐ Stacks three-block tower
☐ Puts 2 or more words together	☐ Kicks and throws a ball	☐ Handles spoon well
☐ 7 to 20-word vocabulary	☐ Name at least 1 color	☐ Puts on simple clothes

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐

Name: DOB:

Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead (at 2 Yrs old)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD (PRN through age 4)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Caloric balance
☐ Whole grains / iron-rich foods	☐ Switch to low-fat milk	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt / Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Parallel peer play
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

30 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
BMI Value		BMI %	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History	
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:
Appetite	☐ Good ☐ Fair ☐ Poor
Elimination	☐ Normal ☐ Abnormal
Has WIC	☐ Yes ☐ No
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)
Sleep Pattern	☐ Regular ☐ Sleep regression ☐ Night time fears
Fluoridated Water Supply	☐ Yes ☐ No
Fluoride Varnish	Date last applied:
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		

Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Balances on each foot, 1 second	☐ Eats independently	☐ Helps in dressing
☐ Uses 3-word sentences	☐ Goes up stairs alternating feet	☐ Draws a single circle
☐ Plays with other children	☐ Knows age, sex, first, & last name	☐ Cuts with scissors

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐

Comprehensive Health Assessment

Name: DOB:

Neurologic	Alert, no gross sensory or motor deficit ☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PPSV	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD (PRN through age 4)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt /Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

3 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			

Name: **DOB:**

Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Balances on each foot, 1 second	☐ Eats independently	☐ Helps in dressing
☐ Uses 3-word sentences	☐ Goes up stairs alternating feet	☐ Draws a single circle
☐ Plays with several children	☐ Knows age, sex, first, & last name	☐ Cuts with scissors

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐

Comprehensive Health Assessment

Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PPSV	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD (PRN through age 4)	☐ Fluoride varnish application
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ School lunch program

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt /Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

4 to 5 Years Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain	
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		

Name: DOB:

Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ Hops on one foot	☐ Counts four pennies	☐ Copies a square
☐ Catches, throws a ball	☐ Knows opposites	☐ Recognizes 3-4 colors
☐ Plays with several children	☐ Knows name, address, & phone number	☐ Holds crayon between finger and thumb

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐

Name: DOB:

Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PCV13 (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis at 5 years
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD (PRN through age 4)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ School lunch program

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: DOB:

6 to 8 Years Old	Actual Age: Date:		
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter:			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ Rides bicycle	☐ Knows right from left	☐ Reads for pleasure
☐ Ties shoelaces	☐ Draws person with 6 parts including clothing	☐ Tells time
☐ Rules and consequences	☐ Independence	☐ Prints first name

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities & grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals		
☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dietician / Nutritionist	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders		
☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A (if not up to date)	☐ Tdap (≥7 YO)	☐ Lipid panel (if high risk)
☐ Hep B (if not up to date)	☐ Varicella (if not up to date)	☐ PPD skin test (if high risk) ☐ QFT (if high risk)
☐ IPV (if not up to date)	☐ Blood Lead (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)		
Diet, Nutrition & Exercise		
☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder
Accident Prevention & Guidance		
☐ Routine dental care	☐ Use of social media	☐ Peer pressure
☐ Lead Poisoning Prevention	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Non-violent conflict resolution	☐ Physical growth
☐ Form caring & supportive relationships with family & peers	☐ Safety helmet ☐ Seat belt	☐ Daily mindful movements
☐ Early Sex education	☐ Limit screen time	☐ Puberty
☐ Smoking/vaping use/exposure	☐ Skin cancer prevention	☐ Bedtime
Next Appointment		
☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

9 to 12 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):		☐ Menorrhagia	
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			

Name: DOB:

Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		
AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ-9A, ☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ PEARLS-12&UP ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ PSC-Y, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ School achievement	☐ Performs chores	☐ Plays / listens to music
☐ School attendance	☐ Exhibit compassion & empathy	☐ Reads for pleasure
☐ Cause and effect are understood	☐ Participates in organized sports / social activities	☐ Demonstrate social & emotional competence (including self-regulation)
☐ Caring & supportive relationships with family & peers	☐ Adheres to predetermined rules	☐ Knows right from left

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐

Comprehensive Health Assessment

Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not given previously)	☐ Varicella (if not up to date)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if not up to date)	☐ Lipid panel (once between 9-11 YO)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (11 to 12 YO)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social media use	☐ Peer pressure
☐ Signs of depression (suicidal ideation)	☐ Avoid risk-taking behavior	☐ Independence
☐ Mental health (emotional support)	☐ Gun safety	☐ Personal development
☐ Form caring & supportive relationships with family & peers	☐ Non-violent conflict resolution	☐ Physical growth
☐ Early Sex education / Safe sex practices	☐ Safety helmet	☐ Mindful of daily movements
☐ Skin cancer prevention	☐ Seat belt	☐ Puberty
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Bedtime

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: **DOB:**

13 to 16 Years Old	Actual Age: Date:		
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):		☐ Menorrhagia	
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			

Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ-9A, ☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ PEARLS-12&UP, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ PSC-Y, ☐ HEADSSS, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ School achievement	☐ Performs chores	☐ Plays / listens to music
☐ School attendance	☐ Learns new skills	☐ Reads
☐ Understands parental limits & consequences for unacceptable behavior	☐ Participates in organized sports / social activities	☐ Uses both hands independently
☐ Ability to get along with peers	☐ Learns from mistakes & failures, tries again	☐ Preoccupation with rapid body changes

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐

Comprehensive Health Assessment

Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest/Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Varicella (if not up to date)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Lipid panel (if high risk)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social Media Use	☐ Goals in life
☐ Signs of depression (suicidal ideation)	☐ Avoid risk-taking behavior	☐ Independence
☐ Mental health (emotional support)	☐ Gun safety	☐ Personal development
☐ Intimate partner violence	☐ Violent behavior	☐ Academic or work plans
☐ Sex education (partner selection)	☐ Safety helmet	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Mindful of daily movements
☐ Skin cancer prevention	☐ Motor vehicle safety (no texting & driving)	☐ Physical growth
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Sexuality

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

17 to 20 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		
Advance Directive Info given/discussed	☐ Yes ☐ Refused Starting at 18 Years Old		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
☐ Taking 0.4 to 0.8 mg of folic acid daily (females of reproductive age)			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):	G P A	☐ Menorrhagia	
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	

Name: **DOB:**

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ-9A, ☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ ACEs, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC-Y, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ Hobbies / work	☐ Plays sports	☐ Plays / listens to music
☐ School achievement / attendance	☐ Acts responsibly for self	☐ Takes on new responsibility
☐ Improved social skills; maintains family relationships	☐ Sets goals & works towards achieving them	☐ Preparation for further education, career, marriage & parenting

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐

Comprehensive Health Assessment

Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Normal	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist/ Ophthalmologist	☐ Dietician/ Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (at least once ≥ 18 YO)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Rx for folic acid 0.4-0.8mg daily (females)	☐ Lipid panel (once between 17-21 YO)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Other:	

Name: **DOB:**

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social media use	☐ Transitioning to adult provider
☐ Routine dental care	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development & goals in life
☐ Intimate partner violence	☐ Violent behavior	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt / Safety Helmet	☐ Testicular self-exam
☐ Skin cancer prevention	☐ Motor vehicle safety (no texting & driving)	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Mental health (emotional support)	☐ Prenatal care / encourage breastfeeding

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

21 to 39 Years: Female	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
LMP:	G P A	☐ Menorrhagia	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last PAP	Date:	☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Hip fracture	
☐ High cholesterol	☐ Cancer	☐ Other:	

Name: DOB:

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ HARK, ☐ HITS, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear, Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐

Comprehensive Health Assessment

Name: **DOB:**

Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Varicella (if not up to date)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ HPV vaccine (if not up to date)	☐ Hep C Antibody test	☐ Low to moderate dose statin
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Pneumococcal (if high risk)	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose / HbA1C
☐ Tdap	☐ PAP	☐ Bone Density Test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Routine dental care	☐ Gun safety	☐ Personal development
☐ Signs of depression (suicidal ideation)	☐ Violent behavior	☐ Goals in life
☐ Intimate partner violence	☐ Mindful of daily movements	☐ Family support, social interaction & communication
☐ Diabetes management	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Skin cancer prevention	☐ Safety helmet	☐ Breastfeeding
☐ Smoking/vaping use/exposure	☐ ASA use	☐ Sex education (partner selection)

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: **DOB:**

21 to 39 Years: Male	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info given/discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Other:	

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐

Comprehensive Health Assessment

Name: **DOB:**

Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Varicella (if not up to date)	☐ Hct / Hgb ☐ Lipid panel
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if at risk)	☐ Low to moderate dose statin
☐ Influenza vaccine	☐ Hep C Antibody test	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ Chlamydia ☐ Gonorrhea	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ ECG ☐ COVID 19 test
☐ Pneumococcal (if high risk)	☐ Syphilis ☐ Trichomonas	☐ Fasting plasma glucose ☐ HbA1C
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes Management	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Family support, social interaction & communication
☐ Skin cancer prevention	☐ Safety helmet	☐ Testicular self-exam
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Sex education (partner selection

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem/Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: DOB:

40 to 49 Years: Female	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:	

Intake		Vital Signs	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List
☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)

Limitations (physical or mental):

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional	
LMP:	G P A	☐ Menorrhagia ☐ Menopause
Hysterectomy	☐ Partial ☐ Total	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last PAP	Date:	☐ WNL
Last Mammogram	Date:	☐ WNL
Last Colonoscopy	Date:	☐ WNL
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:
Family History	☐ None	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Hip fracture
☐ High cholesterol	☐ Cancer	☐ Other:

Immunization History / Date		
☐ COVID #1: ☐ COVID #2:	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID Booster(s):	☐ Influenza:	☐ Varicella:
☐ Hepatitis B:	☐ MMR:	☐ Zoster:
	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Breast Cancer	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ HARK, ☐ HITS, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐

Comprehensive Health Assessment

Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ Pneumococcal (if high risk)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Varicella (if not up to date)	☐ gFOBT or Fit ☐ Colonoscopy	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster (if high risk)	☐ PAP ☐ Mammogram	☐ Bone Density Test ☐ TSH
☐ Other:		

Name: **DOB:**

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work activities
☐ Intimate partner violence	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Sex education (partner selection)	☐ Seat belt	☐ Self-breast exam
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Safety helmet	☐ Aging process
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Perimenopause education

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment

Name: DOB:

40 to 49 Years: Male	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider		Last visit date:	
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last Colonoscopy	Date:	☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Other:	
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:	
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:	
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:	
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:	

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ/uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal vaccine	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ HbA1C	☐ Fasting plasma glucose
☐ Zoster	☐ PSA	☐ Oral glucose tolerance test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Testicular self-exam
☐ Smoking/vaping use/exposure	☐ Safety helmet	☐ Routine dental care

Tobacco Cessation

Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: **DOB:**

50+ Years: Female	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
LMP:	G P A	☐ Menorrhagia ☐ Menopause	
Hysterectomy	☐ Partial ☐ Total		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last PAP	Date:	☐ WNL	
Last Mammogram	Date:	☐ WNL	
Last Colonoscopy	Date:	☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Hip fracture	
☐ High cholesterol	☐ Cancer	☐ Other:	

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Breast Cancer	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐

Comprehensive Health Assessment

Name: **DOB:**

Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Varicella (if not up to date)	☐ gFOBT or Fit ☐ Colonoscopy	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster	☐ PAP ☐ Mammogram ☐ Bone Density Test	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Safety helmet	☐ Aging process
☐ Routine dental care	☐ ASA use	☐ Perimenopause education

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: DOB:

50+ Years: Male	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last Colonoscopy	Date: ☐ WNL		
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Other:	
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:	
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:	
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:	
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:	

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Abdominal Aortic Aneurism	☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ /uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐

Comprehensive Health Assessment

Name: **DOB:**

Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Zoster	☐ AAA Ultrasound (65 to 75 who have ever smoked >100 cigarettes in lifetime)	☐ HbA1C ☐ PSA
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Diabetes management	☐ Violent behavior	☐ Goals in life
☐ Sex education (partner selection)	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Smoking/vaping use/exposure	☐ Seat belt	☐ Testicular self-exam
☐ Routine dental care	☐ Safety helmet	☐ Aging process

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Primary Care Provider-Medical Record Review Tool

Health Plan: _____

Site ID: _____ **Site NPI:** _____

Address: _____

City and Zip Code: _____

Phone: _____ **Fax:** _____

No. of Physicians: _____

Review Date: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Collaborating MCP(s): 1. _____

2. _____

Contact person/title: _____

Provider Name	Credentials (MD, NP, PA, CNM, LM)	NPI

Electronic Medical Record (EMR): Yes (#)___ No(#) __

Medical Record Review: Onsite _____ Remote Access _____

Paper/Hard Copy Medical Records: Yes ___ No___ Shared Medical Records: Yes_____ No_____

Number of Records Reviewed: _____

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic Type
_____Initial Full Scope _____Monitoring _____Periodic Full Scope _____Follow-up _____Focused Review _____Technical Assistance ____Other_____ (type)	_____ AAAHC _____ JC _____ CHDP _____ NCQA _____ CPSP _____ None _____ PCMH _____ Other _____	_____ Family Practice _____ Internal Medicine _____ General Practice _____ Pediatrics _____ OB/GYN as PCP_____ _____ Certified Nurse Midwife _____ Licensed Midwife	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Solo _____ Group _____ Staff/Teaching _____ Other (Type)_____

Medical Record Scores

Note: Score "R" for Documented Member Refusal (due to member non-compliance with evidence showing provider outreach, referrals, lab orders, awaiting results.)
When scoring for OB/CPSP Preventive, score the Adult or Pediatric Preventive criteria for the same record.

	Points possible	Yes Pts. Given	R Pts. Given	No's	N/A's	Section Score %
I. Format	**(8) x 10 = 80**					
II. Documentation	**(8) x 10 = 80**					
III. Coordination of Care	**(8) x 10 = 80**					
IV. Pediatric Preventive	**(34) x # of records**					
V. Adult Preventive	**(30) x # of records**					
VI. OB/CPSP Preventive	**(59) x # of records**					
	Points Possible	**Yes Pts. Given**	**R Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

Scoring is based on 10 medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ ÷ _____ = _____ x 100 = _____%

Points Given | Total/ Adjusted Pts. Poss. | Decimal Score | Compliance Rate

Note:
Since Preventive Criteria have different points possible per type (Ped-34, Adult-30, OB/CPSP-59, the total points possible will differ from site to site, depending on the number of *types* of records that are selected. The "No's" column *may* be used to help double-check math. The far-right Section Score % column may be used to determine if section is <80%.

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

____ **Exempted Pass: 90% or above:**
(Total score is ≥ 90% ***and*** all section scores are 80% or above)

____ **Conditional Pass: 80-89%:**
(Total MRR is 80-89% ***OR*** *Any* section(s) score is < 80%)

____ **Fail: 79% and Below**

____ CAP Required

____ Other follow-up

Next Review Due: _____

Medical Records Reference:

Medical Record	CIN	Age Year/Month	Gender	Member's Health Plan Code or Name	Member's Enrollment Date in MCP or Effective Date PCP Assigned to Member*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

* Whichever is more recent

I. Format Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Individual Medical Record is established for each member.												
A. Member identification is on each page.	1											
B. Individual personal biographical information is documented.	1											
C. Emergency "contact" is identified.	1											
D. Medical records are maintained and organized.	1											
E. Member's assigned and/or rendering primary care physician (PCP) is identified.	1											
F. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.	1											
G. Person or entity providing medical interpretation is identified.	1											
H. Signed Copy of the Notice of Privacy.	1											
Comments:	Yes											
	R											
	No											
	NA											

II. Documentation Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Allergies are prominently noted.	1											
B. Chronic problems and/or significant conditions are listed.	1											
C. Current *continuous* medications are listed.	1											
D. Appropriate consents are present:												
1) Release of Medical Records	1											
2) Informed Consent for invasive procedures	1											
E. Advance Health Care Directive Information is offered.	1											
F. All entries are signed, dated, and legible.	1											
G. Errors are corrected according to legal medical documentation standards.	1											
Comments:	Yes											
	R											
	No											
	N/A											

III. Coordination of Care Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. History of present illness or reason for visit is documented.	**1**											
B. Working diagnoses are consistent with findings.	**1**											
C. Treatment plans are consistent with diagnoses.	**1**											
D. Instruction for follow-up care is documented.	**1**											
E. Unresolved/continuing problems are addressed in subsequent visit(s).	**1**											
F. There is evidence of practitioner *review* of specialty/consult/referral reports and diagnostic test results.	**1**											
G. There is evidence of *follow-up* of specialty consult/referrals made, and results/reports of diagnostic tests, when appropriate.	**1**											
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	**1**											
Comments:	**Yes**											
	R											
	No											
	N/A											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment												
1) Comprehensive History and Physical	**1**											
2) Member Risk Assessment	**1**											
B. Subsequent Comprehensive Health Assessment												
1) Comprehensive History and Physical exam completed at age-appropriate frequency	**1**											
2) Subsequent Risk Assessment	**1**											
C. Well-child visit												
1) Alcohol Use Disorder Screening and Behavioral Counseling	**1**											
2) Anemia Screening	**1**											
3) Anthropometric Measurements	**1**											
4) Anticipatory Guidance	**1**											
5) Autism Spectrum Disorder Screening	**1**											
6) Blood Lead Screening	**1**											
7) Blood Pressure Screening	**1**											
8) Dental/Oral Health Assessment	**1**											
a) Fluoride Supplementation	**1**											
b) Fluoride Varnish	**1**											
9) Depression Screening	**1**											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
a) Suicide-Risk Screening	**1**											
b) Maternal Depression Screening	**1**											
10) Developmental Disorder Screening	**1**											
11) Developmental Surveillance	**1**											
12) Drug Use Disorder Screening and Behavioral Counseling	**1**											
13) Dyslipidemia Screening	**1**											
14) Hearing Screening	**1**											
15) Hepatitis B Virus Infection Screening	**1**											
16) Hepatitis C Virus Infection Screening	**1**											
17) Human Immunodeficiency Virus (HIV) Infection Screening	**1**											
18) Psychosocial/Behavioral Assessment	**1**											
19) Sexually Transmitted Infections (STIs) Screening and Counseling	**1**											
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening	**1**											
21) Tobacco Use Screening, Prevention, and Cessation Services	**1**											
22) Tuberculosis Screening	**1**											
23) Vision Screening	**1**											
D. Childhood Immunizations												
1) Given according to Advisory Committee on Immunization Practices (ACIP) guidelines	**1**											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
2) Vaccine administration documentation	**1**											
3) Vaccine Information Statement (VIS) documentation	**1**											
Comments:	**Yes**											
	R											
	No											
	N/A											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment												
1) Comprehensive History and Physical	**1**											
2) Member Risk Assessment	**1**											
B. Periodic Health Evaluation according to most recent United States Preventive Services Taskforce (USPSTF) Guidelines												
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	**1**											
2) **Subsequent** Risk Assessment	**1**											
C. Adult Preventive Care Screenings												
1) Abdominal Aneurysm Screening	**1**											
2) Alcohol Use Disorder Screening and Behavioral Counseling	**1**											
3) Breast Cancer Screening	**1**											
4) Cervical Cancer Screening	**1**											
5) Colorectal Cancer Screening	**1**											
6) Depression Screening	**1**											
7) Diabetic Screening	**1**											
a) Comprehensive Diabetic Care	**1**											
8) Drug Use Disorder Screening and Behavioral Counseling	**1**											
9) Dyslipidemia Screening	**1**											
10) Folic Acid Supplementation	**1**											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
11) Hepatitis B Virus Screening	**1**											
12) Hepatitis C Virus Screening	**1**											
13) High Blood Pressure Screening	**1**											
14) HIV Screening	**1**											
15) Intimate Partner Violence Screening for Women of Reproductive Age	**1**											
16) Lung Cancer Screening	**1**											
17) Obesity Screening and Counseling	**1**											
18) Osteoporosis Screening	**1**											
19) Sexually Transmitted Infection (STI) Screening and Counseling	**1**											
20) Skin Cancer Behavioral Counseling	**1**											
21) Tobacco Use Screening, Counseling, and Intervention	**1**											
22) Tuberculosis Screening	**1**											
D. Adult Immunizations												
1) Given according to ACIP guidelines	**1**											
2) Vaccine administration documentation	**1**											
3) Vaccine Information Statement (VIS) documentation	**1**											
Comments:	**Yes**											
	R											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point
Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)
Criteria not met: 0 points
Criteria not applicable: N/A

	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
	No											
	N/A											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Comprehensive Prenatal Assessment (ICA)												
1) Initial prenatal visit	**1**											
2) Obstetrical and Medical History	**1**											
3) Physical Exam	**1**											
4) Dental Assessment	**1**											
5) Healthy Weight Gain and Behavioral Counseling	**1**											
6) Lab tests												
a) Bacteriuria Screening	**1**											
b) Rh Incompatibility Screening	**1**											
c) Diabetes Screening	**1**											
d) Hepatitis B Virus Screening	**1**											
e) Hepatitis C Virus Screening	**1**											
f) Chlamydia Infection Screening	**1**											
g) Syphilis Infection Screening	**1**											
h) Gonorrhea Infection Screening	**1**											
i) Human Immunodeficiency Virus (HIV) Screening	**1**											
B. First Trimester Comprehensive Assessment												
1) Individualized Care Plan (ICP)	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder	**1**											
4) Breast Feeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
6) Intimate Partner Violence Screening	**1**											
C. Second Trimester Comprehensive assessment												
1) ICP	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breast Feeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
a) Low Dose Aspirin	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
6) Intimate Partner Violence Screening	**1**											
7) Diabetes Screening	**1**											
D. Third Trimester Comprehensive assessment												
1) ICP Update and Follow Up	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breastfeeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
a) Low Dose Aspirin	**1**											
6) Intimate Partner Violence Screening	**1**											
7) Diabetic Screening	**1**											
8) Screening for Strep B	**1**											
9) Screening for Syphilis	**1**											
10) Tdap Immunization	**1**											
E. Prenatal care visit periodicity according to most recent American College of Obstetricians and Gynecologists (ACOG) standards	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
F. Influenza Vaccine	**1**											
G. COVID Vaccine	**1**											
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and assessment of Infant Feeding Status	**1**											
I. HIV-related services *offered*	**1**											
J. AFP/Genetic Screening offered	**1**											
K. Family Planning Evaluation	**1**											
L. Comprehensive Postpartum Assessment												
1) ICP	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening/Postpartum Depression screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breastfeeding and other Health Education Assessment	**1**											
5) Comprehensive Physical Exam	**1**											
Comments:	**Yes**											
	R											
	No											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
	N/A											

Primary Care Provider-Medical Record Review Standards

Purpose: The Medical Record Review (MRR) Standards provide instructions, rules, regulations, parameters, and indicators for conducting medical record reviews using the MRR Tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Medical Record Selection: Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are reviewed for each primary care physician (PCP) site. For sites with *only* adult or *only* pediatric patient members, all ten records reviewed will be in *only* one preventive care criteria. For sites with adult and pediatric members, five (5) adults and five (5) pediatrics preventive criteria will be reviewed. For PCP sites where the OB-GYN providers both specialty and preventive services, based on the age of the patient, reviewer must review either adult or pediatric preventive criteria as well as OB Comprehensive Perinatal Services Program (CPSP) criteria.

PCP sites that document patient care performed by multiple PCPs in the same medical record are considered "shared." The MCP must consider shared medical records as those that are not identifiable as "separate" records belonging to any specific PCP. Scores calculated on shared medical records apply only to PCPs sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, 20 records for 4-6 PCPs, and 30 records for 7 or more PCPs based on specialty and/or population served.

Example for determining the number of medical records to review:

> A site that has three (3) providers, two (2) providers see only adults and share records, and one (1) only see pediatrics and does not share records, 10 medical records on the two providers who share medical records and 10 medical records on the provider who does not share records will be conducted and scored separately. A total of 20 medical records shall be reviewed for this site. Two (2) scores will be reported for this site.

Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife is labeled "**RN/NP/MD/PA/CNM/LM".**

Reviewers must ensure confidentiality on Protected Health Information (PHI) or Personally Identifiable Information (PII).

Scoring: The review score is based on a review standard of 10 records per individual primary care provider (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for review criteria determinations. Compliance levels are:
An Exempted Pass is 90%.
Conditional Pass is 80-89%.
Failure is 79% and below.

The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

Directions: Score one point if criterion is met. . Score ”R” for documented member refusal, Provider outreach, referral or member non-compliance*. Score zero points if criterion is not met. Not Applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed and must be explained in the comment section. Do not score partial points for any criterion.

When to use “Documented member refusal”
1. When there is documentation in the record that the site/provider addressed the preventive service and ordered/offered/referred, there was adequate follow up, the member was noncompliant/no-show/nonresponsive and/or the member refused.i.e mammogram ordered, referral given and follow up during the next visit to remind member to get mammogram or ii.mammogram ordered but member declined

2. When there is documentation of the site requesting information, signature/completion of a form or questionnaire and “member refused” or evidence of request/offering is documented. i.e. Requested emergency contact information and member didn’t provide it, “refusal” is documented in the record; Requested completion of privacy notice and member refused to sign, “refusal” is documented in the record

When to use “N/A”
1. When the member is out of the age range or not the same gender for preventive services ie. Blood lead for 8 year old or mammogram for a male

2. When the preventive service is not indicated due to their medical history, 45 year old female with total abdominal hysterectomy or 50 year old male with total colectomyi.e. reviewers may add medical reason in the comment:

If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP.
If 20 records are reviewed, divide total points given by the “adjusted” total points possible.
If 30 records are reviewed, divide total points given by the “adjusted” total points possible.
Multiply by 100 to calculate percentage rate.

Reviewers have the option to request additional records to review but must calculate scores accordingly.

Scoring Example:

Step 1: Add the points given in each section.
Step 2: Add the points given (Yes + R) for all six sections.
(Format points given)
(Documentation points given)
(Coordination of Care points given)
(Pediatric Preventive points given)
(Adult Preventive points given)
+ (OB/CPSP Preventive points given)
= (Total points given)

Step 3: Subtract the “N/A” points from total points possible.
(Total points possible)
– (N/A points)
= (“Adjusted” total points possible)

Step 4: Divide total points given by the “adjusted” points possible, then multiply by 100 to calculate percentage rate.

Total points given	Example:	267
“Adjusted” total points possible		305 = 0.875 X 100 = 88%

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

I. Format Criteria	
An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit.[1] "Family charts" are not acceptable.
A. Member identification is on each Page.	• Member identification includes first and last name, and a unique identifier established for use on clinical site. • Electronically maintained records and printed records from electronic systems must contain member identification.
B. Individual personal biographical information is documented.	Personal biographical information includes: o Date of birth o Current address o Home/work phone numbers o Name of parent(s)/legal guardian if member is a minor If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
C. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include: o Spouse, relative or friend, and must include at least one of the following: o Home, work, pager, cellular, or message phone number. • If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. • Adults and emancipated minors may list anyone of their choosing. • If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner.

[1] See the U.S. Department of Health and Human Services Summary of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

I. Format Criteria	
	• Next of kin category is not considered as an emergency contact. The member's emergency contact may be different from the next of kin.
D. Medical records are maintained and organized	• Contents and format of printed and/or electronic records within the practice site are uniformly organized, securely fastened, attached or bound to prevent medical record loss. • Hard copy printed documents shall belong to the medical record established for each member (e.g., reusing the blank side of printed documents from another member is not acceptable and should be scored a "0"). • Medical Record information should be readily available.
E. Member's assigned and/or rendering PCP is identified.	• The assigned and/or rendering PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. • Various methods can be used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc. • If there is only one PCP/Practitioner onsite and is not identified, reviewer may score "N/A".
F. Primary language and linguistic service needs of non-or of limited-English proficiency (LEP) or hearing/speech-impaired persons are prominently noted.	• The primary language is prominently documented at least once in the medical record. • Language documentation is not necessary, score "N/A," if English is the primary language. However, if "English" is documented, the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services.[2]

[2] See All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language assistance Services, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

I. Format Criteria	
G. Person or entity providing medical interpretation is identified.	• Requests for language and/or interpretation services by a non-or limited-English proficient member are documented. • Member refusal of interpreter services may be documented at least once and be accepted throughout the member's care unless otherwise specified. • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member and documented in the member's chart. • Minors (under 18 years old) accompanying member shall not be used as an interpreter. • The Affordable Care Act (ACA) 2010 section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • Sign language interpreter services may be utilized for medically necessary health care services and related services such as obtaining medical history and health assessments, obtaining informed consents and permission for treatments, medical procedures, providing instructions regarding medications, explaining diagnoses, treatment and prognoses of an illness, providing mental health assessment, therapy or counseling. Various documents can be accepted to document linguistic service needs such as intake form, demographic form, Electronic Medical Record (EMR) fields, consent forms, etc. **Note:** See Commonly Asked Questions and Answers Regarding LEP Individuals, available at: https://www.lep.gov/faq/faqs-rights-lep-individuals/commonly-asked-questions-and-answers-regarding-limited-english. See also Title 22 California Code

I. Format Criteria	
	of Regulations (CCR) Section 51309.5. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
H. Signed Copy of the Notice of Privacy	The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The right to inspect, review and receive a copy of the medical records is covered by the Privacy Rule.[3]

[3] See the U.S. Department of Health and Human Services Understanding of Some of HIPAA's Permitted Uses and Disclosures, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html.

Rationale: Well-documented records facilitate communication and coordination and promote efficiency and effectiveness of treatment.

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II. Documentation Criteria	
A. Allergies are prominently noted.	• Allergies and adverse reactions are listed in a prominent, easily identified, and consistent location in the medical record. • If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.[4]
B. Chronic problems and/or significant conditions are listed.	• Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. • All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.[5]
C. Current continuous medications are listed.	• Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. • List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. • Discontinued medications are noted on the medication list or in progress notes.[6]
D. Appropriate Consents are present.	1) Consent must be obtained prior to release of patient information.[7] 2) Adults, parents/legal guardians of a minor or emancipated minor may sign consent forms for operative and invasive procedures.[8] Persons under 18 years

[4] 22 CCR 70527 and 28 CCR 1300.80
[5] 22 CCR 70527 and 28 CCR 1300.80
[6] 22 CCR 70527 and 28 CCR 1300.80
[7] 22 CCR 73524, 22 CCR 51009, and Title 45, Code of Federal Regulations Section 164.524. The CFR is searchable at: https://www.ecfr.gov.
[8] An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific

II. Documentation Criteria	
	of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.[9] **Note:** Human sterilization requires the Department of Health Care Services (DHCS) Consent Form PM 330 if services are performed at the site.
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; emancipated minors).	• Adult medical records include documentation of whether the member has been *offered* information or has executed an Advance Health Care Directive.[10] The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.[11] **Note:** Advance Health Care Directive Information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.
F. All entries are signed, dated and legible.	**Signature** includes: • First initial, last name, and title of health care personnel providing care, including Medical Assistants. • Initials and titles may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). • Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. **Dated entries** include: • Month/day/year. • Entries are in reasonably consecutive order by date.

tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. (Ref: National Institutes of Health; American Cancer Society)

[9] California Law is searchable at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml.

[10] See Probate Code, Section 4701, 42 CFR 422.128, 42 CFR 489.100, and APL 05-010.

[11] See AB 3000, Chapter 266, Statutes of 2008, available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=200720080AB3000.

II. Documentation Criteria	
	• Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. • Omissions are charted as a new entry. • Late entries are explained in the medical record, signed and dated. **Legibility** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures, and initials are entered in ink that can be readily/clearly copied. Only standard abbreviations are used. All medical record documentation must be in English.[12] **Note:** • In EMR, methods to document signatures (and/or authenticate initials) will vary and must be individually evaluated. • Signature page may be in the member's medical record or available elsewhere onsite and all previous and current employees who document in medical records need to be included on the signature page. • Reviewers should assess the log-in process and may need to request printouts of entries. See the Centers for Medicare and Medicaid Services' (CMS) Guidance on Medicaid Documentation for Medical Office Staff, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf.
G. Errors are corrected according to legal medical documentation standards.	• The person that makes the documentation error corrects the error. Example correction methods: • Single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. • Single line and initial.

[12] ACA Section 1557

II. Documentation Criteria	
	• The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. **Note:** Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.

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III. Coordination Criteria	
A. History of present illness or reason for visit is documented.	Each focused visit (e.g., primary care, follow-up ER/urgent care, hospital discharge, etc.) includes a documented history of present illness or reason for visit.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of documented information but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
C. Treatment plans are consistent with diagnoses.	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of treatment rendered or care plan but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
D. Instruction for follow-up care is documented.	• Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. • Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed). • Every visit with the provider shall have follow-up instructions.
E. Unresolved continuing problems are addressed in subsequent visit(s).	• Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made.

III. Coordination Criteria	
	• Each problem need not be addressed at every visit as long as the provider documents a reason for deferring the unresolved problem(s) for subsequent visits. • Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner review of specialty/consult/referral reports and diagnostic test results.	• There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. • Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. **Note:** Electronically maintained medical reports must also show evidence of practitioner review and may differ from site to site. Evidence of practitioner review on any page of the report(s) or diagnostic result(s) that have multiple pages is acceptable.
G. There is evidence of follow-up of specialty/consult/referrals made, and results/reports of diagnostic tests, when appropriate.	Documentation includes: • Consultation reports and diagnostic test results for ordered requests. • Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. • Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions. If diagnostic appointments or referrals are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements. **Note:**

III. Coordination Criteria	
	• Abnormal test results/diagnostic reports without follow-up documentation for specific pediatric or adult preventive screening criteria/diagnostic tests will be scored under this criterion. • If results are normal and there are no missing reports, then the reviewer may score "N/A" for this criterion. • If specific pediatric or adult preventive screenings are ordered and there is no documentation of normal results and/or follow-up, the reviewer shall score this under the appropriate preventive services criteria. • If the provider/staff does not follow up or attempt outreach to the member regarding a missed specialty referral, give a zero "0" score. Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.
H. **Missed primary care appointments and outreach efforts/follow-up contacts are documented.**	Documentation includes: • Incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. • Attempts to contact the member or parent/guardian and the results of follow-up actions. Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record. **Note:** Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.

Rationale: Pediatric preventive services are provided to members under 21 years of age in accordance with current American Academy of Pediatrics (AAP) bright future and US Preventive Task Force (USPSTF) recommendations. See the DHCS Boilerplate contract, available at: https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf.

RN/NP/MD/PA/CNM/LM

IV. Pediatric Preventive Criteria	
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. The IHA include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. A complete IHA enables the PCP to assess current acute, chronic, and preventive needs and to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version
1) Comprehensive History and Physical	**New members** The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: ○ History of present illness ○ Past medical history ○ Social history ○ Review of Organ Systems (ROS) If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.

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2) Member Risk Assessment	**New members** Initial Member Risk Assessments related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one (1) of the following risk assessment domains within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date meets the standard: • Health Risk Assessment: MCPs will not be required to retain the use of their existing HRA tools. If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers • SDOH: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH includes housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of the following examples of SDOH screening tools meet the standard: o Social Needs Screening Tool • Adverse Childhood Experiences (ACEs) (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools that meet the standards are as follows: o The Pediatric ACEs and Related Life-Events Screener (PEARLS) is used to screen children and adolescents ages 0-19 for ACEs. o The ACE Questionnaire for Adults is used to screen adults 18 years and older for ACEs. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf https://www.cdc.gov/about/sdoh/index.html

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	https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-017.pdf https://www.cdc.gov/violenceprevention/aces/fastfact.html
B. Subsequent Comprehensive Health Assessment	**Existing/Current Members** The examination must be comprehensive, focus on specific assessments that are appropriate for the child's or adolescent's age, developmental phase, and needs building on the history gathered earlier. The physical examination provides opportunities to identify silent or subtle illnesses or conditions and time for the health care professional to educate children and their parents about the body and its growth and development. See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	• Health assessments containing age-appropriate requirements are provided per the most recent AAP periodicity schedule. • Assessments and identified problems are documented in the progress notes. • Follow-up care or referral is provided for identified physical health problems as appropriate. **Note:** The AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention Program (CHDP) periodicity examination schedule. The AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.[13]
2) Subsequent Risk Assessment	• Subsequent Member Risk Assessments shall be completed annually or more frequently if any significant changes in health status are identified. An assessment of at least one (1) of the above risk assessment domains (HRA, SDOH and ACEs) meets the standard. • https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

[13] See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

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C. Well-child Visit	The Bright Futures/AAP developed a set of comprehensive health guidelines for well-childcare, known as the "periodicity schedule."[14] It is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. **Screening** pertains to an assessment of the eligible population for presence of risk factors. • If the patient is positive for risk factors, (e.g., obesity, menstrual status, etc.) age and gender parameters of the criterion the provider shall offer and document appropriate follow-up intervention(s) (e.g., diagnostic testing, counseling, referral to specialist, documentation of patient refusal, etc.). • Providers who fail to document the presence or absence of risk factors shall receive zero points since the patient's risk status could not be determined and the preventive care criterion was not addressed. • Evidence of risk assessments and screenings for other preventive care criteria may be found in the progress notes, comprehensive history forms, or elsewhere in the medical record. **Note:** The AAP does not approve nor endorse any specific tool for screening purposes. Examples of screening tools are available at: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/?page=1 https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
1) Alcohol Use Disorder Screening and Behavioral Counseling	Per AAP recommendations, alcohol use disorder screening and behavioral counseling should begin at 11 years of age. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Brief Assessment and Screening

[14] The Bright Futures/AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

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	When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use is present. Validated assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy alcohol use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. The AAP/Bright Futures periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, refer to APL 21-014 or any superseding APL. Please refer to the link below to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx
2) **Anemia Screening**	Per AAP, perform risk assessment or screening at 4, 15, 18, 24, and 30 months, 3 years old, and then annually thereafter. Test serum hemoglobin at 12 months old. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Acceptable evidence of anemia screening: evaluate patient's diet, nutrition supplement intake, menstrual status, medical history for chronic conditions, etc.

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	Chronic conditions to assess that are associated with anemia: ○ A diet consistently low in iron, vitamin B-12 and folate ○ Heavy Menstruation. See link for signs of heavy menstrual bleeding: https://www.acog.org/womens-health/faqs/heavy-menstrual-bleeding ○ Pregnancy ○ Slow, chronic blood loss from an ulcer; Crohn's disease, celiac disease, cancer, kidney failure, diabetes, etc. The Bright Futures/AAP periodicity schedule is available at: https://www.aap.org/en-us/documents/periodicity_schedule.pdf. See the National Institutes of Health information on Anemia, available at: https://www.nhlbi.nih.gov/health-topics/anemia#:~:text=Some%20people%20are%20at%20a,such%20as%20chemotherapy%20for%20cancer. See the Center for Disease Control and Prevention's (CDC) information on heavy menstrual bleeding, available at: https://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html.
3) **Anthropometric measurements**	For each well exam: • Infants up to 24 months old: assess for length/height and head circumference (HC). Measurements are plotted in a World Health Organization (WHO) growth chart. • 2-21 years old: assess for height, weight, and body mass index (BMI) measurements are plotted in a CDC growth chart. • Provider should measure and track BMI to identify patient at risk for being overweight, obese, or underweight. Patients identified as overweight and/or obese are provided counseling for nutrition to promote healthy eating habits and regular physical activity. For additional information on anthropometric measurements, refer to the following link: https://www.dhcs.ca.gov/services/chdp/Documents/HAG/4AnthropometricMeasure.pdf

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	Note: Site is deficient if anthropometric measurements are not plotted on the appropriate growth chart.[15]
4) Anticipatory Guidance	• Must be documented at each well child visit. • Is given by the health care provider to assist parents or guardians in the understanding of the expected growth and development of their children. • Specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_PreventiveServices_Tipsheet.pdf#search=document%20anticipatory%20document
5) Autism Spectrum Disorder (ASD) Screening	ASD screening must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures". If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). ASD screening tools examples: ○ Ages and Stages Questionnaires (ASQ) ○ Communication and Symbolic Behavior Scales (CSBS) ○ Parents' Evaluation of Developmental Status (PEDS) ○ Modified Checklist for Autism in Toddlers (MCHAT) ○ Screening Tool for Autism in Toddlers and Young Children (STAT) ○ Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context) Refer to APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, and APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APLs for more information on ASD. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder"

[15] CDC growth charts are available at: https://www.cdc.gov/growthcharts/.

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	Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449. See the AAP publication regarding Identification, Evaluation, and Management of Children with ASD, available at: https://pediatrics.aappublications.org/content/145/1/e20193447. See the Tufts Children's Hospital Survey of Well-being of Young Children, available at: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview. See the AAP Screening Tools, available at: https://screeningtime.org/star-center/#/screening-tools
6) Blood Lead Screening	• Children receiving health services through publicly funded programs must receive anticipatory guidance on lead poisoning prevention at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screen reveals elevated Blood Lead Levels. Medi-Cal managed care health plans (MCPs) must ensure that the providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes 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. Childhood Lead Poisoning Prevention Branch (CLPPB) anticipatory guidance includes information about other common sources of lead exposure for children.[16]

[16] The CLPPB Guidance is available at: https://vchca.org/images/public_health/VCCHDP/Chapter6.pdf.

<table>
<tr><th colspan="2">IV. Pediatric Preventive Criteria</th></tr>
<tr><td></td><td>Spanish version:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(S).pdf.

Order or perform blood lead screening tests on all child members in accordance with the following:
• At 12 months and at 24 months of age.
• When the network provider performing a PHA becomes aware that a child 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.
• When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
• At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
• If requested by the parent or guardian.

Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.[17]

<u>Note</u>: Network providers are not required to perform a blood lead screening test if either of the following applies:
• In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member’s health than the risk of lead poisoning.
• If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Evidence of provider compliance of blood lead screening test if not performed:
• The provider must document the reason(s) for not performing the blood lead screening test in the child member’s medical record.
• In cases where consent has been withheld, the provider must obtain a signed statement of voluntary refusal by parent or guardian.</td></tr>
</table>

[17] The CDC Recommendations are available at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html.

If the provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent, refuses or declines to sign it, or is unable to sign it (e.g., when services are provided via telehealth modality), it is acceptable for the provider to document the refusal.

See APL 20-016, Blood Lead Screening of Young Children, or any superseding APL for more information.

Please refer to California Department of Public Health (CDPH) CLPPB and the CDC for recommended actions based on BLL levels:

- Information on how to report blood lead screening test results to CLPPB can be found at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx.
- Health care providers using a point-of-care device are considered laboratories and must report.[18]
- See the CDC Guidance on Childhood Lead Poisoning Prevention, available at: https://www.cdc.gov/nceh/lead.
- See the California Management Guidelines on Childhood Lead Poisoning for Health Care Providers publication, available at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx
- For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity”, available at: https://publications.aap.org/pediatrics/article-pdf/138/1/e20161493/929122/peds_20161493.pdf, and “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention”, available at: https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf

[18] See Health and Safety Code Section 124130. State law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.

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7) Blood Pressure Screening	• Per AAP, blood pressure screening starts at 3 years old. • In infants and children with specific risk conditions, blood pressure measurements should be performed at visits before age 3 years. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals elevated blood pressure. In persons aged 3-18 years, the prevalence of hypertension is 3.6 %. Evidence suggests that elevated blood pressure in childhood increases the risk for adult Hypertension and Metabolic Syndrome. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents", available at: http://pediatrics.aappublications.org/content/140/3/e20171904 See the Bright Futures Medical Screening Reference Table, available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_InfancyVisits_BF4.pdf. See the AAP guidance on Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents, available at: https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and
8) Dental/Oral Health Assessment	• Per DHCS contracts, the provider is responsible for ensuring that dental screening/oral health assessment for all members are included as part of the IHA.[19] • Inspection of the mouth, teeth, and gums is performed at every health assessment visit and refer to a dentist if a dental problem is detected or suspected. • Per AAP, referral to a dental home begins at 12 months. If patients do not have an established dental home after 12 months, continue performing an oral health risk assessment and refer to a dental home.[20]

[19] For additional information, see the MCP Contract, Exhibit A, Attachment 11, Provision 15.
[20] See the AAP Oral Health Practice Tools, available at: https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/.

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	• Documentation of "HEENT" is acceptable. See the Caries-risk Assessment and Management for Infants, Children, and Adolescents, available at: https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf See the AAP guidance on Fluoride Use in Caries Prevention in the Primary Care Setting, available at: http://pediatrics.aappublications.org/content/134/3/626.
a. Fluoride Supplementation	• The AAP and USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. • Parents or legal guardian should be encouraged to check with local water utility agency if water has fluoride. • If local water does not contain fluoride, provider may recommend the purchase of fluoridated water or give prescription for fluoride drops or tablets. • Per AAP, fluoride supplementation for all children ages 6 months until their fifth-year birthday (age range according to the most current AAP periodicity schedule) whose daily exposure to systemic fluoride is deficient. For the fluoridation status of a community water supply, contact the local water department or the link for "My Water's Fluoride", available at: https://nccd.cdc.gov/doh_mwf/default/default.aspx See the AAP's guidance on Maintaining and Improving the Oral Health of Young Children, available at: http://pediatrics.aappublications.org/content/134/6/1224. See the USPSTF guidance on Dental Caries in Children Younger Than 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1 Comment: USPSTF changed their recommendation as of 12/7/21 which is what AAP is referencing in the AAP periodicity schedule footnote 35 and 36.

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	See guidance on fluoride supplementation, available at: https://publichealth.nc.gov/oralhealth/library/includes/IMBresources/2020-FluorideSupplementation.pdf#:~:text=Pediatric%20Dentistry%20%28AAPD%29%20recommend%20the%20daily%20administration%20of,years%20of%20age%20to%20provide%20the%20maximum%20benefits.
b. Fluoride Varnish	• Fluoride varnish is a dental treatment that can help prevent tooth decay, slow it down, or stop it from getting worse by strengthening the tooth enamel (outer coating on teeth). • AAP recommends that fluoride varnish be applied to the teeth of infants and children starting at tooth eruption until their fifth-year birthdate (age range according to the most current AAP periodicity schedule). All children in this category should receive fluoride varnish application at least once every 3-6 months in the primary care or dental office. **Note:** Documentation of "seeing a dentist" without specific notation that fluoride varnish was applied at the dentist office does not meet the criterion. Not all dentists routinely apply fluoride varnish during routine dental visits. See the USPSTF guidance on Dental Caries in Children Younger Than age 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1. See APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, for additional guidance on fluoride varnish. See the AAP publication on Maintaining and Improving the Oral Health of Young Children, available at: https://publications.aap.org/pediatrics/article/134/6/1224/33112/Maintaining-and-Improving-the-Oral-Health-of-Young.

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9) Depression Screening	• AAP recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 20 years. • Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up if screening is positive and a follow up plan is documented. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for depression. • Depression screening must be done using a validated screening tool. Per AAP, screen using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit, and available at: https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf and https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/?page=1
a) Suicide Risk Screening	Anyone who screens positive on a suicide risk screening tool should be followed up with a brief suicide safety assessment. Age Recommendations for Screening: • Universal Screening for children 12 years and older • Patients ages 8-11 should be screened for suicide risk when they are presenting with behavioral health chief complaints, if the patient or parent raises a concern, if there is a reported history of suicidal ideation or behavior, or if the patient displays warning signs of suicide. • Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present o Warning signs of suicide risk that requires further evaluation in children under age 8 include (but not limited to): o Talking about wanting to die or wanting to kill oneself o Actions such as grabbing their throat in a “choking” motion, or placing their hands in the shape of a gun pointed toward their head o Engaging in self-harming behaviors o Acting with impulsive aggression o Giving away treasured toys or possessions

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	Examples of Screening Tools: • Ask Suicide-Screening Questions (ASQ) • Suicide Behavior Questionnaire-Revised (SBQ-R) • Other publicly available tools that are commonly used in primary care settings: • Columbia Suicide Severity Rating Scale (C-SSRS) – Triage Version • Patient Health Questionnaire – 9 Adolescent Version (PHQ-9A) • Patient Safety Screener – 3 (PSS-3) References: • https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/ • https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/conducting-a-brief-suicide-safety-assessment/
b) Maternal Depression Screening	• Maternal mental health condition is defined as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. • Maternal depression screen at 1-, 2-, 4-, and 6-month visits. • Maternal depression screening must be done using a validated screening tool, such as the Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale, or Patient Health Questionnaire (PHQ) 9.[21] • As with any screening test, results should be interpreted within the clinical context and when appropriate referral to the PCP and/or to mental health care providers for follow up.[22] • Provider shall offer and document appropriate follow-up intervention(s) for women whose screening is positive for maternal depression.

[21] See the American College of Obstetricians and Gynecologists (ACOG) guidance on Screening for Perinatal Depression, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression.

[22] For additional resources on perinatal depression, see: http://www.acog.org/More-Info/PerinatalDepression.

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	Assembly Bill (AB) 2193 requires provider who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions.[23] It also requires interpregnancy care providers to do the same when the patient has experienced a stillbirth or miscarriage. (Health and Safety Code, section 123640 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=123640.&lawCode=HSC), with the most recent version effective 1/1/2022, as amended by AB 1477. Per AAP, "screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice', available at: https://pediatrics.aappublications.org/content/143/1/e20183259 See the ACOG Frequently Asked Questions on Postpartum Depression, available at: https://www.acog.org/Patients/FAQs/Postpartum-Depression. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1 See the U.S. Department of Health and Human Services guidance on Postpartum Depression, available at: https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression.
10) Developmental Disorder Screening	• Screen for developmental disorders at the 9th, 18th, and 30th month visits. • 30th month screening can be done at 24 months. • Providers must use an AAP validated screening tool that must also be a global, not domain specific, consistent with criteria set forth in the CMS Technical Specifications. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for developmental disorder.

[23] AB 2193 (Chapter 755, Statutes of 2018) is available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2193.

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	• The CMS Technical Specifications are consistent with age recommendations and use of a validated screening tool; however, tech spec excludes MCHAT tool which AAP allows. CMS determined that the ASQ: SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays. For detailed information on the CMS Technical Specifications please refer to the link: https://www.medicaid.gov/license/form/6466/4391. The developmental screening measure starts on page 65. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.
11) Developmental Surveillance	Developmental surveillance is a component of every well care visit. If the patient is positive for potential delays, provider shall offer and document appropriate follow-up intervention(s).
12) Drug Use Disorder Screening and Behavioral Counseling	Per AAP recommendations, drug use screening and behavioral counseling should begin at 11 years of age. Provider shall offer and document appropriate follow-up interventions for patient whose screening reveals unhealthy drug use. Brief Assessment and Screening When a screening is positive, validated assessment tools should be used to determine if unhealthy drug use is present. Validated drug assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy drug use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered.

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	Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. See APL 21-014 or any superseding APL for details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. See the AAP guidance on Substance Use Screening, Brief Intervention, and Referral to Treatment, available at: https://pediatrics.aappublications.org/content/138/1/e20161211.
13) Dyslipidemia Screening	Family history of obesity, diabetes, hypertension, and heart disease is commonly associated with a combined dyslipidemia. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals dyslipidemia. Per AAP perform a risk assessment at: ○ 2, 4, 6, and 8 years old, then annually thereafter. ○ Order one lipid panel between 9 and 11. ○ Perform again between 17 and 21 years old to identify children with genetic dyslipidemia or more lifestyle-related dyslipidemia. For more information see “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents”, available at: https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents For more information on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, see: https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx

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14) Hearing Screening	Per AAP audiometric screenings are performed at: ○ Birth to 2 months old, 4, 5, 8, and 10 years old ○ Once between 11-14 years old ○ Once between 15-17 years old ○ Once between 18-21 years old Per AAP, clinicians must confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs", available at: http://pediatrics.aappublications.org/content/120/4/898.full. A failed audiometric screening is followed-up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, the primary care provider must make a referral to a specialist. • Non-audiometric assessments shall be performed at each health assessment visit until the child reaches 21 years old and includes an assessment of birth/family history (hearing loss in the family), history of ear infection and the signs and symptoms of hearing loss (i.e. does not startle at loud noises, does not turn to the source of a sound after 6 months of age, speech is delayed and unclear, often says, "Huh?", turns the TV volume up too high, etc.). • Audiometric testing is performed using a newborn hearing screening test (e.g. Automated Auditory Brainstem Response [AABR] or Otoacoustic Emission [OAE] technology) at the birth hospital or specialty facility; or a Behavioral Audiometry Evaluation with an audiometer at the primary care facility starting at 4 years old and includes follow-up care as appropriate. See the AAP periodicity schedule, available at: www.aap.org/periodicityschedule. See the CDC recommendations and guidelines on Hearing Loss in Children, available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html. See the CDC guidance on Hearing Screenings for Children, available at: https://www.cdc.gov/ncbddd/hearingloss/screening.html.

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	For more information on Hearing Loss in Children, see: https://www.cdc.gov/ncbddd/hearingloss/facts.html.
15) Hepatitis B Virus Infection Screening	Chronic HBV infection in children is typically asymptomatic and blood tests for liver enzymes may be normal. Appropriate screening, postexposure, prophylaxis and vaccination are the keys to prevention. • Evidence of serum HBsAg, along with anti-HBs, which is the most effective screening tool for HBV infection. A lack of anti-HBs identifies susceptible children who need vaccination. Children found to be HBsAg-positive should be retested 6 months later to document chronic infection • The CDC recommends: o children born in the United States to immigrant parents from endemic areas be screened o children born to HBsAg-positive mothers should be tested (generally at 1 year of age) o children who live in a household with a known HBsAg-positive person(s) should be screened References: https://www.cdc.gov/hepatitis/hbv/testingchronic.htm https://publications.aap.org/pediatrics/article/124/5/e1007/72122/Recommendations-for-Screening-Monitoring-and https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/PerinatalHepB-PediatricProviderQuicksheet.pdf
16) Hep C Virus Infection Screening	• Per AAP, all individuals 18 and older should be assessed for risk of hepatitis C virus (HCV) infection. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal potential for Hepatitis C Virus infection. • Per USPSTF and CDC, test at least once between the ages of 18 and 79. Persons with increased risk of HCV infection, including those who are persons with past or

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	current injection drug use, should be tested for HCV infection and reassessed annually.[24] . For more information refer to Hepatitis C Virus Infection in Adolescents and Adults: Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening.
17) HIV Screening	• Per AAP, risk assessment for HIV shall be completed at each well child visit starting at 11 years old. • Adolescents should be tested for HIV according to the USPSTF recommendations once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent.[25] • Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Recommendations for STD screening are listed in Box 3 at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#B3_down. Additional information on screening recommendations is available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm; https://stacks.cdc.gov/view/cdc/82088. The CDC Recommendations for Providing Quality STD Clinical Services is available at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm. For additional information on clinical considerations for risk assessment, screening intervals, treatment, and prevention, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

[24] See the USPSTF recommendations on HCV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening, and the CDC recommendations on HCV screening, available at: https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm.
[25] See the USPSTF recommendation on HIV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

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	The AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For those at risk, look for documented evidence that pre-exposure prophylaxis (PrEP) was offered.
18) Psychosocial/Behavioral Assessment	• Psychosocial/Behavior Assessment should be done at each well child visit. • This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. • **Note: Social Determinants Of Health (SDOH)** • Per AAP, social determinants of health (SDOH) are the web of interpersonal and community relationships experienced by children, parents, and families. • Per CDC, social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_IntegrateSDoH_Tipsheet.pdf https://www.cdc.gov/socialdeterminants/about.html See the AAP publication titled “Promoting Optimal Development: Screening for Behavioral and Emotional Problems”, available at: http://pediatrics.aappublications.org/content/135/2/384. See the AAP publication titled “Poverty and Child Health in the United States”, available at: http://pediatrics.aappublications.org/content/137/4/e20160339 https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.
19) Sexually Transmitted Infections	Per AAP, adolescents should be screened for STIs per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. • Sexual activity shall be assessed at every well child visit starting at 11 years old.

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	• If adolescents are identified as sexually active the provider shall offer and provide contraceptive care with the goals of helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and STIs. • For adolescents that have been pregnant, provider should engage in a discussion of counseling on inter-pregnancy intervals and contraceptive care, such as moderately and most effective contraceptive options. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals STI.AAP refers to CDC for full list of STIs, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Treatment-Guidelines.aspx • **Risk assessments for Adolescents and 24 years and younger:** Annual chlamydia and gonorrhea screenings should be done for sexually active women under age 25 as well as older women who are at risk. Screening for syphilis, HIV, chlamydia, and Hepatitis B should be given to all pregnant women, and gonorrhea screening for all pregnant women.[26] • **Men Who Have Sex with Men** (MSM): These men have higher rates of STIs, such as HIV and syphilis and should be tested for these as well as chlamydia, and gonorrhea. • **Men Who Have Sex with Women**: There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, and STI/sexual health clinic). • **Sex Workers**: This population is at higher risk for HIV and other STIs than others, and should be tested at least annually for HIV. • **Transgender and Gender Diverse Persons**: Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for Chlamydia in cis-gender women < 25 years old should be extended to all transgender men and

[26] See the AAP guidance on Screening and Nonviral STIs in Adolescents and Young Adults: https://publications.aap.org/pediatrics/article/134/1/e302/62344/Screening-for-Nonviral-Sexually-Transmitted, the AAP periodicity schedule, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf, and the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en/patient-care/adolescent-sexual-health/.

	gender diverse people with a cervix. Consider screening at the rectal site based on reported sexual behaviors and exposure. **Persons with HIV**: For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology. **Syphilis** • People who are pregnant • Male adolescents and young adults in settings with high prevalence rates (e.g. jails or juvenile correction facilities) • MSM at least annually (every 3 to 6 months if high risk because of multiple or anonymous partners, sex in conjunction with illicit drug use, or having sex partners who participated in these activities) See the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx See the DHCS webpage on the Staying Healthy Assessment, available at: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx. For information on chlamydia and gonorrhea screening. see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening. For USPSTF information on syphilis screening, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-nonpregnant-adults-and-adolescents. Senate Bill (SB) 306 (Pan, Chapter 486, Statutes of 2021) https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306 https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=120685&lawCode=HSC
20) Sudden Cardiac Arrest	SCA and SCD screening should be performed for all children (athlete or not) at the same time as the Pediatric Physical Examination or at a minimum of every 3 years or on entry into middle or junior high school and into high school. AAP recommended 4

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	questions directed toward SCA and SCD detection for which a positive response suggested an increased risk for SCA and SCD • Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones? • Have you ever had exercise-related chest pain or shortness of breath? • Has anyone in your immediate family (parents, grandparents, siblings) or other, more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or SIDS • Are you related to anyone with HCM or hypertrophic obstructive cardiomyopathy, Marfan syndrome, ACM, LQTS, short QT syndrome, BrS, or CPVT or anyone younger than 50 years with a pacemaker or implantable defibrillator? A positive response from the 4 questions above or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist. https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-all-children-should-be-screened-for-potential-heart-related-issues/ https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the
21) Tobacco Use Screening	Tobacco Use Screening, Prevention, and Cessation Services • Screen all children 11 years and older at each well child visit for tobacco products use.

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	• Tobacco products include but not limited to smoked cigarettes, chewed tobacco, electronic cigarette, and vaping products use, and/or exposure to secondhand smoke. • At any time the PCP identifies a potential tobacco use problem, then the provider shall document prevention and/or cessation services to potential/active tobacco users. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal tobacco use. Tobacco cessation services must be documented in the patient's medical record as follows: 1) Initial and annual assessment of tobacco (e-cigarette, vaping products, and/or secondhand smoke) use for each adolescent (11-21 years of age). 2) FDA-approved tobacco cessation medications (for non-pregnant adults of any age). 3) Individual, group, and telephone counseling for members of any age who use tobacco products. 4) Services for pregnant tobacco users. 5) Prevention of tobacco use in children and adolescents (including counseling and pharmacotherapy). For information on comprehensive tobacco prevention and cessation services for Medi-Cal beneficiaries is available at, see APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL. The AAP recommended assessment tool is available at: http://crafft.org.
22) Tuberculosis Screening	• Per AAP, Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, testing should be performed on recognition of high-risk factors. • All children are assessed for risk of exposure to tuberculosis (TB) at 1, 6, and 12-months old and annually thereafter.

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	• Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals positive risk factors for TB. • Two tests that are used to detect TB bacteria in the body: the TB skin test (TST) (Mantoux) and TB blood tests QuantiFERON-TB Gold Plus. A positive TB skin test or TB blood test only tells that a person has been infected with TB bacteria. TB infection screening test is administered to children *identified at risk,* if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). • Providers are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. The California Pediatric Tuberculosis Risk Assessment tool is available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf. CDC guidance on TB testing and diagnosis is available at: https://www.cdc.gov/tb/topic/testing/default.htm.
23) Vision Screening	• Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. • Per AAP, visual acuity screenings using optotypes (figures or letters of different sizes used for vision screening) are to be performed at ages 3 (if cooperative), 4, 5, 6, 8, 10, 12, and 15 years old. • Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. • Documentation of “PERRLA” is acceptable for children below the age of 3 years. • If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). • AAP recommended eye charts are: ○ LEA Symbols (3-5 years old)

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	○ HOTV Chart (3-5 years old) ○ Sloan Letters (preferred) or Snellen Letters (over 5 years old) See the AAP publications titled “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” available at: http://pediatrics.aappublications.org/content/137/1/e20153596 and “Procedures for the Evaluation of the Visual System by Pediatricians”, available at: http://pediatrics.aappublications.org/content/137/1/e20153597. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations Such as external eye inspection, ophthalmoscopy red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years. AAP guidance on Visual System Assessment in Infants, Children, and Young Adults by Pediatricians is available at: https://pediatrics.aappublications.org/content/137/1/e20153596.
D) Childhood Immunizations	Every visit should be an opportunity to update and complete a child’s immunizations. Childhood Immunizations Schedules, per the AAP Committee on Infectious Diseases, are available at: https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. For reference, see the CDC’s ACIP webpage, available at: https://www.cdc.gov/vaccines/acip/index.html, also see APL 18-004, Immunization Requirements, or any superseding APL For details on Immunization Requirements.
1) Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC’s most recent ACIP guidelines, unless medically contraindicated, vaccine shortage or refused by the parent. Refer to the following link for more information on ACIP Vaccine Recommendations and Guidelines: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

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2) **Vaccine administration documentation**	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act. For additional details on the National Childhood Vaccine Injury Act, refer to: https://www.congress.gov/bill/99th-congress/house-bill/5546
3) **Vaccine Information Statement (VIS) documentation**	• VISs are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to the vaccine recipients. • Federal law requires that healthcare staff provide a VIS to a patient, parent, or legal representative before each dose of certain vaccines. VIS documentation in the medical/electronic record, medication logs, or immunization registries include the date the VIS was given or presented/offered *and* the VIS publication date. Refer to the following link from the CDC for the current VISs: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. **Note:** Federal law allows up to 6 months for the updated VIS to be distributed.

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services.

RN/NP/MD/PA/CNM/LM

V. Adult Preventive Criteria	
A. Initial Health Appointment (IHA): Includes H&P and Risk Assessment	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. The IHA include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: o History of present illness o Past medical history o Social history o Review of Organ Systems (ROS) including dental assessment Referrals for any abnormal findings must be documented. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. A review of the organ systems that include documentation of "inspection of the mouth" or "seeing dentist" meets the criteria for dental assessment during a comprehensive history and physical.
	New members:

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2) Member Risk Assessment	Initial Member Risk Assessments related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one (1) of the following risk assessment domains within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date meets the standard: • Health Risk Assessment: MCPs will not be required to retain the use of their existing HRA tools. If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers • SDOH: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH includes housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of the following examples of SDOH screening tools meet the standard: o Social Needs Screening Tool • Cognitive Health Assessment (65 years and older): Annual cognitive assessment for Medi-Cal members to identify whether the patient has signs of Alzheimer's disease or related dementias. Examples of validated screening tools that meet the standard are as follows: o General Practitioner Assessment of Cognition (GPCOG) o Mini-Cog o Eight-item Informant Interview to Differentiate Aging and Dementia • Adverse Childhood Experiences (ACEs) (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools: o The ACE Questionnaire for Adults is used to screen adults 18 years and older for ACEs. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

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	https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf https://mini-cog.com/wp-content/uploads/2022/03/Standardized-English-Mini-Cog-1-19-16-EN_v1-low-1.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf https://www.cdc.gov/about/sdoh/index.html https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf https://www.alz.org/media/documents/gpcog-screening-test-english.pdf
B. Periodic Health Evaluation according to most recent USPSTF guidelines	The type, quantity, and frequency of preventive services is based on the most recent USPSTF recommendations.
1) Comprehensive History and Physical Exam completed at age-appropriate frequency.	• Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. • In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
2) Subsequent Risk Assessment	• Risk Assessment including social, cultural and health education needs, is completed by the member or parent/guardian must be completed annually or any significant change of health status. An assessment of at least one (1) of the above risk assessment domains (HRA, SDOH, CHA and ACEs) meets the standard. •https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf •https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf • https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version

V. Adult Preventive Criteria	
C. Adult Preventive Care Screenings	The following adult preventive care screenings are based on USPTSF Grade A and B recommendations. • If the patient falls within the eligible condition (e.g. obesity, post-menopausal, etc.), age and gender parameters of the criterion, the provider shall assess for risk factors. • If the patient is positive for risk factors, the provider shall offer and document follow-up intervention(s). • Providers who fail to document the presence or absence of risk factors shall receive zero (0) points. • An "NA" score is warranted if the patient falls outside of the eligible condition, age and gender parameters of the specific criterion. If specific preventive care screening tests are ordered, but results are not found in the member's record, and no documentation of follow-up is documented, these deficiencies will be cited under the appropriate preventive care criteria. The Follow-up of Specialty Referrals criteria pertain to referrals/lab tests that are not specified under preventive care criteria (i.e. ophthalmology, nephrology, etc.).
1) Abdominal Aneurysm Screening	Assess all individuals during well adult visits for past and current tobacco use. USPSTF recommends that medical providers should perform a one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked 100 or more cigarettes in their lifetime. Indirect evidence shows that smoking is the strongest predictor of Abdominal Aortic Aneurysm (AAA) prevalence, growth, and rupture rates.[27] There is a dose-response relationship, as greater smoking exposure is associated with an increased risk for AAA. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

[27] See the USPSTF recommendation on AAA Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

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2) Alcohol Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for alcohol misuse. If at any time the PCP identifies a potential alcohol misuse problem , the provider shall: • Refer any member identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for evaluation and treatment. • Use the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (AUDIT-C). • Complete at least one expanded screening, using a validated screening tool every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. • Offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use on the expanded screening tool. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. See the NIH guidance on Screening Tests, available at: https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for adverse health consequences but not meeting criteria for AUD (e.g. the National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "risky use" as exceeding the recommended limits of 4 drinks per day (56 g/d based on the US standard of 14 g/drink) or 14 drinks per week (196 g/d) for healthy adult men aged 21 to 64 years or 3 drinks per day or 7 drinks per week (42 g/d or 98 g/week) for all adult women of any age and men 65 years or older).

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	Screening Unhealthy alcohol use screening must be done with validated screening tools. The US Surgeon General, NIAAA, CDC, and ASAM recommend routinely screening adult patients for unhealthy alcohol use and providing them with appropriate interventions, https://www.niaaa.nih.gov/guide Brief Assessment When a screen is positive, providers should use validated assessment tools to determine if an alcohol use disorder is present. Validated alcohol assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to: • CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) • NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST) • Alcohol Use Disorders Identification Test (AUDIT) Brief Interventions and Referral to Treatment For recipients with brief assessments revealing alcohol misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to recipients whose brief assessment demonstrates probable alcohol use disorder. Alcohol brief interventions includes alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results. • Discussing negative consequences that have occurred and the overall severity of the problem. • Supporting the patient in making behavioral changes. • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. Documentation Requirements Member medical records must include the following:

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	• The service provided, for example: screen and brief intervention. • The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record). • 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). • If and where a referral to an alcohol or substance use disorder program was made. A recommended substance abuse assessment tool is available at http://crafft.org. Please refer to the following link to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
3) Breast Cancer Screening	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.[28]
4) Cervical Cancer Screening	• Screen for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years. • Women ages 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years OR with high-risk human papillomavirus (hrHPV) testing alone every 5 years. • Follow-up of abnormal test results are documented. Routine Pap testing may not be required for the following: • Women who have undergone hysterectomy in which the cervix is removed (TAH - Total Abdominal Hysterectomy), unless the hysterectomy was performed because of invasive cancer. • Women 66 years and older who have had regular previous screening in which the Pap result have been consistently normal.

[28] See the USPSTF recommendation on Breast Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

V. Adult Preventive Criteria	
	The USPSTF recommendation on Cervical Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening.
5) Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 45 years old and concluding at age 75 years to include: • High sensitivity gFOBT or FIT every year • sDNA-FIT every 1 to 3 years • CT colonography every 5 years • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every 10 years + FIT every year • Colonoscopy screening every 10 years. When abnormal results are found on flexible sigmoidoscopy or CT colonography, follow-up with colonoscopy is needed for further evaluation. Rates of colorectal cancer incidence are higher in Black adults and American Indian and Alaskan Native adults, persons with a family history of colorectal cancer (even in the absence of any known inherited syndrome such as Lynch syndrome or familial adenomatous polyposis), men, and persons with other risk factors (such as obesity, diabetes, long-term smoking, and unhealthy alcohol use. The decision to screen for colorectal cancer in adults **aged 76 to 85 years** should be an individual one,taking into account the patient's overall health and prior screening history. The USPSTF recommendation on Colorectal Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.
6) Depression Screening	• Per USPSTF, screen for depression in the general adult population, including pregnant and postpartum women. • Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

V. Adult Preventive Criteria	
	• Providers should screen all adults who have not been previously screened using a validated screening tool. If the depression screening is positive, a follow up plan must be documented. • Providers should use clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted. Recommended screening tools include: ○ Patient Health Questionnaire (PHQ) in various forms ○ Hospital Anxiety and Depression Scales in adults ○ Geriatric Depression Scale in older adults ○ The Edinburgh Postnatal Depression Scale (EPDS) pregnant and postpartum The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations The USPSTF recommendation on Screening for Depression in Adults is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening.
7) Diabetic Screening and Comprehensive Care	• Per USPSTF, screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese. • Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. • Glucose abnormalities can be detected by measuring HbA1c or fasting plasma glucose or with an oral glucose tolerance test. • Hemoglobin A1C (HbA1c) is a measure of long-term blood glucose concentration and is not affected by acute changes in glucose levels due to stress or illness. HbA1c measurements do not require fasting, they are more convenient than using a fasting plasma glucose or oral glucose tolerance test. The oral glucose tolerance

V. Adult Preventive Criteria	
7.a)	test is done in the morning in a fasting state; blood glucose concentration is measured 2 hours after ingestion of a 75-g oral glucose load. • The diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeated testing with the same test on a different day is the preferred method of confirmation. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes. See APL 18-018, Diabetes Prevention Program, or any superseding APL for additional information. • When reviewing medical records of patients with a diagnosis of Diabetes, the reviewer should score based on documented routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology, etc. • Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking. See the National Community for Quality Assurance guidance on Comprehensive Diabetes Care, available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.
	Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential drug use problem the provider shall:

V. Adult Preventive Criteria	
8) Drug Use Disorder Screening and Behavioral Counseling	• Refer any member identified with possible drug use disorders to the drug treatment program in the county where the member resides for evaluation and treatment. • Complete at least one expanded screening, using a validated screening tool, every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. • Offer behavioral counseling intervention(s) to those members that a provider identified as having risky or hazardous drug use on the expanded screening tool. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. The term "unhealthy drug use" is defined as the use of illegally obtained substances, excluding alcohol and tobacco, or the use of nonmedical prescription medications that differ than the parameters for which they were prescribed such as duration, frequency, and amount. <u>Brief Assessment</u> When a screen is positive, providers should use validated assessment tools to determine if a drug use disorder is present. Validated drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to: • CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) • NIDA-modified Alcohol, Smoking, and Substance Involvement Screening Test (NM-ASSIST) • Drug Abuse Screening Test (DAST-20) <u>Brief Interventions and Referral to Treatment</u> For recipients with brief assessments revealing drug misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to

<table>
<tr><th colspan="2">V. Adult Preventive Criteria</th></tr>
<tr><td></td><td>recipients whose brief assessment demonstrates probable substance use disorder. Drug brief interventions includes misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
• Providing feedback to the patient regarding screening and assessment of results.
• Discussing negative consequences that have occurred and the overall severity of the problem.
• Supporting the patient in making behavioral changes.
• Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

<u>Documentation Requirements</u>
Member medical records must include the following:
• The service provided, for example: screen and brief intervention.
• The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electric health record).
• 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).
• If and where a referral to an alcohol or substance use disorder program was made.

A recommended substance abuse assessment tool is available at: http://crafft.org.

Please refer to the following link to the Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.</td></tr>
<tr><td>9) Dyslipidemia Screening</td><td>USPSTF recommends that adults without a history of cardiovascular disease (CVD) (e.g., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met:
1) They are aged 40 to 75 years;
2) They have one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension, or smoking); and</td></tr>
</table>

V. Adult Preventive Criteria	
	3) They have a calculated 10-year risk of a cardiovascular event of 10% or greater. Screen universal lipids at every well visit for those with increased risk of heart disease and at least every 6 years for healthy adults. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
10) Folic Acid Supplementation	• The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.[29] • USPSTF and WHO categorize women in the age range of 12-49 years as "women who are capable of becoming pregnant".
11) Hepatitis B Virus Screening	Assess all adults for risk of acquiring Hepatitis B Virus (HBV) at each well visit. Screening those at risk should include testing to three HBV screening seromarkers (HBsAg, antibody to HBsAg [anti-HBs], and antibody to hepatitis B core antigen [anti-HBc]) so that persons can be classified into the appropriate hepatitis B category and properly recommended to receive vaccination, counseling, and linkage to care and treatment. Important risk groups for HBV infection with a prevalence of ≥2% that should be screened include: • Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as sub-Saharan Africa and Central and Southeast Asia (Egypt, Algeria, Morocco, Libya, Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.). • U.S.-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%).

[29] See the USPSTF recommendation on Folic Acid to Prevent Neural Tube Defects, available at: https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/folic-acid-supplementation-prevent-neural-tube-defects

V. Adult Preventive Criteria	
	• HIV-positive persons • Injection drug users • MSM • Household contacts or sexual partners of persons with HBV infection See the CDC guidance on Viral Hepatitis, available at: https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm
12) Hepatitis C Virus Screening	• All adults 18 to 79 years old shall be assessed for risk of Hepatitis C Virus (HCV) exposure at each well visits. • Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. Persons for whom HCV Testing is recommended: • All Adults ages 18 to 79 years should be tested once. • Currently, or had history of, ever injecting drugs. • Medical Conditions: Long term hemodialysis, persons who received clotting factor concentrates produced before 1987; HIV infection; Persistent abnormal alanine aminotransferase levels (ALT). • Prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection. Persons with continued risk for HCV infection (e.g., injection drug users) should be screened periodically. There is limited information about the specific screening interval that should occur in persons who continue to be at risk for new HCV infection or how pregnancy changes the need for additional screening. See the USPSTF recommendation on Screening for HCV in Adolescents and Adults Practice Considerations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening#bootstrap-panel--6. See the CDC Recommendations for Hepatitis C Screening Among Adults in the United States, available at: https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm.

V. Adult Preventive Criteria	
	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
13) High Blood Pressure Screening	• All adults including those without known hypertension are screened. • A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. • B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. See the USPSTF Grade A and B Recommendation, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening.
14) HIV Screening	USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger: • Those at high risk (regardless of age) i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown. • IV drug users. • MSM. All shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). [30] Lab results are documented. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
	• Per the USPSTF, clinicians shall screen for Intimate Partner Violence (IPV) on asymptomatic women of reproductive age, which is defined across studies as

[30] See the USPSTF recommendation on Prevention of HIV Infection, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

V. Adult Preventive Criteria	
15) Intimate Partner Violence Screening for Women of Reproductive Age	ranging from 12 to 49 years, with most research focusing on women age 18 years or older. • Provide or refer those who screen positive to ongoing support services. Per USPSTF the following instruments accurately detect IPV in the past year among adult women: ○ Humiliation, Afraid, Rape, Kick (HARK) ○ Hurt, Insult, Threaten, Scream (HITS) ○ Extended–Hurt, Insult, Threaten, Scream (E-HITS) ○ Partner Violence Screen (PVS) ○ Woman Abuse Screening Tool (WAST) The USPSTF A and B recommendations are the minimum that is required by DHCS. The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. See the CDC guidance on IPV, available at: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/
16) Lung Cancer Screening	• Assess all individuals during well adult visits for past and current tobacco use. • Per USPSTF, screen annually for lung cancer with low-dose computed tomography in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. See the USPSTF recommendation on Lung Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening.

V. Adult Preventive Criteria	
17) Obesity Screening and Counseling	• USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. • Documentation shall include weight and BMI • There is fair to good evidence that high-intensity counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies produces modest, sustained weight loss (typically 3-5 kg for 1 year or more) in adults who are obese (as defined by BMI ≥ 30 kg/m2). Although the USPSTF did not find direct evidence that behavioral interventions lower mortality or morbidity from obesity, the USPSTF concluded that changes in intermediate outcomes, such as improved glucose metabolism, lipid levels, and blood pressure, from modest weight loss provide indirect evidence of health benefits. See the USPSTF recommendation on Screening and Counseling for Obesity in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-counseling-2003.
18) Osteoporosis Screening	Assess all postmenopausal women during well adult visits for risk of osteoporosis. USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, or who have at least one risk factor, as determined by a formal clinical risk assessment tool.[31] These risk factors include: • Parental history of hip fracture • Smoking • Excessive alcohol consumption • Low body weight.

[31] See the USPSTF recommendations on Screening for Osteoporosis to Prevent Fractures, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/osteoporosis-screening.

V. Adult Preventive Criteria	
	USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. For postmenopausal women younger than 65 years who have at least 1 risk factor, a reasonable approach to determine who should be screened with bone measurement testing is to use a clinical risk assessment tool.
19) Sexually Transmitted Infection (STI) Screening and Counseling	Assess all individuals during well adult visits for risk of STI.[32] Chlamydia & Gonorrhea: • Test all sexually active women under 25 years old • Older women who have new or multiple sex partners • MSM regardless of condom use or persons with HIV shall be tested at least annually Syphilis: • MSM or persons with HIV shall be screened at least annually Trichomonas: • Sexually active women seeking care for vaginal discharge • Women who are IV drug users • Exchanging sex for payment • HIV+, have History of STD, etc. Herpes: • Men and women requesting STI evaluation who have multiple sex partners shall be tested. • HIV+ • MSM w/ undiagnosed genital tract infection.

[32] See the USPSTF recommendation on STIs: Behavioral Counseling, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling.

V. Adult Preventive Criteria	
	Intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle.
20) Skin Cancer Behavioral Counseling	USPSTF recommends that young adults 24 years and younger should be counseled to minimize exposure to Ultraviolet (UV) radiation to reduce their risk of skin cancer.[33]
21)Tobacco Use: Screening, Counseling, and Intervention	• Assess all individuals during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. ○ Per USPSTF, providers can document any combination of the following since not all may apply especially to pregnant tobacco users: tobacco cessation services, behavioral counseling and/or pharmacotherapy. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information. If the PCP identifies tobacco use, documentation that the provider offered tobacco cessation services, behavioral counseling, and/or pharmacotherapy to include any or a combination of the following must be in the patient's medical record: • FDA-approved tobacco cessation medications (for non-pregnant adults of any age). • Individual, group, and telephone counseling for members of any age who use tobacco's products. • Services for pregnant tobacco users. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information.
22) Tuberculosis Screening	• Adults are assessed for TB risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations.

[33] See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling.

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	• The Mantoux skin test, or other approved TB infection screening test,[34] is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. • Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care, for example: ○ Further medical evaluation ○ Chest x-ray ○ Diagnostic laboratory studies ○ Referral to specialist Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. See the CDPH guidance on California Adult TB Risk Assessment, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf. See the USPSTF recommendation on Latent TB Infection Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening. See the CDC publications on TB, available at: www.cdc.gov/tb/publications//.
D) Adult Immunizations	

[34] Per June 25, 2010, CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot).

V. Adult Preventive Criteria	
1) **Given according to ACIP guidelines**	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member.[35] Vaccination status must be assessed for the following: ○ Td/Tdap (every 10 years) ○ Flu (annually) ○ Pneumococcal (ages 65 and older; or anyone with underlying conditions) ○ Zoster (starting at age 50) ○ Varicella and MMR Documented evidence of immunity (i.e. titers, childhood acquired infection) in the medical record meets the criteria for Varicella and MMR. The name of the vaccines and date the member received the vaccines must be documented as part of the assessment. See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
2) **Vaccine administration documentation**	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act.
3) **Vaccine Information Statement (VIS) documentation**	The date the VIS was given (or presented and offered) and the VIS publication date are documented in the medical record.

[35] See the CDC ACIP Guidance on Immunization Schedules, available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines.[36] Reviewers please note, if the OB-GYN provider is also acting as the member's PCP and the member is/was pregnant during the review period (e.g. the last three years), the appropriate preventive services criteria, based on the members' age, i.e. Pediatric or Adult shall ALSO be reviewed and scored.

RN/NP/MD/PA/CNM/LM

VI. OB/CPSP Preventive Criteria	
A. Initial Comprehensive Prenatal Assessment (ICA)	**Initial Prenatal Visit - First entry to OB Care:** During the initial Comprehensive assessment, provider gathers baseline information on the pregnant woman, such as: ○ Obstetric and medical history, including medical documentation from prior visits with other providers. ○ Nutrition status ○ Health education ○ Psychosocial needs Based on the information gathered, the provider and the pregnant woman develop an individualized care plan (ICP) to meet her unique needs. Documentation of ICP services received, or reasons why not received, must be provided. See VI, B, below, for the First Trimester Comprehensive Assessment, which may be completed over more than one visit during the trimester. See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.
1) Initial Prenatal Visit	Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.
2) Obstetrical and Medical History	**Obstetric/medical:** The H&P exam must be consistent with the most recent ACOG Guidelines for Perinatal Care.[37]

[36] See the CDPH webpage on CPSP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
[37] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.

VI. OB/CPSP Preventive Criteria	
3) Physical Exam	Physical exam: includes breast and pelvic exam and calculation of estimated date of delivery. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
4) Dental Assessment	Dental Screening and referral as indicated must be documented. Oral health problems are associated with other diseases including heart disease, diabetes, and respiratory infections.[38]
5) Healthy Weight Gain and Behavior Counseling	The USPSTF recommends that clinicians offer pregnant women effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.[39] Effective behavioral counseling interventions promotes healthy weight gain and decreases risk of gestational diabetes mellitus, emergency cesarean delivery, infant macrosomia, and LGA infants.
6) Lab tests	
a) Bacteriuria Screening	USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.[40]

[38] See the ACOG guidance on Oral Health Care During Pregnancy and Through the Lifespan, available at: https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles/2013/08/Oral%20Health%20Care%20During%20Pregnancy%20and%20Through%20the%20Lifespan

[39] See the USPSTF recommendation on Healthy Weight and Weight Gain in Pregnancy, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-weight-and-weight-gain-during-pregnancy-behavioral-counseling-interventions

[40] See the USPSTF recommendation on Screening for Asymptomatic Bacteria in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/asymptomatic-bacteriuria-in-adults-screening.

VI. OB/CPSP Preventive Criteria	
	Urine culture is recommended for bacteriuria screening in pregnancy and is the method for diagnosis. Pregnant women with asymptomatic bacteriuria usually receive antibiotic therapy, based on urine culture results and follow-up monitoring.
b) Rh Incompatibility Screening	• Rh incompatibility screening: 24-28 weeks gestation.[41] • Rh incompatibility is a condition that occurs during pregnancy if a woman has Rh-negative blood and her baby has Rh-positive blood.
c) Diabetes Screening	USPSTF recommends screening for gestational diabetes mellitus **(**GDM**)** in asymptomatic pregnant women after 24 weeks of gestation.[42] • In the two-step approach: the 50-g OGCT is performed between 24 and 28 weeks of gestation. A diagnosis of GDM is made when two or more glucose values fall at or above the specified glucose thresholds. • One-step approach: a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after 1 and 2 hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
d) Hepatitis B Virus Screening	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.[43] The screening tests for detecting maternal HBV infection is the serologic identification of HBsAg. Screening should be performed in each pregnancy, regardless of previous HBV vaccination or previous negative HBsAg test results.

[41] See the USPSTF recommendation on Rh(D) Incompatibility Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/rh-d-incompatibility-screening, and the NIH guidance on Rh Incompatibility, available at: https://www.nhlbi.nih.gov/health-topics/rh-incompatibility.
[42] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.
[43] See the USPSTF recommendation on HBV Infection in Pregnant Women, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-in-pregnant-women-screening.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864180/

VI. OB/CPSP Preventive Criteria	
	Following referral required for women with positive HBV: • Case management during pregnancy • HBV DNA viral load testing • Referral to specialty care for counseling and medical management of HBV infection. See Hepatitis B information on the CDC website, available at: https://www.cdc.gov/hepatitis/hbv/index.htm.
e) Hepatitis C Virus Screening	Per ACOG all pregnant women should receive Hepatitis C screening with blood assessment during the first prenatal visit. Pregnant woman with newly diagnosed HCV infection and abnormal serum aminotransferase and/or platelet levels should be referred for further medical assessment to rule out liver fibrosis or injury and so antiviral treatment can be initiated at the appropriate time. Providers should report HCV infection in a pregnant person to infant's health care provider so that follow-up HCV testing can be conducted at the recommended time, and to the local health department so that ongoing risk factors can be assessed and relevant contacts can receive hepatitis A and hepatitis B testing and vaccination, as indicated, and can be linked, as appropriate, to preventive services. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/05/routine-hepatitis-c-virus-screening-in-pregnant-individuals
f) Chlamydia Infection Screening	Per CDC, All pregnant women under 25 years old and older women with increased risk such as new or multiple sex partners, or a sex partner who has an STD, should be tested for chlamydia at their first prenatal visit pregnant women with chlamydial infection should have a test-of-cure four weeks after treatment and be retested within three months. Retest during the 3rd trimester for women under 25 years of age or at risk.

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	See the CDC guidance on Chlamydia, available at: https://www.cdc.gov/std/chlamydia. See the CDC guidance on STD Tests, available at: https://www.cdc.gov/std/prevention/screeningreccs.htm. See the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.
g) Syphilis Infection Screening	Per CDC, all pregnant women should be tested for syphilis at the first prenatal visit.[44] High risk women need to be tested again during the third trimester (28 weeks gestation) and at delivery. This includes women who live in areas of high syphilis morbidity, are previously untested, had a positive screening test in the first trimester, or are at higher risk for syphilis (i.e., multiple sex partners, drug use, transactional sex, late entry into prenatal care or no prenatal care, meth or heroin use, incarceration themselves or of sex partners, unstable housing, or homelessness).
h) Gonorrhea Infection Screening	All pregnant women under 25 years old, and older pregnant women who are at increased risk, are screened for gonorrhea during their first prenatal visit.[45] Specific microbiologic diagnosis of *N. gonorrhea* infection should be performed for all women at risk for or suspected of having gonorrhea. See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm.

[44] See the CDC information on syphilis, available at: https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm.
[45] See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm, and the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.

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i) **Human Immunodeficiency Virus (HIV) Screening**	Per ACOG, all pregnant women should be informed that HIV test is part of the routine panel of the prenatal tests.[46] If woman declines HIV testing this should be documented in the medical record. Repeat testing in the third trimester is recommended for woman known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy.
B. **First Trimester Comprehensive Assessment**	A Comprehensive Perinatal Assessment must be completed each trimester and during the postpartum period. A Comprehensive Assessment tool must be used and updated every trimester and during the 12-month post-pregnancy period. The assessment tool must be consistent with CDPH's template tool, as confirmed by the local county or city Perinatal Health Coordinator.[47] See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available link bottom of the page.
1) **Individualized Care Plan (ICP)**	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and during the 12-month post-pregnancy period. The ICP must be updated based on the Comprehensive Assessments in each trimester, during the 12-month post-pregnancy period, and more frequently as needed. Documentation must be provided of the services offered and whether received.**
2) **Nutrition Assessment**	A complete initial nutrition assessment should be performed at the initial visit or within four weeks thereafter and should be documented in the

[46] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

[47] See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx, and the Title 22 CPSP regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf

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	pregnant woman medical record: • anthropometric data • biochemical data • clinical data • dietary data
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record.[48] The assessment should include the following: o Depression assessment o Social and mental history o Substance use Disorder including alcohol and tobacco o Unintended pregnancy o Support systems o Documentation of referral as appropriate. See the proposed changes for the 20202 Prenatal and Postpartum care HEDIS measures, available at: https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf.
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. *Health and Safety Code (HSC) Section 123640: and* AB-1477 Maternal mental *health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling, referrals, or any interventions is documented.

[48] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.

"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

- USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women.
- CMS Technical Specifications include screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression.
- Patient is screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

- Edinburgh Postnatal Depression Scale (EPDS),
- Patient Health Questionnaire (PHQ) 9

Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation or assessment for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Additional information on CMS Technical Specifications, is available at: https://www.medicaid.gov/license/form/6466/4391.

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	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
b) Social Needs Assessment	The comprehensive Assessments in each trimester must also provide social needs assessment includes housing, food, transportation, unintended pregnancy, support system available.[49] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.
4) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence. And education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[50]

[49] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

[50] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.

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5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[51]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[52] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening • Documentation of physical injuries • Documentation of illnesses attributable to spousal/partner abuse • Referral to appropriate community service agencies[53]
C. Second Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. ICP must be updated every trimester and more frequently as needed

[51] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[52] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[53] HSC 1233.5

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2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate.
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use/abuse including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referrals as appropriate. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented.

	Health and Safety Code (HSC) Section 123640 and AB-1477 Maternal Mental Health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. Counseling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.* • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions

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	• Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF Grade A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
b) Social Needs Assessment	Social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[54]
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco, and drugs, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.
4) Breastfeeding and Other Health Education Assessment	• Health Education including breast feeding, language, cultural competence, and education needs must be assessed. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[55]

[54] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

[55] See APL 18-106, Readability and Suitability of Written Health Education Materials, or any superseding APL.

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5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[56]
a) Low Dose Aspirin	The Provider should advise on the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[57]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[58] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening. • Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[59]

[56] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[57] See the USPSTF Grande A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
[58] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[59] HSC 1233.5

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7) Diabetes Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[60] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds. • 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold.
D. Third Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.
1) Individualized Care Plan (ICP) Update and Follow Up	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CPCP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.

[60] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

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2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status. • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf
3) Psychosocial Assessment	Psychosocial assessment must be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: • Depression Assessment • Social and Mental History • Substance use/abuse including alcohol and tobacco; unintended pregnancy • Support systems • Documentation of referrals as appropriate See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
	Practitioner who provides prenatal, interpregnancy, or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for

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a) Maternal Mental Health Screening	*maternal mental health conditions.* Counselling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.*[61] • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression

[61] HSC 123640

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	For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening. The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.[62]
b) Social Needs Assessment	The comprehensive assessments in each trimester must also provide social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[63] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

[62] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions.
[63] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

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	See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information. The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[64] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.
4) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence, and education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[65]
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[66]

[64] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions.
[65] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[66] See the ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html.

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a) Low-Dose Aspirin	USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[67]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[68] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening. • Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[69]
7) Diabetic Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[70] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds.

[67] See the USPSTF recommendation on Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication.
[68] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[69] HSC 1233.5
[70] See the USPSTF recommendation on Screening for Gestational Diabetes, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

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	• 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. • Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
8) Screening for Strep B	All pregnant women are screened for Group B Streptococcus (GBS) between their 35th and 37th week of pregnancy. Vaginal or rectal swab cultures at 36 – 37 weeks of gestation are positive for GBS, they should receive appropriate intrapartum antibiotic prophylaxis unless a prelabor cesarean birth is performed in the setting of intact membranes. Please refer to the following link for ACOG Frequently Asked Questions on Group B Streptococcus and pregnancy: https://www.acog.org/womens-health/faqs/group-b-strep-and-pregnancy. See the ACOG guidance on Prevention of Group B Streptococcal Early-Onset Disease in Newborns, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/prevention-of-group-b-streptococcal-early-onset-disease-in-newborns?utm_source=vanity&utm_medium=web&utm_campaign=clinical.
9) Screening for Syphilis	Pregnant women with high risk for syphilis and women who live in areas with high syphilis morbidity should be re-tested for syphilis between 28 and 32 weeks and at delivery. Stat RPR should be performed at delivery for women with no prenatal care. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CS_Eval_Management_pregnant%20women.pdf
10) Tdap Immunization	• Pregnant women should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation.

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	• Tdap is recommended only in the immediate postpartum period before discharge from the hospital or birthing center for new mothers who have never received Tdap before or whose vaccination status is unknown. • Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member. See the CDC's ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1. See the CDC's ACIP guidelines on vaccines, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Please note-the administration of pertussis is eligible for the Valued Based Payment (VBP) program. Please consult with the MCP for details.
E. Prenatal care visit periodicity according to most recent ACOG Standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: 1) First visit by 6-8th week 2) Approximately every 4 weeks for the first 28 weeks of pregnancy 3) Every 2-3 weeks until 36 weeks gestation 4) Weekly thereafter until delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities. Refer the following link to ACOG for further details: https://www.acog.org/clinical
F. Influenza Vaccine	CDC and ACIP recommend that pregnant women gets vaccinated during any trimester of their pregnancy. Refer to the following link for further information on vaccination schedules:

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	https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/guidelines.html https://www.cdc.gov/vaccines/hcp/acip-recs/rec-vac-preg.html See CDC guidance on pregnancy and vaccination, available at: https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
G. COVID Vaccine	The American College of Obstetricians and Gynecologists (ACOG) recommends that all eligible persons greater than age 12 years, including pregnant and lactating individuals, receive a COVID-19 vaccine or vaccine series. Provider should document the discussion in the medical record if pregnant woman refused to receive the vaccine. During the subsequent office visits, obstetrician–gynecologists should address ongoing questions and concerns and offer vaccination again. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/covid-19-vaccination-considerations-for-obstetric-gynecologic-care
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (**WIC) and assessment of Infant Feeding Status**	Pregnant and breastfeeding mothers must be referred to WIC.[71] • Referral to WIC is documented in the medical record.[72] • Infant feeding plans are documented during the prenatal period. • Infant feeding/breastfeeding status is documented during the postpartum period.[73] Refer to the following link for information on the WIC program: https://www.myfamily.wic.ca.gov/

[71] Public Law 103-448, Section 203(e)
[72] 42 CFR 431.635
[73] PL 98-010, Breastfeeding Promotion

VI. OB/CPSP Preventive Criteria	
	Note: Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
I. HIV-related services *offered*	Per ACOG, repeat testing in the third trimester is recommended for women known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy. • The ***offering*** of prenatal HIV information, counseling, and HIV antibody testing is documented.[74] • Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. • Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the CDC STI Screening Recommendations, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm. See the ACOG guidance on Prenatal and Perinatal HIV Testing, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false. See the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening.

[74] HSC 125107

VI. OB/CPSP Preventive Criteria	
J. AFP/Genetic Screening *offered*	The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented.[75] Genetic screening documentation includes: • Family history • Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG) • Member's consent or refusal to participate For information on the Alpha-Fetoprotein Test, see: https://americanpregnancy.org/prenatal-testing/alpha-fetoprotein-test **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
K. Family Planning Evaluation	• Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months which have been associated with adverse perinatal outcomes, including preterm birth, low birth weight, and small size of gestational age, as well as adverse maternal outcomes. • All postpartum women can be considered at risk for unintended pregnancy for that period of time. Family Planning counseling, including counseling of interpregnancy intervals, contraceptive care, referral or provision of services is documented.[76] Prenatal discussions should include the woman's reproductive life plans, including the desire for and timing of any future pregnancies. See the HHS guidance on Contraceptive Care Measures, available at: https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures

[75] 17 CCR 6521-6532
[76] See PL 98-011, Family Planning Services in Medi-Cal Managed Care, or any superseding APL for additional information.

<table>
<tr><th colspan="2">VI. OB/CPSP Preventive Criteria</th></tr>
<tr><td></td><td>See DHCS' Office of Family Planning webpage, available at:
https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx

See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.</td></tr>
<tr><td>L. Comprehensive Postpartum Assessment</td><td>The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
As of April 1, 2022, Medi-Cal's postpartum period is extended from 60 to 365 days, regardless of how the pregnancy ends.

• Per ACOG, women should contact their OB-GYN or other obstetric care providers within the first three weeks postpartum.
• The comprehensive postpartum visit should be scheduled between four weeks and six weeks after delivery.
• This initial postpartum assessment should be followed up with ongoing care as needed throughout the 12 month postpartum period, including with a comprehensive postpartum visit no later than 12 weeks after birth.

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains:
○ Mood and emotional well-being
○ Infant care and feeding
○ Sexuality
○ Contraception
○ Birth spacing
○ Sleep and fatigue
○ Physical recovery from birth
○ Chronic disease management
○ Health maintenance</td></tr>
</table>

	Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. See the ACOG guidance on Postpartum Care, available at: https://www.acog.org/news/news-releases/2018/04/acog-redesigns-postpartum-care See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf. https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I21-13.pdf#:~:text=Individuals%20in%20Medi-Cal%20with%20a%20SOC%20may%20be,for%20the%20rest%20of%20pregnancy%20and%20postpartum%20period. See PL 12-003, Obstetrical Care-Perinatal Services, or any superseding APL for additional information. See ACOG information on Optimizing Postpartum Care, available at: https://www.acog.org/More-Info/OptimizingPostpartumCare. **Note:** Postpartum care is eligible for the VBP program. Please consult with the MCP for details.

VI. OB/CPSP Preventive Criteria	
	For screening: If the postpartum assessment visit is not documented a point will not be given. A point can be given if there is documentation in the medical record of missed appointments and attempts to contact member and/or outreach activities. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and post-partum.** See the CDPH CPSP Integrated Initial 1st, 2nd, and 3rd Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.
2) Nutrition Assessment	• USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding. Nutrition Assessment should include mother and infant including support for breast feeding.[77] • Any needed interventions must be noted. • Documentation of referrals as indicated. Infant feeding/breastfeeding status is documented during the postpartum period.[78] See the ACOG guidance on Optimizing Support for Breastfeeding as Part of Obstetric Practice, available at: https://www.acog.org/Clinical-Guidance-and-

[77] See the USPSTF recommendation on Breastfeeding: Primary Care Interventions, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions.

[78] See PL 98-010, Breastfeeding Promotion, or any superseding APL for additional information.

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	Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice?IsMobileSet=false. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf
3) Psychosocial Assessment	Psychosocial Assessment includes mood and emotional wellbeing; sleep and fatigue.[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.
a) Maternal Mental Health Screening/Postpartum Depression screening	*Practitioner who provides prenatal or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling and intervention must be documented. • USPSTF recommends that clinicians provide or refer postpartum persons who are at increased risk of postpartum depression to counseling interventions.[80] • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for postpartum depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care?utm_source=redirect&utm_medium=web&utm_campaign=otn.
[80] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

VI. OB/CPSP Preventive Criteria	
	Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression ○ Suicide Risk Assessment ○ Referral to a practitioner who is qualified to diagnose and treat depression ○ Pharmacological interventions ○ Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. Edinburgh Postnatal Depression Scale (EPDS) is most commonly used and has been translated in 50 different languages.[81]
b) Social Needs Assessment	Social and Mental History (past and current). Follow up on pre-existing mental health disorders and social care needs such as housing, food, and transportation refer as appropriate.
c) Substance Use Disorder Assessment	Screen for tobacco and alcohol use and provide counseling; Screen for substance use disorder and refer as indicated. USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[82] See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information.

[81] HSC 123640
[82] See the USPSTF recommendation on Unhealthy Alcohol Use in Adolescents and Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions.

VI. OB/CPSP Preventive Criteria	
	USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[83]
4) Breastfeeding and other Health Education Assessment	• Health Education on infant care and feeding including breast feeding, contraception, and birth spacing. • Materials must be in threshold language and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[84] See the USPSTF recommendation on Breastfeeding, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions. See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.
5) Comprehensive Physical Exam	The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: • Mood and emotional well-being • Infant care and feeding • Sexuality • Contraception • Birth spacing • Sleep and fatigue • Physical recovery from birth • Chronic disease management • Health maintenance

[83] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions

[84] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. It is recommended that all women have contact with their OB-GYN or other obstetric care providers within the first three weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

REFERRAL, CONSULTS, DIAGNOSTIC TESTING TICKLER LOG

Date	Patient Name	Refer To	Appointment Date	Report Received	Calls to Specialist/Lab, X-Ray, Etc.	Results of Follow-Up Action

Instructions: When the physician orders a procedure, test or consultation, enter the date, patient's name, the referred to office and the date of the appointment. When the report of the ordered services is received, enter the date received. If the report is not received within 2 weeks of the scheduled date of the ordered service, call the provider of the service to inquire about the results report and document the call(s). Record results of actions taken to obtain reports.

Signature Page

(Please post on left-hand side of each Medical Record)

Please Write Signature as Entries are Typically Signed	Print Name in Full (First Name, Last Name, Title)

YEAR:

Medical Waste Collection Tracking Log
Collected by Medical Building Personnel

California Health and Safety Code § 117915 - 117946 permits associated medical/hospital buildings to collect and haul for accumulation, treatment and disposal of appropriately contained biohazard and sharps waste generated by their tenant clinics. Please complete the information below and keep this record on site for at least three (3) years.

Name, Address & Telephone Number of Medical/Hospital Building Administration who collects the medical from the tenant clinics:
Name & Address of Registered Waste Hauler contracted with the Medical/Hospital Building Administration:
Telephone & Registration number of the Medical Building's Registered Waste Hauler:
Name, Address & Telephone Number of the Provider/Clinic (tenant) where the medical waste is generated and collected from:

In each respective box below, clinic personnel shall document their initials and the number of biohazard and sharp waste containers collected by the medical building personnel during collection days. Clinic personnel shall initial and sign the bottom of this form for proper identification.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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Staff Signature / Initials:

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

MEDICAL WASTE LOG SHEET
FOR SMALL QUANTITY GENERATOR FACILITY
Per CA Health & Safety Code (HSC) § 117928 & 117945

California law allows hospitals to pick up bio-hazardous waste from associated medical buildings when they are not required to cross any city streets or public roads. Our medical building located at the following address meets this requirement:

_____
_____
_____

As a service to the physicians of this building, _____ (name of hospital/medical building) will pick up bio-hazardous and sharps waste when properly contained. It will then be transported to the hospital's common storage facility. The hospital is contracted with _____, a registered hazardous waste hauler for the proper transport, treatment and disposal of the bio-hazardous waste. The contract is kept current and on file at: _____

IMPORTANT: Completed log sheets must be kept on-site for at least TWO years.

Container Type (e.g. sharps container, red bag with biohazard waste, etc)	**Quantity**	**Name of Hospital Staff Transporter**	**Date of Removal**	**Comments**

MD Name:

Address:

Member Complaint Log
Health Net of California
(*All complaints must be logged)*

Member Name	Member ID#	Date of Complaint	Nature of Member's Complaint	Action (include action taken, Health Net notified)	Date Complaint Resolved	Date Log Sent to Health Net

Medi-Cal Member Instructions for Post-Emergency Room Care

Dear Medi-Cal Member:

You or your child has completed a medical screening examination at this emergency department. If it has been determined that you or your child's medical condition does not need immediate emergency treatment in this emergency department, you should call your primary care physician (PCP) for further instructions.

Your PCP, or the doctor on call for your PCP, is available to direct your present or follow-up care needs. Your PCP's name and telephone number are on the front of your Plan's member identification card.

If you cannot reach your PCP or the doctor on call for your PCP, call your Plan's Member Services Department, available 24 hours per day to assist you. This telephone number is on the back of your Plan's identification card.

في Health Net Community Solutions يُشار إليها اختصارًا (Health Net)، نولي اهتمامًا كبيرًا بمشكلاتك. إذا لم توافق على القرار، فيمكنك أنت أو أي شخص آخر تقديم طعن بشأن الخدمة المرفوضة. يمكنك تقديم تظلم إذا لم تكن راضيًا عن الرعاية أو العلاج الذي تلقيته.

يجب أن نحصل على موافقتك الخطية إذا كان مقدم الخدمة الخاص بك أو أي شخص تختاره يقدم طعنًا أو تظلمًا نيابةً عنك. قد نحتاج إلى موافقتك الخطية للحصول على السجلات الطبية من أجل الطعن أو التظلم المقدم منك. يمكنك الاتصال بقسم خدمة أعضاء Health Net عن طريق الاتصال بالرقم 1-800-675-6110 أو زيارة www.healthnet.com للحصول على هذه النماذج.

- نموذج الممثل المعتمد
- نموذج الإفراج عن السجلات الطبية

قم بتضمين أي أوراق أو معلومات ذات صلة بالطعن أو التظلم المقدم منك. يمكنك اختيار أي من الطرق التالية لإرسال الطعن أو التظلم.

- اتصل بقسم خدمة أعضاء Health Net على الرقم 1-800-675-6110. تتوفر خدمات اللغة إذا كنت في حاجة إليها.
- 711 (TTY) لضعاف السمع والنطق
- أكمل نموذج الطعن أو التظلم عبر الإنترنت على: www.healthnet.com
- أكمل هذا النموذج وأرسله عبر البريد أو الفاكس

عبر البريد: Health Net Community Solutions
Member Appeals and Grievance Department: Attn
PO Box 10348
Van Nuys, CA 91410-0348
أو
فاكس رقم 1-877-831-6019

تتوفر مواد الأعضاء بتنسيقات أخرى مثل طريقة برايل للمكفوفين، والطباعة بأحرف كبيرة، والتسجيل الصوتي، والمزيد.

Member Appeal or Grievance Form

الجزء 1: معلومات العضو:		
الاسم الأول والاسم الأخير:	رقم بطاقة الهوية:	تاريخ الميلاد:
العنوان:	المدينة:	الرمز البريدي:
رقم الهاتف:	أفضل وقت للاتصال:	

الجزء 2: معلومات حول الطعن أو التظلم	
اسم مقدم الخدمة:	تاريخ الخدمة (الخدمات)/الحدث:
رقم (أرقام) المطالبة:	الرقم (الأرقام) المرجعية:

أخبرنا بمشكلتك (مشكلاتك) والإجراء الذي تريده. يشمل ذلك: اسم مقدم الخدمة، تاريخ الخدمة (الخدمات)، المطالبة أو الرقم (الأرقام) المرجعية.

بخصوص الطعون: إرفاق نسخة من خطاب الإشعار باتخاذ إجراء.

يمكنك طلب عقد اجتماع إذا تم رفض علاج أو مستلزمات تعتبر تجريبية لديك وأنت مصاب بمرض عضال.

أعاني من مرض عضال وأطلب عقد اجتماع. ☐

الجزء 3: لمعلوماتك

إشعار اتخاذ إجراء هو خطاب رسمي نخبرك فيه بأننا سنرفض خدمة (خدمات) أو نؤخرها أو نغيرها أو ننهيها. يمكن إرسال التظلم في أي وقت.

اطلب مراجعة سريعة إذا كان الطعن أو التظلم المقدم منك ينطوي على تهديد فوري أو خطير لصحتك. سوف نقوم بمراجعة الطعن أو التظلم الخاص بك في غضون 72 ساعة من وقت الاستلام.

ستصلك رسالة خلال خمسة (5) أيام تقويمية بمجرد أن نتلقى الطعن أو التظلم المقدم منك.

قد يتحدث معك الموظف في Health Net الذي سيعمل على حالتك للحصول على مزيد من المعلومات.

تواصل مع DMHC أو DHCS إذا لم تكن راضيًا عن الطريقة التي تحل بها Health Net مشكلاتك.

California Department of Managed Health Care (DMHC)

تتحمل California Department of Managed Health (DMHC) مسؤولية تنظيم خطط خدمات الرعاية الصحية. وإذا كان لديك تظلم ضد خطتك الصحية، فينبغي لك أولاً الاتصال هاتفيًا بخطتك الصحية على الرقم **(1-800-675-6110, TTY:711)** واتباع إجراءات تقديم التظلم في خطتك الصحية قبل التواصل مع الإدارة. لا يحول استخدام إجراءات التظلم هذه دون الحصول على أي حقوق أو تعويضات قانونية محتملة قد تكون متوفرة لك. وإذا كنت بحاجة إلى مساعدة بشأن تظلم يتعلق بحالة طارئة، أو تظلم لم تتخذ فيه الخطة الصحية قرارًا مُرضيًا، أو تظلم لم يتم البت فيه لمدة تزيد عن 30 يومًا، يمكنك الاتصال بالإدارة للحصول على المساعدة. كما يمكن أن تكون مؤهلاً للحصول على Independent Medical Review (IMR). وإذا كنت مؤهلًا للحصول على IMR، فستوفر عملية IMR مراجعة حيادية للقرارات الطبية المتخذة من قبل خطة الرعاية الطبية فيما يتعلق بحالات الضرورة الطبية لتقديم الخدمة أو العلاج الموصي بهما، وقرارات التغطية للعلاجات التجريبية، أو قيد الدراسة وخلافات السداد في حالات الطوارئ، أو الخدمات الطبية العاجلة. يتوفر لدى الإدارة أيضًا رقم هاتف مجاني **(1-888-466-2219)** وخط TDD برقم **(1-877-688-9891)** لمن يعانون من صعوبات في السمع والتحدُّث. يحتوي موقع الإدارة الإلكتروني **www.dmhc.ca.gov** على نماذج الشكاوى، ونماذج طلب IMR، وتعليمات عبر الإنترنت.

مشروع قانون مجلس الشيوخ 923 (SB) – قانون الرعاية الشاملة للأشخاص المتحولين جنسيًا، أو متنوعي الهوية الجندرية، أو ثنائيي الجنس (TGI)

لديك الحق في تقديم شكوى لدى Health Net و DMHC إذا أخفق موفر الرعاية الخاص بك أو موظفو Health Net في تقديم الرعاية الشاملة للمتحولين جنسيًا لك.

تُعرّف الرعاية الصحية الشاملة للمتحولين جنسياً بأنها رعاية صحية شاملة تتفق مع معايير الرعاية للأفراد الذين يُعرّفون أنفسهم بأنهم TGI، وتحترم الاستقلالية الجسدية الشخصية للفرد، ولا تضع افتراضات حول جنس الفرد، وتقبل مرونة الهوية الجنسية والتعبير الجندري غير التقليدي، وتعامل الجميع بالتعاطف والتفهم والاحترام [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

للحصول Ombudsman Office of the California Department of Health Care Services (DHCS) على المساعدة. يساعد Ombudsman Office المستفيدين من برنامج Medi-Cal على الاستفادة الكاملة من حقوقهم والتزاماتهم بشكل كامل بصفتهم أعضاء في خطة الرعاية المُدارة. لمعرفة المزيد، اتصل على الرقم المجاني **1-888-452-8609**، من الاثنين إلى الجمعة، من 8 صباحًا إلى 5 مساءً.

الجزء 4: التوقيع

توقيع العضو أو الممثل المعتمد _____ التاريخ _____

كتابة اسم العضو أو الممثل المعتمد بحروف واضحة _____

Member Appeal or Grievance Form

Health Net Community Solutions-ում (Health Net), Ձեր մտահոգությունները կարևոր են մեզ համար: Եթե որոշման հետ համաձայն չեք, Դուք կամ որևէ այլ մեկը կարող եք մերժված ծառայության համար բողոքարկում ներկայացնել: Դուք կարող եք բողոք ներկայացնել, երբ գոհ չեք այն խնամքից կամ բուժումից, որն ստացել եք:

Մենք պետք է Ձեր գրավոր համաձայնությունն ունենանք, եթե Ձեր մատակարարը կամ ինչ-որ մեկը, ում ընտրել եք, բողոքարկում կամ բողոք է ներկայացնում Ձեր անունից: Մենք կարող ենք Ձեր գրավոր համաձայնության կարիքն ունենալ՝ բժշկական արձանագրություններ ստանալու Ձեր բողոքի կամ բողոքարկման համար: Դուք կարող եք դիմել Health Net-ի Անդամների սպասարկման բաժին՝ զանգահարելով 1-800-675-6110 հեռախոսահամարով կամ այցելելով www.healthnet.com կայքէջը՝ այս ձևաթղթերն ստանալու համար:

- Լիազորված ներկայացուցչի ձևաթուղթ
- Բժշկական արձանագրությունների հրապարակման ձևաթուղթ

Ներառեք Ձեր բողոքարկմանը կամ բողոքին համապատասխան ցանկացած փաստաթուղթ կամ տեղեկատվություն: Դուք կարող եք ընտրել հետևյալ մեթոդներից որևէ մեկը՝ Ձեր բողոքարկումը կամ բողոքն ուղարկելու համար:

- Զանգահարեք Health Net-ի Անդամների սպասարկման բաժին՝ 1-800-675-6110 հեռախոսահամարով: Լեզվական ծառայություններն անհրաժեշտության դեպքում հասանելի են:
- 711 (TTY)՝ լսելու և խոսելու խանգարում ունեցողների համար
- Բողոքարկումների կամ բողոքների ձևաթղթերն առցանց լրացրեք հետևյալ հասցեով՝ www.healthnet.com
- Լրացրեք այս ձևաթուղթը և ներկայացրեք փոստով կամ ֆաքսով

Փոստ՝ Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348

Կամ

877-831-6019 ֆաքսի համարով

Անդամների նյութերը հասանելի են այլ ձևաչափերով, ինչպես օրինակ՝ բրայլյան այբուբենով, խոշոր տպագիր, աուդիո և ավելին:

Member Appeal or Grievance Form

Մաս 1. Անդամին վերաբերող տվյալներ		
Անունը և ազգանունը՝	Նույնականացման (ID) համարը՝	Ծննդյան ամսաթիվ՝
Հասցե՝	Քաղաք՝	Փոստային դասիչ՝
Հեռախոսահամար	Զանգահարելու լավագույն ժամը	

Մաս 2. Բողոքարկումանը կամ բողոքին վերաբերող տեղեկություններ	
Մատակարարի անունը	Ծառայության (ծառայությունների) տրամադրման ամսաթիվը՝
Հայցի համար(ներ)ը՝	Վկայակոչման համարը՝

Պատմեք մեզ Ձեր մտահոգության (մտահոգությունների) մասին և այն, թե ինչ գործողություն եք ցանկանում: Ներառեք հետևյալը՝ Մատակարարի անունը, ծառայության (ծառայությունների) ամսաթիվը, հայցի կամ վկայակոչման համար(ներ)ը:

Բողոքարկումների համար՝ կցեք «Գործողության ծանուցագրի նամակի» պատճենը:

Դուք կարող եք խորհրդաժողով խնդրել, եթե մերժում եք ստացել բուժման կամ պաշարների համար որպես փորձի ենթակա եղող և մահացու հիվանդություն ունեք:

Ես մահացու հիվանդություն ունեմ և խորհրդաժողով եմ խնդրում: ☐

Մաս 3. Ձեր տեղեկատվության համար

«Գործողության ծանուցագիրը» պաշտոնական նամակ է, որտեղ մենք Ձեզ ասում ենք, որ կմերժենք, կհետաձգենք, կփոխենք կամ կավարտենք ծառայություն(ներ)ը: Բողոքը կարող է ցանկացած պահի ուղարկվել:

Արագ վերանայում խնդրեք, եթե Ձեր բողոքարկումը կամ բողոքը Ձեր առողջության համար անհետաձգելի կամ լուրջ սպառնալիք է ներառում: Մենք Ձեր բողոքարկումը կամ բողոքը կվերանայենք այն ստանալու պահից սկսած 72 ժամվա ընթացքում:

Դուք հինգ (5) օրացուցային օրվա ընթացքում նամակ կստանաք, երբ որ մենք ստանանք Ձեր բողոքարկումը կամ բողոքը:

Health Net-ի աշխատակազմից որևէ մեկը, որը պետք է աշխատի Ձեր գործի վրա, կարող է զրուցել Ձեզ հետ՝ հավելյալ տեղեկությունների համար:

Դիմեք DMHC կամ DHCS, եթե գոհ չեք, թե ինչպես է Health Net-ը լուծում Ձեր մտահոգությունները:

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care-ը կարգավորում է առողջական խնամքի ծառայության ծրագրերը: Եթե Ձեր առողջապահական ծրագրի դեմ բողոք ունեք, ապա, նախքան բաժին դիմելը պետք է զանգահարեք Ձեր առողջապահական ծրագիր **(1-800-675-6110, TTY՝711)** հեռախոսահամարով և օգտագործեք Ձեր առողջապահական ծրագրի բողոքարկման գործընթացը: Բողոքարկման այս ընթացակարգի օգտագործումը չի բացառում որևէ հավանական օրինական իրավունք կամ պաշտպանության միջոց, որը կարող է Ձեզ հասանելի լինել: Շտապ օգնության հետ կապված բողոքի, Ձեր առողջապահական ծրագրի կողմից անբավարար լուծում ստացած բողոքի կամ 30 օրվա ժամկետում չլուծված բողոքի կապակցությամբ օգնության համար կարող եք զանգահարել բաժին: Կարող եք նաև մասնակցել Independent Medical Review-ին (IMR): Եթե IMR-ի իրավասու եք, ապա IMR-ի գործընթացը Ձեզ կընձեռի առողջապահական ծրագրի կողմից կայացված բժշկական որոշումների անաչառ վերանայման հնարավորություն՝ կապված առաջարկված ծառայության կամ բուժման բժշկական անհրաժեշտության, փորձնական կամ հետազոտական բնույթի բուժումն ապահովագրելու որոշումների, ինչպես նաև արտակարգ իրավիճակի կամ հրատապ բժշկական ծառայությունները փոխհատուցելու վեճերի հետ: Բաժինն ունի նաև անվճար հեռախոսահամար **(1-888-466-2219)** և TDD գիծ **(1-877-688-9891)**՝լսողության և խոսքի խանգարում ունեցողների համար: Բաժնի համացանցային կայքը՝ **www.dmhc.ca.gov** ունի առցանց գանգատի ձևաթղթեր, IMR-ի դիմումի ձևաթղթեր և հրահանգներ:

Սենատի օրինագիծ (SB) 923՝ «Տրանսգենդեր, գենդերային բազմազանության կամ միջսեռական (TGI) ներառական խնամքի մասին» օրենք

Իրավունք ունեք գանգատ ներկայացնելու Health Net-ին և DMHC-ին, եթե Ձեր մատակարարին կամ Health Net-ի անձնակազմին չի հաջողվել Ձեզ փոխներառական խնամք մատուցել:

Տրանսներառական առողջական խնամքը սահմանվում է որպես համապարփակ առողջական խնամք, որը համապատասխանում է TGI-ով նույնականացվող անհատների խնամքի չափանիշներին, հարգում է անհատի անձնական մարմնական ինքնավարությունը, չի կատարում ենթադրություններ անհատի սեռի վերաբերյալ, ընդունում է սեռային հոսունությունը և ոչ ավանդական սեռային ներկայացումը, և բոլորին վերաբերվում է կարեկցանքով, հասկացողությամբ և հարգանքով [HSC § 1367.043(d)(3)]:

California Department of Health Care Services (DHCS) Office of the Ombudsman

Դուք նաև կարող եք զանգահարել California Department of Health Care Services (DHCS) Office of the Ombudsman՝ օգնության համար: Office of the Ombudsman-ն օգնում է Medi-Cal-ի նպաստառուներին՝ լիարժեք օգտվել իրենց իրավունքներից և պարտավորություններից՝ որպես կառավարվող խնամքի ծրագրի անդամ: Հավելյալ տեղեկության համար զանգահարեք **1-888-452-8609** անվճար հեռախոսահամարով, երկուշաբթիից ուրբաթ, 8:00-ից 17:00:

Մաս 4. Ստորագրություն

Անդամի կամ լիազորված ներկայացուցչի ստորագրությունը Ամսաթիվ

Անդամի կամ լիազորված ներկայացուցչի տպագիր անունը

Member Appeal or Grievance Form

Health Net Community Solutions (Health Net) 非常重視您的所有顧慮。如果您不同意某項決定，您或任何其他人可以針對被拒絕的服務提出上訴。如果您對所接受的護理或治療不滿意，您可以提出申訴。

如果您的醫療服務提供者或由您所選的某人代表您提出上訴或申訴，我們必須獲得您的書面同意。我們可能需要您的書面同意才能取得供您的上訴或申訴所用的醫療記錄。您可以致電 1-800-675-6110 聯絡 Health Net 會員服務部或前往 www.healthnet.com 以取得這些表格。

- 授權代表表格
- 醫療記錄釋出授權表格

包括與您的上訴或申訴相關的任何文件或資訊。您可以選擇以下任何一種方式來送出您的上訴或申訴申請。

- 致電 Health Net 會員服務部：1-800-675-6110。
  如果您需要，我們可以提供語言服務。
- 聽語障人士請撥打聽障專線(TTY)：711
- 線上填寫上訴或申訴表：www.healthnet.com
- 填寫此表格並透過郵寄或傳真提交

  郵寄：Health Net Community Solutions
  Attn: Member Appeals and Grievance Department
  PO Box 10348
  Van Nuys, CA 91410-0348

  或

  傳真號碼：1-877-831-6019

還可提供其他形式的會員資料，例如盲文版、大字版和語音資料等。

Member Appeal or Grievance Form

第 1 部分：會員資料		
名字和姓氏：	會員卡號碼：	出生日期：
地址：	城市：	郵遞區號：
電話號碼：	最佳聯絡時間：	

第 2 部分：有關上訴或申訴的資訊	
醫療服務提供者名稱：	服務/發生日期：
理賠編號：	參考編號：

告訴我們您的顧慮和您想要採取的行動。包括：醫療服務提供者名稱、服務日期、理賠或參考編號。

對於上訴：附上行動通知函的複本。

如果您因實驗性質的治療或用品被拒絕，而且您患有末期疾病，您可以要求召開會議。

我患有末期疾病，我要求召開會議。 ☐

第 3 部分：供您參考的資訊

行動通知是一封正式函件，我們會在函件中告訴您，我們將拒絕、延遲、變更或終止某項服務。可以隨時送出申訴申請。

如果您的上訴或申訴對您的健康造成直接或嚴重威脅，請要求快速審查。我們將在收到您的上訴或申訴後的 72 小時內審查您的個案。

我們收到您的上訴或申訴後，您將在五 (5) 個日曆天內收到一封信。

Health Net 負責處理您個案的工作人員可能會聯絡您以獲取更多資訊。

如果您對 Health Net 解決您顧慮的方式不滿意，請聯絡 DMHC 或 DHCS。

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care 負責管理醫療保健服務計畫。如果您想對您的健保計畫提出申訴，在致電 Department of Managed Health Care 之前，請先撥 **(1-800-675-6110，聽障專線 TTY：711)** 聯絡您的健保計畫，並使用您健保計畫的申訴程序。使用此申訴程序並不會妨礙您的任何潛在法定權利或可能可使用的補救措施。如果您需要協助處理涉及緊急情況的申訴、您的健保計畫未圓滿解決的申訴、或在提出 30 天後仍未解決的申訴，您可致電 Department of Managed Health Care 尋求協助。您也可能符合獨立醫療審查 (Independent Medical Review, IMR) 資格。若您符合獨立醫療審查 (IMR) 資格，則獨立醫療審查 (IMR) 程序會就健保計畫對建議服務或治療的醫療必要性、對實驗或研究性質治療的承保決定，以及急診或緊急醫療服務給付爭議等相關醫療決定，進行公正的審查。Department of Managed Health Care 也設有免付費電話號碼 **(1-888-466-2219)**，以及為聽語障人士提供的聽障專線 (TDD) **(1-877-688-9891)**。Department of Managed Health Care 的網站 **www.dmhc.ca.gov** 有提供線上投訴表、獨立醫療審查 (IMR) 申請表和說明。

Senate Bill (SB) 923 包含跨性別、多元性別或雙性人 (TGI) 的照護法案

如果您的醫療服務提供者或 Health Net 工作人員未能為您提供跨包容照護，您有權向 Health Net 和 DMHC 提出投訴。

包含跨性別的醫療保健是指為認同自己是 TGI 的個人所提供的符合照護標準的綜合醫療保健，它尊重個人的個人身體自主權、不假設個人的性別、接受性別流動性和非傳統的性別陳述，並且以慈心、理解和尊重對待所有人 [HSC § 1367.043(d)(3)]。

California Department of Health Care Services (DHCS) Office of the Ombudsman

您也可以致電 California Department of Health Care Services (DHCS) 監察人員辦公室以尋求協助。監察人員辦公室協助 Medi-Cal 受益者充分行使作為管理式護理計畫的會員之權利和責任。如需瞭解更多資訊，請撥打免付費電話 1-888-452-8609，服務時間為週一至週五，上午 8 時至下午 5 時。

第 4 部分：簽名

會員或授權代表簽名　　日期

會員或授權代表的正楷姓名

Member Appeal or Grievance Form

在Health Net Community Solutions (Health Net)，您的顾虑对我们很重要。如果您不同意某项决定，您或其他人可以对被拒绝的服务提出上诉。如果您对所接受的护理或治疗不满意，可以提出申诉。

如果您的医疗服务提供者或您选择的某人代表您提出上诉或申诉，必须提供您的书面授权。我们可能需要您的书面授权才能针对您的上诉或申诉获取医疗记录。您可以致电 1-800-675-6110 联系 Health Net 会员服务部，或访问 www.healthnet.com 获取这些表格。

- 授权代表表格
- 医疗记录授权表

请提供与您的上诉或申诉相关的任何文件或信息。您可以选择以下任何一种方式来提交您的上诉或申诉。

- 致电 Health Net 会员服务部：
  1-800-675-6110。如果您需要，我们可以提供语言服务。
- 听语障人士请使用 711 (TTY) 专线
- 在线填写上诉或申诉表：www.healthnet.com
- 填写此表格并通过邮寄或传真提交

邮寄：Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348

或者

传真号：1-877-831-6019

会员材料备有其他格式，如盲文、大字版、音频等。

Member Appeal or Grievance Form

第 1 部分：会员信息		
名字和姓氏：	编号：	出生日期：
地址：	城市：	邮政编码：
电话号码：	最佳致电时间：	

第 2 部分：上诉或申诉相关信息	
医疗服务提供者姓名：	服务/事件日期：
理赔编号：	参考编号：

告诉我们您的顾虑和您想要采取的行动。请包括：医疗服务提供者姓名、服务日期、理赔或参考编号。

上诉：附上行动通知书的副本。

如果您被拒绝接受实验性治疗或用品并且患有绝症，您可以要求召开会议。

我身患绝症，特此请求召开会议。 ☐

第 3 部分：请知悉

行动通知是一封正式信函，用于告知您我们将拒绝、延迟、更改或终止某项服务。可以随时提交申诉。

如果您的上诉或申诉涉及对您健康的直接或严重威胁，请要求进行快速审查。我们将在收到您的上诉或申诉后 72 小时内进行审查。

一旦我们收到您的上诉或申诉，您将在五 (5) 个日历日内收到一封信。

负责您个案的 Health Net 工作人员可能会与您交谈以获取更多信息。

如果您对 Health Net 解决您顾虑的方式不满意，请联系 DMHC 或 DHCS。

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care 负责规管医疗保健服务计划。如您想对您的健保计划提出申诉，在联系该部门之前，请先致电您的健保计划 **(1-800-675-6110，TTY：711)**，并利用您健保计划的申诉程序。利用此申诉程序并不会妨碍您的任何潜在法定权利或可以使用的补救措施。如果您需要协助处理涉及紧急情况的申诉、您的健保计划尚未圆满解决的申诉、或在提出 30 天后仍未解决的申诉，则可致电该部门寻求协助。您也可能符合独立医疗审查 (Independent Medical Review, IMR) 的资格。如果您符合独立医疗审查 (IMR) 的资格，独立医疗审查 (IMR) 程序则会就健保计划对提议之服务或治疗的医疗必要性、对实验或研究性质治疗的承保决定，以及急诊或紧急医疗服务给付争议等相关医疗决定，进行公正的审查。该部门也设有免付费电话号码 **(1-888-466-2219)**，以及为听语障人士提供的听障专线 (Telecommunication Device for the Deaf, TDD) **(1-877-688-9891)**。该部门网站 **www.dmhc.ca.gov** 在线提供投诉表、独立医疗审查 (IMR) 申请表及相关说明。

923 号参议院法案 (SB)：跨性别者、性别多元者或双性人 (TGI) 包容性医疗法案

如果您的医疗服务提供者或 Health Net 工作人员未能为您提供跨性别包容性医疗服务，您有权向 Health Net 和 DMHC 提出投诉。

跨性别包容性医疗服务被定义为一种综合性医疗服务，它符合被认定为 TGI 的个人的护理标准，尊重个人的身体自主权，不对个人的性别做出假设，接纳性别流动性和非传统的性别表现，并以同理心、理解和尊重对待每个人 [HSC § 1367.043(d)(3)]。

California Department of Health Care Services (DHCS) Office of the Ombudsman

您也可以致电 Ombudsman Office of the California Department of Health Care Services (DHCS) 寻求帮助。Ombudsman Office 帮助 Medi-Cal 受益人充分履行其作为管理式医疗计划会员的权利和责任。如需了解更多信息，请拨打免费电话 **1-888-452-8609**，工作时间：周一至周五上午 8:00 至下午 5:00。

第 4 部分：签名

会员或授权代表签名

日期

工整书写会员或授权代表姓名

Member Appeal or Grievance Form

At Health Net Community Solutions (Health Net), your concerns matter to us. If you do not agree with a decision, you, or someone else may file an Appeal for a denied service. You can file a Grievance if you are not happy with the care or treatment you received.

We must have your written consent if your Provider or someone you choose is filing an Appeal or Grievance on your behalf. We may need your written consent to get medical records for your Appeal or Grievance. You may contact Health Net Member Service Department by calling 1-800-675-6110 or go to www.healthnet.com to get these forms.

- Authorized Representative form
- Medical Records Release form

Include any papers or information relevant for your Appeal or Grievance. You can choose any of the following ways to send your Appeal or Grievance.

- Call the Health Net Member Service Department at 1-800-675-6110. Language services are available if you need.
- 711 (TTY) for the hearing and speech impaired
- Complete the Appeals or Grievance form online at: www.healthnet.com
- Complete this form and submit it via mail or fax

Mail: Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348
Or
Fax # 1-877-831-6019

Member materials are on hand in other formats such as, Braille, large print, audio, and more.

Member Appeal or Grievance Form

Part 1: Member Information		
First and Last Name:	ID#:	Date of Birth:
Address:	City:	Zip Code:
Phone Number:	Best Time to Call:	

Part 2: Information about the Appeal or Grievance	
Name of Provider:	Date of Service(s)/Occurrence:
Claim Number(s):	Reference Number(s):

Tell us your concern(s) and action you want. Include: Name of Provider, date of service(s), claim or reference number(s).

For Appeals: Attach a copy of the Notice of Action Letter.

You can ask for a conference if you received a denial for treatment or supplies as experimental and have a terminal illness.

I have a terminal illness and am asking for a conference. ☐

Part 3: For Your Information

Notice of Action is a formal letter that we tell you we will deny, delay, change, or end a service(s). A Grievance can be sent at any time.

Ask for a fast review if your Appeal or Grievance involves an immediate or serious threat to your health. We will review your Appeal or Grievance within 72 hours from the time of receipt.

You will get a letter in five (5) calendar days once we get your Appeal or Grievance.

The staff person at Health Net that will work on your case may talk to you for more information.

Reach out to DMHC or DHCS if you are not happy with how Health Net resolves your concerns.

California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-675-6110, TTY:711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Senate Bill (SB) 923 Transgender, Gender Diverse or Intersex (TGI) Inclusive Care Act

You have a right to file a complaint with Health Net and the DMHC if your provider or Health Net staff failed to provide you trans-inclusive care.

Trans-inclusive health care is defined as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding and respect [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

You may also call the Ombudsman Office of the California Department of Health Care Services (DHCS) for help. The Ombudsman Office helps Medi-Cal beneficiaries to fully use their rights and responsibilities as a member of a managed care plan. To find out more, call toll-free **1-888-452-8609,** Monday to Friday, 8:00am to 5:00pm.

Part 4: Signature

Signature of Member or Authorized Representative

Date

Print Name of Member or Authorized Representative

ما در Health Net Community Solutions (Health Net) به نگرانی‌های شما اهمیت می‌دهیم. اگر با تصمیم اتخاذ شده موافق نیستید، شما یا شخصی از طرف شما می‌توانید بابت آن خدماتی که تایید نشده‌اند درخواست استیناف دهید. اگر از مراقبت یا روند درمانی که دریافت کرده‌اید راضی نیستید، می توانید شکایت خود را ثبت کنید.

اگر ارائه‌دهنده شما یا شخصی که انتخاب می‌کنید از طرف شما درخواست تجدیدنظر یا شکایت کند، باید رضایت کتبی شما را دریافت کنیم. برای دریافت سوابق پزشکی مربوط به درخواست تجدیدنظر یا شکایت شما، ممکن است به رضایت کتبی شما نیاز داشته باشیم. برای دریافت این فرم‌ها می‌توانید از طریق شماره 1-800-675-6110 با اداره خدمات اعضای Health Net تماس بگیرید یا به www.healthnet.com مراجعه کنید.

- فرم نماینده مجاز
- فرم دسترسی به مدارک پزشکی

تمام مدارک یا اطلاعات مربوط به درخواست تجدیدنظر یا شکایت خود را وارد کنید. می‌توانید یکی از راه‌های زیر را برای ارسال درخواست تجدیدنظر یا شکایت خود انتخاب کنید.

- با بخش خدمات اعضای Health Net از طریق شماره 1-800-675-6110 تماس بگیرید.
  خدمات ترجمه در صورت نیاز ارائه می‌شود.
- (TTY: 711) برای اشخاصی دارد که مشکلات شنوایی و گفتاری دارند.
- فرم تجدیدنظر یا شکایت را به صورت آنلاین تکمیل کنید در: www.healthnet.com
- این فرم را پر کرده و از طریق پست یا فکس برگردانید.

از طریق پست: Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348
یا
فکس 1-877-831-6019

اطلاعات مورد نیاز اعضا در قالب‌های دیگری مانند خط بریل، چاپ بزرگ، صوتی و غیره در دسترس هستند.

Member Appeal or Grievance Form

بخش 1: اطلاعات عضو		
نام و نام خانوادگی:	شماره شناسه:	تاریخ تولد:
نشانی:	شهر:	زیپ کد:
شماره تلفن:	بهترین زمان برای تماس:	

بخش 2: اطلاعات مربوط به درخواست تجدیدنظر یا شکایت	
نام ارائه‌دهنده:	تاریخ خدمات/رویداد:
شماره(های) مطالبات:	شماره(های) پیگیری:

نگرانی(ها) و اقدام مورد نظر خود را به ما بگویید. شامل این موارد: نام ارائه دهنده، تاریخ(های) خدمات، شماره(های) مطالبه یا پیگیری.

برای درخواست تجدیدنظر: یک نسخه از نامه «اعلامیه اقدامات» را ضمیمه کنید.

اگر درخواست شما برای درمان یا تجهیزات آزمایشی رد شده است و بیماری لاعلاج دارید، می‌توانید درخواست کنفرانس کنید.

من به بیماری لاعلاج مبتلا هستم و تقاضای کنفرانس دارم. ☐

بخش 3: جهت اطلاع

«اعلامیه اقدامات» یک نامه رسمی است که در آن به شما می‌گوییم چه سرویس(های) را رد می‌کنیم، به تاخیر می‌اندازیم، تغییر می‌دهیم یا پایان می‌دهیم. شما می‌توانید در هر زمانی شکایت خود را ارائه دهید.

اگر درخواست تجدیدنظر یا شکایت شما به خطری فوری یا جدی برای سلامتی شما مربوط می‌شود، درخواست بررسی سریع کنید. ما درخواست تجدیدنظر یا شکایت شما را ظرف 72 ساعت از زمان دریافت آن بررسی خواهیم کرد.

پس از دریافت درخواست تجدیدنظر یا شکایت، شما ظرف پنج (5) روز تقویمی نامه‌ای دریافت خواهید کرد.

کارمند Health Net که روی پرونده شما کار می‌کند، ممکن است برای کسب اطلاعات بیشتر با شما تماس بگیرد.

اگر از نحوه رفع نگرانی‌های خود توسط Health Net راضی نیستید، با DMHC یا DHCS تماس بگیرید.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care (سازمان مراقبت درمانی هماهنگ کالیفرنیا) مسئول نظارت بر برنامه های خدمات مراقبت درمانی می باشد. اگر برعلیه برنامه درمانی خود شکایت دارید، باید در ابتدا به برنامه درمانی خود تلفن کنید **(1-800-675-6110 یا TTY:711)** و قبل از تماس با این اداره از روال شکایت برنامه درمانی خود استفاده کنید. استفاده از این فرایند نارضایتی، شما را از هرگونه حقوق یا راه حل‌های قانونی احتمالی که ممکن است در اختیارتان باشد محروم نمی‌کند. اگر در رابطه با نارضایتی که مربوط به مواقع اضطراری می شود، نارضایتی که به طور رضایتبخش توسط برنامه درمانی تان حل و فصل نشده یا نارضایتی که برای بیش از 30 روز حل نشده باقی مانده به کمک نیاز دارید، می توانید برای دریافت کمک با این اداره تماس بگیرید. همچنین ممکن است برای «بررسی مستقل پزشکی» (Independent Medical Review, IMR) واجد شرایط باشید. اگر برای بررسی مستقل پزشکی (IMR) واجد شرایط باشید، روال بررسی مستقل پزشکی (IMR) به طریقی بي طرفانه تصمیمات پزشکی اتخاذ شده توسط برنامه درمانی را مورد رسیدگی قرار می دهد. این تصمیمات می تواند در رابطه با لزوم دریافت خدمات یا معالجه پیشنهاد شده، تصمیمات مربوط به پوشش برای معالجات با ماهیت تجربی یا تحقیقاتی و اختلافات در میزان هزینه خدمات پزشکی اضطراری یا فوری باشد. همچنین سازمان یک شماره تلفن رایگان **(1-888-466-2219)** و یک خط TDD به شماره **(1-877-688-9891)** برای افراد دارای ناتوانی گفتاری و شنیداری دارد. وبسایت این اداره به آدرس **www.dmhc.ca.gov** حاوی فرم های شکایت، فرم های تقاضا برای بررسی مستقل پزشکی (IMR) و دستورالعمل های آنلاین است.

طرح سنا 923 (SB) – قانون مراقبت فراگیر برای افراد ترنس‌جندر، با تنوع جنسیتی یا اینترسکس (TGI)

اگر ارائه‌دهنده خدمات یا کارکنان Health Net در ارائه مراقبت فراگیر برای افراد ترنس کوتاهی کرده باشند، شما حق دارید شکایت خود را نزد Health Net و اداره مدیریت مراقبت‌های بهداشتی (DMHC) ثبت کنید.

مراقبت بهداشتی فراگیر برای افراد ترنس به مراقبتی جامع گفته می‌شود که با استانداردهای مراقبتی برای افرادی که خود را TGI (ترنسجندر، با تنوع جنسیتی یا اینترسکس) می‌دانند مطابقت دارد، به خودمختاری بدنی فرد احترام می‌گذارد، درباره جنسیت فرد فرضیه‌سازی نمی‌کند، سیالیت جنسیتی و نمودهای غیرسنتی جنسیت را می‌پذیرد، و با همگان با شفقت، درک و احترام رفتار می‌کند [HSC § 1367.043(d)(3)].

<u>California Department of Health Care Services (DHCS) Office of the Ombudsman</u>

برای دریافت کمک همچنین می‌توانید با California Department of Health Care Services (DHCS) Office of the Ombudsman (دفتر بازرس کل اداره خدمات مراقبت درمانی کالیفرنیا) تماس بگیرید. دفتر Ombudsman Office به ذینفعان Medi-Cal کمک می‌کند تا از حقوق و مسئولیت‌های خود به عنوان عضوی از یک طرح مراقبت مدیریت شده استفاده کنند. برای کسب اطلاعات بیشتر، از دوشنبه تا جمعه و از ساعت8:00 صبح تا 5:00 بعدازظهر با شماره رایگان **1-888-452-8609** تماس بگیرید.

بخش 4: امضاء

_____ _____

امضای عضو یا نماینده مجاز تاریخ

_____

نام کامل عضو یا نماینده مجاز

Member Appeal or Grievance Form

Ntawm Health Net Community Solutions (Health Net), koj cov kev txhawj xeeb txog rau peb. Yog tias koj tsis pom zoo nrog qhov kev txiav txim siab, ces koj, los sis ib tus neeg tuaj yeem sau ntawv thov Ib Qhov Kev Rov Txiav Txim Dua rau qhov tsis kam lees muab kev pab. Koj tuaj yeem sau ntawv Foob Tsis Txaus Siab yog tias koj tsis zoo siab nrog qhov kev saib xyuas los sis kev kho mob uas koj tau txais.

Peb yuav tsum muaj koj ib daim ntawv sau tso cai yog tias koj Tus Kws Kho Mob los sis lwm tus neeg uas koj xaiv los sau Daim Ntawv Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab sawv cev rau koj. Tej zaum peb yuav xav tau koj daim ntawv sau tso cai kom tau txais cov ntawv sau tseg kev kho mob rau koj Qhov Kev Thov Rov Txiav Txim Dua los sis Foob Kev Tsis Txaus Siab. Tej zaum koj tuaj yeem tiv tauj Health Net Lub Chaw Hauj Lwm Saib Xyuas Kev Pab Cuam Tswv Cuab uas yog hu rau 1-800-675-6110 los sis mus rau www.healthnet.com kom tau txais cov ntawv foos no.

- Daim foos Kev Tso Cai Ua Tus Neeg Sawv Cev
- Daim foos Nthuav Tawm Cov Ntaub Ntawv Sau Tseg Kev Kho Mob

Suav nrog ib cov ntawv twg los sis cov ntaub ntawv uas cuam tshuam txog koj Qhov Kev Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab. Koj tuaj yeem xaiv ib txoj hauv kev txuas ntxiv no txhawm rau xa koj Daim Ntawv Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab.

- Hu rau Health Net Lub Chaw Hauj Lwm Saib Xyuas Kev Pab Cuam Tswv Cuab ntawm 1-800-675-6110. Muaj kev pab cuam txhais lus yog tias koj xav tau.
- 711 (TTY) rau cov neeg tsis hnov lus thiab hais tsis tau lus
- Sau tiav Daim Ntawv Foos Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab hauv online ntawm: www.healthnet.com
- Sau tiav daim foos no thiab xa nws ncaj qha hauv chaw xa ntawv los sis fev

Xa ntawv: Health Net Community Solutions
Txog rau: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348
Los sis
Fev # 1-877-831-6019

Tus tswv cuab cov cuab yeej muaj nyob ntawm tes ua ntau hom qauv xws li, Ntawv Neeg Dig Muag, luam tus ntawv loj, kaw ua suab lus, thiab ntau yam ntxiv.

Member Appeal or Grievance Form

Ntu 1: Tswv Cuab Cov Ntaub Ntawv		
Lub Npe thiab Lub Xeem:	ID#:	Hnub Yug:
Chaw Nyob:	Nroog:	Lab Hav Zip:
Npawb Xov Tooj:	Lub Sij Hawm Zoo Tshaj Plaws Rau Hu:	

Ntu 2: Cov Ntaub Ntawv hais txog Kev Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab	
Lub Npe ntawm Tus Kws Kho Mob:	Hnub Tim ntawm Qhov Kev Pab Tshwm Sim:
Tus Npawb Daim(cov) Ntawv Thov:	Tus(cov) Npawb Ua Pov Thawj:

Qhia peb txog koj qhov(cov) kev txhawj xeeb thiab qhov kev nqis tes ua uas koj xav tau. Suav nrog: Lub Npe ntawm Tus Kws Kho Mob, hnub tim ntawm qhov(cov) kev pab, tus(cov) npawb ua ntawv thov los sis ntawv pov thawj.

Rau Kev Rov Txiav Txim Dua: Xa ib daim ntawv theej ntawm Tsab Ntawv Ceeb Toom Kev Nqis Tes Ua.

Koj tuaj yeem thov ib lub rooj sib tham yog tias koj tau txais qhov kev tsis kam lees muab kev kho mob los sis cov khoom siv raws kev tshawb nrhiav pom thiab muaj ib qho kev kho mob nyob hauv.

Kuv muaj ib qho kev kho mob sab hauv thiab kuv tab tom thov rau ib lub rooj sib tham. ☐

Ntu 3: Rau Koj Cov Ntaub Ntawv

Tsab Ntawv Ceeb Toom Kev Nqis Tes Ua yog ib tsab ntawv raws cai uas peb qhia rau koj paub tias peb yuav tsis kam lees, ua qeeb, hloov pauv, los sis xaus qhov kev pab cuam. Qhov Kev Tsis Txaus Siab tuaj yeem xa tau txhua lub sij hawm.

Thov kom tshuaj xyuas sai yog tias koj Tsab Ntawv Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab cuam tshuam nrog ib qho mob hnyav uas yuav tau kho koj tus mob sai. Peb yuav tshuaj xyuas koj daim Ntawv Thov Rov Txiav Txim Dua los sis Ntawv Foob Kev Tsis Txaus Siab tsis pub dhau 72 teev suav txij thaum tau txais tsab ntawv.

Koj yuav tau txais ib tsab ntawv nyob hauv sij hawm tsib (5) hnub thaum peb tau txais koj Daim Ntawv Thov Rov Txiav Txim Dua los sis Ntawv Foob Tsis Txaus Siab.

Tusneeg ua hauj lwm ntawm Health Net uas ua hauj lwm saib xyuas koj qhov xwm txheej tej zaum yuav tham nrog koj rau cov ntaub ntawv ntau ntxiv.

Tiv tauj rau DMHC los sis DHCS yog tias koj tsis txaus siab nrog Health Net qhov kev daws koj cov kev txhawj xeeb.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care (Tuam Tsev Tswj Xyuas Kev Kho Kab Mob Kev Nkeeg) muaj tes luag num tswj cov kev pab them nqi kho mob. Yog tias koj muaj kev tsis txaus siab rau koj txoj phiaj xwm kho mob, koj yuav tsum xub hu xov tooj rau koj txoj phiaj xwm kho mob ntawm **(1-800-675-6110, TTY:711)** thiab siv koj txoj phiaj xwm kev kho mob qhov txheej txheem foob kev tsis txaus siab ua ntej tiv tauj Lub Chaw Hauj Lwm. Kev siv qhov txheej txheem lis kev tsis txaus siab no yuav tsis txwv tej cai lij choj los sis cov kev kho mob uas muaj rau koj. Yog koj xav tau kev pab hais ibqho tsis txaus siab los ntawm kis saib xyuas xwm txheej kub ntxhov ceev, koj tseem tsis txaus siab rau qhov daws qhov teeb meem ntawm koj hom kev npaj saib xyuas kev noj qab haus huv, los sis tseem tsis tau daws qhov teeb meem ntev txog 30 hnub, tej zaum koj tuaj yeem hu mus thov kev pab rau ntawm Lub Tsev Haujlwm Loj. Tej zaum koj tsim nyog tau Kev Nrog Xyuas Txog Kab Mob Kev Nkeeg Ywj Pheej (Independent Medical Review, IMR). Yog koj muaj cai rau kis IMR, yuav tau rov qab saib xyuas raws li txheej txheem IMR txog feem kev txiav txim siab khomob rau koj lossis tau muab kev saib xyuas rau koj, kev txiav txim pab them cov nqi khomob rau feem kev sim khomob lossis feem tshuaj ntsuam xyuas keeb kwm ntawm tus mob thiab qhov tsis pom zoo them cov nqi rau kis saib xyuas xwm txheej kub ntxhov ceev lossis kev khomob sai sai. Lub tuam tsev ua hauj lwm tseem muaj tus xov tooj hu dawb **(1-888-466-2219)** thiab ib tus xov tooj TDD **(1-877-688-9891)** rau lub rooj rov txiav txim dua thiab cov neeg puas qhov kev hais lus. Lub chaw hauj lwm li internet wibsite **www.dmhc.ca.gov** muaj daim foos kev tsis tsaus siab, daim ntawv foos thov IMR thiab cov lus qhia hauv online.

Senate Bill (SB) 923 Tus Hloov Ua Poj Niam Txiv Neej, Ntau Hom Poj Niam Txiv Neej los sis Intersex (TGI) Tsab Cai Kev Saib Xyuas Txhua Tus

Koj muaj cai sau ntawv kev tsis txaus siab rau Health Net thiab DMHC yog tias koj tus muab kev pab cuam los sis Health Net cov neeg ua hauj lwm tsis muab kev saib xyuas kev noj qab haus huv rau txhua tus rau koj.

Kev saib xyuas kev kho mob rau txhua tus txhais tau tias yog kev saib xyuas kev kho mob uas ua raws li cov qauv kev saib xyuas rau cov tib neeg uas txheeb xyuas tias yog TGI, hwm tus neeg ntawm tus neeg lub cev, tsis muaj kev sib cais raws li qhov yog poj niam txiv neej, lees txais poj niam txiv neej fluidity thiab tsis yog poj niam txiv neej, thiab kho txhua tus nrog kev hlub tshua, kev nkag siab thiab kev hwm [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

Koj kuj tuaj yeem hu rau Ombudsman Office of California Department of Health Care Services (DHCS) kom tau txais kev pab. Ombudsman Office pab Medi-Cal cov neeg tau txais txiaj ntsig los siv tag nrho lawv cov cai thiab cov luag hauj lwm thaum yog ib tus tswv cuab ntawm txoj phiaj xwm kev tuav tswj kho mob. Kom pom cov ntaub ntawv ntau ntxiv, hu rau tus xov tooj hu dawb **1-888-452-8609**, Hnub Monday txog Friday, 8:00 teev sawv ntxov txog 5:00 teev tsaus ntuj.

Ntu 4: Kos npe

Kev Kos Npe ntawm Tus Tswv Cuab los sis Tus Tau Kev Tso Cai Ua Tus Neeg Sawv Cev	Hnub Tim
Sau Lub Npe Tus Ntawv Loj ntawm Tus Tswv Cuab los sis Tau Tso Cai Ua Tus Neeg Sawv	

Member Appeal or Grievance Form

នៅ Health Net Community Solutions (Health Net) យកចិត្តទុកដាក់ខ្លាំងចំពោះការព្រួយបារម្ភរបស់អ្នក។ ប្រសិនបើអ្នកមិនយល់ស្របនឹងសេចក្តីសម្រេចនេះទេ អ្នក ឬនរណាម្នាក់ផ្សេងទៀតអាចដាក់ពាក្យបណ្តឹងឧទ្ធរណ៍ចំពោះសេវាដែលបានបដិសេធ។ អ្នកអាចដាក់ពាក្យបណ្តឹងសាទុក្ខ ប្រសិនបើអ្នកមិនពេញចិត្តនឹងការថែទាំ ឬការព្យាបាលដែលអ្នកបានទទួល។

យើងខ្ញុំត្រូវតែមានការយល់ព្រមជាលាយលក្ខណ៍អក្សរពីអ្នក ប្រសិនបើអ្នកផ្តល់សេវា ឬនរណាម្នាក់ដែលអ្នកជ្រើសរើស ដាក់ពាក្យបណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខជំនួសអ្នក។ យើងខ្ញុំអាចត្រូវការការយល់ព្រមជាលាយលក្ខណ៍អក្សរពីអ្នក ដើម្បីទទួលបានកំណត់ត្រាសុខភាពសម្រាប់បណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខរបស់អ្នក។ អ្នកអាចទាក់ទងផ្នែកបម្រើសេវាសមាជិករបស់ Health Net ដោយទូរសព្ទទៅលេខ 1-800-675-6110 ឬទៅកាន់គេហទំព័រ www.healthnet.com ដើម្បីទទួលបានទម្រង់ទាំងនេះ។

- ទម្រង់បែបបទផ្ទេរសិទ្ធិឱ្យអ្នកតំណាង
- ទម្រង់បែបបទអនុញ្ញាតឱ្យចេញផ្សាយកំណត់ត្រាសុខភាព

រួមបញ្ចូលឯកសារ ឬព័ត៌មានណាមួយដែលពាក់ព័ន្ធនឹងបណ្តឹងតវ៉ា ឬបណ្តឹងសាទុក្ខរបស់អ្នក។ អ្នកអាចជ្រើសរើសវិធីណាមួយខាងក្រោមដើម្បីផ្ញើបណ្តឹងឧទ្ធរណ៍ ។

- សូមទូរសព្ទទៅផ្នែកបម្រើសេវាសមាជិករបស់ Health Net តាមរយៈលេខ 1-800-675-6110។ សេវាផ្នែកភាសាអាចរកបាន ប្រសិនបើអ្នកត្រូវការ។
- 711(TTY)សម្រាប់អ្នកពិការភាពការស្តាប់ និងនិយាយ
- បំពេញទម្រង់បែបបទបណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខតាមអនឡាញនៅៈ www.healthnet.com
- សូមបំពេញទម្រង់បែបបទនេះ ហើយបញ្ជូនវាតាមរយៈប្រៃសណីយ៍ ឬទូរសារ

ប្រៃសណីយ៍ៈ Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348
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ទូរសារលេខ 1-877-831-6019

ឯកសារសមាជិកមានជាទម្រង់ផ្សេងទៀតដូចជា អក្សរស្តាបសម្រាប់ជនពិការភ្នែក អក្សរពុម្ពធំៗ អូឌីយ៉ូ និងច្រើនទៀត។

Member Appeal or Grievance Form

ផ្នែកទី 1៖ ព័ត៌មានសមាជិក		
នាមត្រកូល និងនាមខ្លួន៖	លេខសម្គាល់៖	ខែថ្ងៃឆ្នាំកំណើត៖
អាសយដ្ឋាន៖	ក្រុង៖	លេខកូដតំបន់៖
លេខទូរសព្ទ៖	ពេលវេលាល្អបំផុតដើម្បីទូរសព្ទទៅ៖	

ផ្នែកទី 2៖ ព័ត៌មានអំពីបណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខ	
ឈ្មោះរបស់អ្នកផ្តល់សេវា៖	កាលបរិច្ឆេទនៃសេវា/ព្រឹត្តិការណ៍៖
លេខទាមទារសំណង៖	លេខយោង៖

សូមប្រាប់យើងអំពីការព្រួយបារម្ភរបស់អ្នក និងអំពីសកម្មភាព ដែលអ្នកចង់បាន។ រាប់បញ្ចូល៖ ឈ្មោះអ្នកផ្តល់សេវា កាលបរិច្ឆេទផ្តល់សេវា ការទាមទារសំណង ឬលេខយោង។

សម្រាប់បណ្តឹងឧទ្ធរណ៍៖ ភ្ជាប់ច្បាប់ចម្លងនៃលិខិតជូនដំណឹងអំពីចំណាត់ការ។

អ្នកអាចស្នើសុំការជួបប្រជុំគ្នាមួយ ប្រសិនបើអ្នកបានទទួលការបដិសេធសម្រាប់ការព្យាបាល ឬសម្ភាផ្តត់ផ្គង់ក្នុងការពិសោធ និងមានជំងឺដំណាក់កាលចុងក្រោយ។

ខ្ញុំមានជំងឺធ្ងន់ធ្ងរ ហើយខ្ញុំស្នើសុំការជួបប្រជុំមួយ។ ☐

ផ្នែកទី 3: សម្រាប់ជាព័ត៌មានរបស់អ្នក

សេចក្តីជូនដំណឹងអំពីចំណាត់ការ គឺជាលិខិតផ្លូវការដែលយើងប្រាប់អ្នកថាយើងនឹងបដិសេធ ពន្យារពេល ផ្លាស់ប្តូរ ឬបញ្ចប់សេវាកម្មមួយឬច្រើន។ បណ្តឹងសាទុក្ខអាចត្រូវបានផ្ញើនៅគ្រប់ពេលវេលា។

ស្នើសុំការពិនិត្យឡើងវិញរហ័ស ប្រសិនបើបណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខរបស់អ្នកពាក់ព័ន្ធនឹងការគំរាមកំហែងភ្លាមៗ ឬធ្ងន់ធ្ងរដល់សុខភាពរបស់អ្នក។ យើងនឹងពិនិត្យឡើងវិញនូវបណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខរបស់អ្នកក្នុងរយៈពេល 72 ម៉ោងចាប់ពីពេលទទួលបាន។

អ្នកនឹងទទួលបានលិខិតមួយក្នុងរយៈពេលប្រាំ (5) ថ្ងៃតាមប្រតិទិន នៅពេលដែលយើងទទួលបានបណ្តឹងឧទ្ធរណ៍ ឬបណ្តឹងសាទុក្ខរបស់អ្នក។

បុគ្គលិកនៅ Health Net ដែលនឹងធ្វើការលើករណីរបស់អ្នកអាចនិយាយជាមួយអ្នកសម្រាប់ព័ត៌មានបន្ថែមនានា។

ទាក់ទងទៅ DMHC ឬ DHCS ប្រសិនបើអ្នកមិនពេញចិត្តនឹងរបៀបដែល Health Net ដោះស្រាយកង្វល់របស់អ្នក។

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care មានការៈកិច្ចសម្រាប់ការដាក់បញ្ចត្តិ ដល់គម្រោងសេវាថែទាំសុខភាព។ ប្រសិនបើអ្នកមានបណ្តឹងសាទុក្ខប្រឆាំងនឹងគម្រោងសុខភាពរបស់អ្នកដំបូង អ្នកគួរតែទូរសព្ទមកគម្រោងសុខភាពរបស់អ្នកតាមរយៈលេខ **(1-800-675-6110, TTY:711)** ហើយប្រើប្រាស់ដំណើរការបណ្តឹងសាទុក្ខរបស់គម្រោងសុខភាពរបស់អ្នក មុនទាក់ទងទៅក្រសួងនោះ។ ការប្រើវិធីធ្វើសាទុក្ខនេះ មិនហាមឃាត់សិទ្ធិស្របច្បាប់អ្វី មួយ ដែលអាចយកមកប្រើ ឬដំណោះស្រាយអ្វីៗ ដែលអាចមានសម្រាប់អ្នកឡើយ។ បើសិនអ្នកត្រូវការជំនួយឲ្យដោះស្រាយសាទុក្ខ ដែលទាក់ទងនឹងភាពអាសន្ន ឬសាទុក្ខអ្វីមួយដែលគម្រោងសុខភាពរបស់អ្នក មិនទាន់បានដោះស្រាយឲ្យគាប់ចិត្តនៅឡើយ ឬក៏សាទុក្ខដែលនៅតែមិនទាន់ដោះស្រាយរួច លើសពីចំនួន 30 ថ្ងៃ អ្នកអាចទូរសព្ទទៅក្រសួងសម្រាប់ជំនួយ។ អ្នកក៏អាចនឹងមានសិទ្ធិទទួល ការពិនិត្យពិច័យដោយពេទ្យឯករាជ្យ (Independent Medical Review, IMR) ដែរ។ បើសិនអ្នកមានសិទ្ធិទទួល ការពិនិត្យ ពិច័យដោយពេទ្យឯករាជ្យ (IMR) នោះវិធី ការពិនិត្យពិច័យដោយពេទ្យឯករាជ្យ (IMR) នឹងផ្តល់ការពិនិត្យឡើងវិញ ដោយមិន លំអៀង នូវការសម្រេចខាងសុខភាព ដែលគម្រោងសុខភាពបានសម្រេច ចំពោះរោគាព្យាបាលចាំបាច់ នូវសេវា ឬការព្យាបាលបានស្នើ, ការសម្រេចពីការរ៉ាប់រង សម្រាប់ការព្យាបាលជាលក្ខណៈនៃការពិសោធន៍ ឬការស៊ើបអង្កេត និងទំនាស់ការបង់ប្រាក់ សម្រាប់ ថ្លៃព្យាបាលជាអាសន្ន ឬសេវាសុខភាពជាបន្ទាន់។ ក្រសួងក៏មានលេខទូរសព្ទឥតគិតថ្លៃមួយខ្សែផងដែរ តាមរយៈលេខ **(1-888-466-2219)** និងបណ្តាញ TDD **(1-877-688-9891)** សម្រាប់អ្នកដែលមានបញ្ហាក្នុងការស្តាប់ និងការនិយាយ។ គេហទំព័ររបស់ក្រសួង **www.dmhc.ca.gov** មានទម្រង់បំពេញបណ្តឹង ទម្រង់បំពេញពាក្យសុំ IMR និងសេចក្តីណែនាំតាមអនឡាញ។

<u>សេចក្តីព្រាងច្បាប់របស់ព្រឹទ្ធសភា (SB) លេខ 923 ស្តីពីការថែទាំដែលមានលក្ខណៈរួមបញ្ចូលសម្រាប់ជនប្តូរភេទ ភេទចម្រុះ ឬអន្តរភេទ (TGI)</u>

អ្នកមានសិទ្ធិដាក់ពាក្យបណ្តឹងជាមួយ Health Net និង DMHC ប្រសិនបើអ្នកផ្តល់សេវា ឬបុគ្គលិក Health Net ខកខានក្នុងការផ្តល់ការថែទាំដែលមានលក្ខណៈរួមបញ្ចូលសម្រាប់ជនប្តូរភេទ។

ការថែទាំសុខភាពប្រកបដោយលក្ខណៈរួមបញ្ចូលជនប្តូរភេទ ត្រូវបានកំណត់ថា ជាការថែទាំសុខភាពដ៏ទូលំទូលាយដែលស្របតាមស្តង់ដានៃការថែទាំសម្រាប់បុគ្គលដែលកំណត់អត្តសញ្ញាណថា ជា TGI។ វាគោរពស្ថេរភាពរាងកាយផ្ទាល់ខ្លួនរបស់បុគ្គល មិនធ្វើការសន្មត់អំពីយេនឌ័រ ទទួលយកភាពប្រែប្រួលនៃយេនឌ័រ និងការបង្ហាញយេនឌ័រខុសពីលក្ខណៈប្រពៃណី ហើយមានការប្រព្រឹត្តចំពោះមនុស្សគ្រប់រូបដោយមានការយោគយល់ ការគោរព និងការយកចិត្តទុកដាក់ [HSC § 1367.043(d)(3)] ។

<u>California Department of Health Care Services (DHCS) Office of the Ombudsman</u>

អ្នកក៏អាចទូរសព្ទទៅការិយាល័យ Office of the Ombudsman នៃក្រសួង California Department of Health Care Services (DHCS)សម្រាប់ជំនួយផងដែរ ។ ការិយាល័យ Ombudsman Office ជួយអ្នកទទួលអត្ថប្រយោជន៍របស់កម្មវិធី Medi-Cal ឱ្យប្រើប្រាស់យ៉ាងពេញលេញនូវសិទ្ធិ និងទំនួលខុសត្រូវរបស់ពួកគេក្នុងនាមជាសមាជិកនៃគម្រោងថែទាំដែលស្ថិតក្រោមការគ្រប់គ្រង។ ដើម្បីស្វែងយល់បន្ថែម សូមទូរសព្ទទៅលេខឥតគិតថ្លៃលេខ **1-888-452-8609** ពីថ្ងៃចន្ទ ដល់ថ្ងៃសុក្រ ពីម៉ោង 8:00ព្រឹក ដល់ម៉ោង 5:00ល្ងាច។

ផ្នែកទី 4៖ ហត្ថលេខា

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ហត្ថលេខារបស់សមាជិក ឬអ្នកតំណាងដែលមានសិទ្ធិ កាលបរិច្ឆេទ

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សរសេរឈ្មោះសមាជិក ឬអ្នកតំណាងដែលមានសិទ្ធិជាអក្សរធំ

Member Appeal or Grievance Form

Health Net Community Solutions (Health Net) 는 귀하의 우려를 중요하게 생각합니다. 귀하가 결정에 동의하지 않는 경우, 귀하 또는 다른 사람이 거부된 서비스에 대해 이의를 제기할 수 있습니다. 귀하가 받은 진료나 치료가 만족스럽지 않은 경우 불만 사항을 제기할 수 있습니다.

귀하의 서비스 제공자 또는 귀하가 선택한 사람이 귀하를 대신하여 이의나 불만 사항을 제기하는 경우 저희는 귀하의 서면 동의를 받아야 합니다. 귀하의 이의 제기 또는 불만 사항과 관련한 의료 기록을 받기 위해 저희는 귀하의 서면 동의가 필요할 수 있습니다. 1-800-675-6110으로 전화하거나 웹사이트 www.healthnet.com 을 통해 Health Net 가입자 서비스부에 연락해 양식을 받아보실 수 있습니다.

- 대리인 위임 양식
- 의료 기록 공개 양식

귀하의 이의제기 또는 불만 사항과 관련된 서류나 정보를 포함시키십시오. 이의 제기 또는 불만 사항은 다음의 방법으로 보내실 수 있습니다.

- Health Net 가입자 서비스부에 1-800-675-6110번으로 전화하십시오.
  필요한 경우 언어 서비스를 이용할 수 있습니다.
- 청각 및 언어 장애인용 711(TTY)
- 다음 웹사이트에서 온라인으로 이의 제기 또는 불만 사항을 작성하십시오.
  www.healthnet.com
- 이 양식을 작성하여 우편이나 팩스로 제출하십시오.

우편: Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348

또는

팩스 번호 1-877-831-6019

가입자 자료는 점자, 대형 활자체, 오디오 등과 같은 다른 형식으로도 준비되어 있습니다.

Member Appeal or Grievance Form

파트 1: 가입자 정보		
이름과 성:	ID#:	생년월일:
주소:	도시:	우편번호:
전화번호:	전화하기 가장 좋은 시간:	

파트 2: 이의 제기 또는 불만 사항에 대한 정보	
제공자 이름:	서비스 날짜/발생 날짜:
클레임 번호:	참조 번호:

우려 사항과 원하는 조치를 알려주십시오. 포함할 내용: 제공자 이름, 서비스 날짜, 클레임 또는 참조 번호.

이의 제기의 경우: 결정 통지서 사본을 첨부하십시오.

실험적 치료나 용품이 거부되었고 말기 질환을 앓고 있는 경우 회의를 요청할 수 있습니다.

저는 말기 질환을 앓고 있으며 회의를 요청합니다. ☐

파트 3: 정보 제공

결정 통지서는 서비스를 거부, 지연, 변경 또는 종료할 것임을 귀하에게 알리는 공식 서신입니다. 불만 사항은 언제든지 보낼 수 있습니다.

귀하의 이의 제기 또는 불만 사항이 귀하의 건강에 즉각적이거나 심각한 위협을 수반하는 경우 빠른 검토를 요청하십시오. 귀하의 이의제기 또는 불만사항을 접수된 시점으로부터 72시간 이내에 검토할 것입니다.

이의 제기 또는 불만 사항 접수 후 5일 이내에 서신을 받으실 것입니다.

귀하의 케이스를 담당할 Health Net 직원이 자세한 정보를 얻기 위해 귀하에게 연락할 수도 있습니다.

Health Net이 귀하의 우려사항을 해결하는 방법에 만족하지 않으시면 DMHC 또는 DHCS에 연락하십시오.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care는 의료 서비스 플랜 규제 업무를 담당하고 있습니다. 귀하의 건강 보험에 불만 사항이 있을 경우, 보건 관리부에 연락하기 전에 우선 **(1-800-675-6110, TTY:711)**번으로 귀하의 건강 보험에 연락해 건강 보험의 불만 사항 절차를 이용해주십시오. 불만 사항 처리 절차를 이용한다고 해서 귀하가 이용할 수 있는 귀하의 잠재적 법적 권리나 보상이 제한되는 것은 아닙니다. 응급 상황과 관련된 불만 사항, 귀하의 건강 보험을 통해 만족스럽게 처리되지 못한 불만 사항, 또는 30일이 넘게 해결되지 않고 남아 있는 불만 사항에 도움이 필요한 경우, 보건 관리부에 연락해 도움을 요청하실 수 있습니다. 귀하는 또한 독립 의료 심사(IMR, Independent Medical Review)를 받으실 수도 있습니다. 귀하가 독립 의료 심사(IMR)의 자격이 있는 경우, 제기된 서비스 또는 치료에 대한 의학적인 필요성에 대해 건강 보험이 내린 의학적 필요성, 실험적이거나 연구적 속성을 가진 치료에 대한 보장 결정 및 응급 또는 긴급 상황의 의료 서비스에 대한 비용 분쟁에 대해 독립 의료 심사(IMR) 절차를 통해 공정한 심사를 받게 됩니다. 본 부서에는 또한 청각 및 언어 장애인을 위한 무료 전화번호 **(1-888-466-2219)** 와 TDD 전화**(1-877-688-9891)**가 있습니다. 불만 사항 신고 양식, 독립 의료 심사(IMR) 신청서 및 안내 사항 등은 보건 관리부의 웹사이트 **www.dmhc.ca.gov**에서 온라인으로 이용하실 수 있습니다.

상원 법안(SB) 923 트랜스젠더, 성별 다양성 또는 간성(TGI) 포용 의료법

귀하의 의료 제공자 또는 Health Net 직원이 귀하에게 트랜스 포용적인 진료를 제공하지 못한 경우 귀하는 Health Net 및 DMHC에 불만 사항을 제출할 권리가 있습니다.

트랜스 포용적 의료 서비스는 TGI로 식별되는 개인에 대한 치료 표준에 부합하고, 개인의 신체적 자율성을 존중하며, 개인의 성별을 추정하지 않고, 성별 유동성과 비전통적 성별 표현을 수용하며, 모든 사람을 포용하는 마음, 이해 및 존중으로 대하는 포괄적 의료 서비스로 정의됩니다[HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

또한 캘리포니아주 보건 복지부(DHCS) 옴부즈맨 사무소(California Department of Health Care Services (DHCS) Office of the Ombudsman)에 전화하여 도움을 요청할 수도 있습니다. 옴부즈맨 사무소(Office of the Ombudsman)는 Medi-Cal 수혜자가 관리 의료 플랜의 가입자로서 자신의 권리와 책임을 최대한 활용하도록 돕습니다. 더 자세한 사항을 알아보시려면 무료 전화 **1-888-452-8609**번으로 월요일부터 금요일 사이 오전 8시부터 오후 5시까지 전화하십시오.

파트 4: 서명

가입자 또는 위임 대리인의 서명 _____ 날짜 _____

가입자 또는 공식 대리인의 이름(인쇄체) _____

Member Appeal or Grievance Form

Компания Health Net Community Solutions (Health Net) уделяет большое внимание Вашим проблемам. Если Вы не согласны с решением, Вы или кто-то другой от Вашего имени можете подать апелляцию на отказ в предоставлении услуги. Вы вправе подать претензию в случае возникновения нареканий по поводу полученного Вами медицинского обслуживания или лечения.

У нас должно быть Ваше письменное согласие, если Ваш поставщик или выбранное Вами лицо подает апелляцию или претензию от Вашего имени. Нам может понадобиться Ваше письменное согласие, чтобы получить медицинские документы для рассмотрения Вашей апелляции или претензии. Чтобы получить эти формы, можно обратиться в отдел обслуживания участников Health Net по телефону 1-800-675-6110 или на веб-сайт www.healthnet.com.

- Форма назначения уполномоченного представителя
- Форма согласия на предоставление медицинской документации

Приложите все документы или информацию, имеющие отношение к Вашей апелляции или претензии. Вы можете выбрать любой из следующих способов отправки апелляции или претензии.

- Позвоните в отдел обслуживания участников Health Net по телефону 1-800-675-6110. При необходимости Вы можете воспользоваться услугами по переводу.
- Линия TTY: 711 — для лиц с нарушениями слуха и речи
- Заполните форму апелляции или претензии онлайн по адресу: www.healthnet.com
- Заполните эту форму и отправьте ее по почте или факсу

Почтовый адрес: Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348

Или

Факс: 1-877-831-6019

Материалы для участников могут быть предоставлены в других форматах, таких как шрифт Брайля, крупный шрифт, аудио и другие.

Member Appeal or Grievance Form

Часть 1. Информация об участнике.		
Имя и фамилия:	Идентификационный номер:	Дата рождения:
Номер дома и улица:	Город:	Почтовый индекс:
Номер телефона:	Оптимальное время для связи по телефону:	

Часть 2. Информация об апелляции или претензии.	
Имя поставщика услуг:	Дата оказания услуг/возникновения проблемы:
Номер(-а) страхового(-ых) требования(-ий):	Справочный(-е) номер(-а):

Изложите нам свою проблему (проблемы) и желаемые действия. Укажите следующую информацию: имя поставщика услуг, дата оказания услуги, номер(-а) страхового(-ых) требования (-ий) и справочный(-е) номер(-а).

При подаче апелляции: приложите копию письма-уведомления о принятом решении.

Вы можете попросить о проведении конференции, если получили отказ в предоставлении лечения или расходных материалов как экспериментальных и страдаете неизлечимым заболеванием.

У меня неизлечимое заболевание, и я прошу о конференции. ☐

Часть 3. К Вашему сведению

Уведомление о принятом решении — это официальное письмо, в котором мы сообщаем Вам о том, что отказываем, задерживаем, изменяем или прекращаем предоставление услуги (услуг). Претензию можно подать в любое время.

Попросите ускорить рассмотрение, если Ваша апелляция или претензия связана с непосредственной или серьезной угрозой Вашему здоровью. В этом случае мы рассмотрим Вашу апелляцию или претензию в течение 72 часов с момента получения.

Вы получите письмо в течение пяти (5) календарных дней после того, как мы получим Вашу апелляцию или претензию.

Сотрудник Health Net, который будет работать над Вашим делом, может обратиться к Вам за дополнительной информацией.

Если Вы не удовлетворены тем, как Health Net решает Ваши вопросы, воспользуйтесь услугами DMHC или DHCS.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care (DMHC) отвечает за регулирование деятельности планов медицинского страхования. Если у Вас есть претензии к плану медицинского страхования, то, прежде чем обращаться в Департамент, Вам следует позвонить в план по телефону **(1-800-675-6110; линия TTY: 711)** и воспользоваться внутренней процедурой рассмотрения претензий. Использование такой процедуры рассмотрения претензий не ограничивает возможность пользования какими-либо юридическими правами или средствами защиты, доступными Вам. Если Вам потребуется помощь в подаче претензии, требующей ускоренного рассмотрения, претензии, решение по которой не удовлетворяет Вас, либо претензии, которая не была рассмотрена в течение 30 дней, Вы можете обратиться в Департамент. У Вас также может быть право на проведение независимой медицинской экспертизы (Independent Medical Review, IMR). Данная процедура представляет собой независимую оценку медицинских решений, принятых планом медицинского страхования в отношении медицинской

целесообразности предложенных услуг или лечения, страхового покрытия лечения экспериментального или исследовательского характера, а также споров, касающихся оплаты экстренной или неотложной медицинской помощи. В Департамент также можно позвонить по бесплатному номеру телефона **(1-888-466-2219)** или на линию TDD **(1-877-688-9891)** для лиц с нарушениями слуха и речи. На веб-сайте Департамента **www.dmhc.ca.gov** представлены бланки жалоб, заявления о проведении IMR и указания по их заполнению.

Законопроект Сената (SB) 923 «О инклюзивном уходе за трансгендерами, представителями разных полов и интерсексуалами (TGI)»

Вы имеете право подать жалобу в Health Net и DMHC, если ваш поставщик услуг или сотрудники Health Net не обеспечили вам инклюзивное медицинское обслуживание, предусмотренное для транссексуалов законом.

Инклюзивное медицинское обслуживание для транссексуалов означает комплексное медицинское обслуживание, которое соответствует стандартам обслуживания лиц, идентифицирующих себя как TGI, предусматривает соблюдение принципа индивидуальной физической автономии, не допускает суждений о половой принадлежности человека, признает возможность смены пола и нетрадиционное гендерное представление, а также предполагает проявление сострадания, понимания и уважения к каждому человеку [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

Также Вы можете обратиться за помощью, позвонив в California Department of Health Care Services (DHCS) Office of the Ombudsman. Office of the Ombudsman оказывает содействие получателям льгот Medi-Cal в пользовании своими правами в качестве участника плана управляемого медицинского обслуживания. Дополнительную информацию можно узнать по линии для бесплатного звонка **1-888-452-8609** с понедельника по пятницу с 8:00 a.m. до 5:00 p.m.

Часть 4. Подпись

Подпись участника или уполномоченного им представителя

Дата

Имя участника или уполномоченного им представителя печатными буквами

Member Appeal or Grievance Form

En Health Net Community Solutions (Health Net), sus inquietudes nos importan. Si no está de acuerdo con una decisión, usted u otra persona puede presentar una Apelación por un servicio denegado. Puede presentar una Queja Formal si no está conforme con la atención o el tratamiento que recibió.

Debemos tener su consentimiento por escrito si su Proveedor o alguien que usted elija presenta una Apelación o Queja Formal en su nombre. Es posible que necesitemos su consentimiento por escrito para obtener los Expedientes Médicos para su Apelación o Queja Formal. Puede comunicarse con el Departamento de Servicios al Afiliado de Health Net llamando al 1-800-675-6110 o puede visitar www.healthnet.com para obtener estos formularios.

- Formulario de Representante Autorizado
- Formulario de Divulgación de Expedientes Médicos

Incluya cualquier documento o información relevante para su Apelación o Queja Formal. Puede elegir cualquiera de las siguientes formas de enviar su Apelación o Queja Formal.

- Llame al Departamento de Servicios al Afiliado de Health Net al 1-800-675-6110. Los servicios lingüísticos están a su disposición si los necesita.
- TTY: 711 para las personas con dificultades de audición y del habla
- Complete el formulario de Apelaciones o Quejas Formales en línea en: www.healthnet.com
- Complete este formulario y envíelo por correo o fax

Correo postal: Health Net Community Solutions
Atte: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348

O

Fax: 1-877-831-6019

Los afiliados tienen a su disposición material en otros formatos, como braille, letra grande, audio, etc.

Member Appeal or Grievance Form

Parte 1: Información de afiliado		
Nombre y Apellido:	N.º de Identificación:	Fecha de Nacimiento:
Dirección:	Ciudad:	Código Postal:
Número de Teléfono:	Horario Preferido para Llamar:	

Parte 2: Información sobre la Apelación o Queja Formal	
Nombre del Proveedor:	Fecha del Servicio/Incidente:
Número(s) del Reclamo:	Número(s) de Referencia:

Cuéntenos su(s) inquietud(es) y la acción que desea. Incluya: Nombre del Proveedor, fecha del servicio, número(s) de referencia o reclamo.

Para Apelaciones: Adjunte una copia de la Carta de Aviso de Acción.

Puede solicitar una conferencia si recibió una denegación de tratamiento o suministros como experimentales y tiene una enfermedad terminal.

Tengo una enfermedad terminal y solicito una conferencia. ☐

Parte 3: Para Su Información

Un Aviso de Acción es una carta formal en la que le informamos que denegaremos, retrasaremos, cambiaremos o finalizaremos un servicio. La Queja Formal se puede enviar en cualquier momento.

Solicite una revisión rápida si su Apelación o Queja Formal implica una amenaza inmediata o grave para su salud. Revisaremos su Apelación o Queja Formal dentro de las 72 horas siguientes al momento de su recepción.

Recibirá una carta en cinco (5) días calendario una vez que recibamos su Apelación o Queja Formal.

El miembro del personal de Health Net que trabajará en su caso puede hablar con usted para obtener más información.

Comuníquese con el Departamento de Atención Médica Administrada de California (por sus siglas en inglés, DMHC) o con el Departamento de Servicios de Atención Médica de California (por sus siglas en inglés, DHCS) si no está conforme con la forma en que Health Net resuelve sus inquietudes.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care (Departamento de Atención Médica Administrada de California) es la entidad responsable de regular los planes de servicios de atención de salud. Si tiene alguna queja formal contra su plan de salud, debe llamar primero al plan de salud al **(1-800-675-6110, TTY: 711)** y seguir el proceso de quejas formales del plan de salud antes de comunicarse con el Departamento. La utilización de este procedimiento de quejas formales no prohíbe el ejercicio de ningún derecho ni recurso legal potencial que pueda estar a su disposición. Si necesita ayuda con una queja formal relacionada con una emergencia, una queja formal que su plan de salud no haya resuelto satisfactoriamente o una queja formal que no se haya resuelto en un plazo de 30 días, puede llamar al Departamento para recibir asistencia. También podría ser elegible para una Independent Medical Review (Revisión Médica Independiente, por sus siglas en inglés, IMR).

Si es elegible para una IMR, el proceso de IMR proporcionará una revisión imparcial de las decisiones médicas tomadas por un plan de salud en relación con la necesidad médica de un servicio o tratamiento propuesto, las decisiones de cobertura para los tratamientos que son de naturaleza experimental o de investigación y las disputas por pagos de servicios médicos de emergencia o de urgencia. El Departamento también tiene un número de teléfono gratuito **(1-888-466-2219)** y una línea TDD **(1-877-688-9891)** para las personas con dificultades de audición y del habla. En el sitio Web del departamento, **www.dmhc.ca.gov**, podrá encontrar formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

Ley del Senado (SB) 923 de atención inclusiva para personas transgénero, con género diverso o intersexuales (por sus siglas en inglés, TGI)

Tiene derecho a presentar una queja ante Health Net y el DMHC si su proveedor o el personal de Health Net no le han proporcionado atención transinclusiva.

La atención de salud transinclusiva se define como atención de salud integral que cumple con los estándares de atención para las personas que se identifican como TGI, honra la autonomía corporal personal, no hace hipótesis sobre el género de una persona, acepta la fluidez de género y la presentación no tradicional del género, y trata a todos con compasión, comprensión y respeto [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

También puede llamar a la Ombudsman Office del California Department of Health Care Services (por sus siglas en inglés, DHCS) para obtener ayuda. La Ombudsman Office ayuda a los beneficiarios de Medi-Cal a aprovechar al máximo sus derechos y responsabilidades como afiliados a un plan de atención administrada. Para obtener más información, llame al número de teléfono gratuito **1-888-452-8609**, de lunes a viernes, de 8:00 a.m. a 5:00 p.m.

Parte 4: Firma

Firma del Afiliado o Representante Autorizado

Fecha

Nombre en Letra de Imprenta del Afiliado
o Representante Autorizado

Member Appeal or Grievance Form

Sa Health Net Community Solutions (Health Net), mahalaga ang inyong mga alalahanin. Kung hindi kayo sang-ayon sa isang pasiya, kayo o kung sinupaman ay maaaring maghain ng Apela para sa isang tinanggihang serbisyo. Maaari kayong maghain ng Karaingan kung hindi kayo nasiyahan sa pangangalaga o paggamot na natanggap niyo.

Kailangan namin ang inyong nakasulat na pahintulot kung ang inyong Tagapagkaloob o isang tao na pinili niyo ang naghahain ng Apela o Karaingan sa ngalan ninyo. Maaaring kailanganin namin ang inyong nakasulat na pahintulot upang makuha ang mga medikal na talaan para sa inyong Apela o Karaingan. Maaari kayong makipag-ugnayan sa Departamento ng Serbisyo para sa Miyembro ng Health Net sa pamamagitan ng pagtawag sa 1-800-675-6110 o pumunta sa www.healthnet.com upang makuha ang mga form na ito.

- Form ng Pinahintulutang Kinatawan
- Form ng Pagpapalabas ng mga Medikal na Talaan

Magsama ng anumang mga papel o impormasyong kaugnay para sa inyong Apela o Karaingan. Maaari kayong pumili ng anuman sa mga sumusunod na paraan para ipadala ang inyong Apela o Karaingan.

- Tumawag sa Departamento ng Serbisyo para sa Miyembro ng Health Net sa 1-800-675-6110. Mayroong mga serbisyo sa wika kung kailangan ninyo ito.
- 711 (TTY) para sa mga may kapansanan sa pandinig at pagsasalita
- Kumpletuhin ang form ng mga Apela o Karaingan online sa: www.healthnet.com
- Kumpletuhin ang form na ito at isumite ito sa pamamagitan ng koreo o fax

Koreo: Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348

O

Fax # 1-877-831-6019

Mayroon ring mga materyal para sa miyembro na nasa ibang format gaya ng, Braille, malaking print, audio, at iba pa.

Member Appeal or Grievance Form

Bahagi 1: Impormasyon ng Miyembro		
Pangalan at Apelyido:	ID#:	Petsa ng Kapanganakan:
Address:	Lungsod:	Zip Code:
Numero ng Telepono:	Pinakamagandang Oras para Tumawag:	

Bahagi 2: Impormasyon tungkol sa Apela o Karaingan	
Pangalan ng Tagapagkaloob:	Petsa ng (mga) Serbisyo/Kung Kailan Nangyari:
(Mga) Numero ng Claim:	(Mga) Reference Number:

Sabihin sa amin ang inyong (mga) alalahanin at aksyon na nais ninyo. Isama: Pangalan ng Tagapagkaloob, petsa ng (mga) serbisyo, (mga) numero ng claim o reference.

Para sa Mga Apela: Maglakip ng isang kopya ng Liham ng Abiso ng Pagkilos.

Maaari kayong humingi ng pagtitipon kung nakatanggap kayo ng isang pagtanggi para sa paggamot o mga supply bilang experimental at mayroong nakamamatay na sakit.

Mayroon akong nakamamatay na sakit at humihingi ako ng isang pagtitipon. ☐

Bahagi 3: Para sa Inyong Impormasyon

Ang Abiso ng Pagkilos ay isang pormal na liham na nagsasabi sa inyo kung tatanggihan, maaantala, mababago o matatapos ang isang (mga) serbisyo. Maaaring mapadala ng isang Karaingan sa anumang panahon.

Humiling para sa isang pinabilis na pagsusuri kung may kasamang agaran o malubhang banta sa inyong kalusugan ang inyong Apela o Karaingan. Susuriin namin ang inyong Apela o Karaingan sa loob ng 72 oras mula sa oras ng pagtanggap.

Makakakuha kayo ng isang liham sa loob ng limang (5) araw ng kalendaryo kapag natanggap na namin ang inyong Apela o Karaingan.

Ang empleyado sa Health Net na magtatrabaho sa inyong kaso ay maaaring makipag-usap sa inyo para sa karagdagang impormasyon.

Makipag-ugnayan sa DMHC o DHCS kung hindi kayo nasiyahan sa kung paano nilutas ng Health Net ang inyong mga alalahanin.

California Department of Managed Health Care (DMHC)

Responsibilidad ng Departamento ng Pinamamahalaang Pangangalagang Pangkalusugan ng California (California Department of Managed Health Care) na pangasiwaan ang mga plano ng serbisyo sa pangangalagang pangkalusugan. Kung mayroon kayong karaingan laban sa inyong planong pangkalusugan, dapat muna ninyong tawagan ang inyong planong pangkalusugan sa **(1-800-675-6110, TTY:711)** at gamitin ang proseso sa karaingan ng inyong planong pangkalusugan bago makipag-ugnayan sa Departamento. Hindi makakahadlang ang paggamit sa pamamaraan ng karaingan na ito sa anumang potensyal na legal na karapatan o solusyon na maaari ninyong gamitin. Kung kailangan ninyo ng tulong sa isang karaingang nauugnay sa emergency, karaingang hindi kasiya-siyang nalutas ng inyong planong pangkalusugan, o karaingang hindi pa rin nalulutas makalipas ang mahigit 30 araw, maaari kayong tumawag sa Departamento para sa tulong. Maaari rin kayong maging kwalipikado para sa isang Independiyenteng Medikal na Pagsusuri (Independent Medical Review, IMR).

Kung kwalipikado kayo para sa IMR, magsasagawa sa proseso ng IMR ng isang walang kinikilingang pagsusuri ng mga medikal na pasya na ginawa ng isang planong pangkalusugang nauugnay sa medikal na pangangailangan ng isang iminumungkahing serbisyo o paggamot, mga pasya ukol sa pagsaklaw para sa mga paggamot na pang-eksperimento o sinisiyasat pa lang, at di-pagkakasundo sa pagbabayad ng mga medikal na serbisyong pang-emergency o kinakailangan kaagad. Mayroon ding toll- free na numero ng telepono ang departamento **(1-888-466-2219)** at linya ng TDD **(1-877-688-9891)** para sa mga may kapansanan sa pandinig at pagsasalita. Ang internet website ng departamento na **www.dmhc.ca.gov** ay may mga form ng reklamo, form ng aplikasyon sa IMR at tagubilin online.

Senate Bill (SB) 923 Transgender, Gender Diverse o Intersex (TGI) Inclusive Care Act

May karapatan kayong magsampa ng reklamo sa Health Net at sa DMHC kung nabigo ang inyong tagapagkaloob o kawani ng Health Net na magbigay sa inyo ng pangangalagang inklusibo para sa trans.

Ipinapaliwanag ang pangangalagang pangkalusugang inklusibo para sa trans bilang komprehensibong pangangalagang pangkalusugan na naaayon sa mga pamantayan ng pangangalaga para sa mga indibidwal na kinikilala ang mga sarili bilang TGI, iginagalang ang personal na awtonomiya sa katawan ng isang indibidwal, hindi gumagawa ng mga pagpapalagay tungkol sa kasarian ng isang indibidwal, tumatanggap ng gender fluidity at hindi tradisyonal na pagrerepresenta ng kasarian, at tinatrato ang lahat nang may habag, pag-unawa at paggalang [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

Maaari rin kayong tumawag sa Tanggapan ng Ombudsman ng Departamento ng Mga Serbisyo sa Pangangalagang Pangkalusugan (Department of Health Care Services, DHCS) para sa tulong. Tinutulungan ng Tanggapan ng Ombudsman ang mga benepisyaryo ng Medi-Cal upang magamit nang buo ang kanilang mga karapatan at tungkulin bilang miyembro ng isang pinamamahalaang plano ng pangangalaga. Para malaman ang higit pa, tumawag sa toll-free **1-888-452-8609**, Lunes hanggang Biyernes, 8:00am hanggang 5:00pm.

Bahagi 4: Lagda

Lagda ng Miyembro o Pinahintulutang Kinatawan

Petsa

Pangalan ng Miyembro o Pinahintulutang Kinatawan na Naka-Print

Member Appeal or Grievance Form

Tại Health Net Community Solutions (Health Net), chúng tôi thật sự quan tâm đến những quan ngại của quý vị. Nếu quý vị không đồng ý với quyết định, quý vị hoặc người khác có thể nộp Đơn kháng cáo về dịch vụ bị từ chối. Quý vị có thể nộp Đơn khiếu nại nếu quý vị không hài lòng với sự chăm sóc hoặc điều trị mà quý vị nhận được.

Chúng tôi phải có sự đồng ý bằng văn bản của quý vị nếu Nhà cung cấp của quý vị hoặc người mà quý vị chọn thay mặt quý vị nộp đơn Kháng cáo hoặc Khiếu nại. Chúng tôi sẽ phải cần sự đồng ý bằng văn bản của quý vị để lấy hồ sơ y khoa liên quan đến Kháng cáo hoặc Khiếu nại của quý vị. Quý vị có thể liên hệ với Ban Dịch vụ hội viên của Health Net bằng cách gọi đến số 1-800-675-6110 hoặc truy cập www.healthnet.com để lấy những mẫu đơn này.

- Mẫu đơn của người đại diện được ủy quyền
- Mẫu phát hành hồ sơ y khoa

Quý vị vui lòng gửi kèm theo mọi giấy tờ hoặc thông tin liên quan đến Kháng cáo hoặc Khiếu nại của quý vị. Quý vị có thể chọn bất kỳ cách nào sau đây để gửi Kháng cáo hoặc Khiếu nại.

- Gọi cho Ban Dịch vụ hội viên của Health Net theo số 1-800-675-6110. Dịch vụ ngôn ngữ luôn sẵn sàng hỗ trợ nếu quý vị cần.
- 711 (TTY) dành cho người khiếm thính và khiếm ngôn
- Hoàn thành biểu mẫu Kháng cáo hoặc Khiếu nại trực tuyến tại: www.healthnet.com
- Điền vào mẫu đơn này và gửi qua đường bưu điện hoặc fax

Đường bưu điện: Health Net Community Solutions
Attn: Member Appeals and Grievance Department
PO Box 10348
Van Nuys, CA 91410-0348
Hoặc
Fax # 1-877-831-6019

Tài liệu dành cho hội viên có sẵn ở các định dạng khác như chữ nổi Braille, bản in khổ lớn, tệp âm thanh, v.v.

Member Appeal or Grievance Form

Phần 1: Thông tin hội viên		
Họ và tên:	Số ID:	Ngày sinh:
Địa chỉ:	Thành phố:	Mã ZIP:
Số điện thoại:	Thời gian tốt nhất để gọi:	

Phần 2: Thông tin về Kháng cáo hoặc Khiếu nại	
Tên nhà cung cấp:	(Các) ngày cung cấp dịch vụ/xảy ra vụ việc:
(Các) số yêu cầu thanh toán:	(Các) số tham chiếu:

Hãy cho chúng tôi biết (các) mối quan ngại và hành động mà quý vị mong muốn. Bao gồm: Tên Nhà cung cấp, (các) ngày cung cấp dịch vụ, (các) số yêu cầu thanh toán hoặc số tham chiếu.

Đối với Kháng cáo: Đính kèm một bản sao của Thư Thông báo hành động.

Quý vị có thể yêu cầu hội chẩn nếu quý vị bị từ chối điều trị hoặc được cung cấp vật tư dưới dạng thử nghiệm và mắc bệnh nan y.

Tôi bị bệnh nan y và yêu cầu được hội chẩn. ☐

Phần 3: Thông tin quý vị cần biết

Thông báo hành động là một bức thư chính thức mà chúng tôi cho quý vị biết rằng chúng tôi sẽ từ chối, trì hoãn, thay đổi hoặc chấm dứt (các) dịch vụ. Khiếu nại có thể được gửi đi bất cứ lúc nào.

Hãy yêu cầu duyệt xét nhanh nếu Kháng cáo hoặc Khiếu nại của quý vị liên quan đến mối đe dọa trực tiếp hoặc nghiêm trọng đối với sức khỏe của quý vị. Chúng tôi sẽ xem xét Kháng cáo hoặc Khiếu nại của quý vị trong vòng 72 giờ kể từ thời điểm nhận được.

Quý vị sẽ nhận được thư trong năm (5) ngày theo lịch sau khi chúng tôi nhận được Kháng cáo hoặc Khiếu nại của quý vị.

Nhân viên tại Health Net phụ trách trường hợp của quý vị có thể trao đổi với quý vị để biết thêm thông tin.

Hãy liên hệ với DMHC hoặc DHCS nếu quý vị không hài lòng với cách Health Net giải quyết mối quan ngại của mình.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care chịu trách nhiệm về quản lý các chương trình dịch vụ chăm sóc sức khỏe. Nếu quý vị có khiếu nại đối với chương trình bảo hiểm sức khỏe của mình, trước tiên quý vị cần gọi điện thoại đến chương trình bảo hiểm sức khỏe theo số **(1-800-675-6110, TTY: 711)** và sử dụng quy trình khiếu nại của chương trình bảo hiểm sức khỏe của quý vị trước khi liên lạc với Sở. Việc sử dụng thủ tục khiếu nại này không cấm bất kỳ quyền pháp lý hoặc biện pháp sửa chữa tiềm năng nào có thể có sẵn cho quý vị. Nếu quý vị cần hỗ trợ về khiếu nại liên quan đến trường hợp cấp cứu, khiếu nại không được chương trình bảo hiểm sức khỏe của quý vị giải quyết thỏa đáng hoặc khiếu nại vẫn chưa được giải quyết trong hơn 30 ngày, quý vị có thể gọi cho Sở để được hỗ trợ. Quý vị cũng có thể đủ điều kiện được Independent Medical Review (IMR). Nếu quý vị đủ tiêu chuẩn cho IMR, quy trình IMR sẽ cung cấp đánh giá khách quan về các quyết định y tế được chương trình bảo hiểm sức khỏe đưa ra liên quan đến sự cần thiết về mặt y tế của dịch vụ hoặc phương pháp điều trị được đề xuất, quyết định về bảo hiểm đối với các phương pháp điều trị có tính chất thí nghiệm hoặc mang tính nghiên cứu và các tranh chấp về thanh toán cho trường hợp cấp cứu hoặc dịch vụ y tế khẩn cấp. Sở cũng có số điện thoại miễn phí **(1-888-466-2219)** và đường dây TDD **(1-877-688-9891)** dành cho người khiếm thính và khiếm ngôn. Trang web trên internet của sở **www.dmhc.ca.gov** có mẫu đơn IMR và hướng dẫn trực tuyến.

Dự luật thượng viện (SB) 923 Người chuyển giới, Đa dạng giới hoặc Liên giới (TGI) Đạo luật chăm sóc hòa nhập

Quý vị có quyền nộp đơn than phiền với Health Net và DMHC nếu nhà cung cấp dịch vụ chăm sóc sức khỏe của quý vị hoặc nhân viên của Health Net không cung cấp dịch vụ chăm sóc hòa nhập đối với người chuyển giới cho quý vị.

Chăm sóc sức khỏe hòa nhập đối với người chuyển giới được định nghĩa là chăm sóc sức khỏe toàn diện phù hợp với các tiêu chuẩn chăm sóc cho các cá nhân xác định là TGI, tôn trọng quyền tự chủ cơ thể cá nhân của một cá nhân, không đưa ra các nhận định về giới của một cá nhân, chấp nhận tính linh động về giới tính và biểu hiện giới tính khác với truyền thống, và đối xử với mọi người bằng lòng trắc ẩn, hiểu biết và tôn trọng [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

Quý vị cũng có thể gọi cho Ombudsman Office of the California Department of Health Care Services (DHCS) để được trợ giúp. Ombudsman Office hỗ trợ những người thụ hưởng Medi-Cal sử dụng đầy đủ các quyền và trách nhiệm của mình với tư cách là hội viên của chương trình chăm sóc được quản lý. Để tìm hiểu thêm, vui lòng gọi đến số điện thoại miễn phí **1-888-452-8609,** từ thứ Hai đến thứ Sáu, từ 8:00am đến 5:00pm.

Phần 4: Chữ ký

Chữ ký của Hội viên hoặc Người đại diện được ủy quyền

Ngày

Viết in tên Hội viên hoặc Người đại diện được ủy quyền

Member Appeal or Grievance Form

At Community Health Plan of Imperial Valley, your concerns matter to us. If you do not agree with a decision, you, or someone else may file an Appeal for a denied service. You can file a Grievance if you are not happy with the care or treatment you received.

We must have your written consent if your provider or someone you choose is filing an appeal or grievance on your behalf. We may need your written consent to get medical records for your Appeal or Grievance. You may contact Community Health Plan Imperial Valley Member Service Department by calling toll-free 1-833-236-4141, 24 hours a day, 7 days a week or go to www.CHPIV.org to get these forms.

- Authorized Representative form
- Medical Records Release form

Include any papers or information relevant for your Appeal or Grievance. You can choose any of the following ways to send your Appeal or Grievance.

- Call Community Health Plan of Imperial Valley Member Service Department toll-free at 1-833-236-4141, 24 hours a day, 7 days a week. Language services are available if you need.
- 711 (TTY) for the hearing and speech impaired
- Complete the appeals or grievance form online at: www.CHPIV.org
- Complete this form and send it by mail or fax

Mail: Community Health Plan of Imperial Valley
Attn: Member Appeals and Grievance Department
PO Box 10287
Van Nuys, CA 91410-0287
Or
Fax # 1-833-405-0312

Member materials are on hand in other formats such as braille, large print, audio and more.

Member Appeal or Grievance Form

Part 1: Member Information		
First and Last Name:	ID#:	Date of Birth:
Address:	City:	Zip Code:
Phone Number:	Best Time to Call:	

Part 2: Information about the Appeal or Grievance	
Name of Provider:	Date of Service(s)/Occurrence:
Claim Number(s):	Reference Number(s):

Tell us your concern(s) and action you want. Include: Name of Provider, date of service(s), claim or reference number(s).

For Appeals: Attach a copy of the Notice of Action Letter.

Member Appeal or Grievance Form

You can ask for a conference if you received a denial for treatment or supplies as experimental and have a terminal illness.

I have a terminal illness and am asking for a conference. ☐

Part 3: For Your Information

You have 60 calendar days from the Notice of Action letter to file an appeal. A Notice of Action is a formal letter that we tell you we will deny, delay, change, or end a service(s). A grievance can be sent at any time.

Please ask for a fast review if your appeal or grievance involves an immediate or serious threat to your health. We will review your appeal or grievance within 72 hours from the time of receipt.

You will get a letter in five (5) calendar days once we get your appeal or grievance.

The staff person at Community Health Plan of Imperial Valley that will work on your case may talk to you for more information.

Reach out to DMHC or DHCS if you are not happy with how Community Health Plan of Imperial Valley resolves your concerns.

California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-833-236-4141; TTY:711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR

Member Appeal or Grievance Form

application forms, and instructions online.

Senate Bill (SB) 923 Transgender, Gender Diverse or Intersex (TGI) Inclusive Care Act

You have a right to file a complaint with Community Health Plan of Imperial Valley and the DMHC if your provider or Community Health Plan of Imperial Valley staff failed to provide you trans-inclusive care.

Trans-inclusive health care is defined as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding and respect [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

You may also call the Ombudsman Office of the California Department of Health Care Services (DHCS) for help. The Ombudsman Office helps Medi-Cal beneficiaries to fully use their rights and responsibilities as a member of a managed care plan. To find out more, call toll-free **1-888-452-8609**, Monday through Friday from 8 am to 5 pm.

Part 4: Signature

Signature of Member or Authorized Representative

Date

Print Name of Member or Authorized Representative

Formulario de Queja Formal o Apelación del Afiliado

En Community Health Plan of Imperial Valley, sus inquietudes nos importan. Si no está de acuerdo con una decisión, usted u otra persona puede presentar una Apelación por un servicio denegado. Puede presentar una Queja Formal si no está conforme con la atención o el tratamiento que recibió.

Debemos tener su consentimiento por escrito si su Proveedor o alguien que usted elija presenta una Apelación o Queja Formal en su nombre. Es posible que necesitemos su consentimiento por escrito para obtener los expedientes médicos para su Apelación o Queja Formal. Puede comunicarse con el Departamento de Servicios al Afiliado de Community Health Plan Imperial Valley llamando al número de teléfono gratuito 1-833-236-4141, las 24 horas del día, los 7 días de la semana o puede visitar www.CHPIV.org para obtener estos formularios.

- Formulario de Representante Autorizado
- Formulario de Divulgación de Expedientes Médicos

Incluya cualquier documento o información relevante para su Apelación o Queja Formal. Puede elegir cualquiera de las siguientes formas de enviar su Apelación o Queja Formal.

- Llame al Departamento de Servicios al Afiliado de Community Health Plan of Imperial Valley al número de teléfono gratuito 1-833-236-4141, las 24 horas del día, los 7 días de la semana. Los servicios lingüísticos están a su disposición si los necesita.
- TTY: 711 para las personas con dificultades de audición y del habla
- Complete el formulario de Apelaciones o Quejas Formales en línea en: www.CHPIV.org
- Complete este formulario y envíelo por correo o fax

Correo postal: Community Health Plan of Imperial Valley
Atte: Member Appeals and Grievance Department
PO Box 10287
Van Nuys, CA 91410-0287
O
Fax: 1-833-405-0312

Los afiliados tienen a su disposición material en otros formatos, como braille, letra grande, audio, etc.

Formulario de Queja Formal o Apelación del Afiliado

Parte 1: Información de afiliado		
Nombre y Apellido:	N.º de Identificación:	Fecha de Nacimiento:
Dirección:	Ciudad:	Código Postal:
Número de Teléfono:	Horario Preferido para Llamar:	

Parte 2: Información sobre la Apelación o Queja Formal	
Nombre del Proveedor:	Fecha del Servicio/Incidente:
Número(s) del Reclamo:	Número(s) de Referencia:

Cuéntenos su(s) inquietud(es) y la acción que desea. Incluya: Nombre del Proveedor, fecha del servicio, número(s) de referencia o reclamo.

Para Apelaciones: Adjunte una copia de la Carta de Aviso de Acción.

Formulario de Queja Formal o Apelación del Afiliado

Puede solicitar una conferencia si recibió una denegación de tratamiento o suministros como experimentales y tiene una enfermedad terminal.

Tengo una enfermedad terminal y solicito una conferencia. ☐

Parte 3: Para Su Información

Tiene 60 días calendario a partir de la Carta de Aviso de Acción para presentar una Apelación. Un Aviso de Acción es una carta formal en la que le informamos que denegaremos, retrasaremos, cambiaremos o finalizaremos un servicio. La Queja Formal se puede enviar en cualquier momento.

Solicite una revisión rápida si su Apelación o Queja Formal implica una amenaza inmediata o grave para su salud. Revisaremos su Apelación o Queja Formal dentro de las 72 horas siguientes al momento de su recepción.

Recibirá una carta en cinco (5) días calendario una vez que recibamos su Apelación o Queja Formal.

El miembro del personal de Community Health Plan of Imperial Valley que trabajará en su caso puede hablar con usted para obtener más información.

Comuníquese con el Departamento de Atención Médica Administrada de California (por sus siglas en inglés, DMHC) o con el Departamento de Servicios de Atención Médica de California (por sus siglas en inglés, DHCS) si no está conforme con la forma en que Community Health Plan of Imperial Valley resuelve sus inquietudes.

California Department of Managed Health Care (DMHC)

California Department of Managed Health Care (Departamento de Atención Médica Administrada de California) es la entidad responsable de regular los planes de servicios de atención de salud. Si tiene alguna queja formal contra su plan de salud, debe llamar primero al plan de salud al **(1-833-236-4141, TTY: 711)** y seguir el proceso de quejas formales del plan de salud antes de comunicarse con el Departamento. La utilización de este procedimiento de quejas formales no prohíbe el ejercicio de ningún derecho ni recurso legal potencial que pueda estar a su disposición. Si necesita ayuda con una queja formal relacionada con una emergencia, una queja formal que su plan de salud no haya resuelto satisfactoriamente o una queja formal que no se haya resuelto en un plazo de 30 días, puede llamar al Departamento para recibir asistencia. También podría ser elegible para una Independent Medical Review (Revisión Médica Independiente, por sus siglas en inglés, IMR). Si es elegible para una IMR, el proceso de

Formulario de Queja Formal o Apelación del Afiliado

IMR proporcionará una revisión imparcial de las decisiones médicas tomadas por un plan de salud en relación con la necesidad médica de un servicio o tratamiento propuesto, las decisiones de cobertura para los tratamientos que son de naturaleza experimental o de investigación y las disputas por pagos de servicios médicos de emergencia o de urgencia. El Departamento también tiene un número de teléfono gratuito **(1-888-466-2219)** y una línea TDD **(1-877-688-9891)** para las personas con dificultades de audición y del habla. En el sitio Web del departamento, **www.dmhc.ca.gov**, podrá encontrar formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

Ley del Senado (SB) 923 de atención inclusiva para personas transgénero, con género diverso o intersexuales (por sus siglas en inglés, TGI)

Tiene derecho a presentar una queja ante Community Health Plan of Imperial Valley y el DMHC si su proveedor o el personal de Community Health Plan of Imperial Valley no le han proporcionado atención transinclusiva.

La atención de salud transinclusiva se define como atención de salud integral que cumple con los estándares de atención para las personas que se identifican como TGI, honra la autonomía corporal personal, no hace hipótesis sobre el género de una persona, acepta la fluidez de género y la presentación no tradicional del género, y trata a todos con compasión, comprensión y respeto [HSC § 1367.043(d)(3)].

California Department of Health Care Services (DHCS) Office of the Ombudsman

También pueden llamar a la Ombudsman Office del California Department of Health Care Services (por sus siglas en inglés, DHCS) para obtener ayuda. La Ombudsman Office ayuda a los beneficiarios de Medi-Cal a aprovechar al máximo sus derechos y responsabilidades como afiliados a un plan de atención administrada. Para obtener más información, llame al número de teléfono gratuito **1-888-452-8609**, de lunes a viernes, de 8 a.m. a 5 p.m.

Parte 4: Firma

Firma del Afiliado o Representante Autorizado

Fecha

Nombre en Letra de Imprenta del Afiliado
o Representante Autorizado

health net.

सदस्य कष्ट/ शिकायत फॉर्म

तारीख: _____

कृपया सभी जानकारी प्रिंट करें।

शिकायतकर्ता की जानकारी:

_____ ( ) _____ ( ) _____

नाम कार्यकारी फोन नंबर घर का टेलीफोन नंबर

_____

पता शहर राज्य ज़िप कोड

शिकायतकर्ता से संबंधित व्यक्ति(यों) के नाम:

_____ #: _____

नाम आईडी नंबर

_____ #: _____

नाम आईडी नंबर

_____ #: _____

नाम आईडी नंबर

शिकायत का प्रकार: [जो लागू हों उन सभी को टिक करें]

_____ विपणन ___एनरोलमेंट निरस्त करने में कठिनाई _____सदस्य केलिए बिलिंग

_____ गुणवत्ता ___परिवहन _____देखभाल की सुविधा

_____ आपातकालीन देखभाल___स्टाफ का रवैया _____प्राधिकरण

अन्य: _____

_____

समस्या का विवरण: घटना की तिथि: _____ स्थान: _____

प्रदाता का नाम _____

समस्या/ शिकायत को विस्तार से बताएं:

_____

_____

_____

_____

यदि अतिरिक्त स्थान की आवश्यकता है तो इस फॉर्म के पिछले भाग का उपयोग करें।

_____ _____

सदस्य के हस्ताक्षर तिथि

(या माता-पिता के हस्ताक्षर जहां सदस्य नाबालिग या अक्षम है)

<u>मेडिकल रिलीज़</u>

सदस्य: कृपया उन प्रदाताओं के नाम और टेलीफोन नंबर प्रदान करें जिन्होंने आपका इस स्थिति के लिए इलाज किया है जो कि इस शिकायत का विषय है|

प्राप्त किये गए सभी मेडिकल रिकॉर्ड्स गोपनीय रखे जायेंगे और केवल आपकी शिकायतों की समीक्षा करने केलिए उपयोग किए जाएंगे।

मैं उपरोक्त लिखे प्रदाताओं को अधिकृत और अनुरोध करता हूँ कि इस शिकायत के विषय में आवश्यक सभी मेडिकल रिकॉर्ड को चिकित्सीय जरूरतों की पूर्ति हेतु HEALTH NET को जारी करें:

_____

हस्ताक्षर:_____**दिनांक:**_____

(यदि सदस्य के अलावा अन्य द्वारा हस्ताक्षर किए गए हैं) रिश्ता:_____

(माँ, पिता, अभिभावक)

यदि आपके पास कोई और प्रश्न हो या इस मामलेसे आपको इस संबंधमें अतिरिक्त सहायता की आवश्यकता हो, तो कृपया हमारे सदस्य सेवा विभाग को टोलफ्री नंबर (800) 675-6110 या टीटीवाय: 711 पर संपर्क करें| पूरा हो जाने पर कृपया इस फॉर्मको यहाँ जमा करें: Health Net, एटीटीएन: Medi-Cal Member Appeals and Grievance Department, P.O Box 10348, Woodland Hills, CA 91367| फैक्सनंबर: (877) 831-6019.

कैलिफोर्निया डिपार्टमेंट ऑफ मैनेज्ड हैल्थ (California Department of Managed Health Care) केयर स्वास्थ्य देखभाल सेवा योजनाओं को विनियमित करने के लिए जिम्मेदार है। अगर आपकी स्वास्थ्य योजना के खिलाफ आपकी कोई शिकायत है, तो आपको पहले **1-800-675-6110** पर अपनी स्वास्थ्य योजना को फोन करना चाहिए और विभाग से संपर्क करने से पहले अपने स्वास्थ्य संबंधी योजना की शिकायत प्रक्रिया का उपयोग करना चाहिए। इस शिकायत की प्रक्रिया का उपयोग किसी भी संभावित कानूनी अधिकारों या उपचारों को प्रतिबंधित नहीं करता है जो आपके लिए उपलब्ध हो सकते हैं। अगर आपको आपातकालीन स्थिति से सम्बंधित किसी शिकायत में, ऐसी शिकायत जिसे आपकी स्वास्थ्य योजना द्वारा संतोषजनक ढंग से हल नहीं किया गया है, या ऐसी शिकायत जो कि 30 दिनों से ज्यादा अवधि तक अनसुलझी रह गई है, के लिए मदद की जरूरत है, तो आप सहायता के लिए विभाग को कॉल कर सकते हैं। आप एक स्वतंत्र चिकित्सा समीक्षा (Independent Medical Review, IMR) के लिए भी योग्य हो सकते हैं। यदि आप IMR के लिए योग्य हैं, IMR प्रक्रिया प्रस्तावित सेवा या उपचार की चिकित्सा की जरूरत से संबंधित स्वास्थ्य योजना द्वारा किए गए चिकित्सा निर्णय, आपातकालीन या तत्काल चिकित्सा सेवायें जिनकी प्रकृति प्रयोगात्मक या अनुसंधानात्मक हैं उनके उपचार के लिए बीमा निर्णय और भुगतान विवादों की निष्पक्ष समीक्षा प्रदान करेगी। विभाग का एक टोल फ्री टेलीफोन नंबर **(1-888-466-2219)** है और सुनने और बोलने में अक्षम लोगों के लिए एक TDD (टीडीडी) लाइन **(1-877-688-9891)** है। विभाग की इंटरनेट वेबसाइट **www.dmhc.ca.gov** पर शिकायत फॉर्म, IMR आवेदन फॉर्म और निर्देश ऑनलाइन उपलब्ध हैं।

health net.

メンバー用苦情申し立てフォーム

日付：_____

情報はすべて楷書でご記入ください。

苦情の内容：

_____ (　　) (　　)

氏名　勤務先電話番号　自宅電話番号

_____

住所（町名・番地）　市　州　ジップコード

苦情申し立てに関係する個人の氏名：

_____ #：_____

氏名　ID 番号

_____ #：_____

氏名　ID 番号

_____ #：_____

氏名　ID 番号

苦情申し立ての内容：[該当するものをすべてにチェックマークを付けてください]

_____ マーケティング　___ 契約解除の困難さ　_____ 請求

_____ サービスの質　___ 交通手段　_____ 治療へのアクセス

_____ 緊急時のケア　___ スタッフの態度　_____ 承認

その他：_____

_____

問題の記述：発生日：_____　発生場所：_____

プロバイダーの名前 _____

問題・苦情の内容を詳しく説明してください:

_____

_____

_____

_____

記入欄が足りない場合はこのフォームの裏面をご利用ください。

_____　_____

メンバーの署名　日付

（メンバーが未成年もしくは判断能力がない場合は親の署名）

医療情報の開示

メンバー：この苦情申し立ての対象となる、あなたの症状を治療したプロバイダーの名前と電話番号を提供してください。

入手されるすべての医療記録は極秘扱いとなり、この苦情申し立ての審査目的にのみ使用されます。

私は、上記のプロバイダーがこの苦情申し立ての対象に関する医学的必要性の根拠となるすべての医療記録を HEALTH NET に開示することを承認および要請します。

署名：_____ 日付：_____

（メンバー以外の個人が署名した場合） メンバーとの関係：_____
（父、母、後見人）

本件に関するご質問がある場合、または援助が必要な場合は、メンバーサービス部門まで、フリーダイヤル (800) 675-6110 (TTY:711) にてご連絡ください。記入済みの本フォームを以下まで提出してください。Health Net, Attn: Medi-Cal Member Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348。ファクス番号： (877) 831-6019.

カリフォルニア州マネージドヘルスケア局は、医療サービスプランの規制に責任を負っています。健康保険プランに対して苦情申し立てをする場合、同局に連絡する前に、まず健康保険プランまで **1-800-675-6110** にお電話になり、健康保険プランの苦情申し立て手続きをご利用ください。この苦情申し立て手続きを利用することにより、ご利用になれる可能性がある法的権利や救済手段が妨げられることはありません。緊急医療が関連する苦情申し立て、健康保険プランによって満足いく方法で解決されなかった苦情申し立て、または 30 日を超えて未解決のままである苦情申し立てについての支援を必要とされる場合は、同局に電話して支援を求めることができます。また、独立医療審査（Independent Medical Review, IMR）を受ける資格がある場合もあります。IMR を受ける資格がある場合、提案されたサービスもしくは治療の医療上の必要性、本質的に実験的もしくは試験的な治療に関する決定、または緊急医療もしくは応急治療サービスの支払いに関する争議に関連して、健康保険プランが行った医療上の決定に関する公平な審査が IMR の手続きにより提供されます。 同局には、フリーダイヤル（**1-888-466-2219**）のほか、耳や会話が不自由な方のための TDD 回線（**1-877-688-9891**）も用意されています。同局のウェブサイト（**www.dmhc.ca.gov**）には、オンラインの苦情申し立てフォーム、IMR 申請フォーム、および記入方法が掲載されています。

3.30.20

health net

ແບບຟອມສຳລັບໄຂຂໍ້ຂ້ອງໃຈ/ຮ້ອງທຸກຂອງສະມາຊິກ

ວັນທີ: _____

ກະລຸນາພິມຂໍ້ມູນທັງໝົດ.

ຂໍ້ມູນຜູ້ຮ້ອງທຸກ:

	( )	( )
ຊື່	ໝາຍເລກໂທລະສັບຢູ່ບ່ອນເຮັດວຽກ	ໝາຍເລກໂທລະສັບເຮືອນ

ທີ່ຢູ່	ເມືອງ	ລັດ	ລະຫັດໄປສະນີ

ຊື່ຂອງບຸກຄົນທີ່ກ່ຽວຂ້ອງກັບຜູ້ຮ້ອງທຸກ:

	#:
ຊື່	ເລກບັດປະຈຳຕົວ #:
ຊື່	ເລກບັດປະຈຳຕົວ #:
ຊື່	ເລກບັດປະຈຳຕົວ

ປະເພດຂອງການຮ້ອງທຸກ: [ເລືອກທັງໝົດທີ່ເຫັນວ່າແມ່ນ]

_____ ການຕະຫຼາດ	_____ ຄວາມຫຍຸ້ງຍາກໃນການຖອນລົງທະບຽນ	_____ ການຮຽກເກັບເງິນສຳລັບສະມາຊິກ
_____ ຄຸນນະພາບ	_____ ການຂົນສົ່ງ	_____ ຄວາມສາມາດໃນການເຂົ້າເຖິງການປິ່ນປົວ
_____ ການປິ່ນປົວກ່ອນນິສຸກເສີນ	_____ ທັດສະນະຂອງພະນັກງານ	_____ ການອະນຸຍາດ

ອື່ນໆ: _____

_____

ຄຳຊີ້ແຈງບັນຫາ: ວັນທີເກີດບັນຫາ: _____ ສະຖານທີ່: _____

ຊື່ຜູ້ໃຫ້ບໍລິການ _____

ອະທິບາຍບັນຫາ/ຄຳຮ້ອງທຸກໂດຍລະອຽດ:

_____

_____

_____

_____

ໃຊ້ດ້ານຫຼັງຂອງແບບຟອມນີ້ ຖ້າຈຳເປັນຕ້ອງຂະຫຍາຍຂໍ້ມູນເພີ່ມຕື່ມ.

_____ _____

ລາຍເຊັນຂອງສະມາຊິກ ວັນທີ

(ຫຼື ລາຍເຊັນຜູ້ປົກຄອງຂອງສະມາຊິກທີ່ເປັນເດັກນ້ອຍ ຫຼື ຜູ້ທີ່ບໍ່ມີຄວາມສາມາດເຊັນເອງໄດ້)

ການເຜີຍແຜ່ຂໍ້ມູນທາງການແພດ

ສະມາຊິກ: ກະລຸນາລະບຸຊື່ ແລະ ໝາຍເລກໂທລະສັບຂອງຜູ້ໃຫ້ບໍລິການທີ່ປະຕິບັດຕໍ່ທ່ານຈົນພາ
ໃຫ້ເກີດມີຂໍ້ຂ້ອງໃຈນີ້.

ຂໍ້ມູນທາງການແພດທັງໝົດທີ່ໄດ້ມາຈະໄດ້ຮັບການເກັບຮັກສາໄວ້ເປັນຢ່າງດີ ແລະ ຈະຖືກນຳໃຊ້ເພື່ອຈຸດປະສົງໃນການກວດກາເພື່ອແກ້ໄຂຂໍ້ຂ້ອງໃຈຂອງ ທ່ານເທົ່ານັ້ນ.

ຂ້າພະເຈົ້າອະນຸຍາດ ແລະ ຂໍໃຫ້ຜູ້ໃຫ້ບໍລິການດັ່ງທີ່ລະບຸໄວ້ຂ້າງເທິງ
ສາມາດເຜີຍແຜ່ຂໍ້ມູນທາງການແພດບາງສ່ວນ ແລະ ທັງໝົດໃຫ້ແກ່ HEALTH NET
ເພື່ອສະໜັບສະໜູນຄວາມຕ້ອງການທາງການແພດ ສຳລັບປະເດັນຂໍ້ຂ້ອງໃຈນີ້:

ລາຍເຊັນ: _____ **ວັນທີ:**

(ຖ້າເຊັນໂດຍຜູ້ອື່ນ ນອກຈາກສະມາຊິກ) ສາຍພົວພັນ: ___

(ແມ່, ພໍ່, ຜູ້ປົກຄອງ)

ຖ້າທ່ານມີຄຳຖາມເພີ່ມຕື່ມ ຫຼື ຕ້ອງການຄວາມຊ່ວຍເຫຼືອເພີ່ມຕື່ມກ່ຽວກັບເລື່ອງນີ້,
ກະລຸນາຕິດຕໍ່ພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາດ້ວຍການໂທໂດຍບໍ່ເສຍຄ່າໄດ້ທີ່ເບີໂທ
(800) 675-6110 (TTY: 711). ເມື່ອຕື່ມຂໍ້ມູນຮຽບຮ້ອຍແລ້ວ, ກະລຸນາສົ່ງແບບຟອມນີ້ໄປທີ່:
Health Net, Attn: Medi-Cal Member Appeals and Grievance Department, P.O Box 10348, Woodland Hills, CA 91367. ແຟັກ: (877) 831-6019.

ພະແນກຄຸ້ມຄອງປິ່ນປົວສຸຂະພາບຂອງລັດແຄລິຟໍເນຍມີໜ້າທີ່ໃນການກຳນົດແຜນບໍລິການປິ່ນປົວສຸຂະພາບ.
ຖ້າມີຂໍ້ຂ້ອງໃຈກ່ຽວກັບແຜນປະກັນສຸຂະພາບຂອງທ່ານ, ທ່ານຄວນໂທຫາ ແຜນປະກັນສຸຂະພາບຂອງທ່ານກ່ອນ
ທີ່ເລກໝາຍ
1-800-675-6110 ແລະ ໃຊ້ຂະບວນການຮ້ອງທຸກ ຂອງແຜນປະກັນສຸຂະພາບຂອງທ່ານ
ກ່ອນຈະຕິດຕໍ່ຫາພະແນກ. ການໃຊ້ຂັ້ນຕອນແກ້ຂໍ້ຂ້ອງໃຈນີ້ ບໍ່ໄດ້ເປັນການຫ້າມບໍ່ໃຫ້ມີສິດທິ ຫຼື
ຄວາມສາມາດໃນການແກ້ໄຂບັນຫາຕາມກົດໝາຍທີ່ອາດຈະເກີດຂຶ້ນກັບທ່ານ.
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອກ່ຽວກັບຂໍ້ຂ້ອງໃຈໃນກໍລະນີສຸກເສີນ,
ຂໍ້ຂ້ອງໃຈທີ່ບໍ່ໄດ້ຮັບການແກ້ໄຂຢ່າງໜ້າເພິ່ງພໍໃຈຈາກແຜນປະກັນສຸຂະພາບຂອງທ່ານ, ຫຼື
ຂໍ້ຂ້ອງໃຈທີ່ຍັງບໍ່ໄດ້ຮັບການແກ້ໄຂເປັນເວລາດົນກວ່າ 30 ວັນ, ທ່ານຍັງ
ສາມາດໂທຫາພະແນກເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ນອກຈາກນີ້
ທ່ານຍັງມີສິດຮ້ອງຂໍກັບອົງການກວດກາການແພດອິດສະຫຼະ (Independent Medical Review, IMR).
ກໍລະນີຫາກທ່ານມີສິດຮ້ອງຂໍກັບ IMR, ຂະບວນການ IMR ຈະດຳເນີນການກວດກາ
ຄຳຕັດສິນທາງການແພດຈາກແຜນປະກັນສຸຂະພາບ
ທີ່ກ່ຽວຂ້ອງກັບຄວາມຈຳເປັນທາງການແພດຂອງການບໍລິການ ຫຼື ການປິ່ນປົວທີ່ສະເໜີ,
ຄຳຕັດສິນກ່ຽວກັບການຄຸ້ມຄອງສຳລັບການປິ່ນປົວທີ່ມີລັກສະນະເປັນ ແບບທົດລອງ ຫຼື ແບບສຳຫຼວດ ແລະ
ຂໍ້ຂັດແຍ່ງດ້ານການຈ່າຍເງິນສຳລັບການບໍລິການທາງການແພດສຸກເສີນ ຫຼື ຮີບດ່ວນ. ນອກຈາກນີ້
ພະແນກຍັງມີການບໍລິການໂທໂດຍບໍ່ເສຍຄ່າ **(1-888-466-2219)** ແລະ ສາຍ TDD **(1-877-688-9891)**
ສຳລັບຜູ້ທີ່ມີຄວາມບົກຜ່ອງທາງການໄດ້ຍິນ ແລະ ການເວົ້າ. ເວັບໄຊທ໌ຂອງພະແນກ **www.dmhc.ca.gov**
ມີແບບຟອມຮ້ອງທຸກ, ແບບຟອມສະໝັກ IMR, ແລະ ຄຳແນະນຳອອນໄລນ໌.
3.30.20

health net

ਮੈਂਬਰ ਸ਼ਿਕਾਇਤ ਫਾਰਮ

ਤਰੀਕ: _____

ਕਿਰਪਾ ਕਰਕੇ ਸਾਰੀ ਜਾਣਕਾਰੀ ਪ੍ਰਿੰਟ ਕਰੋ
ਸ਼ਿਕਾਇਤ-ਕਰਤਾ ਦੀ ਜਾਣਕਾਰੀ:

_____ (____) _____ (____) _____

ਨਾਮ ਕੰਮ ਦਾ ਫੋਨ ਨੰਬਰ ਘਰ ਦਾ ਫੋਨ ਨੰਬਰ

_____ _____ _____ _____

ਪਤਾ ਸ਼ਹਿਰ ਪ੍ਰਾਂਤ ਪੋਸਟਲ ਕੋਡ

ਸ਼ਿਕਾਇਤ-ਕਰਤਾ ਦੇ ਨਾਲ ਸੰਬੰਧਿਤ ਲੋਕਾਂ ਦੇ ਨਾਮ:

_____ #: _____

ਨਾਮ ਆਈ.ਡੀ. ਨੰਬਰ

_____ #: _____

ਨਾਮ ਆਈ.ਡੀ. ਨੰਬਰ

_____ #: _____

ਨਾਮ ਆਈ.ਡੀ. ਨੰਬਰ

ਸ਼ਿਕਾਇਤ ਦੀ ਕਿਸਮ: [ਜਿਹੜੀਆਂ ਲਾਗੂ ਹੁੰਦੀਆਂ ਹਨ ਉਹਨਾਂ ਸਾਰੀਆਂ ਉੱਤੇ ਸਹੀ ਦਾ ਨਿਸ਼ਾਨ ਲਾਉ]

_____ ਮਾਰਕੀਟਿੰਗ _____ਭਰਤੀ ਵਿੱਚੋਂ ਨਿਕਲਣ ਵਿੱਚ ਮੁਸ਼ਕਿਲ _____ਮੈਂਬਰਾਂ ਦੇ ਬਿਲ

_____ ਗੁਣਵੱਤਾ _____ਪਰਿਵਹਨ _____ਦੇਖਭਾਲ ਦੀ ਉਪਲੱਬਧਤਾ

_____ ਐਮਰਜੈਂਸੀ ਧਿਆਨ _____ਸਟਾਫ ਰਵੱਈਆ _____ਪ੍ਰਮਾਣਿਕਤਾ

ਹੋਰ: _____

_____

ਸਮੱਸਿਆ ਦਾ ਬਿਆਨ: ਘਟਨਾ ਦੀ ਤਰੀਕ: _____ ਪਤਾ: _____

ਪ੍ਰਦਾਤਾ ਦਾ ਨਾਮ _____

ਸਮੱਸਿਆ/ਸ਼ਿਕਾਇਤ ਦਾ ਵਿਸਤਾਰ **ਵਿੱਚ ਵਰਨਣ** ਕਰੋ:

_____

_____

_____

_____

ਜੇਕਰ ਵਾਧੂ ਥਾਂ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਇਸ ਫਾਰਮ ਦੇ ਪਿਛਲੇ ਹਿੱਸੇ ਦੀ ਵਰਤੋਂ ਕਰੋ

_____ _____

ਮੈਂਬਰ **ਦੇ ਦਸਤਖ਼ਤ** ਤਰੀਕ

(ਜਾਂ ਮਾਤਾ-ਪਿਤਾ **ਦੇ ਦਸਤਖ਼ਤ** ਜੇਕਰ ਮੈਂਬਰ ਨਾਬਾਲਗ ਜਾਂ ਅਯੋਗ ਹੈ)

<u>ਮੈਡੀਕਲ ਰੀਲੀਜ਼</u>

ਮੈਂਬਰ: ਕਿਰਪਾ **ਕਰਕੇ ਹਰ ਉਸ** ਪ੍ਰਦਾਤਾ ਦਾ ਨਾਮ ਅਤੇ ਫੋਨ ਨੰਬਰ ਮੁਹੱਈਆ ਕਰਵਾਓ ਜਿਹਨਾਂ ਨੇ ਤੁਹਾਡੀ ਉਸ ਹਾਲਤ ਦਾ ਇਲਾਜ ਕੀਤਾ ਹੈ ਜਿਹੜੀ ਕੇ ਇਸ ਸ਼ਿਕਾਇਤ ਦਾ ਵਿਸ਼ਾ ਹੈ

ਪ੍ਰਾਪਤ ਕੀਤੇ ਗਏ ਸਾਰੇ ਡਾਕਟਰੀ ਦਸਤਾਵੇਜ ਗੁਪਤ ਰੱਖੇ ਜਾਣਗੇ ਅਤੇ ਸਿਰਫ਼ ਤੁਹਾਡੀ ਸ਼ਿਕਾਇਤ ਦਾ ਸਰਵੇਖਣ ਕਰਨ ਲਈ ਹੀ ਵਰਤੇ ਜਾਣਗੇ

ਇਸ ਨਾਲ ਮੈਂ ਉਪਰੋਕਤ ਲਿਖਿਤ ਪ੍ਰਦਾਤਾਵਾਂ ਨੂੰ ਇਸ ਸ਼ਿਕਾਇਤ ਦੇ ਵਿਸ਼ੇ ਦੀ ਡਾਕਟਰੀ ਜ਼ਰੂਰਤ ਦੇ ਸਹਿਯੋਗ ਵਿੱਚ ਕਿਸੇ ਅਤੇ ਸਾਰੇ ਡਾਕਟਰੀ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ HEALTH NET ਨੂੰ ਦੇਣ ਲਈ ਪ੍ਰਮਾਣਿਤ ਅਤੇ ਬੇਨਤੀ ਕਰਦਾ/ਕਰਦੀ ਹਾਂ:

ਦਸਤਖ਼ਤ:_____**ਤਰੀਕ:** _____

(ਜੇਕਰ ਮੈਂਬਰ ਤੋਂ ਇਲਾਵਾ ਕਿਸੇ ਹੋਰ ਦੇ ਦਸਤਖ਼ਤ ਹੋਣ) ਸੰਬੰਧ: _____

(ਮਾਤਾ, ਪਿਤਾ, ਸਰਪ੍ਰਸਤ)

ਜੇਕਰ ਤੁਹਾਡੇ ਕੋਈ ਹੋਰ ਸਵਾਲ ਹੋਣ ਜਾਂ ਤੁਹਾਨੂੰ ਇਸ ਮਾਮਲੇ ਵਿੱਚ ਵਾਧੂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਵਿਭਾਗ (Member Services Department) ਨੂੰ ਟੋਲ-ਫ੍ਰੀ (800) 675-6110 (TTY: 711) ਤੇ ਫੋਨ ਕਰੋ ਜਦੋਂ ਪੂਰਾ ਹੋ ਜਾਵੇ, ਇਸ ਫਾਰਮ ਨੂੰ ਹੇਠ ਲਿਖੇ ਪਤੇ ਉੱਤੇ ਜਮਾਂ ਕਰੋ: Health Net, Attn: Medi-Cal Member Appeals and Grievance Department, P.O Box 10348, Woodland Hills, CA 91367. ਫੈਕਸ ਨੰਬਰ: (877) 831-6019

California Department of Managed Health Care ਸਿਹਤ ਸੰਭਾਲ ਸੇਵਾ ਪਲਾਨ ਦੀ ਪਾਲਣਾ ਕਰਨ ਲਈ

ਜੁੰਮੇਵਾਰ ਹੈ। ਜੇਕਰ ਤੁਹਾਡੀਆਂ ਹੈਲਥ ਪਲਾਨ ਸਬੰਧੀ ਕੋਈ ਸ਼ਿਕਾਇਤਾਂ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਡਿਪਾਰਟਮੈਂਟ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਤੋਂ ਪਹਿਲਾਂ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਨੂੰ **1-800-675-6110** ਨੰਬਰ ਉੱਤੇ ਫੋਨ ਕਰਨਾ ਚਾਹੀਦਾ ਹੈ ਅਤੇ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਦੀ ਸ਼ਿਕਾਇਤ ਪ੍ਰਕਿਰਿਆ ਦੀ ਵਰਤੋਂ ਕਰਨੀ ਚਾਹੀਦੀ ਹੈ। ਇਸ ਸ਼ਿਕਾਇਤ ਦੀ ਵਿਧੀ ਦਾ ਉਪਯੋਗ ਤੁਹਾਨੂੰ ਉਪਲਬਧ ਕਿਸੇ ਵੀ ਸੰਭਵ ਕਾਨੂੰਨੀ ਹੱਕਾਂ ਤੋਂ ਜਾਂ ਇਲਾਜ ਤੋਂ ਵਾਂਝਾ ਨਹੀਂ ਕਰਦਾ। ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਐਮਰਜੈਂਸੀ ਦੇ ਮਾਮਲੇ ਨਾਲ ਜੁੜੀ ਕਿਸੇ ਸ਼ਿਕਾਇਤ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਜਿਸ ਨੂੰ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਦੁਆਰਾ ਤਸੱਲੀਬਖਸ਼ ਢੰਗ ਨਾਲ ਹੱਲ ਨਹੀਂ ਕੀਤਾ ਗਿਆ ਹੈ, ਜਾਂ ਕੋਈ ਸ਼ਿਕਾਇਤ ਜੋ 30 ਦਿਨਾਂ ਤੋਂ ਵੱਧ ਸਮੇਂ ਤੱਕ ਹੱਲ ਨਹੀਂ ਕੀਤੀ ਗਈ ਹੈ, ਤਾਂ ਤੁਸੀਂ ਸਹਾਇਤਾ ਲਈ ਡਿਪਾਰਟਮੈਂਟ ਨੂੰ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀ ਸੁਤੰਤਰ ਡਾਕਟਰੀ ਮੁਆਇਨੇ (Independent Medical Review, IMR) ਲਈ ਵੀ ਯੋਗ ਹੋ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀ IMR ਲਈ ਯੋਗ ਹੋ, ਤਾਂ IMR ਵਿਧੀ ਸਿਹਤ ਪਲੈਨ ਵਲੋਂ ਡਾਕਟਰੀ ਲੋੜ ਲਈ ਕੀਤੀ ਗਈ ਪ੍ਰਸਤਾਵਿਤ ਸੇਵਾ ਜਾ ਇਲਾਜ ਤੋਂ ਸੰਬੰਧਿਤ, ਤਜਰਬੇ ਜਾਂ ਜਾਂਚ ਦੇ ਸੁਭਾ ਵਾਲੇ ਇਲਾਜ ਲਈ ਫੈਸਲੇ ਅਤੇ ਸੰਕਟ ਜਾਂ ਜ਼ਰੂਰੀ ਡਾਕਟਰੀ ਸੇਵਾਵਾਂ ਦੇ ਭੁਗਤਾਨ ਦੇ ਵਿਵਾਦ, ਡਾਕਟਰੀ ਫੈਸਲਿਆਂ ਦਾ ਇਕ ਨਿਰਪੱਖ ਮੁਆਇਨਾ ਮੁਹੱਈਆ ਕਰਵਾਏਗੀ। ਡਿਪਾਰਟਮੈਂਟ ਦਾ ਇੱਕ ਟੋਲ-ਫ੍ਰੀ ਨੰਬਰ **(1-888-466-2219)** ਅਤੇ ਗੂੰਗੇ ਅਤੇ ਬਹਿਰੇ ਲੋਕਾਂ ਲਈ ਇੱਕ TDD ਲਾਈਨ **(1-877-688-9891)** ਵੀ ਹੈ। ਡਿਪਾਰਟਮੈਂਟ ਦੀ ਇੰਟਰਨੈੱਟ ਵੈੱਬਸਾਈਟ **www.dmhc.ca.gov** ਉੱਤੇ ਔਨਲਾਈਨ ਸ਼ਿਕਾਇਤ ਫ਼ਾਰਮ, IMR ਐਪਲੀਕੇਸ਼ਨ ਫ਼ਾਰਮ ਅਤੇ ਹਦਾਇਤਾਂ ਦਿੱਤੀਆਂ ਗਈਆਂ ਹਨ।

3.30.20

health net

แบบฟอร์มคำร้องทุกข์/คำร้องเรียนของสมาชิก

วันที่: _____

กรุณากรอกข้อมูลด้วยตัวบรรจงทั้งหมด

ข้อมูลของผู้ร้องเรียน:

_____ (___) _____ (___) _____

ชื่อ หมายเลขโทรศัพท์ที่ทำงาน หมายเลขโทรศัพท์ที่บ้าน

_____

ที่อยู่ อำเภอ/เขต จังหวัด รหัสไปรษณีย์

ชื่อผู้ที่เกี่ยวข้องกับผู้ร้องเรียน:

_____ #: _____

ชื่อ หมายเลขรหัสประจำตัว

_____ #: _____

ชื่อ หมายเลขรหัสประจำตัว

_____ #: _____

ชื่อ หมายเลขรหัสประจำตัว

ประเภทคำร้องเรียน: [เลือกข้อที่เกี่ยวข้องทั้งหมด]

____ การตลาด ____ ปัญหาการยกเลิกการสมัคร ___ การเรียกเก็บเงินจากสมาชิก

____ คุณภาพ ____ การเดินทาง ____ การเข้าถึงการรับบริการ

____ การบริการฉุกเฉิน ___ ทัศนคติของพนักงาน

____ การอนุญาต

อื่น ๆ: _____

_____

รายละเอียดปัญหา: วันที่เกิดเหตุการณ์: ____ สถานที่: _____

ชื่อผู้ให้บริการ _____

กรุณาอธิบายรายละเอียดปัญหา/คำร้องเรียน:

_____

_____

_____

_____

ใช้ด้านหลังของแบบฟอร์มนี้หากจำเป็นต้องใช้พื้นที่เพิ่มเติม

_____ _____

ลายมือชื่อของสมาชิก วันที่

(หรือลายมือชื่อของผู้ปกครองในกรณีที่สมาชิกเป็นผู้เยาว์หรือเป็นบุคคลไร้ความสามารถ)

<u>การอนุญาตทางการแพทย์</u>

สมาชิก: กรุณาระบุชื่อและหมายเลขโทรศัพท์ของผู้ให้บริการใด ๆ
ที่ได้ทำการรักษาท่านสำหรับสภาวะอาการที่เกี่ยวข้องกับคำร้องเรียนนี้

ประวัติการรักษาทั้งหมดจะถูกเก็บเป็นความลับอย่างเคร่งครัด
และใช้งานเพื่อวัตถุประสงค์ในการพิจารณาคำร้องเรียนของท่านเท่านั้น

ข้าพเจ้าให้อนุญาตและขอให้ผู้ให้บริการที่ระบุข้างต้นเปิดเผยประวัติการรักษาใด ๆ ทั้งหมดกับ HEALTH NET ที่สนับสนุนความจำเป็นทางการแพทย์สำหรับหัวข้อคำร้องเรียนนี้

ลายมือชื่อ: _____ **วันที่**:_____

(หากลงลายมือชื่อโดยผู้อื่นที่ไม่ใช่สมาชิก) ความสัมพันธ์**:** .

_____

_____

(มารดา บิดา หรือผู้ปกครอง)

หากท่านมีคำถามเพิ่มเติมใด ๆ หรือต้องการความช่วยเหลือเพิ่มเติมเกี่ยวกับประเด็นนี้
กรุณาติดต่อแผนกบริการสมาชิกผ่านทางหมายเลขโทรฟรีที่ (800) 675-6110 (TTY: 711)
เมื่อกรอกข้อมูลเสร็จแล้วกรุณาส่งแบบฟอร์มนี้ถึง: Health Net, Attn: Medi-Cal Member Appeals and Grievance Department, P.O Box 10348, Woodland Hills, CA 91367 หมายเลขโทรสาร:
(877) 831-6019

California Department of Managed Health Care มีหน้าที่กำกับควบคุมแผนบริการด้านการรักษาพยาบาล
หากคุณมีเรื่องร้องทุกข์เกี่ยวกับแผนสุขภาพของคุณ
ขั้นแรกคุณควรโทรศัพท์ถึงแผนสุขภาพของคุณที่หมายเลข **1-800-675-6110**
และใช้กระบวนการร้องทุกข์ของแผนสุขภาพของคุณก่อนที่จะติดต่อกับกรม
การใช้วิธีดำเนินการร้องทุกข์นี้ไม่ได้เป็นการห้ามสิทธิหรือการเยียวยาที่พึงมีตามกฎหมายที่อาจมีต่อท่าน
หากท่านต้องการความช่วยเหลือสำหรับการร้องทุกข์ที่เกี่ยวข้องกับกรณีฉุกเฉิน
เรื่องร้องทุกข์ที่ไม่ได้รับการแก้ไขโดยแผนสุขภาพของท่านจนเป็นที่พอใจของท่าน
หรือเรื่องร้องทุกข์ที่ยังไม่ได้รับการแก้ไขเป็นเวลานานกว่า
30 วัน ท่านสามารถติดต่อขอความช่วยเหลือจากทางกรมได้
ท่านยังอาจมีสิทธิ์ขอให้มีการทบทวนด้านการแพทย์โดยอิสระ
(Independent Medical Review, IMR) ด้วย หากท่านมีสิทธิ์ขอ IMR กระบวนการ IMR
จะดำเนินการทบทวนอย่างเป็นกลางเกี่ยวกับการตัดสินใจทางการแพทย์ที่ทำโดยแผนสุขภาพ

อันเกี่ยวข้องกับความจำเป็นทางการแพทย์ของบริการหรือการรักษาที่เสนอ
การตัดสินใจเกี่ยวกับการคุ้มครองสำหรับการรักษาเชิงทดลองหรือวิจัย
และข้อพิพาทเกี่ยวกับการชำระเงินค่าบริการฉุกเฉินหรือเร่งด่วนทางการแพทย์
ทางกรมยังมีหมายเลขโทรฟรี (**1-888-466-2219**) และหมายเลข TDD (**1-877-688-9891**)
สำหรับผู้มีความบกพร่องทางการได้ยินและการพูด เว็บไซต์ของกรม **www.dmhc.ca.gov**
มีแบบฟอร์มคำร้องเรียน แบบฟอร์มการสมัคร IMR และคำแนะนำต่าง ๆ ทางออนไลน์

Member Grievance/Complaint Form

Please print all information

Date:_____

MEMBER INFORMATION:

Last Name: _____ First Name: _____

(____)_____ (____)_____
Cell Phone Number Home Phone Number

Email Address: _____

_____
Address City State Zip Code

Medi-Cal/CIN ID #: _____ Date of Birth (MM/DD/YYYY): _____

NAME OF PERSON MAKING / FILING THIS COMPLAINT:

Relationship to the Member: _____

Last Name: _____ First Name: _____

Phone number if different: (____)_____

NATURE OF COMPLAINT: (Check appropriate box(es)

☐ Marketing	☐ Difficulty disenrolling	☐ Member billing
☐ Quality	☐ Transportation	☐ Accessibility to care
☐ Emergency care	☐ Staff attitude	☐ Authorization

☐ Other: _____

DESCRIBE THE PROBLEM/COMPLAINT IN DETAIL:

_____

_____

_____

DATE OF THE OCCURRENCE: _____ **LOCATION:** _____

☐ I received a denial for treatment, services, or supplies that are experimental. I have an incurable or irreversible condition that has a high chance of causing death within one year or less.

Yes, I have a terminal illness and am asking for a conference: __

Use the back of this form if you need more space.

_____ _____

SIGNATURE OF MEMBER **Date**
(or signature of parent where member is a minor or incapacitated)

You may ask for a Conference if you received a denial. You must have an incurable or irreversible condition with a high chance of causing death within one year or less. This applies to services, or supplies that are experimental, as recommended by a participating plan provider. Within 30 days of your request, CalViva Health will allow you to attend a conference. The conference is held within 5 working days. You may ask for a terminal ill conference by calling our Member Service Department at 1-888-893-1569, TTY 711. You may also ask for a conference by checking the statement above on this form. You can mail the form to CalViva Health Attn: Grievance and Appeals Department 21281 Burbank Blvd. Woodland Hills, CA 91367. You may also fax it to 1-877-831-6019.

You have the right to request a State Hearing from California Department of Social Services if you filed an appeal. You may do so, if you did not receive a Notice of Appeal Resolution (NAR) within 30 days from the receipt date. Also, if you did not receive a NAR within 72 hours for an expedited request. You have 120 days to file from the date you received the NAR. You have the right to request legal counsel or a friend at the hearing.

If you need help with legal service representation, call the California Department of Social Services at 1-800-952-5253, TDD 1-800-952-8349.

You also have the right to request to be disenrolled from the health plan. You may do so by calling Health Care Options at 1-800-430-4263.

You may ask for an expedited review if your life, health, or ability to function is in danger. You may call our Member Service Department at 1-888-893-1569, TTY 711. We will resolve your case within 72 hours if it meets expedited criteria and fast review.

You will receive a letter within 5 days from your initial request. This letter will let you know we received your grievance and are working on it.

You will receive a written letter within 30 days of your initial request or within 72 hours for expedited requests. This letter will let you know your case is resolved.

The Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program is available to provide assistance in investigating and resolving any grievances you may have about this health plan. If you wish to use the services of the DHCS to help you with your grievance, you may call the Ombudsman Program toll-free at 1-888-452-8609, Monday-Friday 8 AM to 5 PM.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-888-893-1569, TTY: 711)**, and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Senate Bill (SB) 923 Transgender, Gender Diverse or Intersex (TGI) Inclusive Care Act

You have a right to file a complaint with CalViva Health and the DMHC if your provider or CalViva Health staff failed to provide you trans-inclusive care.

Trans-inclusive health care is defined as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding and respect [HSC § 1367.043(d)(3)].

MEDICAL RELEASE / MEMBER AUTHORIZATION

All medical records obtained from providers who may have treated you for the condition which is the subject of this grievance will be held in strict confidence and used solely for the purpose of reviewing your grievance.

I HEREBY AUTHORIZE AND REQUEST THE PROVIDER(S) TO RELEASE ANY AND ALL MEDICAL RECORDS TO CALVIVA HEALTH SUPPORTING MEDICAL NECESSITY FOR:

Signature:_____ **Date:** _____

(If signed by other than member) RELATIONSHIP: _____

(MOTHER, FATHER, GUARDIAN)

Tus Tswv Cuab Daim Foos Txog Kev Tsis Zoo Siab/Kev Tsis Txaus Siab

Thov sau txhua yam ntaub ntawv

Hnub tim:_____

TSWV CUAB COV NTAUB NTAWV:

Lub Xeem: _____ Lub Npe: _____

(____)_____ (____)_____
Tus Npawb Xov Tooj Ntawm Tes Tus Npawb Xov Tooj Hauv Tsev

Chaw Nyob Email: _____

_____
Chaw Nyob Nroog Xeev Tus Zauv Xa Ntawv Zip

Medi-Cal/CIN Tus ID #: _____ Hnub Yug (Hli/Hnub/Xyoo): _____

LUB NPE NTAWM TUS NEEG UA / SAU DAIM NTAWV HAIS KEV TSIS TXAUS SIAB NO:

Kev Sib Txheeb Nrog Tus Tswv Cuab: _____

Lub Xeem: _____Lub Npe: _____

Tus npawb xov tooj yog tias sib txawv: (____)_____

QHOV TSEEB NTAWM KEV TSIS TXAUS SIAB: (Xaiv lub(cov) npov uas tsim nyog

- ☐ Feem Kiab Khw
- ☐ Feem Saib Xyuas Qhov Ua Kom Tau Zoo
- ☐ Kev saib xyuas kis xwm txheej kub ntxhov ceev
- ☐ Thim kev tso npe nyuaj
- ☐ Kev thauj mus los
- ☐ Tus neeg ua hauj lwm tus cwj pwm
- ☐ Tswv cuab daim ntawv nqi
- ☐ Kev mus cuag tau kev saib xyuas
- ☐ Kev Tso Cai

☐ Lwm Yam: _____

PIAV QHIA TXOG QHOV TEEB MEEM/QHOV KEV TSIS TXAUS SIAB KOM NTXAWS:

_____

_____

_____

HNUB TIM UAS TSHWM SIM: _____ **THAJ CHAW**: _____

☐ Kuv tau txais ib qho kev tsis lees txais rau kev kho mob, kev pab cuam, los sis cov khoom siv kho mob uas yog kev kuaj sim. Kuv muaj tus mob uas kho tsis tau los sis kho tsis zoo tu qab uas muaj feem yuav ua rau tuag tsis dhau ib xyoos los sis tsawg dua.

Yog, Kuv muaj ib qho kev kho mob sab hauv thiab kuv tab tom thov rau ib lub rooj sib tham: __

Siv sab tom qab ntawm daim ntawv foos no yog xav tau chaw sau ntxiv.

_____ _____

TUS TSWV CUAB KOS NPE **Hnub Tim**
(los sis kos npe ntawm tus niam txiv ntawm tus tswv cuab me nyuam yaus los sis tus neeg tsis taus)

Tej zaum koj yuav thov Ib Lub Rooj Sib Tham yog tias koj tau txais ib qho kev tsis lees txais. Koj yuav tsum muaj tus mob uas kho tsis tau los sis kho tsis zoo tu qab uas muaj feem yuav ua rau tuag tsis dhau ib xyoos los sis tsawg dua. Qhov no siv tau rau cov kev pab cuam, los sis cov khoom siv uas tau sim, raws li kev pom zoo los ntawm tus muab kev pab cuam uas koom nrog txoj phiaj xwm. Tsis pub dhau 30 hnub txij thaum koj ua ntawv thov, CalViva Health yuav tso cai rau koj tuaj koom lub rooj sib tham. Lub rooj sib tham tau teeb tsa hauv 5 hnub ua hauj lwm. Koj tuaj yeem thov ib lub rooj sib tham txog tus mob kho tsis zoo los ntawm kev hu rau peb Lub Chaw Pab Cuam Tswv Cuab ntawm 1-888-893-1569, TTY 711. Koj kuj tseem tuaj yeem thov ib lub rooj sib tham los ntawm kev txheeb xyuas cov lus saum toj no ntawm daim foos no. Koj tuaj yeem xa daim foos hauv chaw xa ntawv mus rau CalViva Health Attn: Lub Chaw Hauj Lwm Saib Xyuas Kev Ua Ntawv Foob/Hais Kev Tsis Txaus Siab, 21281 Burbank Blvd. Woodland Hills, CA 91367. Koj kuj tseem tuaj yeem fev ntawv mus rau 1-877-831-6019.

Koj muaj cai thov lub Xeev Lub Rooj Saib Xyuas Kev Ncaj Ncees los ntawm California Lub Chaw Hauj Lwm Saib Xyuas Kev Noj Qab Haus Huv yog tias koj tau thov kom rov txiav txim dua. Koj tuaj yeem ua tau li ntawd, yog tias koj tsis tau txais Daim Ntawv Ceeb Toom Txog Kev Rov Txiav Txim Dua (Appeal Resolution, NAR) hauv 30 hnub txij li hnub tau txais. Tsis tas li ntawv, yog tias koj tsis tau txais NAR hauv 72 teev rau kev thov sai. Koj muaj 120 hnub los ua ntaub ntawv txij li hnub koj tau txais daim NAR. Koj muaj cai thov tus kws lij choj los sis ib tug phooj ywg ntawm lub rooj sib hais kev ncaj ncees.

Yog tias koj xav tau kev pab rau kev sawv cev kev pab cuam raug cai, hu rau California Lub Chaw Hauj Lwm Saib Xyuas Kev Noj Qab Haus Huv ntawm 1-800-952-5253, TDD 1-800-952-8349.

Koj kuj muaj cai thov kom rho npe tawm ntawm txoj phiaj xwm kho mob. Koj tuaj yeem ua li ntawd uas yog hu rau Health Care Options ntawm 1-800-430-4263.

Koj tuaj yeem thov kom rov tshuaj xyuas sai yog tias koj muaj kev txaus ntshai rau lub neej txoj sia, kev noj qab haus huv, los sis kev peev xwm kev tswj tus kheej. Koj tuaj yeem hu rau peb Lub Chaw Pab Cuam Tswv Cuab ntawm 1-888-893-1569, TTY 711. Peb yuav daws koj qhov xwm txheej tsis pub dhau 72 teev yog tias nws ua tau raws li cov txheej txheem kev hais daws sai thiab tshuaj xyuas sai.

Koj yuav tau txais ib tsab ntawv tsis pub dhau 5 hnub txij li koj thawj daim ntawv thov. Tsab ntawv no yuav qhia rau koj paub tias peb tau txais koj qhov kev tsis txaus siab thiab tab tom saib xyuas nws.

Koj yuav tau txais tsab ntawv sau ua ntej 30 hnub txij thaum koj thawj daim ntawv thov los sis hauv 72 teev rau kev thov saib xyuas sai. Tsab ntawv no yuav qhia rau koj paub tias koj qhov xwm txheej tau txais kev hais daws lawm.

Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program (Txoj Kev Pab Saib Xyuas Kev Ncaj Ncees) muab kev pab tshuaj xyuas thiab pab daws tej kev tsis txaus siab uas tej zaum koj ho muaj nrog lub chaw pab kev them nqi kho mob no. Yog koj xav siv cov kev pab ntawm DHCS los pab koj hais koj cov kev tsis txaus siab, koj tuaj yeem hu rau tus xov tooj hu dawb ntawm Lub Khoos Kas Ombudsman tus xov tooj hu dawb ntawm 1-888-452-8609, Hnub Monday-Hnub Friday 8 teev sawv ntxov 5 teev tsaus ntuj.

California Department of Managed Health Care (Tuam Tsev Tswj Xyuas Kev Kho Kab Mob Kev Nkeeg) muaj tes luag num tswj cov kev pab them nqi kho mob. Yog tias koj muaj kev tsis txaus siab rau koj txoj phiaj xwm kho mob, koj yuav tsum xub hu xov tooj rau koj txoj phiaj xwm kho mob ntawm **(1-888-893-1569, TTY: 711)** thiab siv koj txoj phiaj xwm kev kho mob qhov txheej txheem foob kev tsis txaus siab ua ntej tiv tauj Lub Chaw Hauj Lwm. Kev siv qhov txheej txheem lis kev tsis txaus siab no yuav tsis txwv tej cai lij choj los sis cov kev kho mob uas muaj rau koj. Yog koj xav tau kev pab hais ibqho tsis txaus siab los ntawm kis saib xyuas xwm txheej kub ntxhov ceev, koj tseem tsis txaus siab rau qhov daws qhov teeb meem ntawm koj hom kev npaj saib xyuas kev noj qab haus huv, los sis tseem tsis tau daws qhov teeb meem ntev txog 30 hnub, tej zaum koj tuaj yeem hu mus thov kev pab rau ntawm Lub Tsev Haujlwm Loj. Tej zaum koj tsim nyog tau Kev Nrog Xyuas Txog Kab Mob Kev Nkeeg Ywj Pheej (Independent Medical Review, IMR). Yog koj muaj cai rau kis IMR, yuav tau rov qab saib xyuas raws li txheej txheem IMR txog feem kev txiav txim siab khomob rau koj lossis tau muab kev saib xyuas rau koj, kev txiav txim pab them cov nqi khomob rau feem kev sim khomob lossis feem tshuaj ntsuam xyuas keeb kwm ntawm tus mob thiab qhov tsis pom zoo them cov nqi rau kis saib xyuas xwm txheej kub ntxhov ceev lossis kev khomob sai sai. Lub tuam tsev ua hauj lwm tseem muaj tus xov tooj hu dawb **(1-888-466-2219)** thiab ib tus xov tooj TDD **(1-877-688-9891)** rau lub rooj rov txiav txim dua thiab cov neeg puas qhov kev hais lus. Lub chaw hauj lwm li internet wibsite **www.dmhc.ca.gov** muaj daim foos kev tsis tsaus siab, daim ntawv foos thov IMR thiab cov lus qhia hauv online.

Senate Bill (SB) 923 Tus Hloov Ua Poj Niam Txiv Neej, Ntau Hom Poj Niam Txiv Neej los sis Intersex (TGI) Tsab Cai Kev Saib Xyuas Txhua Tus

Koj muaj cai sau ntawv hais kev tsis txaus siab rau Cal Viva Health thiab DMHC yog tias koj tus muab kev pab cuam los sis Cal Viva Health cov neeg ua hauj lwm tsis muab kev saib xyuas kev noj qab haus huv rau txhua tus rau koj.

Kev saib xyuas kev kho mob rau txhua tus txhais tau tias yog kev saib xyuas kev kho mob uas ua raws li cov qauv kev saib xyuas rau cov tib neeg uas txheeb xyuas tias yog TGI, hwm tus neeg ntawm tus neeg lub cev, tsis muaj kev sib cais raws li qhov yog poj niam txiv neej, lees txais poj niam txiv neej fluidity thiab tsis yog poj niam txiv neej, thiab kho txhua tus nrog kev hlub tshua, kev nkag siab thiab kev hwm [HSC § 1367.043(d)(3)].

KEV TSHAJ TWAM TEJ NTAUB NTAWV KHO MOB / KEV TSO CAI RAU TUS TSWV CUAB

Txhua cov ntaub ntawv sau tseg kev kho mob uas tau los ntawm cov muab kev pab cuam uas tau kho mob rau koj uas cuam tshuam txog qhov tsis txaus siab no yuav raug txwv nruj tsis pub los siv los sis saib tau tej ntaub ntawv no tshwj tsis yog siv rau lub hom phiaj tshuaj xyuas koj qhov kev tsis txaus siab.

NOV NTAWD KUV TSO CAI THIAB THOV COV KWS KHO MOB MUAB IB YAM THIAB TXHUA YAM NTAUB NTAWV KHO MOB TEEV TSEG QHIA RAU CALVIVA HEALTH TXHAWM RAU PAB TXHAWB TXOG KEV KHO MOB TSEEM CEEB:

Kos Npe: _____ **Hnub Tim:** _____

(Yog tau kos npe los ntawm lwm tus neeg uas tsis yog tus tswv cuab) KEV SIB TXHEEB: _____
(NIAM, TXIV, TUS NEEG SAIB XYUAS)

Formulario de Quejas Formales/Quejas del Afiliado

Imprima toda la información

Fecha: _____

INFORMACIÓN DEL AFILIADO:

Apellido: _____ Nombre: _____

(____)_____ (____)_____
Número de teléfono celular Número de teléfono de la casa

Dirección de correo electrónico: _____

_____
Dirección Ciudad Estado Código Postal

N.º de identificación de Medi-Cal/CIN:_____Fecha de nacimiento (MM/DD/AAAA): _____

NOMBRE DE LA PERSONA QUE REALIZA/PRESENTA ESTA QUEJA:
Relación con el afiliado: _____

Apellido: _____ Nombre: _____

Número de teléfono si es diferente: (____)_____

NATURALEZA DE LA QUEJA: Marque la(s) casilla(s) que corresponda(n)

☐ Marketing ☐ Dificultad para cancelar la afiliación ☐ Facturación al afiliado
☐ Calidad ☐ Transporte ☐ Accesibilidad a la atención
☐ Atención de emergencia ☐ Actitud del personal ☐ Autorización

☐ Otro: _____

DESCRIBA EL PROBLEMA/LA QUEJA EN DETALLE:

_____

_____

_____

FECHA EN QUE OCURRIÓ: _____ **UBICACIÓN**: _____

☐ Recibí una denegación de tratamiento, servicios o suministros que son experimentales. Tengo una enfermedad incurable o irreversible que tiene altas probabilidades de causarme la muerte en el plazo de un año o menos.

Sí, tengo una enfermedad terminal y solicito una conferencia: __

Utilice el reverso de este formulario si necesita más espacio.

_____ _____

FIRMA DEL AFILIADO **Fecha**
(o firma del padre/de la madre cuando el afiliado
es menor de edad o está incapacitado)

Puede solicitar una conferencia si recibió una denegación. Debe tener una enfermedad incurable o irreversible con una alta probabilidad de causarle la muerte en el plazo de un año o menos. Esto se aplica a servicios o suministros que son experimentales, según lo recomendado por un proveedor del plan participante. En un plazo de 30 días a partir de su solicitud, CalViva Health le permitirá asistir a una conferencia. La conferencia se celebra dentro de los cinco días laborables. Puede solicitar una conferencia relacionada con una enfermedad terminal llamando a nuestro Departamento de Servicios al Afiliado al 1-888-893-1569, TTY 711. También puede solicitar una conferencia marcando la declaración anterior en este formulario. Puede enviar el formulario por correo a CalViva Health Attn: Grievance and Appeals Department, 21281 Burbank Blvd. Woodland Hills, CA 91367. También puede enviarla por fax al 1-877-831-6019.

Si presentó una apelación, usted tiene derecho a solicitar una audiencia ante el estado al Departamento de Servicios Sociales de California. Puede hacerlo si no recibió un Aviso de Resolución de Apelación (NAR) en un plazo de 30 días a partir de la fecha de recepción. También puede hacerlo si no recibió un NAR en un plazo de 72 horas, en el caso de una solicitud acelerada. Tiene 120 días, a partir de la fecha en que recibió el NAR, para presentar dicha solicitud. Usted tiene derecho a solicitar la presencia de un asesor legal o un amigo en la audiencia.

Si necesita ayuda con la representación de los servicios legales, llame al Departamento de Servicios Sociales de California al 1-800-952-5253, TDD 1-800-952-8349.

También tiene derecho a solicitar que se cancele su afiliación al plan de salud. Puede hacerlo llamando a Opciones de Atención de Salud al 1-800-430-4263.

Puede solicitar una revisión acelerada si su vida, su salud o su capacidad para funcionar están en peligro. Puede llamar a nuestro Departamento de Servicios al Afiliado al 1-888-893-1569, TTY 711. Resolveremos su caso en un plazo de 72 horas si cumple con los criterios para la revisión rápida y acelerada.

Recibirá una carta en un plazo de 5 días a partir de su solicitud inicial. Esta carta le informará que recibimos su queja formal y estamos trabajando en ella.

Recibirá una carta por escrito en un plazo de 30 días a partir de su solicitud inicial o en un plazo de 72 horas para las solicitudes aceleradas. Esta carta le informará que su caso está resuelto.

El Ombudsman Program de Medi-Cal Managed Care del Departament of Health Care Services (DHCS) se encuentra disponible para brindarle asistencia en la investigación y resolución de cualquier queja formal que usted pueda tener sobre este plan de salud. Si desea utilizar los servicios del DHCS para que le ayuden con su queja formal, puede llamar al número de teléfono gratuito del Programa de Defensoría al 1-888-452-8609, de lunes a viernes, de 8 a. m. a 5 p. m.

California Department of Managed Health Care (Departamento de Atención Médica Administrada de California) es la entidad responsable de regular los planes de servicios de atención de salud. Si usted tiene una queja formal contra su plan de salud, debe llamar primero al plan de salud al **(1-888-893-1569, TTY: 711)** y usar el proceso de quejas formales de su plan de salud antes de comunicarse con el departamento. La utilización de este procedimiento de quejas formales no prohíbe el ejercicio de ningún derecho ni recurso legal potencial que pueda estar a su disposición. Si necesita ayuda con una queja formal que tenga que ver con una emergencia, una queja formal que su plan de salud no haya resuelto satisfactoriamente o una queja formal que haya permanecido sin resolverse por más de 30 días, puede llamar al departamento para obtener ayuda. También puede ser elegible para una Revisión Médica Independiente (por sus siglas en inglés, IMR). Si es elegible para una IMR, durante el proceso de IMR se hará una revisión imparcial de las decisiones médicas tomadas por el plan de salud en relación con la necesidad médica de un servicio o tratamiento propuesto, con las decisiones de cobertura para los tratamientos que son de naturaleza experimental o de investigación y con las disputas por pagos de servicios médicos de emergencia o de urgencia. El departamento también tiene un número de teléfono gratuito **(1-888-466-2219)** y una línea TDD **(1-877-688-9891)** para las personas con dificultades de audición y del habla. En el sitio web del Departamento, **www.dmhc.ca.gov**, podrá encontrar formularios de quejas, formularios de solicitud de IMR e instrucciones en línea.

Ley del Senado (SB) 923 de atención inclusiva para personas transgénero, con género diverso o intersexuales (por sus siglas en inglés, TGI)

Usted tiene derecho a presentar una queja ante CalViva Health y el DMHC si su proveedor o el personal de CalViva Health no le brindaron atención trans inclusiva.

La atención de salud trans inclusiva se define como atención de salud integral que cumple con los estándares de atención para las personas que se identifican como TGI, honra la autonomía corporal personal, no hace hipótesis sobre el género de una persona, acepta la fluidez de género y la presentación no tradicional del género, y trata a todos con compasión, comprensión y respeto [HSC § 1367.043(d)(3)].

DIVULGACIÓN MÉDICA / AUTORIZACIÓN DEL AFILIADO

Todos los expedientes médicos obtenidos de proveedores que puedan haberle tratado la afección que es objeto de esta queja formal se mantendrán bajo estricta confidencialidad y se utilizarán únicamente para revisar su queja formal.

POR LA PRESENTE AUTORIZO Y SOLICITO AL PROVEEDOR O PROVEEDORES QUE FACILITEN A CALVIVA HEALTH TODOS Y CADA UNO DE LOS EXPEDIENTES MÉDICOS QUE JUSTIFIQUEN LA NECESIDAD MÉDICA DE:

Firma: _____ Fecha: _____

(Si la persona que firma no es el afiliado) RELACIÓN: _____
(MADRE, PADRE, TUTOR)

PCP:	
SECTION: Office Management	
POLICY AND PROCEDURE: Member Grievances/Complaints	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:

The site has an established process for member grievances and complaints.

- A "grievance" is defined as any written or oral expression of dissatisfaction that involves coverage dispute, healthcare medical necessity, experimental or investigational treatment. The health plan does not delegate the resolution of grievances to contracted medical groups.

- A "complaint" is any expression of dissatisfaction regarding the quality of service (excluding quality of care) which can be resolved in the initial contact. A "complaint" is self limiting (e.g. service complaints, appointment wait times) that can be resolved to the member's satisfaction, such as they do not ask for additional assistance

PROCEDURE:

A. The staff will ensure that any member who expresses a grievance or complaint is informed of the right for a State Fair Hearing and offered the following numbers:

1. The California Department of Managed Health Care 1-888-466-2219
2. For Hearing and Speech impaired call 1-800-735-2929
3. State Fair Hearing 1-800-952-5253

B. Staff will ensure that grievance forms **(in threshold languages) for each participating health plan** will be provided to members promptly upon request.

- The grievance form must be submitted to the health plan **within 1 business day.**

C. The staff will ensure that all complaints (self limiting complaints: e.g. service complaints, appointment wait times) are logged and submitted to the health plan monthly (if there were complaints during the time period).

1. These complaints may be resolved at the point of service
2. Log the complaint and include:
    a. Date of complaint
    b. Name of complainant and ID#
    c. Nature of the complaint
    d. Resolution/action taken (include information that health plan was notified as appropriate)
    e. Date of resolution/action
    f. Date log submitted to health plan

PCP:	
SECTION: Personnel	
POLICY AND PROCEDURE: Minors' Rights	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Provide medical services per California Law Family Code to protect minors' rights to sensitive services.

PROCEDURE:

Sensitive Services/Minors Rights

- Parental consent is not required for members under the age of 18 to access pregnancy-related services, including family planning.
  ** California Law Family Code Section 6925.

- A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Public Health Officer.

  The minor's parents or guardian are not liable for payment for medical care provided pursuant to this section.

** *California Law Family Code Section 6926 (6920-6929).*

- A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied:

(1) The minor is 15 years of age or older.
(2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
(3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.

- The parents or guardian are not liable for medical care or dental care provided pursuant to this section.
- A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the

information given by the minor, the whereabouts of the parent or guardian.

*** California Law Family Code section 6922 (6920-6929).*

- **Special precautions must be taken to ensure that communication regarding the medical information of a minor related to sensitive services is protected** (i.e. letters and phone calls should NOT be directed to the home without the minor's authorization).

Miscellaneous Coding Policies – State Health Programs	
Category	**Coding Edit**
Add-On Code	HCPCS add-on codes are always performed in conjunction with a primary procedure and should never be reported as standalone services. If the primary procedure is not allowed, then the add-on code is also not allowed
Allergy	Evaluation and management (E&M) services for established patients are included in allergy immunotherapy unless a significant, separately identifiable service is performed
Anesthesia	The daily management of post-operative analgesia is considered part of the global services for other major anesthesia services
	Anesthesiologists are required to utilize the appropriate anesthesia CPT does rather than surgical codes
Assistant Surgeon	Health Net denies assistant surgeon services for certain procedures where the concept of assistant surgeon does not apply
Bilateral Procedures	The appropriate billing method for procedures that are bilateral in nature is to bill the procedure on a two claim lines: one line with the modifier 50 with 1 unit of service and the second line without a modifier 50 with 1 unit of service
	Only procedures that can be billed as bilateral should have modifier 50
Bundled Services	There are a number of services/supplies for which payment is bundled into the payment for other related services, whether specified or not. The list of bundled services is based on Centers for Medicare and Medicaid Services' (CMS') National Physician Relative Value File
	The codes included in the bundled services policy are from the CMS National Physician Fee Schedule list and are updated as CMS makes updates on a quarterly bases. Services with RVUs are routinely denied or bundled into other payable services unless they are billed alone and the provider has not billed any services within 12 months for the same member
	A digital rectal exam is considered a bundled service and, therefore, is not eligible for separate payment
Cardiology	Cardiac blood pool imaging is included in myocardial perfusion studies
	PTCA is included in the services for the transcatheter placement of intracoronary stent
	Abdominal autography performed at the time of a cardiac catheterization or percutaneous cardiac interventional procedure is included in the primary procedure
	The insertion of the cardioverter-defibrillator and/or electrodes includes an electronic analysis of the device

	Catheterization of the vena cava is included in the surgical interruption of the vena cava
	The insertion of a pacemaker or cardioverter-defibrillator includes the electronic analysis and reprogramming of the device
	Nuclear imaging of the heart can only be performed in an office or hospital setting
	E&M services are included in pacemaker analysis unless a significant, separately identifiable service is performed
	Pulmonary perfusion imaging is included with myocardial perfusion studies when both are performed at the same time
	When a patient is on continuous monitoring in the hospital, emergency room, or any monitored unit, the interpretation of telemetric rhythm strips is considered to be part of the E&M services
	A non-invasive physiologic study is included in an E&M service unless a significant, separately identifiable service is performed
	Electrocardiogram (EKG) interpretations are considered part of the medical decision-making component of an E&M services performed in any setting and should not be reported separately. Electrocardiogram interpretations are allowed in addition to an E&M service performed in a hospital setting or emergency room setting. Should multiple providers render EKG interpretations, only one reimbursement is provided, to the provider who submits the first claim. The reading must be substantially separate and independent of the usual E&M services. Documentation of a written/dictated report must be available upon request for audit purposes, and medical necessity for EKG testing must be met
Chiropractic Services	Chiropractic manipulation is considered for reimbursement once per day, per patient
CMS Coverage	Pre-administration services for intravenous immunoglobulin (IVIG) infusion must be reported with the IVIG itself
	Medical nutrition therapy is included in the monthly dialysis services
	Codes for measurement for reporting purposes (status M codes for CMS) are not reimbursed
	Active wound care service(s) require the appropriate therapy service modifier, when the service is performed by a therapist
	Transportation of portable X-ray equipment and personnel must be reported with an appropriate radiological procedure
	Presbyopia-correcting intraocular lens inserted in lieu of the conventional IOL is not eligible for reimbursement
CMS National Coverage Determination (NCD) Policy	Services and supplies must be reported with an appropriate diagnosis code
	Services and supplies are considered for reimbursement when reported at an appropriate frequency
	Cellular therapy is not covered
	Services reported with modifiers are considered for reimbursement when reported with appropriate modifiers

	Intragastric hypothermia using gastric freezing is not covered
	Laetrile, amygdalin and vitamin B-17 are not covered
	Magnetic resonance spectroscopy is not covered
	Prolotherapy is not covered
	The code that accurately describes the service performed should be reported
	Services, supplies and medications must be reported with an appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying service and no contractions, reported for appropriate indications and reported with appropriate places of service
	Services and supplies considered for reimbursement when reported with an appropriate place of service
Co-Surgeon	Co-surgeon services should not be billed for procedures where the concept of co-surgeon does not apply
Dental Rule	Dental anesthesia services (D codes) are included in intraoral anesthesia services (00170)
Dermatology	PUVA is only allowed for the following diagnoses: chronic kidney disease, unspecified pruritic disorders, psoriasis, arthropathy, dyshidrosis, malignant mast cell tumors, mycosis fungoides, Seazry disease, pityriasis rosea, other alopecia, acne, or vitiligo
	Debridement, paring, biopsy, shaving, and destruction of benign or premalignant lesions is included in Moh's surgery
Devices and Supplies	Certain imaging agents are applicable to only specific diagnostic or therapeutic imaging services. When imaging agents are billed alone or with imaging services that are not consistent with their use, the imaging agents are denied
Diagnosis – Gender	Certain procedure and diagnosis, by definition or nature of the procedure, are limited to the treatment of one gender
Drugs	Certain medication codes have been assigned a maximum number of units that may be billed based on pharmacology guidelines
	Epogen/Procrit must be reported with an appropriate diagnosis code
Duplicate	Claims that have already been paid should not be resubmitted
	Lab services are only reimbursed to one provider. When both a physician and a laboratory bill for the same lab service, only one provider is reimbursed
Evaluation and Management (E&M) Services	E&M services are included in chemotherapy administration unless they are separate services
	A new patient office visit should only be billed when the patient has not had any previous services in the last 3 years by that provider, including other providers in the same group with the same specialty
	One E&M service is considered for reimbursement per day per provider
	If an inpatient consult is performed within 7 days of another inpatient consult, then the second consult should be billed as an inpatient follow-up consult

	An inpatient admission is allowed once every 7 days unless there is a discharge service between the two admissions
	Initial observation care codes should not be billed on consecutive days
	Unusual travel, physician direction of EMS, ECG monitoring, and ambulatory blood pressure monitoring are included in critical care transport services
	Providers may only bill one E&M service on the same day. Taking care of a problem or abnormality is considered part of the global service when a preventive medicine service is performed unless the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, in which case the latter service should be billed with modifier 25
	Emergency room visits are included in critical care visits
	The following services are included in critical care services during interfacility transport for pediatric patients (99289-99290): routine venous access, blood collection, arterial puncture, naso- or oro-gastric tube placement, chest X-ray interpretation, temporary transcutaneous pacing, ventilation assist and management, CPAP or CNP, pulse oximetry, and analysis of computer data
	In-hospital or out-of-hospital mandated on-call services are included in other services performed
	Instructing a patient on the proper use of medication or devices is included in E&M services
	Services provided at the request of the patient in a location other than the physician's office are included in the office E&M services
	After-hours services are only payable at the same time as office E&M services
	Office visits are included in smoking and tobacco-use cessation counseling unless they are separately identifiable services
	The initial preventative physical examination (IPPE) and the electrocardiogram performed as a part of the IPPE examination should only be reported once per lifetime
	Care plan oversight services are included in monthly ESRD
	Services, supplies and medications must be reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying service and no contradictions, reported for appropriate indications and reported with appropriate places of service
	Observation care services are considered for reimbursement when reported with the appropriate initial observation or discharge codes
Frequent Policy	Services, supplies and medications must be reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying service and no contradictions, reported for appropriate indications and reported with appropriate places of service

Gastroenterology	Colorectal cancer screening done by colonoscopy is included in non-screening colonoscopies
	A portion of the work associated with a gastric analysis procedure is included in an upper GI endoscopy. Report the gastric analysis procedure with modifier –52
General Surgery	Repair of an umbilical hernia is included in the repair of an incisional or ventral hernia
	Partial mastectomy codes should be billed with an appropriate cancer diagnosis
Global Obstetrical Package	Only one delivery code is allowed every 240 days. This excludes multiple gestation delivery and related assistant surgeon(s) for these procedures when done on the same day
	E&M services and procedures performed within the six-week postpartum period are included in the payment for the delivery code
Global Surgery	The Global Surgery package includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. The global surgery package applies only to surgical procedures that have post-operative global periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. The global surgery package includes preoperative and same day E&M visits after the decision is made to operate and all post-operative E&M visits and procedures for 10-day and 90-day global surgeries related to the primary procedure
	Intravenous access and infusion/injection procedures for anesthesia, intra-operative care, and post-operative pain management are included in the global surgical package
Hand Surgery	A ganglion excision or an excision of a tendon sheath of the wrist is included in a carpal tunnel neuroplasty
Health Plan Policy Rules	Office services provided on an emergency basis are not payable at the same time as a preventive office visit
	Supplies and materials billed by providers are only covered for the office place of service
	The CMS physician voluntary reporting program codes G8006-G8186 and G9050-G9130 are for informational and reporting purposes only. They are considered to be included in other services provided to the member
	Supplies and materials billed by providers are only covered for the office place of service. However, syringes, needles, alcohol, betadine, surgical trays, and miscellaneous surgical supplies are not separately payable to providers in the office place of service when billed with laboratory or pathology services
	Services, supplies and medications are considered for reimbursement when reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying services, and no contraindications
	HCPCS codes S0000-S9999 are not payable except as recognized by Health Net Medi-Cal
Home Health/Home Infusion	Add-on codes must be reported with the corresponding primary code on the same date of service

ICD-9 Guidelines	An encounter for chemotherapy or immunotherapy should not be the sole diagnosis for chemotherapy. The underlying disorder should also be listed
	Manifestation diagnoses should be reported with another diagnosis code indicating the underlying disease
	Services must be reported with an appropriate diagnosis code
Incident To Services	Incident To services are those services furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury to the physician's patient. Incident To services, as defined by CMS, should only be billed in the physician's office
Laboratory	Laboratory panel codes should be billed when the components of the panel are performed. Both the lab panel code and the component codes should not be billed
	Laboratory panels are not eligible for reimbursement when submitted with reduced service or discontinued service modifiers
Laboratory & Pathology	Laboratory and pathology services are included in hospital E&M services
Maximum Units	All procedure codes are assigned a maximum number of units that may be billed on a single date of service. Health Net has assigned maximum units based on one or more of the following criteria: CMS' maximum units per day list, the procedure code definition or nomenclature, the anatomical site, clinical guidelines, or determinations made by expert specialty panels
Modifier Policy	Only valid modifiers are considered for reimbursement
Multiple Procedure Reduction	When more than one procedure is billed for the same date of service, the procedure with the highest RVUs is reimbursed at 100% of the allowed amount. Subsequent procedures are reimbursed at 50% of the allowed amount based on principles of multiple procedure reduction
National Correct Coding Initiative (CCI) Policy Manual	Established patient E&M services are included in cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging unless a significant, separately identifiable service was performed
	The introduction of an intravenous needle or catheter is included in a venipuncture
	CCI edits applied to CPT codes are applied to analogous HCPCS codes (or their HCPCS code counterparts)
	Claims are subject to policies that appear in the narrative sections of CMS' CCI policy manual
Nephrology	Epoetin Alpha is covered for the following diagnoses: anemia in end-stage renal disease, hypertensive heart and/or renal disease, or chronic renal failure
Neurology	No more than four sensory nerve conduction studies should be required for the diagnosis of carpal tunnel syndrome

	Electromyogram (EMG) and nerve conduction studies are considered diagnostic services and should not be reported with therapy modifiers such as GN, GP, and GO
	Somatosensory evoked potential studies are considered for reimbursement when reported with an appropriate diagnosis code
	Services, supplies and medications are considered for reimbursement when reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying services, and no contraindications
	Digital analysis of electroencephalogram (EEG) is considered from reimbursement when reported with an appropriate EEG service
Obstetrics and Gynecology	Saline infusion hysterography includes pelvic echography
	Insertion of cervical dilator is included in the global obstetrical package
	For multiple gestation vaginal deliveries (including vaginal deliveries after previous cesarean section), the global care code that includes antepartum, postpartum and delivery care should only be used once. The codes for delivery alone should be used to indicate the birth of the additional gestation(s)
	The global delivery code for babies delivered by cesarean section is considered to include one or more babies. The additional work to deliver more than one baby via cesarean section is considered to be part of that global service
	Services, supplies and medications are considered for reimbursement when reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying services, and no contraindications
	Ultrasounds for multiple gestations should be billed with multiple gestational diagnoses
Once per lifetime services	Services performed once in a lifetime are considered for reimbursement once per member
Ophthalmology	When a patient is over 8-years-old, the sensorimotor exam with multiple measurements of ocular deviation with interpretation and report is considered to be included in the E&M services both general and ophthalmologic
	Radial keratotomy and keratomileusis are only covered for anomalous corneal size/shape or keratoconus
	Photodynamic therapy requires performance of fluorescein angiography
Orthopedic	The following procedures are considered to be an integral part of primary orthopedic or neurosurgical procedures: intravenous fluid administration; explorations of applicable cavity; isolation, retraction and protection of anatomical structures; nerve stimulation; fluoroscopy; cultures; wound closure; scar revision; and cast applications

	Open treatment of a knee dislocation with primary ligamentous repair is included in arthroscopically aided anterior or posterior cruciate ligament repair/augmentation or reconstruction
	The deep excision of a bone cyst or benign tumor includes the partial or superficial excision of a bone cyst or benign tumor
	An injection of a major joint billed with Hylan G-F 20 or sodium hyaluronate is only allowed with the following diagnoses: osteoarthritis or osteoarthrosis of the knee and lower leg
	Removal of a knee prosthesis includes a synovectomy, removal of a foreign body, a capsulotomy, knee ligament reconstruction, partial excision of the bone, a chondroplasty, and an arthrotomy with biopsy
	A knee immobilizer is included in a double-upright knee orthosis
	An arthroscopy with an abrasion arthroplasty is included in an arthroscopy with menisectomy if they are in the same compartment
	Exploration of spinal fusion is included in more comprehensive spine procedures
	Diagnostic shoulder arthroscopy is included in more comprehensive shoulder procedures
Otolaryngology	Tympanostomy for patients older than age 13 should be performed in an office setting
Physical Medicine	Vasopneumatic compression therapy is considered for reimbursement when used for treatment of lymphedema
	Therapeutic procedures or therapeutic activities, in any combination, are only allowed up to four units per date of service
	For physical therapists, E&M services are included in physical therapy modalities and therapeutic procedures
	Physical therapists should use physical therapy evaluation codes, not E&M codes
	Neurostimulator application or physical/occupational therapy re-evaluation is included in unattended electrical stimulation
	Application of unattended electrical stimulation is included in application of manual electrical stimulation
	Unattended electrical stimulation (97014) cannot be billed with other electrical stimulation procedures (G0281 or G0329) because they are mutually exclusive procedures
	Chiropractic manipulative treatment services require specific skills and are therefore limited to providers trained in Chiropractic medicine
	Therapy and athletic training evaluations are considered for reimbursement once a month
Place of Service	Medical supplies, surgical supplies and durable medical equipment may only be billed by the physician in an office setting. In the outpatient or inpatient settings the facility is responsible for the supplies and billing

	E&M codes need to be billed for a place of service consistent with the code definition
	Certain procedures are only appropriate for the inpatient setting
	Emergency department visits are only allowed for place of service 23
	Home care visits are only allowed for place of service 12
	Casts and strappings provided by physical or occupational therapists in a skilled nursing facility are included in the payment to the facility
	In an office setting, a presbyopia-correcting intraocular lens must be reported with an appropriate cataract removal surgical service
	CMS has identified procedures that are rarely or never performed in a non-facility setting. Health Net denies these procedures if they are billed in the office
	Monthly home dialysis services are eligible for reimbursement when performed in the appropriate place of service
Podiatry	Trimming and debridement of nails and benign hyperkeratotic lesions are allowed if they are accompanied by a diagnosis for a fungal infection of the nail or other diagnoses that put the patient at some risk for a complication, such as diabetes or peripheral vascular disease
	Use of codes for examination of the feet for diabetic members with peripheral neuropathy and loss of protective sensation (G0245-G0247) is reserved only for diabetic members with neurological manifestations
	Within the podiatry specialty, there is a set of services that may be rendered by that specialty under the state's licensure. Other services are considered to be outside of the scope of services for that specialty
Procedure Code Definition	When a procedure is described by both a CPT and a HCPCS code, only one of these codes should be billed
	The newborn metabolic screening panel includes galactose, hemoglobin electrophoresis, hydroxprogesterone 17-d, phenylalanine, and total thyroxine
	The services for orthotic management and training are included in the fitting or dispensing of the orthotic
	The EKG as a component of the initial preventive physical examination consists of the tracing and the interpretation. When tracing and interpretation are reported separately, they are combined into the overall EKG for reimbursement
Procedure – Age	Removal of sutures under anesthesia is limited to members under age 7
	Certain procedure codes by definition are limited to specific ages
Procedure – Gender	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender
Professional, Technical and Global Services	Interpretation of most radiologic procedures done in an inpatient or emergency room setting are payable only to radiologists

	Only the professional component is covered when a diagnostic test or radiologic service is performed in an inpatient or outpatient place of service
	Payment for a global ECG is only covered in the physician's office
	Low osmolar contrast media is only covered for patients of extreme age or when there is a contraindication to the use of ionic contrast
	Procedures that are professional component only in nature should not be billed with modifier 26 or TC (technical component)
	Procedures that are technical component only in nature should not be billed with modifier TC or 26
	Providers are not reimbursed for technical only component services provided in the inpatient or outpatient hospital locations
	Physicians are only reimbursed for the professional component of exercise testing when done in an inpatient or outpatient facility
	Physicians are only reimbursed for the report and interpretation portion of a 24-hour ECG when done in an inpatient or outpatient facility
	Physicians are only reimbursed for the report and interpretation portion of a 30-day patient demand event recording when done in an inpatient or outpatient facility
	The professional component of certain radiologic procedures performed in the outpatient facility are only covered when performed by the radiologist
	Only one provider should bill for the professional component of a given procedure
	Only laboratory services that have a professional component may be reported with a modifier 26
	Only services that have a professional and technical component may be billed with modifiers 26 and TC respectively
	Procedures that are professional only should not be billed with a modifier TC
	Professional and technical component modifiers require the use of a code that is appropriate for the modifier
	The Professional component of certain radiologic procedures is eligible for reimbursement one time by radiologists or other appropriate specialists
Radiation Oncology	Continuing medical physics consultation should only be billed weekly
	An E&M service is included in radiation oncology services unless it is a separately identifiable service
	Radiation treatment management represents 5 treatments
	Therapeutic port films are only allowed once every 7 days
Radiology	Indications for performing a bone density measurement study include but are not limited to osteopenia, osteoporosis, ovarian failure, and fractures

	Provision of diagnostic radiopharmaceutical substances is included in the supply of the radiopharmaceutical diagnostic agents
	Radiopharmaceuticals and imaging agents need to be billed with appropriate imaging procedures
	Interpretation of X-rays is included in hospital E&M services
	Radiologic exam of the hand includes the X-ray exam of the wrist
	Complete radiologic exam of the pelvis includes the X-ray exam of the hip
	Digital subtraction angiography needs to be done in conjunction with a related imaging procedure
	A single spot film of the spine is considered to be included in a more comprehensive specific, spinal X-ray procedure
	MRI and CT scans of the same anatomic region are considered to be mutually exclusive procedures performed on the same day
	A CT angiogram and magnetic resonance angiogram of the same anatomic region are considered to be mutually exclusive procedures performed on the same day
	MRI and arthrography of the temporomandibular joint are considered to be mutually exclusive procedures performed on the same day
	Thyroid imaging without vascular flow and thyroid imaging with vascular flow are considered to be mutually exclusive procedures when performed on the same day
	A complete ultrasound of the abdomen includes an examination of the retro-peritoneum
	A CT or DEXA study of the axial skeleton is included in the DEXA study of the appendicular skeleton
	A magnetic resonance angiogram of the pelvis and abdomen are mutually exclusive when performed on the same day
	Plain X-rays of specific regions are included in bone age and bone length studies and in osseous surveys
	Myocardial infarct scanning is mutually exclusive of cardiac blood pool imaging performed on the same day
Separate Procedures	Fluoroscopy is only a separate procedure when it is not performed as an integral part of another service
	Procedures that are defined as separate procedures should not be billed when they are performed as part of another major service
	A service designated as a separate procedure is considered an integral component of the total service
Split Surgical Care	Care split between providers should be reported appropriately to define preoperative care only (modifier 56), surgical care only (modifier 54), and post-operative care only (modifier 55)
	Emergency physicians who perform a surgical procedure with any global period in the emergency department should report the procedure as surgical care only (modifier 54) unless they also provide the post-operative care

Surgery	Venipuncture and exchange transfusion procedures are included in laboratory tests
	Removal of mammary implant material is included in the periprosthetic capsulectomy
	IV infusion during an observation stay is included in any surgical procedure
	Introduction of a needle or catheter in a vein and blood collection services are not covered for providers in the inpatient and outpatient hospital settings
Urology	Injection procedure for pyelography is included in the change of a pyelostomy or nephrostomy tube
	When a post-void residual volume is measured in the bladder after urodynamic testing, the ultrasound performed to obtain this value is limited. The complete pelvic ultrasound should not be used for this measurement
	Ureteral stenting is considered to be part of endoscopic procedures involving the ureter with tumor resection
	Bladder irrigation is included as part of other endoscopic or open procedures of the bladder
	When an initial approach to a procedure is unsuccessful, and an alternative approach is undertaken, the successful approach is considered for reimbursement
	Prostate cancer screening is eligible for reimbursement once annually
Vaccines	Zoster vaccination is limited to members ages 60 and older. For a complete description of the medical policy, select Medical Policies located under Policies and Procedures on the Health Net provider Web site at www.healthnet.com/provider

CONTROL #:_____

EXPIRATION DATE:_____

One Golden Shore Drive ● Long Beach, CA 90802
(800) 526-8196 ● Fax: (562) 901-9330

SERVICE REQUEST FORM

(Schedule non-emergent requested service until authorization is obtained.)

DATE: / /

PATIENT INFORMATION

MEMBER NAME (LAST, FIRST)	DATE OF BIRTH / /	MEMBER I.D. (Social Security Number)
ADDRESS (NO., STREET, CITY, STATE, ZIP)		PHONE NUMBER ( )

SERVICE IS: ☐ EMERGENT* (Needed immediately) ☐ URGENT* (Needed within next 3 days) ☐ ELECTIVE (Not needed within next 3 days)

* ONLY EMERGENT/URGENT REQUESTS MAY BE FAXED.

REFERRAL/SERVICE TYPE REQUESTED

☐ Specialist Consult/Treatment/Follow-Up Care ☐ Surgical Procedure Requested LOS_____

☐ Inpatient Admission ☐ Inpatient Facility_____

☐ Major Diagnostic Procedure ☐ Outpatient Date/Time of Service_____

☐ Home Health ☐ Hospice ☐ Other_____

☐ DME ☐ Comments_____

REQUESTING PROVIDER INFORMATION

REQUESTING PROVIDER NAME: (LAST, FIRST)	SPECIALTY	PHONE NUMBER ( )
ADDRESS (NO., STREET, CITY, STATE, ZIP)		FAX NUMBER ( )

REFERRED TO PROVIDER INFORMATION

REFERRED TO PROVIDER NAME: (PHYSICIAN, MG/IPA, FACILITY, AGENCY)	SPECIALTY	PHONE NUMBER ( )
ADDRESS (NO., STREET, CITY, STATE, ZIP)		FAX NUMBER ( )

PROCEDURE INFORMATION

CPT CODE(s) #/DESCRIPTION	CPT CODE(s) #/DESCRIPTION	HCPCS #/DESCRIPTION

CLINICAL INDICATIONS FOR REQUEST: (INCLUDE PERTINENT PAST MEDICAL HX., TREATMENT, PHYSICAL FINDINGS, AND ATTACH ALL RECORDS AND TEST RESULTS, ETC.)

REQUESTING PROVIDER SIGNATURE: DATE PATIENT SEEN BY PCP / /

MOLINA USE ONLY

CRITERIA/GUIDELINES MET:

☐ YES ☐ NO (If No, Medical Director Review Required)

AUTHORIZATION STATUS: ☐ PENDED

☐ APPROVED ☐ APPROVED with QUALIFCIATIONS ☐ DENIED (Per Medical Director)
(See comments Below)

COMMENTS:

UM DEPARTMENT SIGNATURE:	DATE / /	APPROVED LOS:

MEDICAL DIRECTOR REVIEW:

☐ APPROVED COMMENTS:_____

☐ PENDED _____

☐ DENIED

MEDICAL DIRECTOR SIGNATURE: DATE / /

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE

MONTHLY EQUIPMENT, MEDICATION VERIFICATION AND REPLACEMENT LOG

YEAR:_____

Please initial each category as you check the medication and equipment

An initial indicates that the items have been checked, expired medications and lab supplies purged, properly disposed of and replaced.

Day of Month	Meds, etc. In Refrig/Freezer	All other meds and samples	Emergency Equipment/ Medication Expiration	Emergency Equipment/ Medication Used and Replaced	Oxygen tank,- Key, PSI level, mask and tubing attached	All Lab reagents, hemocults, pap smear containers, etc.	All vacutainer, tubes, culture medium & collection systems	Other Formula, etc…
January/								
February/								
March/								
April/								
May/								
June/								
July/								
August/								
September/								
October/								
November/								
December/								

Initials	Signature	Initials	Signature

Monthly Medication and Lab Supplies Inventory Checklist

- **Print name and sign name and initials.**
- **Document day of month and your initials when medication and lab supplies are verified to be within expiration dates.**
- **Expired medication and lab supplies are purged and properly disposed of and replaced timely/**

YEAR_____ Dr. Name_____

Medications	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Sample and Stock Medications												
Check open date of Multi-dose vials												
Vaccines/Immunizations-private and VFC												
Lab Supplies (vaccutainer, tubes, culture medium and collections systems)												
All Lab reagents (hemocults, urine dip sticks, glucose testing strips)												
Other:												

Print Name_____Signature_____Initials_____

Print Name_____Signature_____Initials_____

Print Name_____Signature_____Initials_____

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)	City	State ZIP code
5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last	first	middle
9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)
12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address
18. Residence address (number, street) *(DO NOT USE P.O. BOX)*	City	State ZIP code
19. Mailing address (if different) (number, street, P.O. box number)	City	State ZIP code
20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
27. Enrolled in commercial insurance plan ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

28.
Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10:_____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached ☐ Yes	36. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days

Additional Services Requested from Other Health Care Provider

40. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address (number, street)	City	State	ZIP code

Description of services	Procedure code	Units	Quantity
Additional information			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.

27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.

CalViva Health complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sex characteristics, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

CalViva Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - If you need these services, contact the CalViva Health at 1-888-893-1569 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to: CalViva Health 7625 N. Palm Ave. Suite 109, Fresno, CA 93711, 1-888-893-1569 (TTY/TDD 711) to use the California Relay Service

If you believe that CalViva Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sex characteristics, sexual orientation, and gender identity), you can file a grievance with CalViva Health Member Services. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact us 24 hours a day, 7 days a week by calling 1-888-893-1569. Or, if you cannot hear or speak well, please call (TTY/TDD 711) to use the California Relay Service
- In writing: Fill out a complaint form or write a letter and send it to: CalViva Health Member Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410-0348.
  Fax: 1-877-831-6019
- In person: Visit your doctor's office or CalViva Health and say you want to file a grievance.
- Electronically: Visit CalViva Health's website at www.CalVivaHealth.org.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711.
- In writing: Fill out a complaint form or write a letter and send it to Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at CalViva Health website:
https://www.calvivahealth.org/nondiscrimination-notice/

English: If you, or someone you are helping, need language services, call Toll-Free 1-888-893-1569 (TTY: 711). Aids and services for people with disabilities, like documents in braille, accessible PDF and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى المساعدة في الحصول على الخدمات اللغوية، فاتصل بالرقم المجاني 1-888-893-1569 (TTY: 711). المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل، والملفات المنقولة (PDF) التي يمكن الوصول إليها، والطباعة الكبيرة، متوفرة أيضاً. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք անվճար 1-888-893-1569 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ բրեյլով փաստաթղթեր, մատչելի PDF և մեծ տպագրությամբ փաստաթղթեր: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខទូរសព្ទដោយគិតថ្លៃ 1-888-893-1569 (TTY: 711) ។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់មនុស្សពិការ ដូចជា ឯកសារជាអក្សរសម្រាប់មនុស្សពិការ PDF ដែលអាចប្រើសម្រាប់មនុស្សពិការ និងឯកសារព្រឹនអក្សរធំៗ ក៏ត្រូវបានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះមិនមានគិតតម្លៃសម្រាប់អ្នកទេ។

Chinese: 如果您或者您正在帮助的人需要语言服务，请免费致电 1-888-893-1569 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文、无障碍 PDF 和大字版文档。这些服务免费为您提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ رایگان 1-888-893-1569 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل، چاپ درشت و PDF دسترس‌پذیر نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो इस टॉल फ्री नंबर पर कॉल करें 1-888-893-1569 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेले लिपि में दस्तावेज़, सुलभ PDF और बड़े प्रिंट वाले दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau Tus Xov Tooj Hu Dawb 1-888-893-1569 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv su uas cov neeg tsis pom kev siv tau, cov ntaub ntawv PDF uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、トールフリーダイアル1-888-893-1569（TTY: 711）にお問い合わせください。点字、アクセシブルPDF、大活字など、障がいのある方のための補助・サービスもご用意しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면무료 전화 1-888-893-1569 (TTY: 711)번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자, 액세스 가능한 PDF 및 대형 활자 인쇄본)도 제공됩니다.
이 서비스는 무료로 이용하실 수 있습니다.

FLY061957EP00 (06/23)

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທຫາເບີໂທຟຣີ 1-888-893-1569 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບ ຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານແບບບຣາແລ (braille) ສຳລັບຄົນຕາບອດ, ເອກະສານ PDF ທີ່ສາມາດ ເຂົ້າເຖິງໄດ້ສະດວກ ແລະ ເອກະສານພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍ ຄ່າໃດໆ.

Mien: Da'faanh Meih, Fai Heuc Meih Haih Tengx, Oix help Janx-kaeqv waac gong, Heuc Bieqcll-Free 1-888-893-1569 (TTY: 711). Jomc Caux gong Bun Yangh mienh Caux mv fungc, Oix dimc in braille, dongh eix PDF Caux Bunh Fiev , Haih yaac kungx nyei. Deix gong Haih buatc Yietc liuz maiv jaax-zinh Bieqc Meih.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-888-893-1569 (TTY: 711) ‹ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਪਹੁੰਚਯੋਗ PDF ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните на бесплатную линию 1-888-893-1569 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы в специальном формате PDF, напечатанные крупным шрифтом или шрифтом Брайля. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al número gratuito 1-888-893-1569 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille, en letra grande y en archivos PDF accesibles. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng tulong sa mga serbisyo sa wika, tumawag nang Walang Bayad sa 1-888-893-1569 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille, naa-access na PDF at malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทรแบบไม่เสียค่าธรรมเนียม บริการ 1-888-893-1569 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารอักษรเบรลล์, PDF ที่เข้าถึงได้, และเอกสารที่พิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на безкоштовну лінію 1-888-893-1569 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи в спеціальному форматі PDF, надруковані великим шрифтом чи шрифтом Брайля. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi Số miễn phí 1-888-893-1569 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu dạng chữ nổi braille, bản in khổ lớn và PDF có thể tiếp cận được. Quý vị được nhận các dịch vụ này miễn phí.

CalViva Health ua raws li Lub Lav thiab Tsoom Hwv Teb Chaws cov cai lij choj fab cai pej xeem uas cuam tshuam thiab tsis muaj kev ntxub ntxaug, ciav cais tib neeg los sis coj rau lawv yam sib txawv vim yog hom neeg, xim tawv nqaij, lub teb chaws yug, hnub nyoog, kev xiam oob qhab fab lub hlwb, kev xiam oob qhab fab lub cev, poj niam los txiv neej (suav nrog kev xeeb tub, cov yam ntxwv fab poj niam los txiv neej, kev nyiam fab kev sib deev, thiab kev txheeb qhia tias yog poj niam los txiv neej), kev ntseeg dab qhuas, caj ces, kev txheeb qhia tias yog haiv neeg tsawg, kev muaj mob, cov ntaub ntawv caj ces, kev muaj txij nkawm, los sis poj niam los txiv neej.

CalViva Health:

- Muab kev pab dawb thiab kev pab cuam rau cov neeg xiam oob qhab kom lawv tuaj yeem sib txuas lus nrog peb tau yam muaj txiaj ntsig zoo, xws li:
  - Cov neeg txhais lus piav tes uas paub tsim nyog
  - Cov ntaub ntawv sau ua lwm hom qauv ntaub ntawv (luam ua tus ntawv loj, kaw suab lus, cov qauv ntaub ntawv es lev thaus niv uas tuaj yeem nkag mus siv tau, lwm hom qauv ntaub ntawv)
- Muab kev pab txhais lus pub dawb rau cov neeg uas nws hom lus hais tas li tsis yog Lus Askiv, xws li:
  - Cov neeg txhais lus uas paub tsim nyog
  - Cov ntaub ntawv uas sau ua lwm hom lus
  - Yog hais tias koj xav tau cov kev pab cuam no, tiv tauj rau CalViva Health ntawm 1-888-893-1569 (TTY: 711), 24 hauv ib hnub, 7 hnub hauv ib lub lim tiam, 365 hnub hauv ib lub xyoos.

Thaum koj thov txog, peb yuav tuaj yeem muab tsab ntawv no rau koj ua ntawv xuas, luam ua tus ntawv loj, kaw suab rau hauv kab xev, los sis cov qauv ntaub ntawv es lev thaus niv. Txhawm rau kom tau txais daim ntawv theej ua ib hom twg ntawm cov qauv ntaub ntawv kev xaiv no, thov hu los sis sau ntawv mus rau: CalViva Health 7625 N. Palm Ave. Suite 109, Fresno, CA 93711, 1-888-893-1569 (TTY/TDD 711) txhawm rau siv California Relay Service.

Yog tias koj ntseeg tias CalViva Health tsis muab cov kev pab cuam no los sis muaj kev ntxub ntxaug mus rau lwm txoj hau kev uas yog saib raws li hom neeg, xim tawv nqaij, lub teb chaws yug, hnub nyoog, kev xiam oob qhab, los sis poj niam los txiv neej (suav nrog kev xeeb tub, cov yam ntxwv fab poj niam los txiv neej, kev nyiam fab kev sib deev, thiab kev txheeb qhia tias yog poj niam los txiv neej), ces koj tuaj yeem ua ntawv hais kev tsis txaus siab mus rau CalViva Health Feem Pab Cuam Tswv Cuab tau. Koj tuaj yeem sau ntawv hais kev tsis txaus siab tau los ntawm kev hu xov tooj, sau ua ntaub ntawv, tus kheej mus kiag, los sis hauv es lev thaus niv:

- Los ntawm kev hu xov tooj: Tiv tauj rau peb tau 24 teev hauv ib hnub, 7 hnub hauv ib lub lim tiam los ntawm kev hu rau 1-888-893-1569. Los sis, yog hais tias koj tsis hnov lus zoo los sis hais tsis tau lus zoo, thov hu rau (TTY/TDD 711) txhawm rau siv California Relay Service
- Kev sau ua ntaub ntawv: Sau daim foos hais kev tsis txaus siab los sis sau ib tsab ntawv thiab muab xa mus rau: CalViva Health Member Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410-0348.
  Fev: 1-877-831-6019
- Tus kheej mus kiag: Mus ntsib kiag koj tus kws kho mob lub chaw ua hauj lwm los sis CalViva Health thiab hais tias koj xav ua ntawv hais kev tsis txaus siab.
- Hauv es lev thaus niv: Mus saib CalViva Health tus vev xaib ntawm www.CalVivaHealth.org.

Tsis tas li xwb, koj kuj tseem tuaj yeem ua daim ntawv hais kev tsis txaus siab fab cai pej xeem mus rau California Feem Hauj Lwm Saib Xyuas Kev Pab Cuam Kev Saib Xyuas Kho Mob, Lub Chaw Hauj Lwm Saib Xyuas Cov Cai Pej Xeem tau tib si thiab los ntawm kev hu xov tooj, sau ntawv los sis hauv es lev thaus niv:

- Los ntawm kev hu xov tooj: Hu rau 1-916-440-7370. Yog hais tias koj tsis hnov lus zoo los sis hais tsis tau lus zoo, thov hu rau 711.
- Kev sau ua ntaub ntawv: Sau daim foos hais kev tsis txaus siab los sis sau ib tsab ntawv thiab muab xa mus rau Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Cov foos sau hais kev tsis txaus siab yog muaj nyob rau ntawm http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Hauv es lev thaus niv: Xa ib tsab email mus rau CivilRights@dhcs.ca.gov

Tsis tas li xwb, koj kuj tseem tuaj yeem ua daim ntawv hais kev tsis txaus siab fab cai pej xeem mus rau Teb Chaws Meskas Feem Hauj Lwm Saib Xyuas Kev Pab Cuam Kev Saib Xyuas Kho Mob, Lub Chaw Hauj Lwm Saib Xyuas Cov Cai Pej Xeem, tau hauv es lev thaus niv dhau los ntawm Lub Chaw Hauj Lwm Saib Xyuas Cov Cai Pej Xeem Lub Qhov Rooj Vev Xaib Rau Kev Hais Kev Tsis Txaus Siab, uas muaj nyob ntawm https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, los sis los ntawm kev xa ntawv los sis hu xov tooj ntawm:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Cov foos sau hais kev tsis txaus siab yog muaj nyob ntawm https://www.hhs.gov/ocr/complaints/index.html.

Tsab ntawv ceeb toom no yog muaj nyob rau hauv CalViva Health tus vev xaib: https://www.calvivahealth.org/nondiscrimination-notice/

English: If you, or someone you are helping, need language services, call Toll-Free 1-888-893-1569 (TTY: 711). Aids and services for people with disabilities, like documents in braille, accessible PDF and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى المساعدة في الحصول على الخدمات اللغوية، فاتصل بالرقم المجاني 1-888-893-1569 (TTY: 711). المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل، والملفات المنقولة (PDF) التي يمكن الوصول إليها، والطباعة الكبيرة، متوفرة أيضاً. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք անվճար 1-888-893-1569 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ բրեյլով փաստաթղթեր, մատչելի PDF և մեծ տպագրությամբ փաստաթղթեր: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខទូរសព្ទដោយគិតថ្លៃ 1-888-893-1569 (TTY: 711) ។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់មនុស្សពិការ ដូចជា ឯកសារជាអក្សរសម្រាប់មនុស្សពិការ PDF ដែលអាចប្រើសម្រាប់មនុស្សពិការ និងឯកសារព្រឹនអក្សរធំៗ ក៏ត្រូវបានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះមិនមានគិតតម្លៃសម្រាប់អ្នកទេ។

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Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो इस टॉल फ्री नंबर पर कॉल करें 1-888-893-1569 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेले लिपि में दस्तावेज़, सुलभ PDF और बड़े प्रिंट वाले दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau Tus Xov Tooj Hu Dawb 1-888-893-1569 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv su uas cov neeg tsis pom kev siv tau, cov ntaub ntawv PDF uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、トールフリーダイアル1-888-893-1569（TTY: 711）にお問い合わせください。点字、アクセシブルPDF、大活字など、障がいのある方のための補助・サービスもご用意しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면무료 전화 1-888-893-1569 (TTY: 711)번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자, 액세스 가능한 PDF 및 대형 활자 인쇄본)도 제공됩니다.
이 서비스는 무료로 이용하실 수 있습니다.

FLY061957EP00 (06/23)

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທຫາເບີໂທຟຣີ 1-888-893-1569 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບ ຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານແບບບຣາແລ (braille) ສຳລັບຄົນຕາບອດ, ເອກະສານ PDF ທີ່ສາມາດ ເຂົ້າເຖິງໄດ້ສະດວກ ແລະ ເອກະສານພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍ ຄ່າໃດໆ.

Mien: Da'faanh Meih, Fai Heuc Meih Haih Tengx, Oix help Janx-kaeqv waac gong, Heuc Bieqcll-Free 1-888-893-1569 (TTY: 711). Jomc Caux gong Bun Yangh mienh Caux mv fungc, Oix dimc in braille, dongh eix PDF Caux Bunh Fiev , Haih yaac kungx nyei. Deix gong Haih buatc Yietc liuz maiv jaax-zinh Bieqc Meih.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-888-893-1569 (TTY: 711) ‹ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਪਹੁੰਚਯੋਗ PDF ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните на бесплатную линию 1-888-893-1569 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы в специальном формате PDF, напечатанные крупным шрифтом или шрифтом Брайля. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al número gratuito 1-888-893-1569 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille, en letra grande y en archivos PDF accesibles. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng tulong sa mga serbisyo sa wika, tumawag nang Walang Bayad sa 1-888-893-1569 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille, naa-access na PDF at malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทรแบบไม่เสียค่าธรรมเนียม บริการ 1-888-893-1569 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารอักษรเบรลล์, PDF ที่เข้าถึงได้, และเอกสารที่พิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на безкоштовну лінію 1-888-893-1569 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи в спеціальному форматі PDF, надруковані великим шрифтом чи шрифтом Брайля. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi Số miễn phí 1-888-893-1569 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu dạng chữ nổi braille, bản in khổ lớn và PDF có thể tiếp cận được. Quý vị được nhận các dịch vụ này miễn phí.

CalViva Health cumple con las leyes estatales y federales vigentes sobre derechos civiles y no discrimina, no excluye ni trata a las personas de forma diferente por motivos de origen racial, color, nacionalidad, edad, discapacidad mental o física, sexo (incluido el embarazo, la orientación sexual y la identidad de género), religión, ascendencia, identidad de origen étnico, enfermedad, información genética, estado civil o género.

CalViva Health brinda lo siguiente:

- Asistencia y servicios gratuitos a personas discapacitadas para que se comuniquen con nosotros de forma eficaz, como los siguientes:
  - intérpretes calificados de lengua de señas;
  - información escrita en otros formatos (en letra grande, en audio, en formatos electrónicos accesibles, en otros formatos).
- Servicios gratuitos de idiomas a personas cuyo idioma principal no es el inglés, como los siguientes:
  - intérpretes calificados;
  - información escrita en otros idiomas;
  - si necesita estos servicios, comuníquese con CalViva Health, al 1-888-893-1569 (TTY: 711), las 24 horas del día, los 7 días de la semana, los 365 días del año.

Podemos brindarle este documento en braille, en letra grande, grabado en un casete o en forma electrónica si lo solicita. Para obtener una copia en alguno de estos formatos alternativos, llame o escriba a: CalViva Health 7625 N. Palm Ave. Suite 109, Fresno, CA 93711, 1-888-893-1569 (TTY/TDD 711) para usar el Servicio de Retransmisión de Datos de California.

Si cree que CalViva Health no le ha brindado estos servicios o que lo ha discriminado de alguna otra manera por origen racial, color, nacionalidad, edad, discapacidad o sexo (incluido el embarazo, las características sexuales, la orientación sexual y la identidad de género), puede presentar una queja formal a Servicios al Afiliado de CalViva Health. Puede hacerlo por teléfono, por escrito, en persona o en línea.

- Por teléfono: Llámenos las 24 horas del día, los 7 días de la semana al 1-888-893-1569. Si tiene dificultades de audición o del habla, llame al Servicio de Retransmisión de Datos de California (TTY/TDD: 711).
- Por escrito: Complete el formulario de quejas o envíe una carta a CalViva Health Member Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410-0348. Fax: 1-877-831-6019.
- En persona: Visite el consultorio de su médico o vaya a CalViva Health e informe que quiere presentar una queja formal.
- En línea: Visite el sitio web de CalViva Health, www.CalVivaHealth.org.

También puede presentar una queja sobre los derechos civiles a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California por teléfono, por escrito o en línea.

- Por teléfono: Llame al 1-916-440-7370. Si tiene dificultades de audición o del habla, llame al 711.

- Por escrito: Complete el formulario de quejas o escriba una carta y envíela a Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Los formularios de quejas están disponibles en http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- En línea: Envíe un correo electrónico a CivilRights@dhcs.ca.gov.

También puede presentar una queja sobre los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. Puede hacerlo de manera electrónica a través del portal habilitado para ello, https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Además, puede enviar la queja por correo o por teléfono:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Los formularios para quejas están disponibles en https://www.hhs.gov/ocr/complaints/index.html.

Este aviso está disponible en el sitio web de CalViva Health:
https://www.calvivahealth.org/nondiscrimination-notice/.

English: If you, or someone you are helping, need language services, call Toll-Free 1-888-893-1569 (TTY: 711). Aids and services for people with disabilities, like documents in braille, accessible PDF and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى المساعدة في الحصول على الخدمات اللغوية، فاتصل بالرقم المجاني 1-888-893-1569 (TTY: 711). المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل، والملفات المنقولة (PDF) التي يمكن الوصول إليها، والطباعة الكبيرة، متوفرة أيضاً. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք անվճար 1-888-893-1569 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ բրեյլով փաստաթղթեր, մատչելի PDF և մեծ տպագրությամբ փաստաթղթեր: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខទូរសព្ទដោយគិតថ្លៃ 1-888-893-1569 (TTY: 711) ។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់មនុស្សពិការ ដូចជា ឯកសារជាអក្សរសម្រាប់មនុស្សពិការ PDF ដែលអាចប្រើសម្រាប់មនុស្សពិការ និងឯកសារព្រឹនអក្សរធំៗ ក៏ត្រូវបានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះមិនមានគិតតម្លៃសម្រាប់អ្នកទេ។

Chinese: 如果您或者您正在帮助的人需要语言服务，请免费致电 1-888-893-1569 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文、无障碍 PDF 和大字版文档。这些服务免费为您提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ رایگان 1-888-893-1569 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل، چاپ درشت و PDF دسترس‌پذیر نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो इस टॉल फ्री नंबर पर कॉल करें 1-888-893-1569 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेले लिपि में दस्तावेज़, सुलभ PDF और बड़े प्रिंट वाले दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau Tus Xov Tooj Hu Dawb 1-888-893-1569 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv su uas cov neeg tsis pom kev siv tau, cov ntaub ntawv PDF uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、トールフリーダイアル1-888-893-1569（TTY: 711）にお問い合わせください。点字、アクセシブルPDF、大活字など、障がいのある方のための補助・サービスもご用意しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면무료 전화 1-888-893-1569 (TTY: 711)번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자, 액세스 가능한 PDF 및 대형 활자 인쇄본)도 제공됩니다.
이 서비스는 무료로 이용하실 수 있습니다.

FLY061957EP00 (06/23)

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທຫາເບີໂທຟຣີ 1-888-893-1569 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບ ຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານແບບບຣາແລ (braille) ສຳລັບຄົນຕາບອດ, ເອກະສານ PDF ທີ່ສາມາດ ເຂົ້າເຖິງໄດ້ສະດວກ ແລະ ເອກະສານພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍ ຄ່າໃດໆ.

Mien: Da'faanh Meih, Fai Heuc Meih Haih Tengx, Oix help Janx-kaeqv waac gong, Heuc Bieqcll-Free 1-888-893-1569 (TTY: 711). Jomc Caux gong Bun Yangh mienh Caux mv fungc, Oix dimc in braille, dongh eix PDF Caux Bunh Fiev , Haih yaac kungx nyei. Deix gong Haih buatc Yietc liuz maiv jaax-zinh Bieqc Meih.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-888-893-1569 (TTY: 711) ‹ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਪਹੁੰਚਯੋਗ PDF ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните на бесплатную линию 1-888-893-1569 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы в специальном формате PDF, напечатанные крупным шрифтом или шрифтом Брайля. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al número gratuito 1-888-893-1569 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille, en letra grande y en archivos PDF accesibles. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng tulong sa mga serbisyo sa wika, tumawag nang Walang Bayad sa 1-888-893-1569 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille, naa-access na PDF at malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทรแบบไม่เสียค่าธรรมเนียม บริการ 1-888-893-1569 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารอักษรเบรลล์, PDF ที่เข้าถึงได้, และเอกสารที่พิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на безкоштовну лінію 1-888-893-1569 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи в спеціальному форматі PDF, надруковані великим шрифтом чи шрифтом Брайля. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi Số miễn phí 1-888-893-1569 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu dạng chữ nổi braille, bản in khổ lớn và PDF có thể tiếp cận được. Quý vị được nhận các dịch vụ này miễn phí.

NONDISCRIMINATION NOTICE

Discrimination is against the law. Community Health Plan of Imperial Valley complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Community Health Plan of Imperial Valley:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Community Health Plan of Imperial Valley (CHPIV) at 1-833-236-4141 (TTY: 711), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:
Community Health Plan of Imperial Valley (CHPIV)
Health Equity Department
P.O. Box 9103
Van Nuys, CA 91410-9103
1-833-236-4141 (TTY: 711)

HOW TO FILE A GRIEVANCE

If you believe that Community Health Plan of Imperial Valley has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender you can file a grievance with CHPIV 1557 Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CHPIV 1557 Coordinator between 8:00 am and 8:00 pm (EST), Monday through Friday by calling 1-855-577-8234 (TTY: 711).
- In writing: Fill out a complaint form or write a letter and send it to:
- 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- In person: Visit your doctor's office or CHPIV and say you want to file a grievance.
- Electronically: Visit CHPIV's website at https://chpiv.org.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- By phone: Call 916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights Department of Health Care Services Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origina, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone, in writing, or electronically:

- By phone: Call 1-800-368-1019. If you cannot speak or hear well, please call TTY/TDD 1-800-537-7697.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services 200 Independence Avenue, SW
  Room 509F, HHH Building Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office of Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

If you, or someone you are helping, need language services, call 1-833-236-4141 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic

إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-833-236-4141 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian

Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-833-236-4141 (TTY: 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-833-236-4141 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified)

如果您或者您正在帮助的人需要语言服务，请致电 1-833-236-4141 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional)

如果您或您正在幫助的其他人需要語言服務，請致電 1-833-236-4141 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi

اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-833-236-4141 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi

यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-833-236-4141 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong
Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-833-236-4141 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese
ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-833-236-4141（TTY: 711）。までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean
귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-833-236-4141 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian
ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-833-236-4141 (TTY: 711) ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien
Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-833-236-4141 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-833-236-4141 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian
Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-833-236-4141 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish
Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-833-236-4141 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog
Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-833-236-4141 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai
หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-833-236-4141 (TTY: 711) **นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ**

Ukrainian
Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-833-236-4141 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese
Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-833-236-4141 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

AVISO DE NO DISCRIMINACIÓN

La discriminación es ilegal. Community Health Plan of Imperial Valley cumple con las leyes estatales y federales vigentes sobre derechos civiles y no discrimina, no excluye ni trata a las personas de forma diferente por motivos de origen racial, color, nacionalidad, edad, discapacidad mental o física, sexo (incluido el embarazo, la orientación sexual y la identidad de género), religión, ascendencia, identificación con un grupo étnico, enfermedad, información genética, estado civil o género.

Community Health Plan of Imperial Valley:

- Brinda herramientas y servicios gratuitos a personas discapacitadas para que se comuniquen con nosotros de forma eficaz, como los siguientes:
  - Intérpretes de lengua de señas calificados
  - Información por escrito en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros)
- Brinda servicios gratuitos de idiomas a personas cuyo idioma principal no es el inglés, como los siguientes:
  - Intérpretes calificados
  - información escrita en otros idiomas

Si necesita estos servicios, llame a Community Health Plan of Imperial Valley al 1-833-236-4141 (TTY: 711) las 24 horas del día, los 7 días de la semana.

Podemos brindarle este documento en braille, en letra grande, grabado en un casete o en forma electrónica si lo solicita. Para obtener una copia en alguno de estos formatos alternativos, llame o escriba a:
Community Health Plan of Imperial Valley (CHPIV)
Health Equity Department
P.O. Box 9103
Van Nuys, CA 91410-9103
1-833-236-4141 (TTY: 711)

CÓMO PRESENTAR UNA QUEJA FORMAL

Si cree que Community Health Plan of Imperial Valley no le ha brindado estos servicios o que le ha discriminado de alguna otra manera por motivos de origen racial, color, nacionalidad, edad, sexo (incluido el embarazo, la orientación sexual y la identidad de género), discapacidad mental o física, religión, ascendencia, identificación con un grupo étnico, enfermedad, información genética, estado civil o género, puede presentar una queja formal ante el coordinador 1557 de CHPIV. Puede hacerlo por teléfono, por escrito, en persona o en línea.

- Por teléfono: Comuníquese con el coordinador 1557 de CHPIV de lunes a viernes de 8:00 a. m. a 8:00 p. m., hora estándar del este, al 1-855-577-8234 (TTY: 711).
- Por escrito: Complete el formulario de quejas o envíe una carta a:
- 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- En persona: Visite el consultorio del médico o CHPIV e informe que quiere presentar una queja formal.
- En línea: Visite el sitio web de CHPIV, https://chpiv.org.

OFICINA DE DERECHOS CIVILES DEL DEPARTAMENTO DE SERVICIOS DE ATENCIÓN MÉDICA DE CALIFORNIA

También puede presentar una queja sobre los derechos civiles a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California por teléfono, por escrito o en línea.

- Por teléfono: Llame al 916-440-7370. Si tiene dificultades de audición o del habla, llame al 711 (Servicio de Retransmisión de Datos).
- Por escrito: Complete el formulario de quejas o envíe una carta a:

Deputy Director, Office of Civil Rights Department of Health Care Services Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Los formularios de quejas están disponibles en http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- En línea: Envíe un correo electrónico a CivilRights@dhcs.ca.gov.

OFICINA DE DERECHOS CIVILES DEL DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS DE LOS EE. UU.

Si cree que fue víctima de discriminación por motivos de origen racial, color, nacionalidad, edad, discapacidad o sexo, también puede presentar una queja sobre los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. en línea, por teléfono o por escrito.

- Por teléfono: Llame al 1-800-368-1019. Si tiene dificultades de audición o del habla, llame a la línea TTY/TDD: 1-800-537-7697.

- Por escrito: Complete el formulario de quejas o envíe una carta a:

  U.S. Department of Health and Human Services 200 Independence Avenue, SW
  Room 509F, HHH Building Washington, D.C. 20201

  Los formularios de quejas están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

- En línea: Visite el portal para quejas de la Oficina de Derechos Civiles, https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

If you, or someone you are helping, need language services, call 1-833-236-4141 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic

إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-833-236-4141 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian

Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-833-236-4141 (TTY: 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-833-236-4141 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified)

如果您或者您正在帮助的人需要语言服务，请致电 1-833-236-4141 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional)

如果您或您正在幫助的其他人需要語言服務，請致電 1-833-236-4141 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi

اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-833-236-4141 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi

यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-833-236-4141 (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong
Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-833-236-4141 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese
ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-833-236-4141（TTY: 711）。までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean
귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-833-236-4141 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian
ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-833-236-4141 (TTY: 711) ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien
Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-833-236-4141 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-833-236-4141 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian
Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-833-236-4141 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish
Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-833-236-4141 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog
Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-833-236-4141 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai
หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-833-236-4141 (TTY: 711) **นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ**

Ukrainian
Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-833-236-4141 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese
Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-833-236-4141 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

- Provides free aids and services to people with disabilities to help them communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services in a timely manner to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - If you need these services, contact the Health Net Customer Contact Center at 1-800-675-6110 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Customer Contact Center 1-800-675-6110 (TTY: 711)
California Relay 711

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender you can file a grievance with the 1557 Coordinator.

You can file a grievance by phone, in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711), Monday-Friday, 8:00a.m. to 8:00p.m. (EST)
- By fax: 1-866-388-1769
- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- Electronically: Send an email to SM_Section1557Coord@centene.com This notice is available at Health Net website: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html
- In person: Visit your doctor's office or Health Net and say you want to file a grievance.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- By phone: Call 916-440-7370. If you cannot speak or hear well, please call 711.
- In writing: Fill out a complaint form or write a letter and send it to Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone, in writing or electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

- In writing: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- By phone: 1-800-368-1019, 1-800-537-7697 (TDD)
- Electronically: Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

تلتزم Health Net بقوانين الحقوق المدنية المعمول بها في الولاية والقوانين الفيدرالية النافذة ولا تميز الأشخاص أو تستبعدهم أو تعاملهم بشكل مختلف بسبب العرق أو اللون أو الأصل القومي أو السن أو العجز العقلي أو البدني أو الجنس (بما في ذلك الحمل والتوجه الجنسي والهوية الجنسية) أو الدين أو النسب أو المجموعة العرقية أو الحالة الطبية أو المعلومات الوراثية أو الحالة الاجتماعية أو النوع.

Health Net:

- توفر وسائل مساعدة وخدمات مجانية للأشخاص المصابين بعجز لمساعدتهم على التواصل الفعال معنا، مثل:
  - مترجمين فوريين مؤهلين للغة الإشارة
  - معلومات مكتوبة بتنسيقات أخرى (حروف طباعة كبيرة، وملفات صوتية، وتنسيقات إلكترونية يسهل الوصول إليها، وغيرها من التنسيقات)
- توفر خدمات لغوية مجانية في الوقت الملائم للأشخاص الذين لا تكون الإنجليزية لغتهم الأساسية، مثل:
  - مترجمين فوريين مؤهلين
  - معلومات مكتوبة بلغات أخرى
- إذا كنت بحاجة إلى هذه الخدمات، فاتصل بمركز اتصال عملاء Health Net على الرقم 1-800-675-6110 (TTY: 711)، على مدار 24 ساعة في اليوم، و7 أيام في الأسبوع، و365 يومًا في السنة.

وبناء على الطلب، يمكن إتاحة هذا المستند بطريقة برايل، أو بحروف طباعة كبيرة، أو تسجيل صوتي أو صيغة إلكترونية. للحصول على نسخة بإحدى تلك الصيغ البديلة، يرجى الاتصال بنا أو مراسلتنا على:

Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
مركز اتصال العملاء: 1-800-675-6110 (TTY: 711)
California Relay 711

إذا كنت تعتقد أن Health Net قد فشلت في تقديم هذه الخدمات أو ميزت بطريقة ما على أساس العرق أو اللون أو الأصل القومي أو السن أو الجنس (بما في ذلك الحمل والتوجه الجنسي والهوية الجنسية) أو العجز العقلي أو البدني أو الدين أو النسب أو المجموعة العرقية أو الحالة الطبية أو المعلومات الوراثية أو الحالة الاجتماعية أو النوع، يمكنك تقديم تظلم إلى منسق 1557.

يمكنك تقديم تظلم عبر الهاتف أو شخصيًا أو عن طريق البريد أو الفاكس أو البريد الإلكتروني. إذا كنت بحاجة إلى مساعدة في تقديم التظلم، فإن **منسق 1557** جاهز لمساعدتك.

- عبر الهاتف: اتصل على 855-577-8234 (TTY: 711)، من الاثنين إلى الجمعة، من الساعة 8 صباحًا إلى 8 مساءً (بالتوقيت الشرقي)
- عبر الفاكس: 1-866-388-1769
- خطيًا: اكتب رسالة وأرسلها إلى Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- إلكترونيًا: أرسل بريدًا إلكترونيًا إلى SM_Section1557Coord@centene.com هذا الإشعار متاح على موقع Health Net على الإنترنت: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html
- شخصيًا: تفضّل بزيارة عيادة طبيبك أو Health Net وأخبرهم أنك تريد تقديم تظلّم.

يمكنك أيضًا تقديم شكوى تتعلق بالحقوق المدنية إلى مكتب الحقوق المدنية التابع لإدارة خدمات الرعاية الصحية في ولاية California عبر الهاتف أو خطيًا أو إلكترونيًا:

- عبر الهاتف: اتصل على 916-440-7370. إذا كنت غير قادرٍ على التحدث أو السمع جيدًا، فيُرجى الاتصال على الرقم 711.
- خطيًا: املأ نموذج الشكوى أو اكتب خطابًا وأرسله إلى Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  تتوفر نماذج الشكوى على http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- إلكترونيًا: أرسل رسالة على البريد الإلكتروني CivilRights@dhcs.ca.gov

ويمكنك تقديم شكوى حقوق مدنية لدى وزارة الصحة والخدمات الإنسانية الأميركية، مكتب الحقوق المدنية، عبر الهاتف أو خطيًا أو إلكترونيًا من خلال بوابة شكاوي مكتب الحقوق المدنية، المتوفر على https://ocrportal.hhs.gov/ocr/portal/lobby.jsf أو من خلال البريد أو الهاتف على:

- خطيًا: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- عبر الهاتف: 1-800-368-1019, 1-800-537-7697 (TDD)
- إلكترونيًا: تتوفر نماذج الشكوى على الموقع الإلكتروني https://www.hhs.gov/ocr/complaints/index.html.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net-ը համապատասխանում է նահանգային և դաշնային քաղաքացիական իրավունքների մասին գործող օրենքներին և խտրականություն չի դնում, չի բացառում մարդկանց կամ այլ կերպ չի վերաբերվում նրանց ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի, մտավոր հաշմանդամության, ֆիզիկական հաշմանդամության, սեռի (ներառյալ հղիությունը, սեռական կողմնորոշումը և գենդերային ինքնությունը), կրոնի, ծագման, էթնիկ խմբի նույնականացման, բժշկական վիճակի, գենետիկական տեղեկատվության, ամուսնական կարգավիճակի կամ սեռի հիման վրա:

Health Net-ը՝

- Հաշմանդամություն ունեցող անձանց տրամադրում է անվճար օգնություն և ծառայություններ՝ օգնելու նրանց արդյունավետ շփվել մեզ հետ, ինչպիսիք են՝
  - Որակավորված նշանների լեզվի թարգմանիչներ
  - Գրավոր նյութեր այլ ձևաչափերով (խոշոր տառատեսակով, աուդիո, մատչելի էլեկտրոնային ձևաչափեր և այլ ձևաչափեր)
- Ժամանակին տրամադրում է անվճար լեզվական ծառայություններ այն մարդկանց, ում առաջնային լեզուն անգլերենը չէ, ինչպես օրինակ՝
  - Որակավորված բանավոր թարգմանիչներ
  - Այլ լեզուներով գրավոր նյութեր
  - Եթե ձեզ անհրաժեշտ են այս ծառայությունները, դիմեք Health Net-ի Հաճախորդների կապի կենտրոնին՝ 1-800-675-6110 (TTY՝ 711), օրը 24 ժամ, շաբաթը 7 օր, տարին 365 օր:

Խնդրանքի դեպքում այս փաստաթուղթը մատչելի կլինի բրեյլով, մեծ տպված, ձայներիզով կամ էլեկտրոնային ձևով: Այս ձևաչափերից մեկով պատճենը ստանալու համար խնդրում ենք զանգահարել կամ գրել՝
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Հաճախորդների կապի կենտրոն՝ 1-800-675-6110 (TTY՝ 711)
California-ի հեռախոսականչ 711

Եթե կարծում եք, որ Health Net-ը չի տրամադրել այս ծառայությունները կամ այլ կերպ խտրականություն է դրսևորել ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի կամ սեռի (ներառյալ հղիությունը, սեռական կողմնորոշումը և գենդերային ինքնությունը), մտավոր հաշմանդամության, ֆիզիկական հաշմանդամության, կրոնի, ծագման, էթնիկ խմբի նույնականացման, բժշկական վիճակի, գենետիկական տեղեկատվության, ամուսնական կարգավիճակի կամ սեռի պատճառով, դուք կարող եք բողոք ներկայացնել 1557 Համակարգողին:

Դուք կարող եք բողոք ներկայացնել հեռախոսով, անձամբ կամ փոստով, ֆաքսով կամ էլփոստով: Եթե բողոք ներկայացնելու համար օգնության կարիք ունեք, մեր **1557 Համակարգողը** հասանելի է ձեզ օգնելու համար:

- Հեռախոսով. զանգահարեք՝ 855-577-8234 (TTY՝ 711) , երկուշաբթիից ուրբաթ, ժամը 8:00a.m.-ից 8p.m.-ը (արևելյան ստանդարտ ժամանակով)
- Ֆաքսով. 1-866-388-1769
- Գրավոր. գրեք նամակ և ուղարկեք հետևյալ հասցեով՝ Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631:
- Էլեկտրոնային. ուղարկեք էլփոստ՝ SM_Section1557Coord@centene.com Այս ծանուցումը հասանելի է նաև Health Net-ի կայքում՝ https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html

- Անձամբ. այցելեք ձեր բժշկի գրասենյակ կամ Health Net և հայտնեք, որ ցանկանում եք բողոք ներկայացնել:

Կարող եք նաև քաղաքացիական իրավունքների գանգատ ներկայացնել California-ի Առողջական խնամքի ծառայությունների բաժանմունքի Քաղաքացիական իրավունքների գրասենյակ՝ հեռախոսով, գրավոր կամ էլեկտրոնային տարբերակով.

- Հեռախոսով. զանգահարեք՝ 916-440-7370: Եթե չեք խոսում կամ լավ չեք լսում, խնդրում ենք զանգահարել 711:
- Գրավոր. լրացրեք գանգատի ձևաթուղթը կամ նամակ գրեք և ուղարկեք այն հետևյալ հասցեով՝ Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Գանգատի ձևերը հասանելի են հետևյալ հղումով՝
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Էլեկտրոնային. էլ. նամակ ուղարկեք CivilRights@dhcs.ca.gov հասցեին:

Դուք կարող եք նաև քաղաքացիական իրավունքների բողոք ներկայացնել ԱՄՆ Առողջապահության և մարդու բաժանմունքի Քաղաքացիական իրավունքների գրասենյակ հեռախոսով, գրավոր կամ էլեկտրոնային ձևով՝ Քաղաքացիական իրավունքների գրասենյակի գանգատների հարթակի միջոցով՝ https://ocrportal.hhs.gov/ocr/portal/lobby.jsf փոստով կամ հեռախոսով՝

- Գրավոր. U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Հեռախոսով. 1-800-368-1019, 1-800-537-7697 (TDD)
- Էլեկտրոնային. գանգատի ձևերը հասանելի են https://www.hhs.gov/ocr/complaints/index.html հղումով:

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net អនុវត្តតាមច្បាប់សិទ្ធិស៊ីវិលរបស់រដ្ឋ និងសហព័ន្ធជាធរមាន ហើយមិនរើសអើងមិនរាប់បញ្ចូលមនុស្ស ឬប្រព្រឹត្តលើពួកគេខុសគ្នាៗដោយសារតែពូជសាសន៍ ពណ៌សម្បុរ ដើមកំណើត អាយុ ពិការភាពផ្លូវចិត្ត ពិការភាពរាងកាយ ភេទ (រួមទាំងការមានផ្ទៃពោះ ទំនោរផ្លូវភេទ និងអត្តសញ្ញាណយេនឌ័រ) សាសនា ពូជពង្ស ការកំណត់អត្តសញ្ញាណក្រុមជនជាតិ ស្ថានភាពវេជ្ជសាស្ត្រ ព័ត៌មានសេនេទិច ស្ថានភាពអាពាហ៍ពិពាហ៍ ឬភេទឡើយ។

Health Net ៖

- ផ្តល់ជំនួយ និងសេវាកម្មតភ្ជាប់ដល់អ្នកមានពិការភាព ដើម្បីជួយពួកគេប្រាស្រ័យទាក់ទងប្រកបដោយប្រសិទ្ធភាពជាមួយពួកយើង ដូចជា៖
  - អ្នកបកប្រែភាសាសញ្ញាដែលមានសមត្ថភាព
  - ព័ត៌មានជាលាយលក្ខណ៍អក្សរជាទម្រង់ផ្សេងៗ (ការព្រីនជាអក្សរខ្នាតធំ ជាសំឡេង ជាទម្រង់អេឡិចត្រូនិកដែលអាចប្រើប្រាស់បាន និងជាទម្រង់ផ្សេងៗទៀត)
- ផ្តល់សេវាកម្មភាសាតភ្ជាប់ថ្លៃយ៉ាងទាន់ពេលវេលាដល់អ្នកដែលភាសាចម្បងមិនមែនជាភាសាអង់គ្លេស ដូចជា៖
  - អ្នកបកប្រែផ្ទាល់មាត់ដែលមានសមត្ថភាព
  - ព័ត៌មានលាយលក្ខណ៍អក្សរជាភាសាផ្សេងៗ
  - ប្រសិនបើអ្នកត្រូវការសេវាកម្មទាំងនេះ សូមទាក់ទងមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន Health Net តាមរយៈលេខ 1-800-675-6110 (TTY: 711) បម្រើការ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ 365 ថ្ងៃក្នុងមួយឆ្នាំ។

តាមការស្នើសុំ ឯកសារនេះអាចត្រូវបានផ្តល់ជូនអ្នកជាអក្សរស្ទាប ការព្រីនជាអក្សរខ្នាតធំ ការសែតជាសំឡេង ឬទម្រង់អេឡិចត្រូនិក។ ដើម្បីទទួលបានច្បាប់ចម្លងជាទម្រង់ផ្សេងទាំងនេះ សូមទូរសព្ទ ឬសរសេរទៅកាន់៖
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន 1-800-675-6110 (TTY: 711)
California Relay 711

ប្រសិនបើអ្នកជឿថា Health Net បានបរាជ័យក្នុងការផ្តល់សេវាទាំងនេះ ឬមានការរើសអើងក្នុងវិធីមួយផ្សេងទៀតដោយផ្អែកលើពូជសាសន៍ ពណ៌សម្បុរ ដើមកំណើត អាយុ ឬភេទ (រួមទាំងការមានផ្ទៃពោះ ទំនោរផ្លូវភេទ និងអត្តសញ្ញាណយេនឌ័រ) ពិការភាពផ្លូវចិត្ត ពិការភាពរាងកាយ សាសនា ពូជពង្ស ការកំណត់អត្តសញ្ញាណក្រុមជនជាតិ ស្ថានភាពវេជ្ជសាស្ត្រ ព័ត៌មានសេនេទិច ស្ថានភាពអាពាហ៍ពិពាហ៍ ឬយេនឌ័រ អ្នកអាចដាក់ពាក្យបណ្តឹងសាទុក្ខទៅកាន់អ្នកសម្របសម្រួល 1557។

អ្នកអាចដាក់ពាក្យបណ្តឹងសាទុក្ខតាមទូរសព្ទដោយផ្ទាល់ ឬតាមប្រៃសណីយ៍ ទូរសារ ឬអ៊ីមែល។ **អ្នកសម្របសម្រួល 1557** របស់យើងខ្ញុំអាចជួយអ្នកបាន ប្រសិនបើអ្នកត្រូវការជំនួយដើម្បីដាក់ពាក្យបណ្តឹងសាទុក្ខ។

- តាមទូរសព្ទ៖ ហៅទៅលេខ 855-577-8234 (TTY: 711) ពីថ្ងៃចន្ទដល់ថ្ងៃសុក្រ ពីម៉ោង 8:00 ព្រឹកដល់ម៉ោង 8:00 យប់ (EST)

- តាមទូរសារ៖ 1-866-388-1769

- ជាលាយលក្ខណ៍អក្សរ៖ សរសេរលិខិតមួយច្បាប់ ហើយផ្ញើទៅកាន់ Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

- តាមអេឡិចត្រូនិក៖ ផ្ញើអ៊ីមែលទៅ SM_Section1557Coord@centene.com ការជូនដំណឹងនេះមាននៅលើគេហទំព័រ Health Net៖ https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discriminationnotice-medi-cal.html

- ដោយផ្ទាល់៖ ទៅកាន់ការិយាល័យវេជ្ជបណ្ឌិត ឬ Health Net ហើយនិយាយថា អ្នកចង់ដាក់ពាក្យបណ្តឹងសាទុក្ខ។

អ្នកក៍អាចដាក់ពាក្យបណ្តឹងតវ៉ាស្តីពីសិទ្ធស៊ីវិលជាមួយក្រសួងសេវាថែទាំសុខភាពរដ្ឋ California ការិយាល័យសិទ្ធិស៊ីវិល តាមរយៈទូរសព្ទ ជាលាយលក្ខណ៍អក្សរ ឬតាមប្រព័ន្ធអេឡិចត្រូនិក៖

- តាមទូរសព្ទ៖ ហៅទៅលេខ 916-440-7370។ ប្រសិនបើអ្នកមិនអាចនិយាយ ឬស្តាប់មិនសូវបានល្អទេ សូមទូរសព្ទទៅ 711។
- ជាលាយលក្ខណ៍អក្សរ៖ បំពេញទម្រង់ពាក្យបណ្តឹងតវ៉ា ឬសរសេរលិខិតមួយច្បាប់ រួចផ្ញើទៅ Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  ទម្រង់បែបបទពាក្យបណ្តឹងតវ៉ាអាចរកបាននៅ
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- តាមប្រព័ន្ធអេឡិចត្រូនិក៖ ផ្ញើអ៊ីមែលទៅ CivilRights@dhcs.ca.gov

អ្នកក៍អាចដាក់ពាក្យបណ្តឹងតវ៉ាសិទ្ធិស៊ីវិលជាមួយ U.S. Department of Health and Human Services, Office for Civil Rights តាមទូរសព្ទ ជាលាយលក្ខណ៍អក្សរតាមប្រព័ន្ធអេឡិចត្រូនិក តាមរយៈ ការិយាល័យសម្រាប់វិបផតថលបណ្តឹងសិទ្ធិស៊ីវិល មាននៅ https://ocrportal.hhs.gov/ocr/portal/lobby.jsf ឬតាមសំបុត្រ ឬទូរសព្ទបានតាមរយៈ៖

- ជាលាយលក្ខណ៍អក្សរ៖ U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- តាមទូរសព្ទ៖ 1-800-368-1019, 1-800-537-7697 (TDD)
- តាមប្រព័ន្ធអេឡិចត្រូនិក៖ ទម្រង់បែបបទពាក្យបណ្តឹងតវ៉ាមាននៅ https://www.hhs.gov/ocr/complaints/index.html។

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net 遵守適用的州和聯邦民權法律，不會因種族、膚色、國籍、年齡、精神障礙、身體殘疾、性別（包括懷孕、性取向和性別認同）、宗教、血統、族裔、醫療狀況、遺傳資訊、婚姻狀況或性別而歧視、排斥他人或以不同方式對待。

Health Net：

- 為殘疾人士及時提供免費援助與服務，幫助他們有效地與我們溝通，例如：
    - 提供合格的手語翻譯
    - 提供其他形式的書面資訊（大字版、音訊、易於讀取的電子格式、其他格式）
- 為非英語母語人士提供免費語言服務，比如：
    - 提供合格的口譯員
    - 以其他語言書寫資訊
    - 如果您需要上述服務，請致電 1-800-675-6110（聽障專線：711）與 Health Net 客戶聯絡中心聯絡，服務時間為每年 365 天、每週 7 天、每天 24 小時。

我們可以根據要求向您提供本文件的盲文版、大字版、錄音帶或電子格式。要獲得上述任一替代格式的副本，請致電或寫信至：
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
客戶聯絡中心 1-800-675-6110 (TTY: 711)
加州聽語障人士轉接服務 711

如果您認為 Health Net 未提供這些服務或以其他方式基於種族、膚色、國籍、年齡或性別（包括懷孕、性取向和性別認同）、精神殘障、身體殘疾、宗教、血統、族群識別、醫療狀況、遺傳資訊、婚姻狀況或性別而歧視您，您可以向 1557 協調員提出申訴。

您可透過電話、當面或信函、傳真或電子郵件的方式提出申訴。如果您需要協助提出申訴，我們的 **1557 協調員**可協助您。

- 透過電話：致電 855-577-8234 (TTY: 711) ，服務時間為週一至週五上午 8:00 至晚上 8:00（美東時間）
- 透過傳真：1-866-388-1769
- 透過信函：寫信並寄送至 Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- 電子方式：傳送電子郵件至 SM_Section1557Coord@centene.com 您可以在 Health Net 網站：https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discriminationnotice-medi-cal.html 找到本通知
- 當面：前往您的醫生辦公室或 Health Net，並表示您要提出申訴。

您也可以透過電話、信函或電子方式向 California Department of Health Care Services 的民權辦公室提交民權投訴：

- 透過電話：Call 916-440-7370。如果您有語言或聽力障礙，請致電 711。

- 透過信函：填寫投訴表，或書寫信函並寄送至民權辦公室副主任，地址為 Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413。您可在 http://www.dhcs.ca.gov/Pages/Language_Access.aspx 網站找到投訴表
- 電子方式：傳送電子郵件至 CivilRights@dhcs.ca.gov

您也可向美國 Department of Health and Human Services, Office for Civil Rights 提出民權投訴。您可透過民權辦公室的投訴入口網站 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf 在線上提出投訴，或者透過電話、信函或電子方式提出投訴，聯絡資訊如下：

- 透過信函：U.S.Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C.20201
- 透過電話：1-800-368-1019，1-800-537-7697（聽障專線 1-800-368-1019，1-800-537-7697（聽障專線）
- 電子方式：您可在 https://www.hhs.gov/ocr/complaints/index.html 網站找到投訴表。

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Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

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विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

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Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net 遵守适用的联邦和州民权法，不会因种族、肤色、原国籍、年龄、精神残疾、身体残疾、生理性别（包括怀孕、性取向和性别认同）、宗教、血统、族群认同、医疗状况、遗传信息、婚姻状况或社会性别而歧视、排斥或区别对待他人。

Health Net：

- 向残障人士提供免费援助和服务，以帮助他们与我们进行有效沟通，例如：
  - 具备资质的手语翻译员
  - 其他格式的书面信息（包括大字版本、音频版本、无障碍电子格式和其他格式）
- 向主要语言非英语人士提供及时且免费的语言服务，例如：
  - 具备资质的口译员
  - 其他语言版本的书面信息
  - 如果您需要上述服务，请致电 1-800-675-6110 (TTY: 711) 联系 Health Net 客户联系中心，服务时间为每周 7 天、每天 24 小时，全年无休。

您可以索要本文件的盲文版本、大字版本、录音或电子版本。如需获取这些替代格式的副本，请致电或致函：Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
客户联系中心 1-800-675-6110 (TTY: 711)
加利福尼亚州中继电话 711

如果您认为 Health Net 未能提供上述服务，或以其他方式基于种族、肤色、原国籍、年龄或生理性别（包括怀孕、性取向和性别认同）、精神残疾、身体残疾、宗教、血统、族群认同、医疗状况、遗传信息、婚姻状况或社会性别非法歧视他人，可以向 1557 Coordinator 提出申诉。

您可以通过电话、亲自到场、邮寄、传真或电子邮件提出申诉。如果您在提交申诉时需要帮助，我们的 **1557 Coordinator** 可随时为您提供帮助。

- 通过电话：致电 855-577-8234 (TTY: 711)，服务时间为周一至周五早上 8 点至晚上 8 点（美国东部时间）
- 通过传真：1-866-388-1769
- 通过书面形式：写信寄至 Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- 通过电子方式：发送电子邮件至 SM_Section1557Coord@centene.com。本通知可在 Health Net 网站查看：
  https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html
- 亲自到场提交：前往医生办公室或 Health Net，说明您要提交申诉。

您还可以通过电话、书面或电子方式向加州医疗保健服务部民权办公室提出民权投诉：
- 通过电话：致电 916-440-7370。如果您在听力和言语方面存在障碍，请致电 711。

- 通过书面形式：填写投诉表或写信并将其邮寄至：Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O.Box 997413, MS 0009, Sacramento, CA 95899-7413。
  如需获取投诉表，请访问 http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- 通过电子方式：发送电子邮件至 CivilRights@dhcs.ca.gov

您也可以通过以下方式，向美国卫生与公众服务部民权办公室提交民权投诉：通过电话；通过书面形式；通过民权投诉门户网站 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf 提交电子投诉；通过邮寄。投诉提交方式如下：

- 通过书面方式：U.S.Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C.20201
- 通过电话：1-800-368-1019、1-800-537-7697 (TDD)
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Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net تابع قوانین حقوق مدنی ایالتی و فدرال است و بر مبنای نژاد، رنگ پوست، تبار ملی، سن، ناتوانی ذهنی، ناتوانی جسمی، جنس (شامل وضعیت بارداری، گرایش جنسی و هویت جنسی)، مذهب، اصل‌ونسب، هویت قومی، وضعیت پزشکی، اطلاعات ژنتیکی، وضعیت تأهل یا جنسیت، افراد را مورد تبعیض قرار نمی‌دهد یا با آن‌ها رفتار متفاوتی ندارد.

Health Net:

- کمک‌ها و خدمات رایگان به افراد معلول ارائه می‌دهد تا بتوانند به‌طور مؤثر با ما ارتباط برقرار کنند؛ خدماتی مانند:
  - مترجمان مجرب زبان اشاره
  - اطلاعات کتبی در سایر فرمت‌ها (چاپ درشت، فرمت صوتی، قالب‌های الکترونیک مناسب معلولان، و سایر فرمت‌ها)
- خدمات زبانی رایگان را به‌موقع به افرادی ارائه می‌دهد که زبان اصلی‌شان انگلیسی نیست؛ خدماتی مانند:
  - مترجمان شفاهی واجدشرایط
  - اطلاعات مکتوب به زبان‌های دیگر
- اگر به این خدمات نیاز دارید، در 24 ساعت شبانه‌روز، 7 روز هفته و 365 روز سال با مرکز تماس مشتریان Health Net به شماره 1-800-675-6110 (TTY: 711) تماس بگیرید.

در صورت درخواست، این سند با خط بریل، چاپ درشت، کاست صوتی یا در قالب الکترونیک نیز قابل‌ارائه است. برای دریافت یک نسخه از این قالب‌های جایگزین، لطفاً با ما تماس بگیرید یه به این نشانی نامه بفرستید:

Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
مرکز تماس مشتریان: 1-800-675-6110 (TTY: 711)
شماره رله California: 711

اگر فکر می‌کنید که Health Net بر مبنای نژاد، رنگ پوست، تبار ملی، سن، جنس (شامل وضعیت بارداری، گرایش جنسی و هویت جنسی)، ناتوانی ذهنی، ناتوانی جسمی، مذهب، اصل‌ونسب، هویت قومی، وضعیت پزشکی، اطلاعات ژنتیکی، وضعیت تأهل یا جنسیت، در ارائه این خدمات قصور داشته یا افراد را مورد تبعیض قرار داده است، می‌توانید نزد هماهنگ‌کننده 1557 شکایت ثبت کنید.

می‌توانید به‌صورت تلفنی، حضوری، پُستی یا از طریق ایمیل، شکایت ثبت کنید. اگر در ثبت شکایت نیاز به کمک دارید، **هماهنگ‌کننده 1557** ما آماده کمک به شماست.

- تلفن: روزهای دوشنبه تا جمعه، از ساعت 8:00 صبح تا 8:00 شب (به وقت منطقه زمانی شرقی) با شماره 855-577-8234 (TTY: 711) تماس بگیرید
- فکس: 1-866-388-1769
- پُست: نامه‌ای بنویسید و به این نشانی پُست کنید: Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- الکترونیک: به نشانی SM_Section1557Coord@centene.com ایمیل بفرستید این اطلاعیه در وب‌سایت Health Net به این نشانی موجود است: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html.
- حضوری: به مطب پزشک خود یا Health Net مراجعه کنید و بگویید که می‌خواهید شکایت ثبت کنید.

همچنین می‌توانید به‌صورت تلفنی، مکاتبه پُستی یا الکترونیک، شکایتی را نزد دفتر حقوق مدنی، اداره خدمات مراقبت از سلامت California ثبت کنید:

- تلفنی: با شماره 916-440-7370 تماس بگیرید. اگر اختلال گفتاری یا شنوایی دارید، لطفاً با 711 تماس بگیرید.
- پستی: فرم شکایت پر کنید یا نامه‌ای بنویسید و به این نشانی پست کنید: Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413
  فرم‌های شکایت در این نشانی موجود هستند: http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- الکترونیک: به این نشانی ایمیل بفرستید: CivilRights@dhcs.ca.gov

همچنین می‌توانید نزد دفتر حقوق مدنی وزارت بهداشت و خدمات انسانی ایالات متحده، به‌صورت تلفنی، پستی، یا الکترونیک از طریق درگاه شکایات دفتر حقوق مدنی به نشانی https://ocrportal.hhs.gov/ocr/portal/lobby.jsf یا از طریق نشانی پستی یا شماره تلفن زیر، شکایت حقوق مدنی ثبت کنید:

- پستی: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- تلفنی: 1-800-368-1019, 1-800-537-7697 (TDD)
- الکترونیک: فرم‌های شکایت در این نشانی موجود هستند: https://www.hhs.gov/ocr/complaints/index.html

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

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Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net ua raws li Lub Lav thiab Tsoom Hwv Teb Chaws cov cai lij choj fab cai pej xeem uas cuam tshuam thiab tsis muaj kev ntxub ntxaug, ciav cais tib neeg los sis coj rau lawv yam sib txawv vim yog hom neeg, xim tawv nqaij, lub teb chaws yug, hnub nyoog, kev xiam oob qhab fab lub hlwb, kev xiam oob qhab fab lub cev, poj niam los txiv neej (suav nrog kev xeeb tub, kev nyiam fab kev sib daj sib deev, thiab kev txheeb qhia tias yog poj niam los txiv neej), kev ntseeg dab qhuas, caj ces, kev txheeb qhia tias yog haiv neeg tsawg, kev muaj kho mob, cov ntaub ntawv caj ces, kev muaj txij nkawm, los sis poj niam los txiv neej.

Health Net:

- Muab kev pab dawb thiab kev pab cuam rau cov neeg xiam oob qhab los pab kom lawv tuaj yeem sib txuas lus nrog peb tau yam muaj txiaj ntsig zoo, xws li:
  - Cov neeg txhais lus piav tes uas paub tsim nyog
  - Cov ntaub ntawv sau ua lwm hom qauv ntaub ntawv (luam ua tus ntawv loj, kaw suab lus, cov qauv ntaub ntawv es lev thaus niv uas tuaj yeem nkag mus siv tau, thiab lwm hom qauv ntaub ntawv)
- Muab kev pab txhais lus raws sij hawm pub dawb rau cov neeg uas nws hom lus hais tas li tsis yog Lus Askiv, xws li:
  - Cov neeg txhais lus uas paub tsim nyog
  - Cov ntaub ntawv uas sau ua lwm hom lus
  - Yog tias koj xav tau cov kev pab cuam no, tiv tauj rau Health Net Lub Chaw Sib Txuas Lus Nrog Cov Tub Lag Luam ntawm 1-800-675-6110 (TTY: 711), 24 teev hauv ib hnub, 7 hnub hauv ib lub lim tiam, 365 hnub hauv ib lub xyoos.

Thaum koj thov txog, peb yuav tuaj yeem muab tsab ntawv no rau koj ua ntawv xuas, luam ua tus ntawv loj, kaw suab rau hauv kab xev, los sis cov qauv ntaub ntawv es lev thaus niv. Txhawm rau kom tau txais daim ntawv theej ua ib hom twg ntawm cov qauv ntaub ntawv kev xaiv no, thov hu los sis sau ntawv mus rau:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Lub Chaw Sib Txuas Lus Nrog Cov Tub Lag Luam 1-800-675-6110 (TTY: 711)
California Relay 711

Yog koj ntseeg tias Health Net tsis muab cov kev pab cuam no los sis muaj kev ntxub ntxaug mus rau lwm txoj hauv kev uas yog saib raws li hom neeg, xim tawv nqaij, lub teb chaws yug, hnub nyoog, los sis poj niam los txiv neej (suav nrog kev xeeb tub, kev nyiam fab kev sib deev, thiab kev txheeb qhia tias yog poj niam los txiv neej), kev xiam oob qhab fab lub hlwb, kev xiam oob qhab fab lub cev, kev ntseeg dab qhuas, poj yawm txwv txoob, kev txheeb qhia tias yog haiv neeg tsawg, kev muaj mob, cov ntaub ntawv caj ces, kev muaj txij nkawm, los sis poj niam los txiv neej, ces koj tuaj yeem ua daim ntawv hais kev tsis txaus siab mus rau Tus Neeg Dhia Dej Num 1557 tau.

Koj tuaj yeem ua daim ntawv hais tsis txaus siab los ntawm hu xov tooj, tim ntsej tim muag los sis xa ntawv, xa fev, los sis xa email. Yog tias koj xav tau kev pab ua daim ntawv hais kev tsis txaus siab, ces peb **Tus Neeg Dhia Dej Num 1557** yuav los pab koj.

- Los ntawm kev hu xov tooj: Hu rau 855-577-8234 (TTY: 711), hnub Monday-Friday, 8:00 teev sawv ntxov txog 8:00 teev tsaus ntuj sij hawm (EST)

- Los ntawm kev xa fev: 1-866-388-1769

- Kev sau ntawv: Sau ib tsab ntawv thiab muab xa mus rau Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

- Hauv es lev thaus niv: Xa ib tsab email mus rau SM_Section1557Coord@centene.com Tsab ntawv ceeb toom no yog muaj nyob rau hauv Health Net tus vev xaib: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discriminationnotice-medi-cal.html

- Kiag ntawm tus kheej: Mus saib koj tus kws kho mob lub chaw ua hauj lwm los sis Health Net thiab hais tias koj xav ua ntawv tsis txaus siab.

Tsis tas li xwb, koj kuj tseem tuaj yeem ua daim ntawv hais kev tsis txaus siab fab cai pej xeem mus rau California Feem Hauj Lwm Saib Xyuas Kev Pab Cuam Kev Saib Xyuas Kho Mob, Lub Chaw Hauj Lwm Saib Xyuas Cov Cai Pej Xeem tau tib si thiab los ntawm kev hu xov tooj, sau ntawv los sis hauv es lev thaus niv:

- Los ntawm kev hu xov tooj: Hu rau 916-440-7370. Yog hais tias koj tsis hnov lus zoo los sis hais tsis tau lus zoo, thov hu rau 711.
- Kev sau ntawv: Sau daim foos hais kev tsis txaus siab kom tiav los sis sau ib tsab ntawv thiab muab xa mus rau Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Cov foos sau hais kev tsis txaus siab yog muaj nyob rau ntawm http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Hauv es lev thaus niv: Xa ib tsab email mus rau CivilRights@dhcs.ca.gov

Tsis tas li xwb, koj kuj tseem tuaj yeem ua daim ntawv hais kev tsis txaus siab fab cai pej xeem mus rau Teb Chaws Meskas Feem Hauj Lwm Saib Xyuas Kev Pab Cuam Kev Saib Xyuas Kho Mob, Lub Chaw Hauj Lwm Saib Xyuas Cov Cai Pej Xeem, los ntawm kev hu xov tooj, kev sau ntawv, tau hauv es lev thaus niv dhau los ntawm Lub Chaw Hauj Lwm Saib Xyuas Cov Cai Pej Xeem Lub Qhov Rooj Vev Xaib Rau Kev Hais Kev Tsis Txaus Siab, uas muaj nyob ntawm https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, los sis los ntawm kev xa ntawv los sis hu xov tooj ntawm:

- Kev sau ntawv: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Los ntawm kev hu xov tooj:1-800-368-1019, 1-800-537-7697 (TDD)
- Hauv es lev thaus niv: Cov foos sau hais kev tsis txaus siab yog muaj nyob ntawm https://www.hhs.gov/ocr/complaints/index.html.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net 은 적용 가능한 주와 연방 인권법을 준수하고 인종, 피부색, 출신 국가, 나이, 정신적 장애, 신체적 장애, 성별(임신, 성적 지향, 성 정체성 포함), 종교, 조상, 민족 정체성, 의료 상태, 유전적 정보, 결혼 여부, 젠더를 이유로 사람을 차별하거나 제외하거나 다르게 대우하지 않습니다.

Health Net 제공 서비스:

- 당사와 효과적으로 소통하실 수 있도록 장애가 있는 분들에게 다음과 같은 보조 인력과 서비스를 무료로 제공합니다.
  - 자격을 갖춘 수어 통역사
  - 다른 형식의 서면 정보(대형 활자 인쇄본, 오디오, 장애인용 전자 형식 및 기타 형식)
- 영어가 주 언어가 아닌 사람들에게 다음과 같은 무료 언어 서비스를적시에 적시에 제공합니다.
  - 자격을 갖춘 통역사
  - 다른 언어로 작성된 서면 정보
  - 이러한 서비스가 필요하시면 연중무휴 하루 24 시간 언제든지 1-800-675-6110 (TTY: 711) 번으로 Health Net 고객 서비스 센터에 문의해 주십시오.

요청 시 본 문서는 점자, 대형 활자 인쇄본, 오디오 카세트 또는 전자 형식으로 제공될 수 있습니다. 이러한 대체 형식 중 하나로 사본을 받아보시려면, 다음으로 전화하거나 서신을 보내십시오.
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
고객 서비스 센터 1-800-675-6110 (TTY: 711)
California 중계 서비스 711

Health Net 에서 이러한 서비스를 제공하지 못했다거나, 인종, 피부색, 출신 국가, 나이, 성별(임신, 성적 지향, 성 정체성 포함), 정신적 장애, 신체적 장애, 종교, 조상, 민족 정체성, 의료 상태, 유전적 정보, 결혼 여부, 젠더에 근거하여 다른 방식으로 차별했다고 생각하는 경우, 1557 Coordinator 에 고충 사항을 제기하실 수 있습니다.

전화 또는 대면, 우편, 우편, 팩스, 이메일을 통해서도 고충 사항을 제기하실 수 있습니다. 고충 사항을 제기하는 데 도움이 필요하신 경우 **1557 Coordinator** 에서 도와드릴 수 있습니다.

- 전화: 855-577-8234 (TTY: 711)번으로 전화해주십시오. 월요일~금요일, 오전 8 시~오후 8 시 (동부 표준시).
- 팩스: 1-866-388-1769
- 서면: 서신을 작성하여 Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631 로 보내 주십시오.
- 온라인: SM_Section1557Coord@centene.com 으로 이메일을 보내 주십시오. 이 통지서는 Health Net 웹사이트(https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discriminationnotice-medi-cal.html)에서 확인하실 수 있습니다.
- 대면: 담당 의사의 사무실 또는 Health Net 을 직접 방문하여 고충 사항을 제기하고자 한다고 말씀하십시오.

California 보건 복지부 인권 사무국에 전화, 서면 또는 온라인으로 인권 관련 불편 사항을 제기하실 수도 있습니다.

- 전화: 916-440-7370 번으로 전화해 주십시오. 듣거나 말하는 것이 불편한 경우, 711 번으로 전화해 주십시오.
- 서면: 불편 사항 양식을 작성하거나 서신을 작성하여 Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413 으로 보내 주십시오.
  불편 사항 양식은 http://www.dhcs.ca.gov/Pages/Language_Access.aspx 에서 받아 보실 수 있습니다.
- 온라인: CivilRights@dhcs.ca.gov 로 이메일을 보내 주십시오.

인권 관련 불편 사항은 전화 또는 서면으로 접수하거나, 미국 보건 복지부 인권 사무국의 인권 사무국 불편 사항 접수 포털 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf 를 통해 온라인으로 접수하실 수 있으며, 우편 또는 전화로 접수하실 수도 있습니다.

- 서면: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- 전화: 1-800-368-1019, 1-800-537-7697 (TDD)
- 온라인: 불편 사항 양식은 https://www.hhs.gov/ocr/complaints/index.html 에서 받아 보실 수 있습니다.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net соблюдает применимые законы штата и федеральное законодательство по защите гражданских прав и не допускает дискриминации, не отказывает в обслуживании и не относится к людям по-разному на основании расовой принадлежности, цвета кожи, страны происхождения, возраста, ограниченных психических и физических возможностей, пола (в том числе беременности, сексуальной ориентации и гендерной самоидентификации), религии, социального происхождения, принадлежности к этнической группе, заболеваний, генетической информации, семейного положения или гендера.

Health Net предоставляет приведенные ниже услуги.

- Бесплатные услуги и помощь людям с ограниченными возможностями для эффективной коммуникации с нами, в том числе:
  - услуги квалифицированных сурдопереводчиков;
  - печатные материалы в других форматах (крупный шрифт, специальный электронный формат, аудиозапись и т. д.).
- Своевременные бесплатные услуги перевода для людей, чей родной язык — не английский, в том числе:
  - услуги квалифицированных устных переводчиков;
  - печатные материалы на других языках.
  - Если вам нужны эти услуги, звоните в контактный центр для клиентов Health Net по телефону 1-800-675-6110 (TTY: 711) круглосуточно и без выходных.

По запросу этот документ можно получить напечатанным шрифтом Брайля, крупным шрифтом, на аудиокассете или в электронной форме. Чтобы получить его в одном из таких альтернативных форматов, позвоните по указанному ниже телефону или напишите на следующий адрес:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Контактный центр для клиентов: 1-800-675-6110 (TTY: 711)
Коммутаторная служба штата California: 711

Если вы считаете, что компания Health Net не предоставила вам эти услуги или иным образом подвергла вас дискриминации на основании расовой принадлежности, цвета кожи, страны происхождения, возраста, пола (в том числе беременности, сексуальной ориентации либо гендерной самоидентификации), ограниченных психических или физических возможностей, религии, социального происхождения, принадлежности к этнической группе, заболеваний, генетической информации, семейного положения либо гендера, вы можете подать претензию координатору по соблюдению требований Раздела 1557.

Вы можете подать претензию лично либо по телефону, почте, факсу или электронной почте. Если вам нужна помощь в подаче претензии, обратитесь к **координатору по соблюдению требований Раздела 1557**.

- По телефону. Позвоните по номеру 855-577-8234 (TTY: 711). Линия работает с понедельника по пятницу с 8:00 до 20:00 по стандартному восточному времени (EST).

- По факсу. 1-866-388-1769.

- В письменном виде. Напишите письмо и отправьте его по адресу Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631.

- В электронном виде. Отправьте электронное письмо по адресу SM_Section1557Coord@centene.com. Это уведомление доступно на сайте Health Net: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html.

- Лично. Посетите офис своего врача или Health Net и сообщите, что хотите подать претензию.

Кроме того, вы можете подать жалобу на нарушение гражданских прав в Управление по вопросам гражданских прав при Департаменте здравоохранения штата California по телефону, в письменном или электронном виде:

- По телефону. Позвоните по номеру 916-440-7370. Если у вас есть нарушения речи или слуха, звоните по номеру 711.
- В письменном виде. Заполните бланк жалобы или напишите письмо и отправьте его по адресу Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Бланки жалоб есть на сайте http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- В электронном виде. Отправьте электронное письмо по адресу CivilRights@dhcs.ca.gov.

Вы также можете подать жалобу на нарушение гражданских прав в Управление по вопросам гражданских прав при Департаменте здравоохранения и социального обеспечения по телефону, в письменном или электронном виде через портал для подачи жалоб этого управления https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, по почте или по телефону:

- В письменном виде. U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201.
- По телефону.1-800-368-1019, 1-800-537-7697 (TDD).
- В электронном виде. Бланки жалоб есть на сайте https://www.hhs.gov/ocr/complaints/index.html.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net cumple con las leyes estatales y federales vigentes sobre derechos civiles y no discrimina, no excluye ni trata a las personas de forma diferente por motivos de origen racial, color, nacionalidad, edad, discapacidad mental o física, sexo (incluido el embarazo, la orientación sexual y la identidad de género), religión, ascendencia, identidad de origen étnico, enfermedad, información genética, estado civil o género.

Health Net brinda lo siguiente:

- Asistencia y servicios gratuitos a personas discapacitadas para ayudarles a que se comuniquen con nosotros de forma eficaz, como los siguientes:
  - Intérpretes de lengua de señas calificados.
  - Información por escrito en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros).
- Servicios gratuitos de idiomas de manera oportuna a personas cuyo idioma principal no es el inglés, como los siguientes:
  - Intérpretes calificados.
  - Información escrita en otros idiomas.
  - Si necesita estos servicios, llame al Centro de Comunicación con el Cliente de Health Net al 1-800-675-6110 (TTY: 711) las 24 horas del día, los 7 días de la semana, los 365 días del año.

Podemos brindarle este documento en braille, en letra grande, grabado en un casete o en forma electrónica si lo solicita. Para obtener una copia en alguno de estos formatos alternativos, llame o escriba a:
Health Net
Post Office Box 9103 Van Nuys, California 91409-9103
Centro de Comunicación con el Cliente: 1-800-675-6110 (TTY: 711)
Servicio de Retransmisión de Datos de California: 711

Si cree que Health Net no le ha brindado estos servicios o que le ha discriminado de alguna otra manera por motivos de origen racial, color, nacionalidad, edad, sexo (incluido el embarazo, la orientación sexual y la identidad de género), discapacidad mental o física, religión, ascendencia, identidad de origen étnico, enfermedad, información genética, estado civil o género, puede presentar una queja formal ante el coordinador 1557.

Puede presentar la queja formal por teléfono, en persona o por correo, fax o correo electrónico.
Si necesita ayuda para presentar una queja formal, nuestro **coordinador 1557** está disponible para ayudarle.

- Por teléfono: Llame al 855-577-8234 (TTY: 711) de lunes a viernes, de 8:00 a. m. a 8:00 p. m. (hora estándar del este).
- Por fax: 1-866-388-1769.
- Por escrito: Envíe una carta a Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631.
- En línea: Envíe un correo electrónico a SM_Section1557Coord@centene.com. Este aviso está disponible en el sitio web de Health Net: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html.
- En persona: Visite el consultorio del médico o Health Net e informe que quiere presentar una queja formal.

También puede presentar una queja sobre los derechos civiles a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California por teléfono, por escrito o en línea.

- Por teléfono: Llame al 916-440-7370. Si tiene dificultades de audición o del habla, llame al 711.
- Por escrito: Complete el formulario de quejas o escriba una carta y envíela a Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Los formularios de quejas están disponibles en http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- En línea: Envíe un correo electrónico a CivilRights@dhcs.ca.gov.

También puede presentar una queja sobre los derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. Puede hacerlo por teléfono, por escrito o de manera electrónica a través del portal habilitado para ello, https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Además, puede enviar la queja por correo o por teléfono:

- Por escrito: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Por teléfono: 1-800-368-1019, 1-800-537-7697 (TDD)
- En línea: Los formularios de quejas están disponibles en https://www.hhs.gov/ocr/complaints/index.html.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

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विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Sumusunod ang Health Net sa mga naaangkop na Pang-estado at Pederal na batas sa mga karapatang sibil at hindi ito nandidiskrimina, nagbubukod ng mga tao o tinatrato sila nang iba dahil sa lahi, kulay, bansang pinagmulan, edad, kapansanan sa pag-iisip, pisikal na kapansanan, kasarian (kasama ang pagbubuntis, sekswal na oryentasyon at kinikilalang kasarian), relihiyon, ninuno, pagkakakilanlan ng grupo ng etniko, medikal na kondisyon, impormasyon ng genes, marital status.

Ang Health Net ay:

- Nagbibigay ng mga libreng tulong at serbisyo sa mga taong may mga kapansanan para matulungan silang makipag-usap nang mas mabuti, gaya ng:
  - Mga kuwalipikadong sign language interpreter
  - Nakasulat na impormasyon sa iba pang mga format (malaking print, audio, mga madaling ma-access na elektronikong format, at iba pang mga format)
- Nagbibigay ng mga libreng serbisyo sa wika sa mga taong hindi Ingles ang pangunahing wika, gaya ng:
  - Mga kwalipikadong interpreter
  - Impormasyong nakasulat sa iba pang wika
  - Kung kailangan mo ang mga serbisyong ito, makipag-ugnayan sa Center ng Pakikipag-ugnayan ng Customer ng Health Net sa 1-800-675-6110 (TTY: 711) 24 na oras sa isang araw, 7 araw sa isang linggo, 365 araw sa isang taon.

Kapag hiniling, maaari mong makuha ang dokumentong ito sa braille, malaking print, audiocassette, o elektronikong paraan. Para makakuha ng kopya na nasa isa sa mga alternatibong format na ito, mangyaring tumawag o sumulat sa:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Center ng Pakikipag-ugnayan ng Customer 1-800-675-6110 (TTY: 711)
California Relay 711

Kung naniniwala kang hindi naibigay ng Health Net ang mga serbisyong ito o nandiskrimina sa iba pang paraan batay sa lahi, kulay, bansang pinagmulan, edad o kasarian (kasama ang pagbubuntis, sekswal na oryentasyon at kinikilalang kasarian), kapansanan sa pag-iisip, pisikal na kapansanan, relihiyon, ninuno, pagkakakilanlan ng grupo ng etniko, medikal na kondisyon, impormasyon ng genes, marital status, maaari kang maghain ng karaingan sa 1557 Coordinator.

Maaari ka ring maghain ng karaingan nang personal o sa pamamagitan ng koreo, fax, o email. Kung kailangan mo ng tulong sa paghahain ng karaingan, available ang aming **1557 Coordinator** para tulungan ka.

- Sa pamamagitan ng telepono: Tumawag sa 855-577-8234 (TTY: 711), Lunes-Biyernes, 8:00 a.m. hanggang 8:00 p.m. (EST)
- Sa pamamagitan ng fax: 1-866-388-1769
- Sa pamamagitan ng sulat: Sumulat at ipadala ito sa Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- Sa pamamagitan ng elektronikong paraan: Magpadala ng email sa SM_Section1557Coord@centene.com Makukuha ang abisong ito sa website ng Health Net: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discrimination-notice-medi-cal.html

- Sa personal: Bisitahin ang opisina ng iyong doktor o ang Health Net at sabihin na gusto mong magsampa ng karaingan.

Maaari ka ring maghain ng reklamo sa mga karapatang sibil sa Departamento ng Mga Serbisyo sa Pangangalagang Pangkalusugan ng California, Tanggapan para sa Mga Karapatang Sibil sa pamamagitan ng telepono, sa pamamagitan ng pagsulat o sa elektronikong paraan:

- Sa pamamagitan ng telepono: Tumawag sa 916-440-7370. Kung hindi ka nakakapagsalita o nakakarinig nang maayos, mangyaring tumawag sa 711.
- Sa pamamagitan ng sulat: Sagutan ang form para sa reklamo o sumulat at ipadala ito sa Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Makukuha ang mga form para sa reklamo sa http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Sa pamamagitan ng elektronikong paraan: Magpadala ng email sa CivilRights@dhcs.ca.gov

Maaari ka ring maghain ng reklamo sa mga karapatang siil sa Departamento ng mga Serbisyo para sa Kalusugan at Tao ng Estados Unidos, Tanggapan para sa Mga Karapatang Sibil, sa pamamagitan ng telepono, sa pamamagitan ng sulat o sa elektronikong paraan sa pamamagitan ng Portal para sa Reklamo ng Tanggapan para sa Mga Karapatang Sibil, na available sa https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o sa pamamagitan ng koreo o telepono sa:

- Sa pamamagitan ng sulat: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Sa pamamagitan ng telepono: 1-800-368-1019, 1-800-537-7697 (TDD)
- Sa pamamagitan ng elektronikong paraan: May available na mga form para sa reklamo sa https://www.hhs.gov/ocr/complaints/index.html.

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Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab nws, xav tau cov kev pab cuam txhais lus, hu rau 1-800-675-6110 (TTY: 711). Tsis tas li ntawd, peb kuj tseem muaj cov khoom siv pab thiab cov kev pab cuam rau cov neeg xiam oob qhab tib si, xws li cov ntaub ntawv uas tuaj yeem nkag cuag tau yooj yim thiab cov ntaub ntawv luam tawm uas pom tus niam ntawv loj. Cov kev pab cuam no yog muaj pab yam tsis xam nqi dab tsi rau koj them li.

Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

Health Net tuân thủ các luật dân quyền hiện hành của Tiểu bang và Liên bang và không phân biệt đối xử, loại trừ mọi người hoặc đối xử với họ khác biệt vì chủng tộc, màu da, quốc tịch, tuổi tác, tình trạng khuyết tật tinh thần, tình trạng khuyết tật thể chất, giới tính (bao gồm cả tình trạng mang thai, khuynh hướng tình dục và bản dạng giới), tôn giáo, tổ tiên, nhận dạng nhóm dân tộc, tình trạng sức khỏe, thông tin di truyền, tình trạng hôn nhân hoặc giới tính.

Health Net:

- Cung cấp trợ giúp và các dịch vụ miễn phí cho những người khuyết tật để giúp họ giao tiếp hiệu quả với chúng tôi, chẳng hạn như:
  - Thông dịch viên ngôn ngữ ký hiệu có trình độ
  - Thông tin bằng văn bản ở các định dạng khác (bản in khổ lớn, âm thanh, các định dạng điện tử có thể truy cập và các định dạng khác)
- Cung cấp các dịch vụ ngôn ngữ miễn phí một cách kịp thời cho những người mà ngôn ngữ chính không phải là tiếng Anh, như:
  - Thông dịch viên có trình độ
  - Thông tin được viết bằng các ngôn ngữ khác
  - Nếu quý vị cần những dịch vụ này, vui lòng liên hệ với Trung tâm Liên lạc Hội viên của Health Net theo số 1-800-675-6110 (TTY: 711), 24 giờ một ngày, 7 ngày mỗi tuần, 365 ngày mỗi năm.

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi Braille, bản in khổ lớn, băng ghi âm hoặc tài liệu điện tử. Để nhận được bản sao bằng một trong những định dạng thay thế này, vui lòng gọi điện thoại hoặc gửi thư tới:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Customer Contact Center 1-800-675-6110 (TTY: 711)
Tiếp âm California 711

Nếu quý vị cho rằng Health Net đã không thể cung cấp những dịch vụ này hoặc phân biệt đối xử theo cách khác dựa trên chủng tộc, màu da, quốc tịch, độ tuổi hoặc giới tính (bao gồm cả tình trạng mang thai, khuynh hướng tình dục và bản dạng giới), tình trạng khuyết tật tinh thần, tình trạng khuyết tật thể chất, tôn giáo, tổ tiên, nhận dạng nhóm dân tộc, tình trạng sức khỏe, thông tin di truyền, tình trạng hôn nhân hoặc giới tính, quý vị có thể nộp đơn khiếu nại tới Điều phối viên 1557.

Quý vị có thể nộp đơn khiếu nại qua điện thoại, trực tiếp, qua đường bưu điện, fax hoặc email.
Nếu quý vị cần trợ giúp nộp đơn khiếu nại, **Điều phối viên 1557** của chúng tôi sẵn sàng trợ giúp.

- Qua điện thoại: Gọi số 855-577-8234 (TTY: 711), Thứ Hai-Thứ Sáu, 8 giờ sáng đến 8 giờ tối (EST)
- Qua fax: 1-866-388-1769
- Bằng văn bản: Viết thư và gửi đến Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- Bằng phương tiện điện tử: Gửi email đến SM_Section1557Coord@centene.com Thông báo này có trên trang web của Health Net: https://www.healthnet.com/content/healthnet/en_us/disclaimers/legal/non-discriminationnotice-medi-cal.html
- Trực tiếp: Đến văn phòng bác sĩ của quý vị hoặc Health Net và nói rằng quý vị muốn nộp đơn khiếu nại.

Quý vị cũng có thể nộp đơn than phiền về dân quyền cho Văn phòng Đặc trách Dân quyền thuộc Sở Quản lý Chăm sóc Sức khỏe của Tiểu bang California qua điện thoại, gửi thư hoặc bằng phương tiện điện tử:

- Qua điện thoại: Gọi số 916-440-7370. Nếu quý vị không thể nói hoặc nghe rõ, vui lòng gọi số 711.
- Bằng văn bản: Điền thông tin vào mẫu đơn than phiền hoặc viết thư và gửi đến địa chỉ Deputy Director, Office of Civil Rights, Department of Health Care Services, Office of Civil Rights, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413.
  Đơn than phiền sẵn có tại http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Bằng phương tiện điện tử: Gửi email đến địa chỉ CivilRights@dhcs.ca.gov

Quý vị cũng có thể nộp đơn than phiền về dân quyền với Văn phòng Đặc trách Dân quyền thuộc Bộ Y tế và Dịch vụ Nhân sinh Hoa Kỳ qua điện thoại, bằng văn bản hoặc phương thức điện tử thông qua Cổng thông tin Than phiền của Văn phòng Đặc trách Dân quyền tại địa chỉ https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, hoặc qua đường bưu điện hay gọi điện đến số:

- Bằng văn bản: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Qua điện thoại: 1-800-368-1019, 1-800-537-7697 (TDD)
- Bằng phương thức điện tử: Mẫu đơn than phiền được đăng tải tại https://www.hhs.gov/ocr/complaints/index.html.

English: If you, or someone you are helping, need language services, call 1-800-675-6110 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. These services are at no cost to you.

Arabic: إذا كنت أنت أو أي شخص تقوم بمساعدته، بحاجة إلى الخدمات اللغوية، فاتصل بالرقم 1-800-675-6110 (TTY: 711) تتوفر أيضاً المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل وبطباعة كبيرة. تتوفر هذه الخدمات بدون تكلفة بالنسبة لك.

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, ունեն լեզվական օգնության կարիք, զանգահարեք 1-800-675-6110 (TTY՝ 711): Հաշմանդամություն ունեցող մարդկանց համար հասանելի են օգնություն և ծառայություններ, ինչպես օրինակ՝ փաստաթղթեր բրայլով կամ խոշոր տպագրությամբ: Այս ծառայությունները ձեզ համար անվճար են:

Cambodian: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ ត្រូវការសេវាផ្នែកភាសា សូមទូរសព្ទទៅលេខ 1-800-675-6110 (TTY: 711)។ ជំនួយ និងសេវាកម្មផ្សេងៗសម្រាប់អ្នកដែលពិការ ដូចជាឯកសារជាអក្សរស្ទាប និងជាអក្សរខ្នាតធំក៏មានផ្តល់ជូនផងដែរ។ សេវាកម្មទាំងនេះត្រូវបានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

Chinese (Simplified): 如果您或者您正在帮助的人需要语言服务，请致电 1-800-675-6110 (TTY: 711)。还可提供面向残障人士的帮助和服务，例如盲文和大字版文档。这些服务免费为您提供。

Chinese (Traditional): 如果您或您正在幫助的其他人需要語言服務，請致電 1-800-675-6110 (TTY: 711)。另外，還為殘疾人士提供輔助和服務，例如盲文和大字版文件。這些服務對您免費提供。

Farsi: اگر شما یا هر فرد دیگری که به او کمک می‌کنید نیاز به خدمات زبانی دارد، با شمارهٔ 1-800-675-6110 (TTY: 711) تماس بگیرید. کمک‌ها و خدماتی مانند مدارک با خط بریل و چاپ درشت نیز برای معلولان قابل عرضه است. این خدمات هزینه‌ای برای شما نخواهد داشت.

Hindi: यदि आपको, या जिसकी आप मदद कर रहे हैं उसे, भाषा सेवाएँ चाहिए, तो कॉल करें 1-800-675-6110 (TTY: 711)।

विकलांग लोगों के लिए सहायता और सेवाएं, जैसे 'ब्रेल' लिपि और बड़े प्रिंट में दस्तावेज़, भी उपलब्ध हैं। ये सेवाएँ आपके लिए मुफ़्त उपलब्ध हैं।

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Japanese: ご自身またはご自身がサポートしている方が言語サービスを必要とする場合は、1-800-675-6110 (TTY: 711)までお問い合わせください。障がいをお持ちの方のために、点字や大活字の文書などの補助・サービスも提供しています。これらのサービスは無料で提供されています。

Korean: 귀하 또는 귀하가 도와주고 있는 분이 언어 서비스가 필요하시면 1-800-675-6110 (TTY: 711) 번으로 연락해 주십시오. 장애가 있는 분들에게 보조 자료 및 서비스(예: 점자 및 대형 활자 인쇄본)도 제공됩니다. 이 서비스는 무료로 이용하실 수 있습니다.

Laotian: ຖ້າທ່ານ, ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ຕ້ອງການບໍລິການແປພາສາ, ໂທ 1-800-675-6110 (TTY: 711). ນອກນັ້ນ, ພວກເຮົາຍັງມີອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການອີກດ້ວຍ, ເຊັ່ນ ເອກະສານເປັນຕົວອັກສອນນູນ ແລະ ພິມຂະໜາດໃຫຍ່. ການບໍລິການເຫຼົ່ານີ້ແມ່ນມີໄວ້ຊ່ວຍເຫຼືອທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າໃດໆ.

Mien: Beiv hnangv meih ganh a’fai meih tengx ga’hlen mienh, se gorngv qiemx zuqc longc tengx porv waac bun muangx, mborqv finx lorz 1-800-675-6110 (TTY: 711). Mbenc duqv maaih jaa-dorngx aengx caux gong tengx waaic fangx mienh, beiv zoux sou benx nzangc-pokc bun hluo aengx caux domh nzangc. Naaiv deix gong-bou jauv-louc mv zuqc heuc meih ndortv nyaanh cingv.

Punjabi: ਜੇ ਤੁਹਾਨੂੰ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਨੂੰ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-800-675-6110 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਹਨ।

Russian: Если вам или человеку, которому вы помогаете, необходимы услуги перевода, звоните по телефону 1-800-675-6110 (TTY: 711). Кроме того, мы предоставляем материалы и услуги для людей с ограниченными возможностями, например документы, выполненные шрифтом Брайля или крупным шрифтом. Эти услуги предоставляются бесплатно.

Spanish: Si usted o la persona a quien ayuda necesita servicios de idiomas, comuníquese al 1-800-675-6110 (TTY: 711). También hay herramientas y servicios disponibles para personas con discapacidad, como documentos en braille y en letra grande. Estos servicios no tienen ningún costo para usted.

Tagalog: Kung ikaw o ang taong tinutulungan mo ay kailangan ng mga serbisyo sa wika, tumawag sa 1-800-675-6110 (TTY: 711). Makakakuha rin ng mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumentong nasa braille at mga malaking print. Wala kang babayaran para sa mga serbisyong ito.

Thai: หากคุณหรือคนที่คุณช่วยเหลือ ต้องการบริการด้านภาษา โทร 1-800-675-6110 (TTY: 711) นอกจากนี้ยังมีความช่วยเหลือและบริการสำหรับผู้ทุพพลภาพ เช่น เอกสารในรูปแบบอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่ บริการเหล่านี้ ไม่มีค่าใช้จ่ายสำหรับคุณ

Ukrainian: Якщо вам або людині, якій ви допомагаєте, потрібні послуги перекладу, телефонуйте на номер 1-800-675-6110 (TTY: 711). Ми також надаємо матеріали та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля або надруковані великим шрифтом. Ці послуги для вас безкоштовні.

Vietnamese: Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ cần dịch vụ ngôn ngữ, hãy gọi 1-800-675-6110 (TTY: 711). Chúng tôi cũng có sẵn các trợ giúp và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ lớn. Quý vị được nhận các dịch vụ này miễn phí.

NEW REGULATION – NOTIFICATION TO CONSUMERS

Effective August 11, 2011, Section 1399.547, Title 16 of the California Code of Regulations, mandated by Business and Professions Code section 138, requires that physician assistants inform patients that they are licensed and regulated by the Physician Assistant Committee (Committee). The notification must include the following statement and information:

NOTIFICATION TO CONSUMERS
PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8780
WWW.PAC.CA.GOV

Physician assistants may provide this notification by one of the following three methods:

- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font.

- Including the notification in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician assistant is licensed and regulated by the Committee.

- Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notification is placed immediately above the signature line for the patient in at least 14-point type.

The regulation language and notification follows and may be downloaded for your use.

For more information, please contact the Executive Officer of the Physician Assistant Committee, Elberta Portman, at (916) 561-8782 or Elberta.Portman@mbc.ca.gov

California Code of Regulations:

1399.547. Notification to Consumers.

(a) A licensee engaged in providing medical services shall provide notification to each patient of the fact that the licensee is licensed and regulated by the committee. The notification shall include the following statement and information:

NOTIFICATION TO CONSUMERS

Physician assistants are licensed and regulated
by the Physician Assistant Committee
(916) 561-8780
www.pac.ca.gov

(b) The notification required by this section shall be provided by one of the following methods:

(1) Prominently posting the notification in an area visible to patients on the premises where the licensee provides the licensed services, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notification in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the physician assistant is licensed and regulated by the committee.

(3) Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

Note: Authority cited: Section 3510, Business and Professions Code. Reference: Section 138, Business and Professions Code.

HISTORY

1. New section filed 7-12-2011; operative 8-11-2011 (Register 2011, No. 28).

NOTIFICATION TO CONSUMERS

Physician Assistants are licensed and regulated by the

Physician Assistant Committee
(916) 561-8780
www.pac.ca.gov

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

Notice of Action Letter Translations and Alternate Formats:

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Introduction

This document outlines the process for submitting Medi-Cal notice of action (NOA) letters for translation into member requested language or alternate format using the Akorbi Plunet portal.

Health Net* will cover these costs for NOA letters when the below criteria are met:

- Must be for Health Net Medi-Cal member NOA translations or alternate formats only.
- Must use current Health Net pre-translated NOA template (available at www.iceforhealth.org/home.asp).
- Must use Health Net's preferred vendor, Akorbi Language Consulting (Akorbi).

To avoid issues and errors, please follow the process shown in this document for each letter submitted.

Please note: You must keep a log of all letters that you are submitting for translation or conversion to an alternate format for our members. During your annual utilization management (UM) compliance audit, this log may be requested so that samples can be selected for validation as part of the audit scope.

Request a username and password

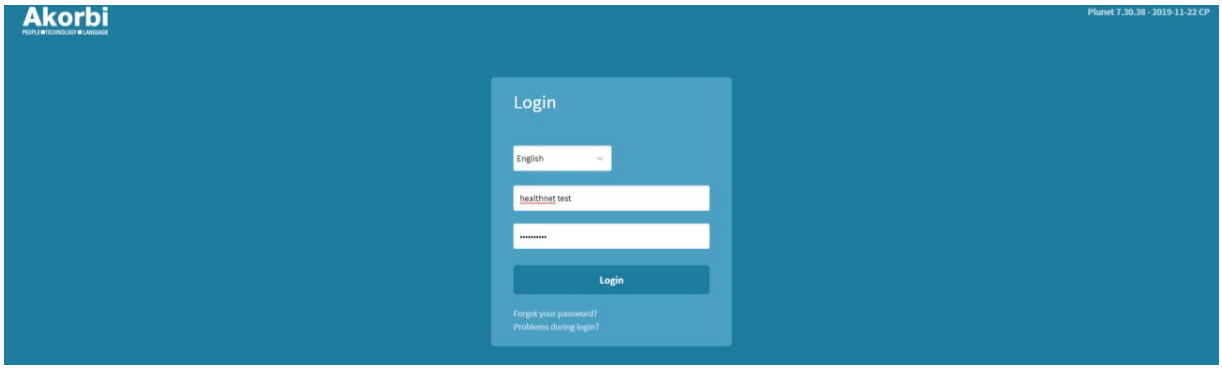
1. If you do not have a Health Net specific username and password for the Akorbi Plunet system, send an email to Delegation_Oversight_Group@Centene.com to request access. Include the following in your email:
    a. Requested username.
    b. First and last name of primary user.
    c. Primary email address (for all notifications from the system).
    d. Secondary email addresses (will be copied via CC on all notifications).

Please note: It is recommended that you have one login and password for all Health Net requests that is shared by the required users in your organization. This will minimize the likelihood of being unable to retrieve your completed project as they can only be retrieved through the account that submitted the request.

Login and password reset

2. Enter the website address plunet.akorbi.com into your browser.
3. Enter your username and password to access the system.
    a. If you use the wrong password for login **three times in a row**, your account will automatically be locked for 24 hours. To unlock the account earlier please contact healthnet@akorbi.com.

Note: To be able to send requests using Akorbi Plunet portal, you need Internet Explorer (Version 8 or higher). You can also use Google Chrome, Mozilla Firefox or Safari.



Password reset

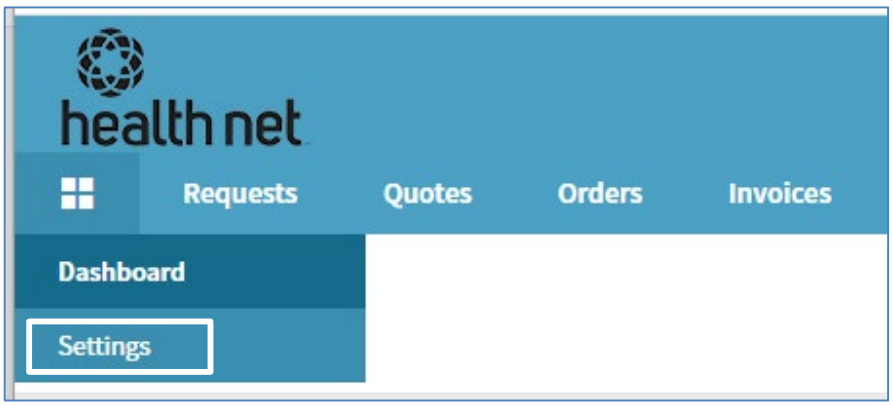
If you have forgotten your password click on "**Forgot your password?"** You will receive an email with a link to trigger a new password. Click the link in the email and you will be sent another email with your temporary password and instructions on how to reset your password.

Please note, there will be two emails sent as part of the password reset process.

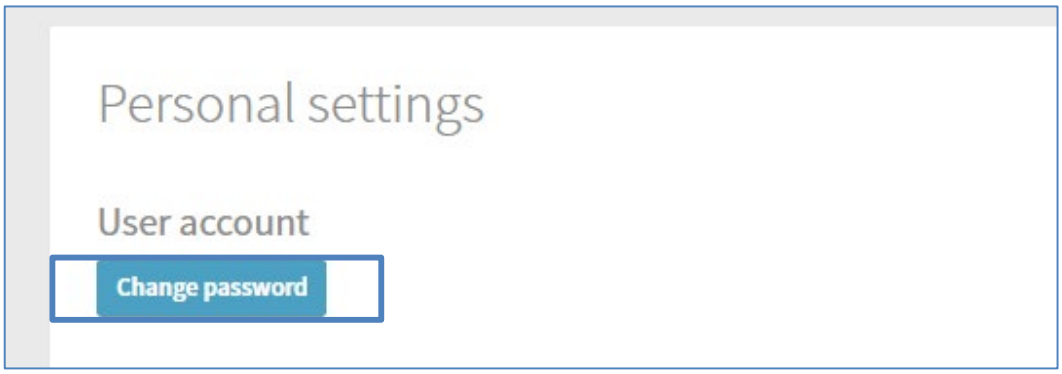
Manually change password

To manually change your password in the Plunet system:

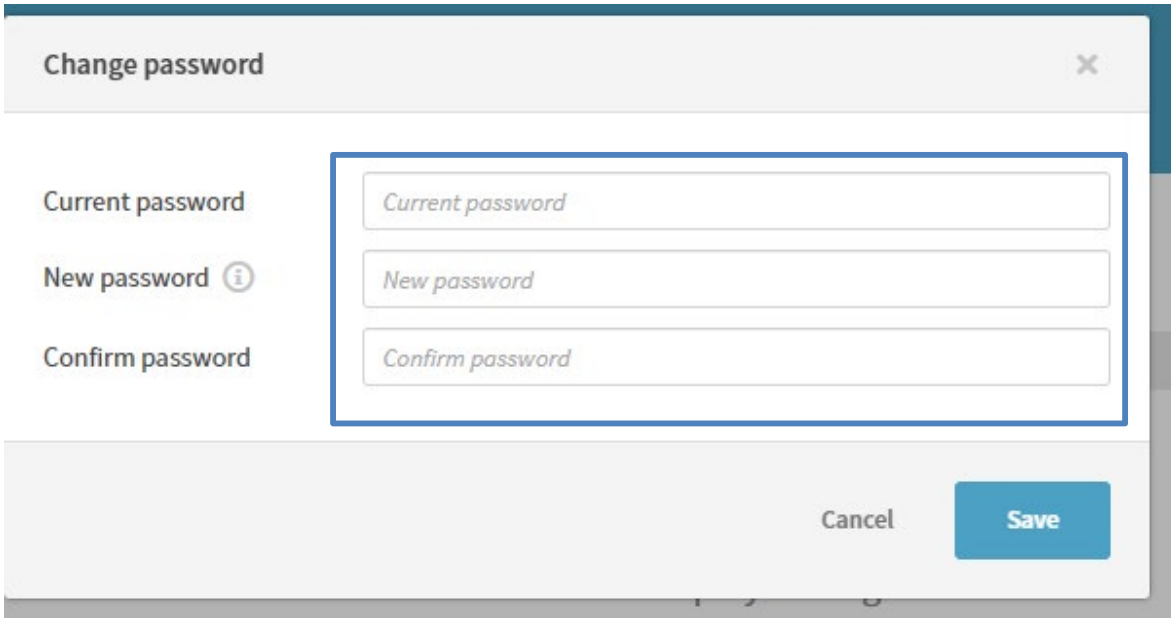
1. Click on the four blocks icon on the top left of your screen.
2. Select "Settings" for the drop down menu.



3. Click “Change password” in the user account section.



4. Enter your old password in the first field.
5. Enter your new password in the second and third fields.
6. Click “Save”.

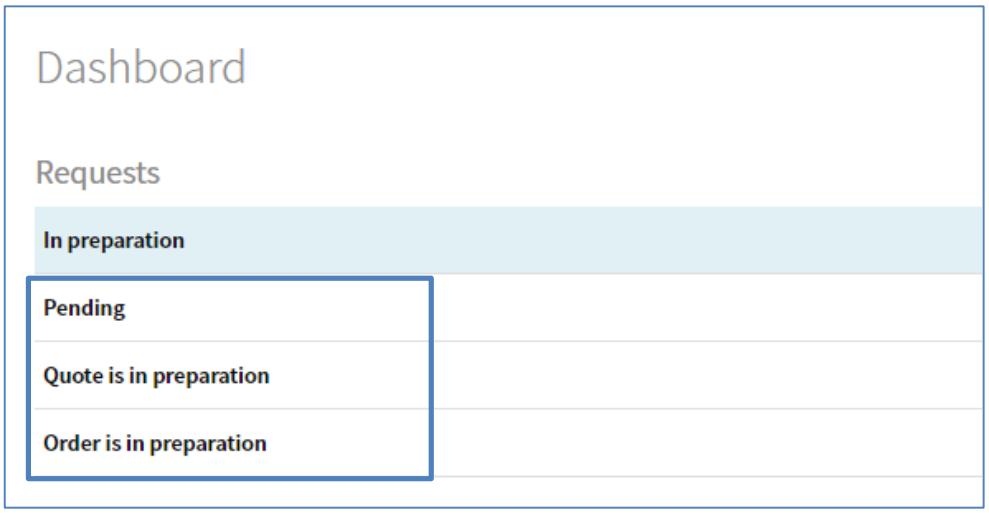


Note: You will receive an automated email every three months requesting you to change your password. To avoid login issues, please complete your password resets as instructed as soon as you receive the email.

Dashboard

Once you log in, you will be taken to your Dashboard. The dashboard displays all your orders in compressed form by status.

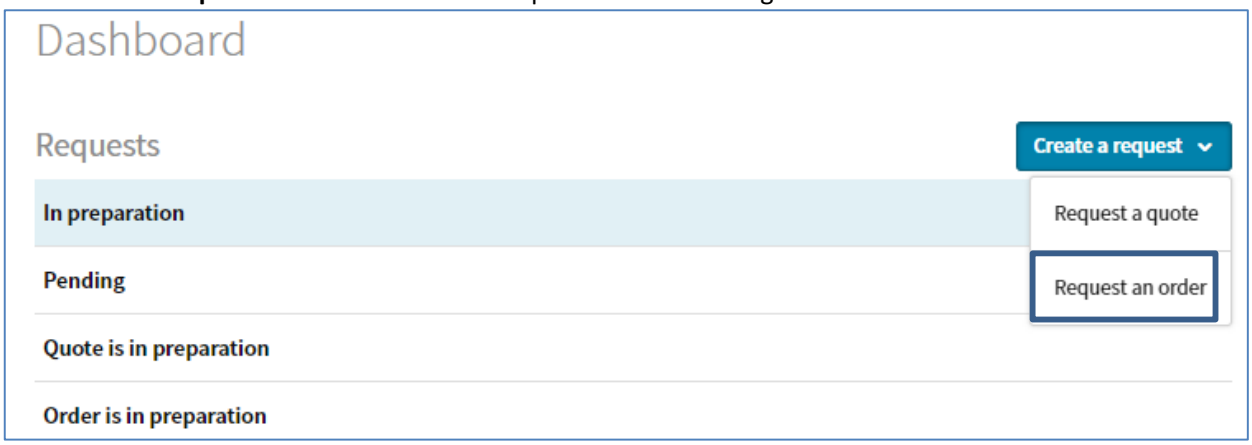
By clicking on the description (e.g. Pending or InProgress) you will be able to see additional information about your requests.



Placing a request

To begin your request for a letter translation or alternate format:

1. Click the "**Create a request"** button on your dashboard**.**
2. Select "**Request an order"** from the drop-down menu to begin.

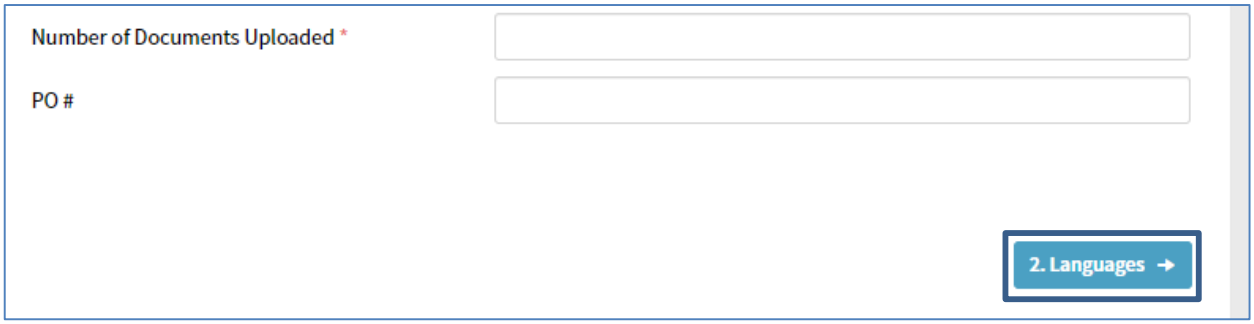


3. Enter the following information into the project fields:

Field	Details
Project Name	Must follow the naming convention: APL 21-011_[Template Type]_[Auth Number]_[Turnaround Time] • **APL 20-011:** Notes the regulatory requirement. • **Template Type:** Enter one of the following - Carve-out, Deny, Delay, Modify, or Terminate. • **Auth Number:** Enter the authorization number for this notification. • **Turnaround Time:** Enter the timeframe in which you need the project completed. Please note, these are business hours. Requests sent after business hours will be processed the following day. Project Name Example: APL-2011_Deny_008776498232_12 hours
Reference Number	Enter the member/subscriber ID number.
Requested Delivery Date	Enter the date and time by which you would like your project completed.
Customer	Should be pre-populated to "Health Net."
PPG	Select the applicable PPG from the drop-down list. Note: They are shown as [PPGID] PPG Name.
Alternate Format	**Select "Not applicable" for translation requests.** For alternate format requests, select one of the following: • Audio Format • Braille • Large Print

Field	Details
Lines of Business	Select the following (once selected, click the checkmark): • CA-Medi-Cal (For Health Net direct members) • Molina (For Health Net Molina members)
Department of	Select “PPG Delegated” from the drop-down list.
Number of Documents	Enter 1. Each letter must be submitted separately.

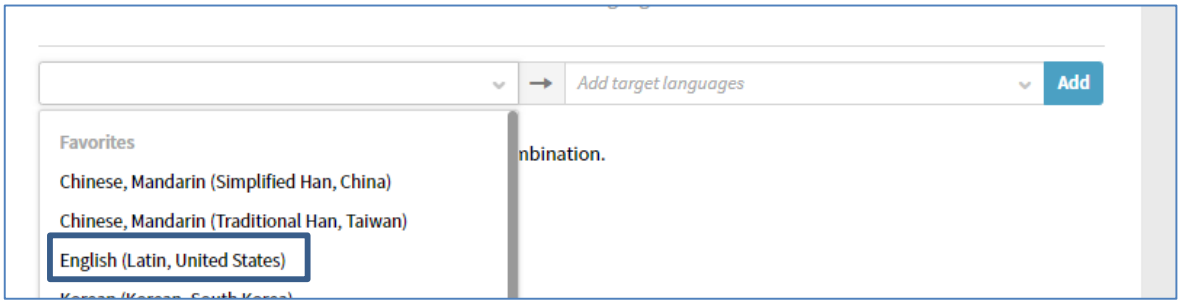
4. Click the Languages button to move to the next screen.



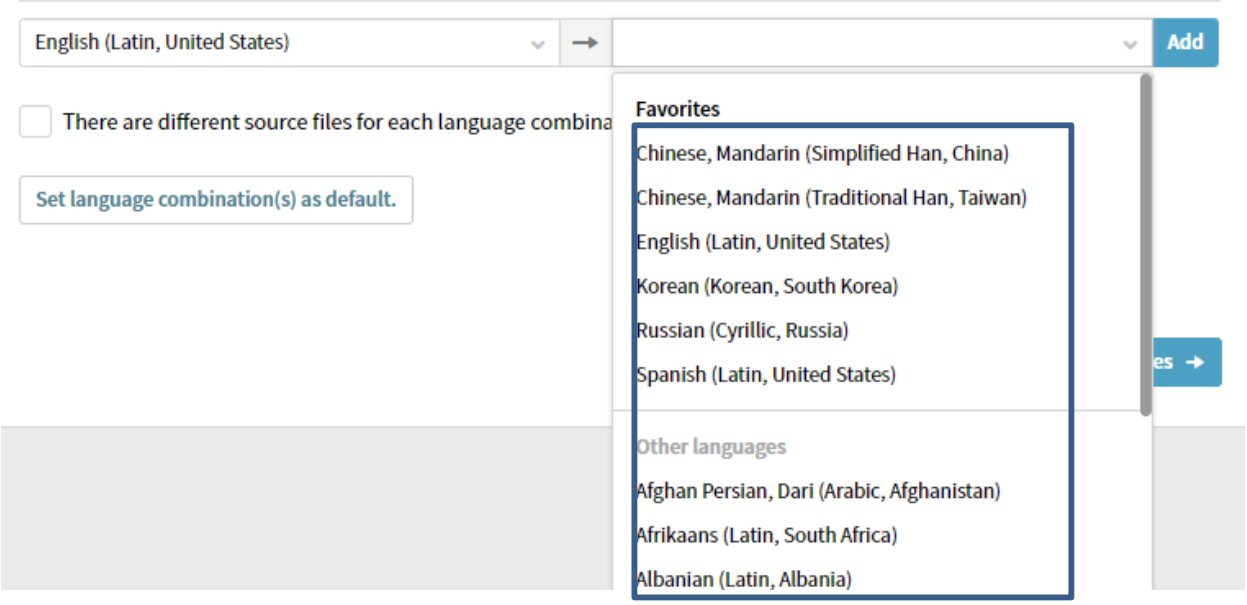
Below are examples of threshold languages you can select from.

English (Latin, United States) → Arabic (Arabic, World)
English (Latin, United States) → Armenian (Armenian, Armenia)
English (Latin, United States) → Chinese, Mandarin (Traditional Han, Taiwan)
English (Latin, United States) → Iranian Persian, Farsi (Arabic, Iran)
English (Latin, United States) → Khmer (Khmer, Cambodia)
English (Latin, United States) → Korean (Korean, South Korea)
English (Latin, United States) → Russian (Cyrillic, Russia)
English (Latin, United States) → Spanish (Latin, United States)
English (Latin, United States) → Tagalog (Latin, Philippines)
English (Latin, United States) → Vietnamese (Latin, Vietnam)
English (Latin, United States) → Hmong, White (Latin, United States)

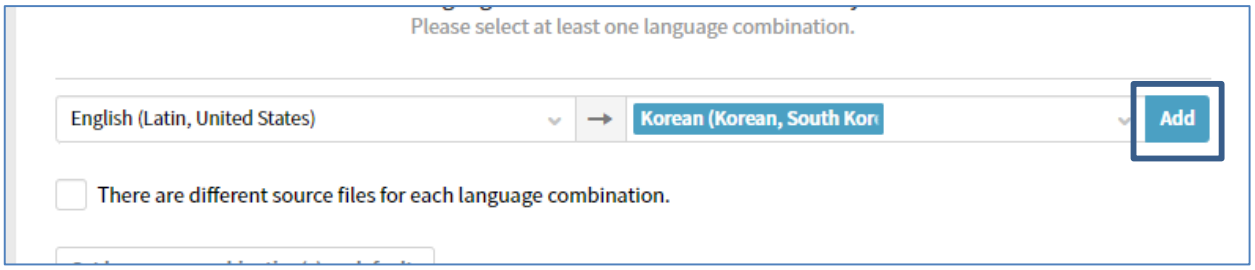
5. Select the Source language from the drop-down box, selecting English.



6. Select the “target language”. This is the member’s preferred language. **Note: For alternate format requests that do not need to be translated, select English for the target language.**



7. Click “add” to confirm your selection.

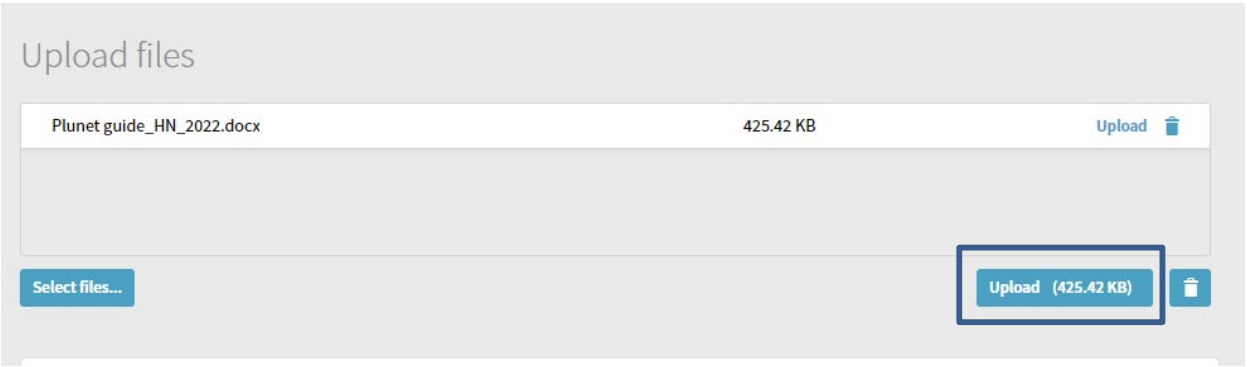


8. Click “Project files” to move to the next screen and upload your document.

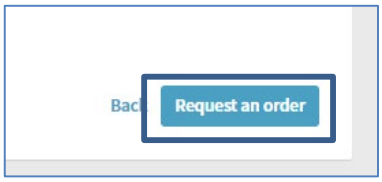
9. Click the “source folder” icon to select and upload your document.

10. In the pop-up window, you can drag and drop your file or click the “select files” button to attach and follow the prompts.

11. Click the “Upload” button to complete the document upload. You can now close the pop-up window.



12. Click the “Summary” button to move to the confirmation page. Review the summary details for accuracy and click “request an order” at the bottom of the page to submit.



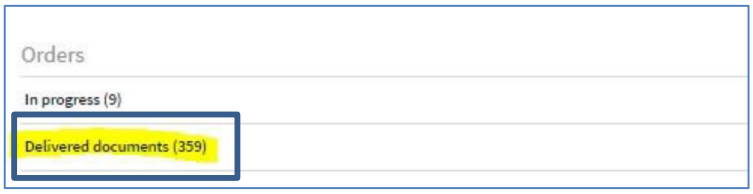
You will receive an email confirmation that will serve as proof that the letter was accepted.

You can also check the status, by looking at the top of your dashboard and clicking on “pending” to verify successful submission.

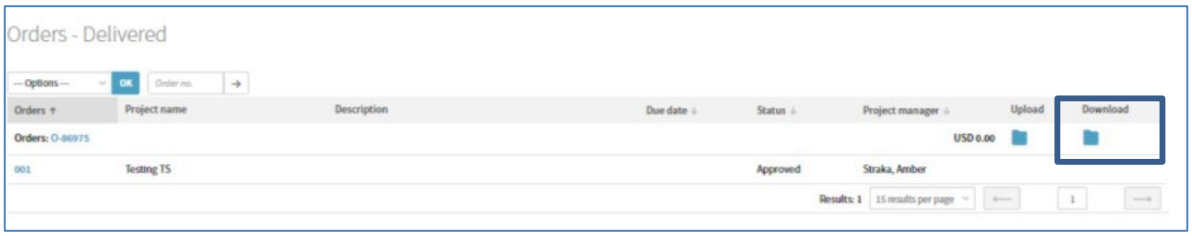
Retrieve completed projects

Once your document has been successfully prepared, you will receive an email notification from Plunet. This is your indication to log in to the system and download your document.

You can see your documents by status when you log in to the system. Click on “delivered documents” to expand the list of documents ready for retrieval.



You can then click on the download icon to retrieve your document.



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- Must use the Plan's preferred vendor, Akorbi Language Consulting (Akorbi).

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Please note: It is recommended that you have one login and password for all Health Net or CalViva Health requests that is shared by the required users in your organization. This will minimize the likelihood of being unable to retrieve your completed project as they can only be retrieved through the account that submitted the request.

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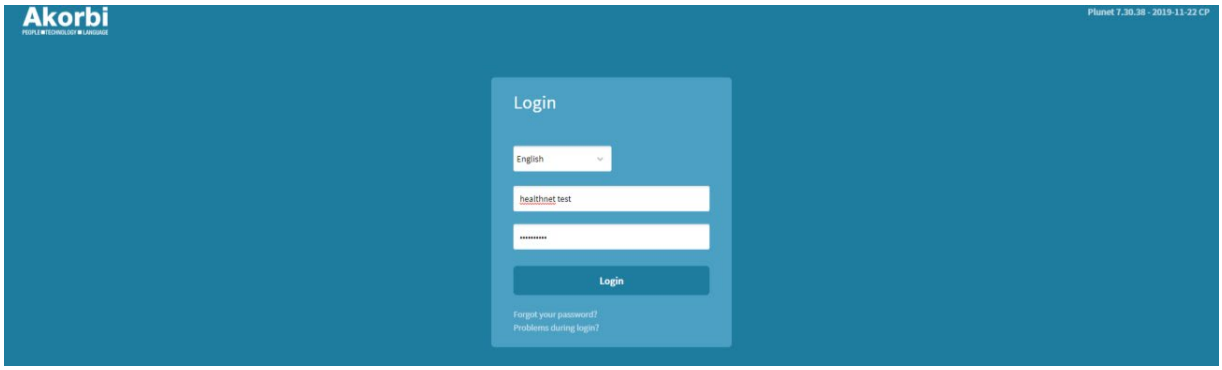

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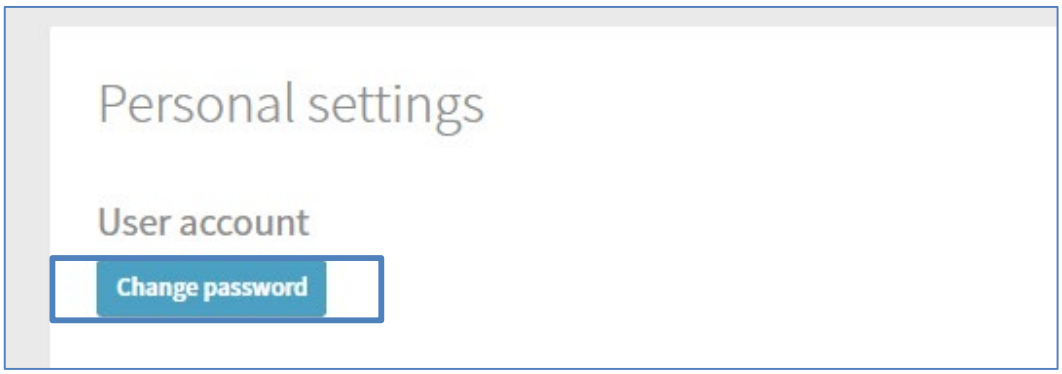
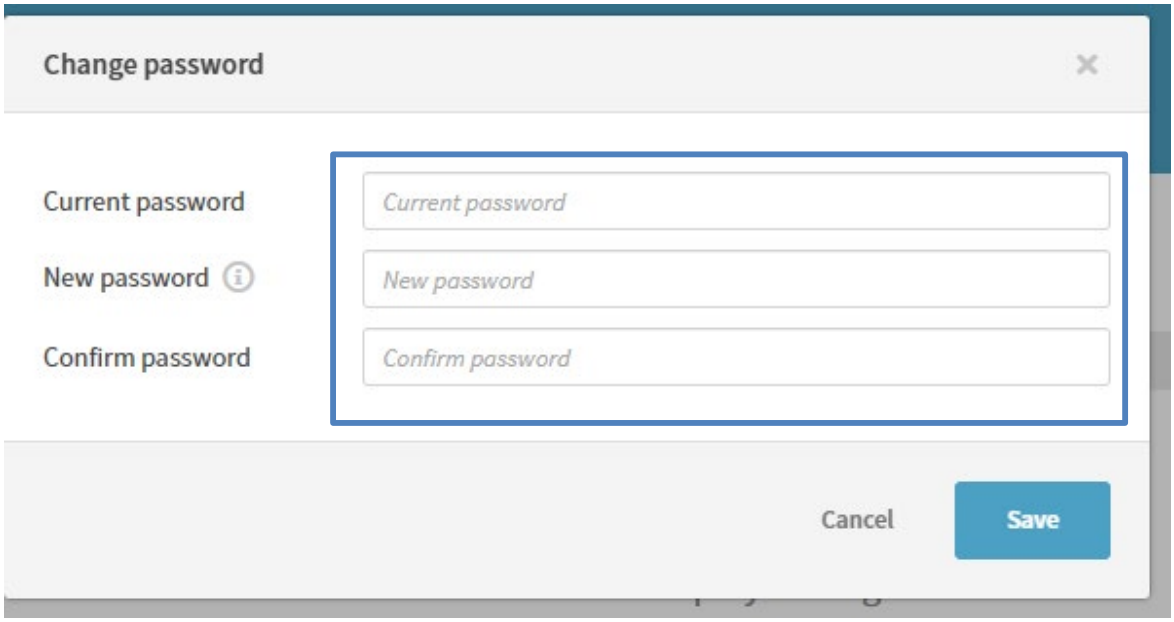


4. Enter your old password in the first field.
5. Enter your new password in the second and third field.
6. Click “Save”.



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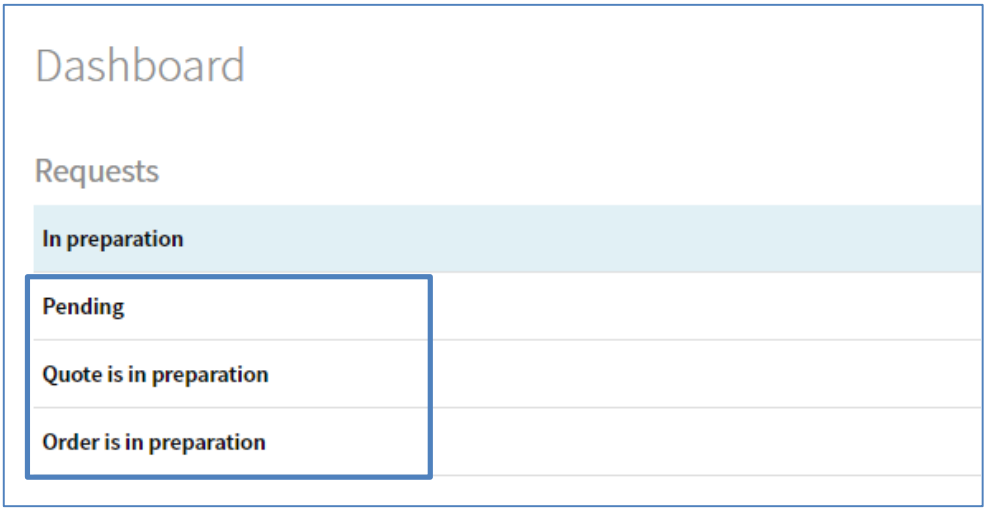

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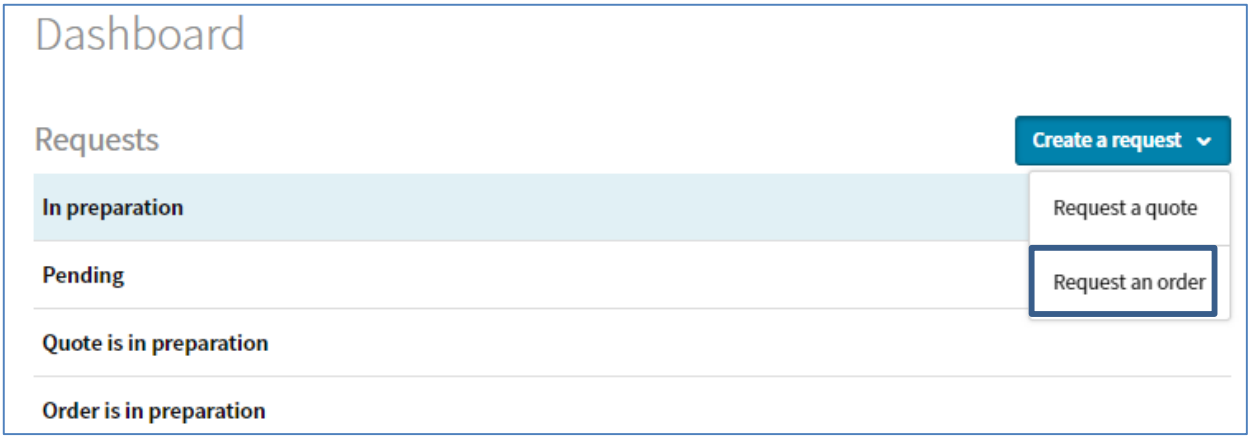
2. Select "**Request an order"** from the drop down menu to begin.

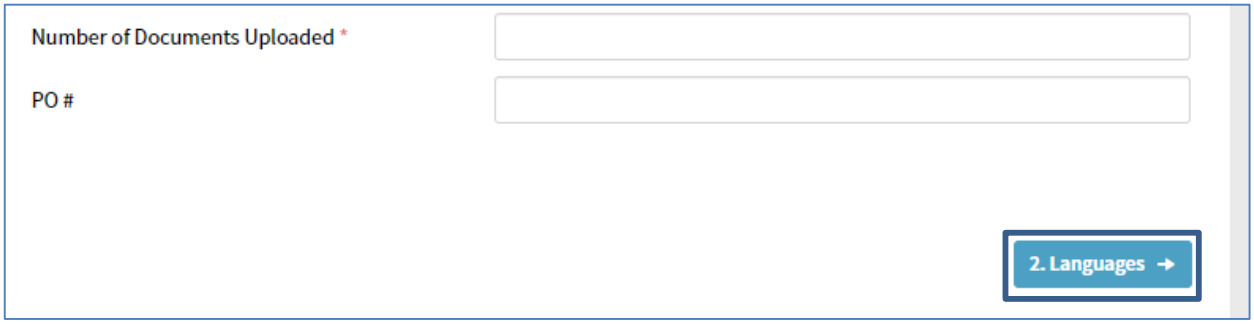


3. Enter the following information into the project fields:

Field	Details
Project Name	Must follow the naming convention: APL 21-011_[Template Type]_[Auth Number]_[Turnaround Time] • **APL 20-011:** Notes the regulatory requirement. • **Template Type:** Enter one of the following - Carve-out, Deny, Delay, Modify, or Terminate. • **Auth Number:** Enter the authorization number for this notification. • **Turnaround Time:** Enter the timeframe in which you need the project completed. Please note, these are business hours. Requests sent after business hours will be processed the following day. Project Name Example: APL-2011_Deny_008776498232_12 hours
Reference Number	Enter the member/subscriber ID number.
Requested Delivery Date	Enter the date and time by which you would like your project completed.
Customer	Should be pre-populated to "Health Net."
PPG	Select the applicable PPG from the drop-down list. Note: They are shown as [PPGID] PPG Name.
Alternate Format	**Select "Not applicable" for translation requests.** For alternate format requests, select one of the following: • Audio Format • Braille • Large Print

Lines of Business	Select the following (once selected, click the checkmark): • CalViva (For CalViva Health members)
Department of	Select “PPG Delegated” from the list.
Number of Documents	Enter 1. Each letter must be submitted separately.

4. Click the Languages button to move to the next screen.



Below are examples of threshold languages you can select from.

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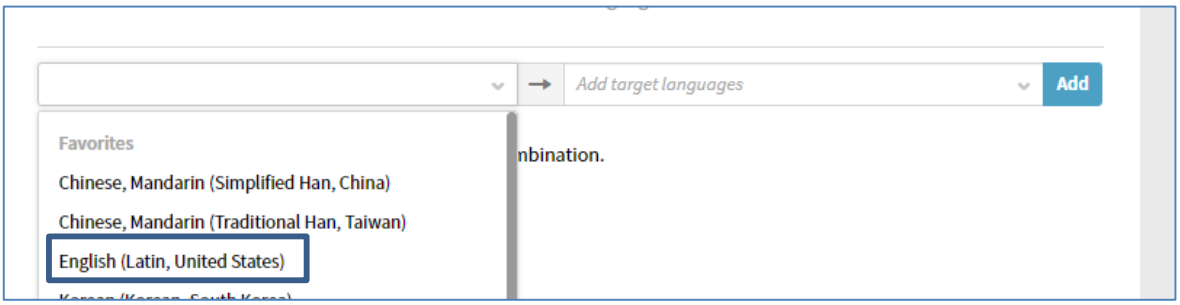
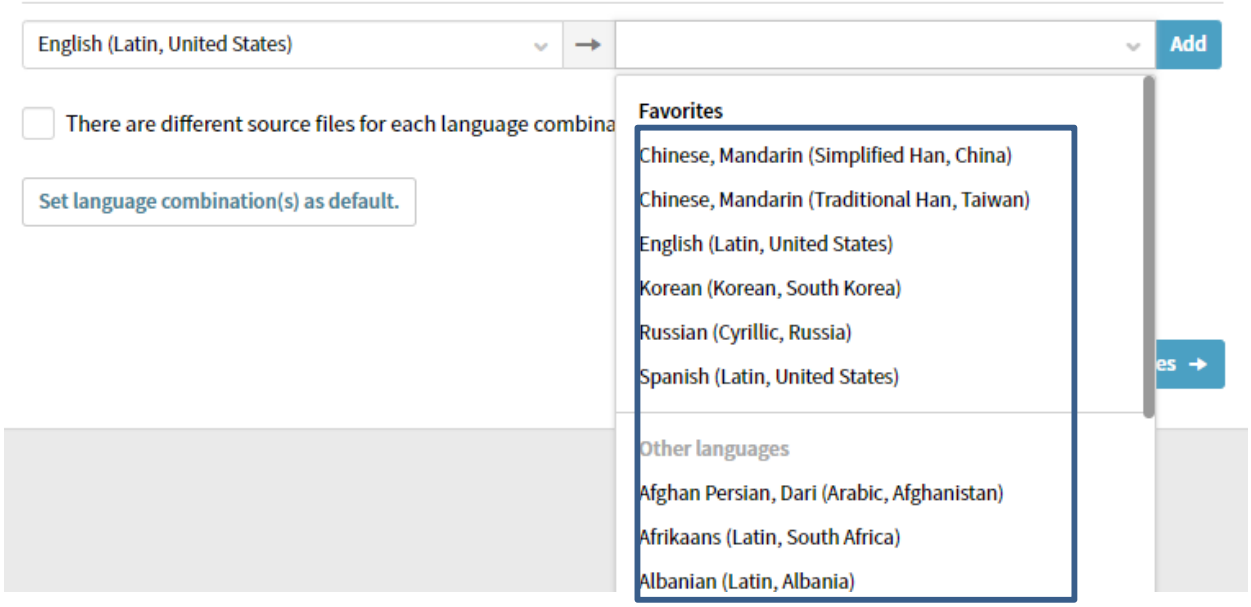
English (Latin, United States) → Hmong, White (Latin, United States)

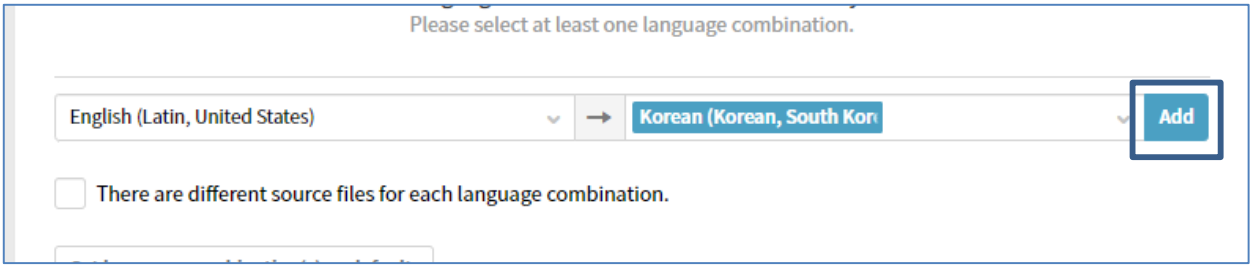
5. Select the Source language from the drop-down box, selecting English.



6. Select the “target language”. This is the members preferred language. **Note: For alternate format requests that do not need to be translated, select English for the target language.**



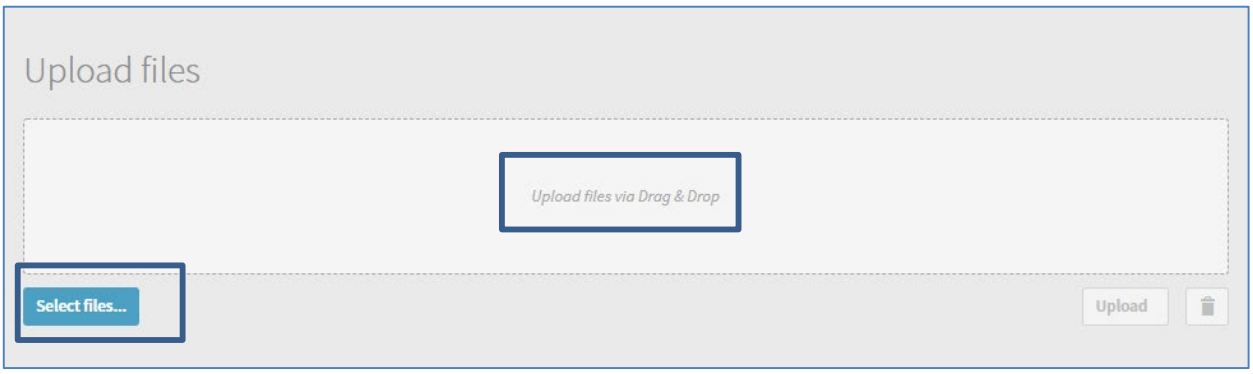
7. Click “add” to confirm your selection.



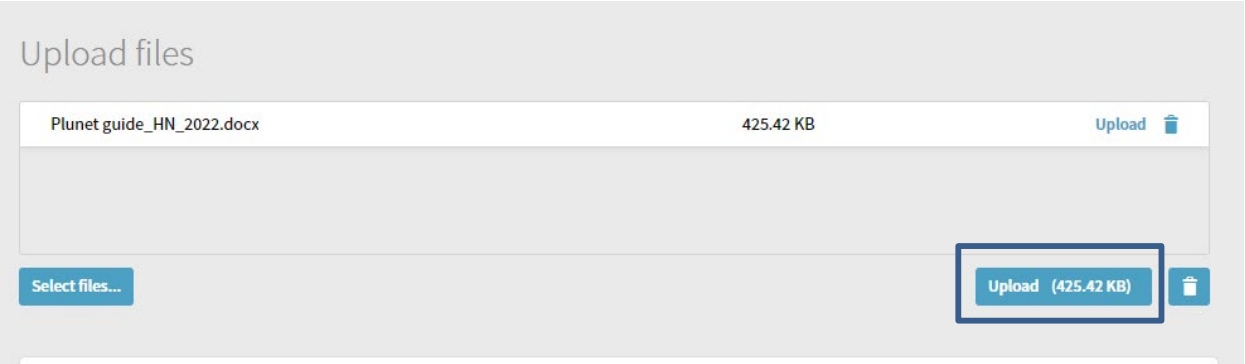
8. Click “Project files” to move to the next screen and upload your document.

9. Click the “source folder” icon to select and upload your document.

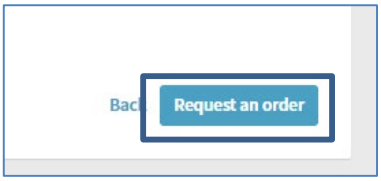
10. In the pop-up window, you can drag and drop your file or click the “select files” button to attach and follow the prompts.



11. Click the “Upload” button to complete the document upload. You can now close the pop-up window.



12. Click the “Summary” button to move to the confirmation page. Review the summary details for accuracy and click “request an order” at the bottom of the page to submit.



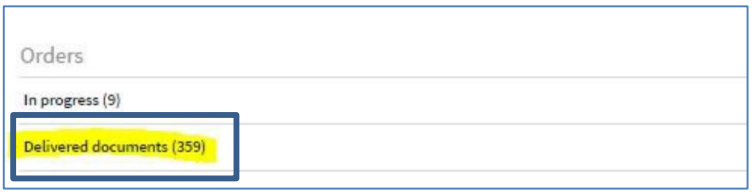
You will receive an email confirmation that will serve as proof that the letter was accepted.

You can also check the status, by looking at the top of your dashboard and clicking on “pending” to verify successful submission.

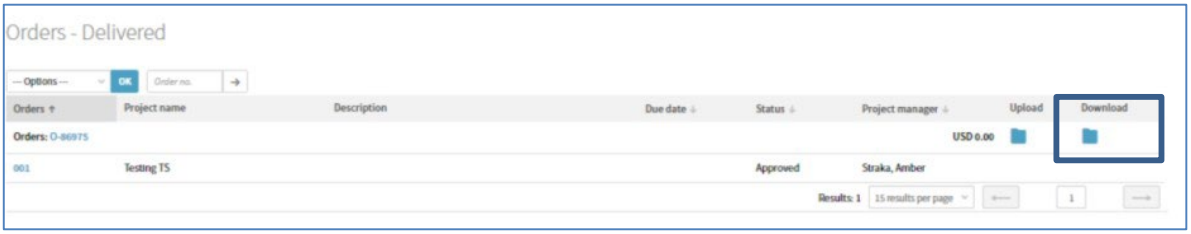
Retrieve completed projects

Once your document has been successfully prepared, you will receive an email notification from Plunet. This is your indication to log in to the system and download your document.

You can see your documents by status when you log in to the system. Click on “delivered documents” to expand the list of documents ready for retrieval.



You can then click on the download icon to retrieve your document.



CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Notice of Action Letter Translations and Alternate Formats:

Akorbi Plunet Portal Guide

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Login and password reset 3

Password reset 3

Dashboard 5

Placing a request 6

Retrieve completed projects 11

Introduction

This document outlines the process for submitting Medi-Cal notice of action (NOA) letters for translation into member requested language or alternate format using the Akorbi Plunet portal.

Health Net*, on behalf of Community Health Plan of Imperial Valley (CHPIV), will cover these costs for NOA letters when the below criteria are met:

- Must be for CHPIV Medi-Cal member NOA translations or alternate formats only.
- Must use current CHPIV pre-translated NOA template.
- Must use the Plan's preferred vendor, Akorbi Language Consulting (Akorbi).

To avoid issues and errors, please follow the process shown in this document for each letter submitted for translation.

Please note: You must keep a log of all letters that you are submitting for translation or conversion to an alternate format for our members. During your annual utilization management (UM) compliance audit, this log may be requested so that samples can be selected for validation as part of the audit scope.

Request a username and password

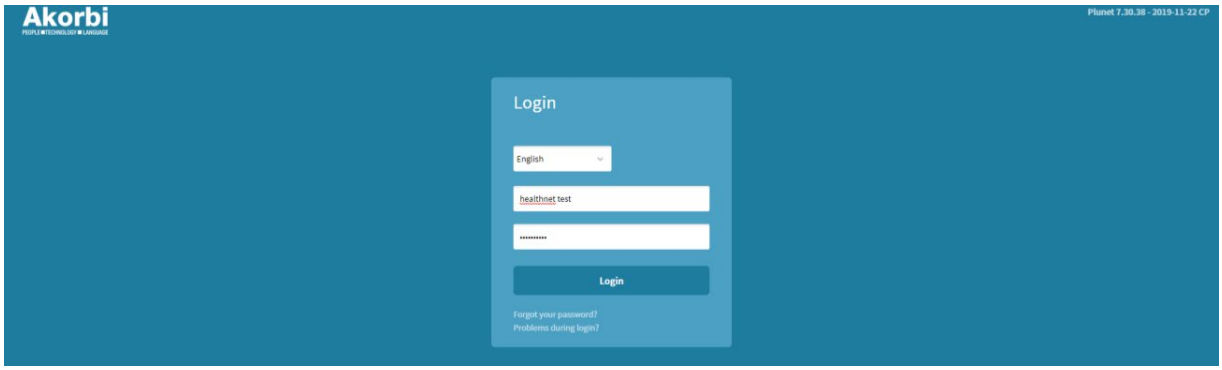
1. If you do not have a Health Net specific username and password for the Akorbi Plunet system, send an email to Delegation_Oversight_Group@Centene.com to request access. Include the following in your email:
    a. Requested username.
    b. First and last name of primary user.
    c. Primary email address (for all notifications from the system).
    d. Secondary email addresses (will be copied via CC on all notifications).

Please note: It is recommended that you have one login and password for all Health Net or CHPIV requests that is shared by the required users in your organization. This will minimize the likelihood of being unable to retrieve your completed project as they can only be retrieved through the account that submitted the request.

Login and password reset

2. Enter the website address plunet.akorbi.com into your browser.
3. Enter your username and password to access the system.
    a. If you use the wrong password for login **three times in a row**, your account will automatically be locked for 24 hours. To unlock the account earlier please contact healthnet@akorbi.com.

Note: To be able to send requests using Akorbi Plunet portal, you need Internet Explorer (Version 8 or higher). You can also use Google Chrome, Mozilla Firefox or Safari.



Password reset

If you have forgotten your password, click on "**Forgot your password?"** You will receive an email with a link to trigger a new password. Click the link in the email and you will be sent another email with your temporary password and instructions on how to reset your password.

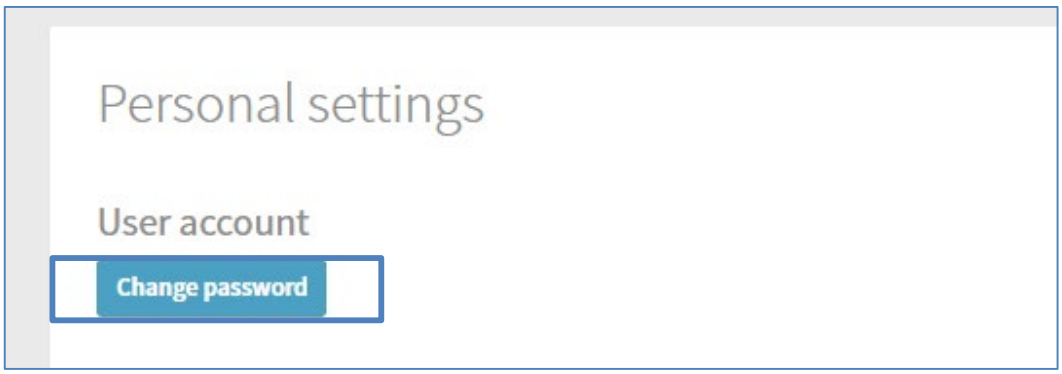
Please note, there will be two emails sent as part of the password reset process.

Manually change password

To manually change your password in the Plunet system:

1. Click on the four blocks icon on the top left of your screen.
2. Select "Settings" for the drop-down menu.

3. Click “Change password” in the user account section.



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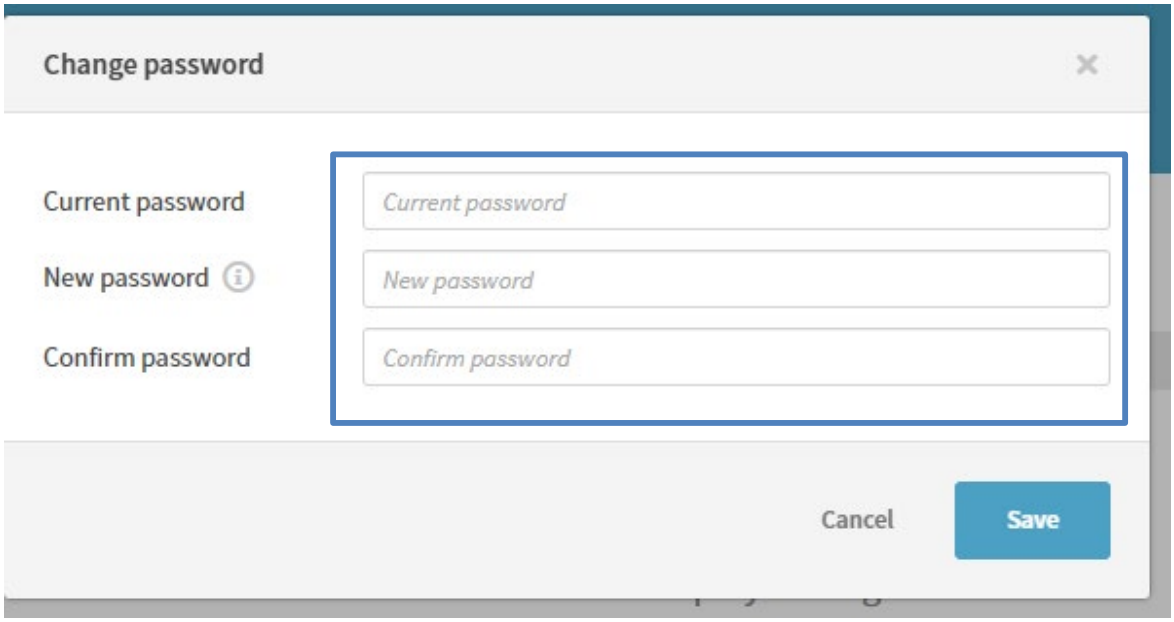

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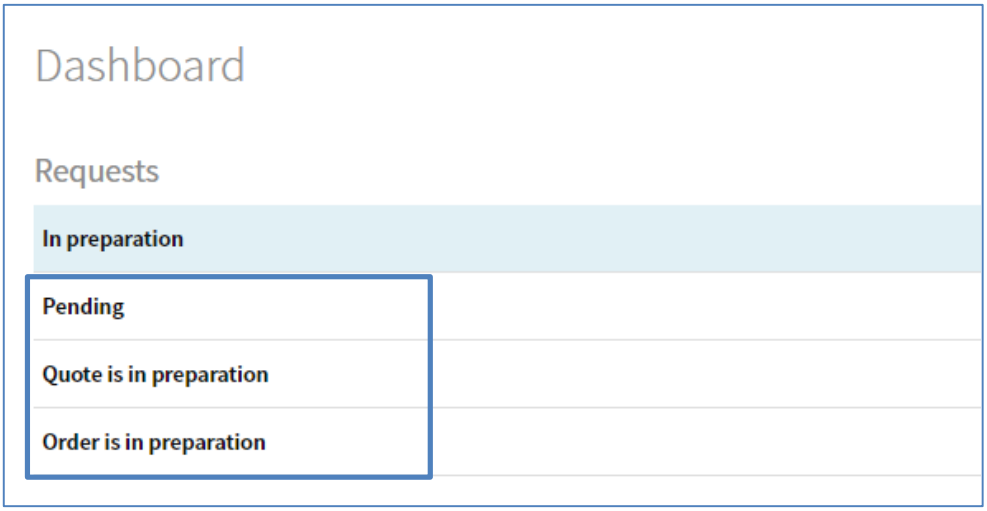

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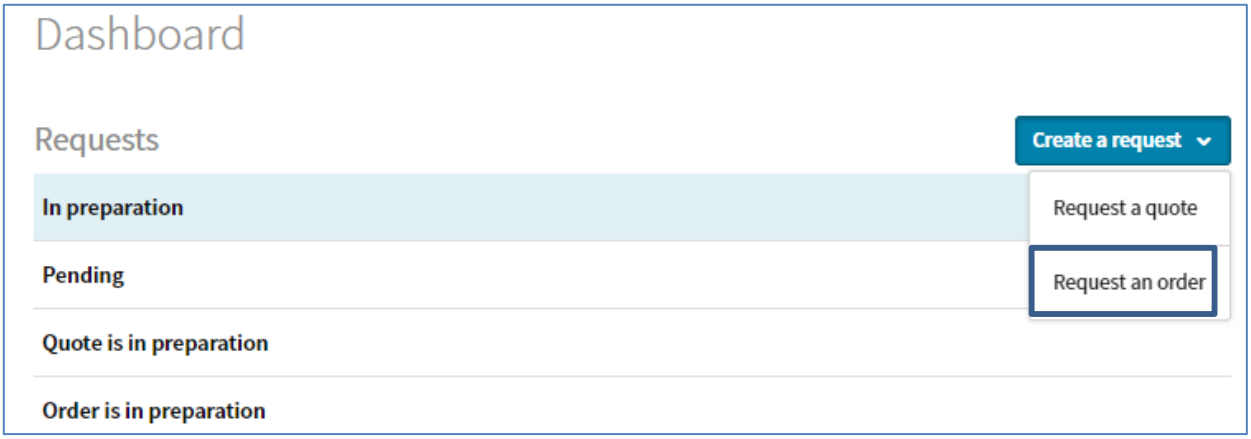

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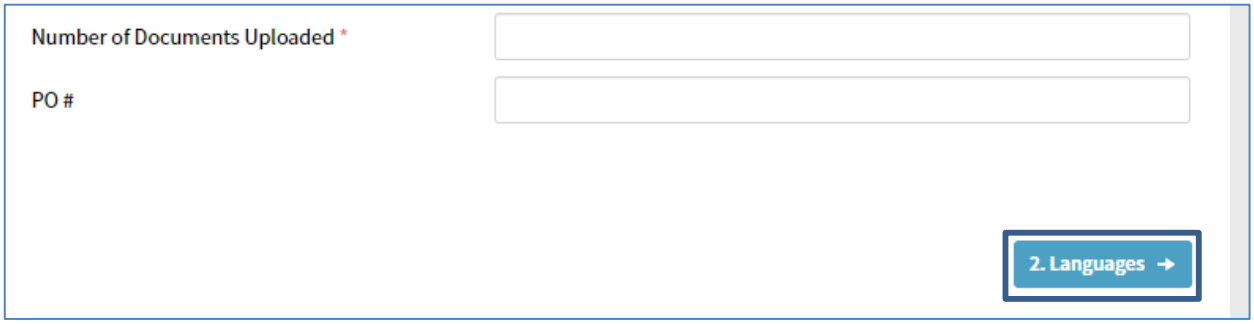

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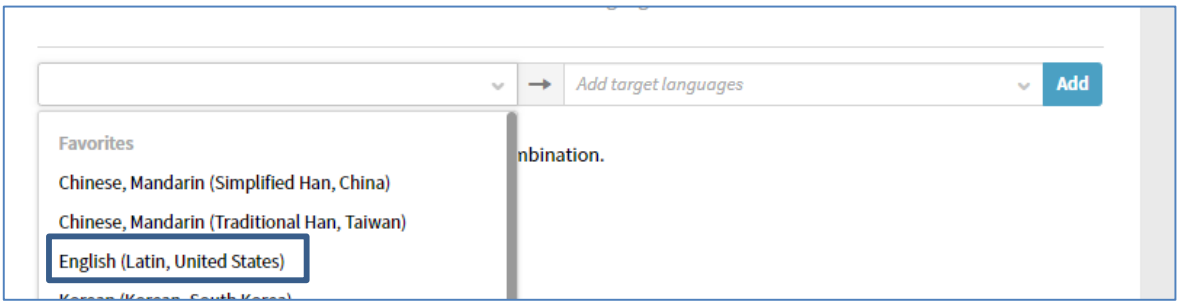

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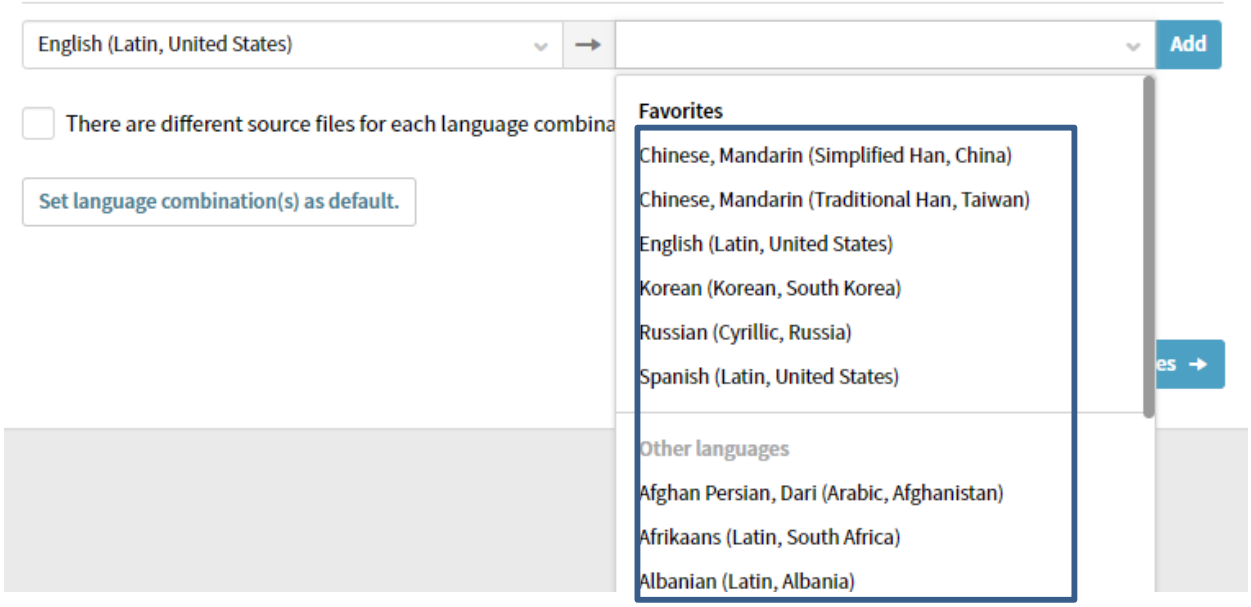

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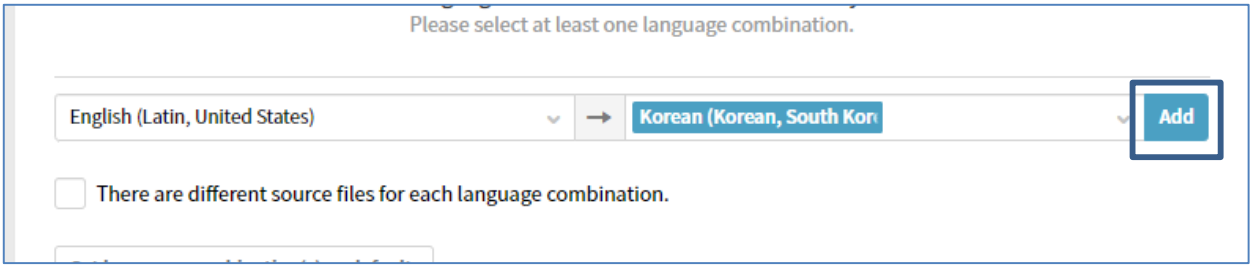

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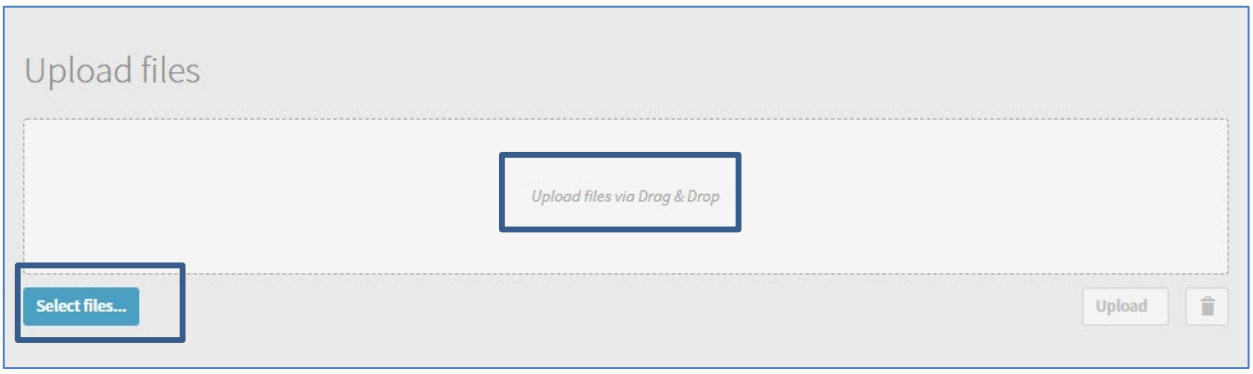

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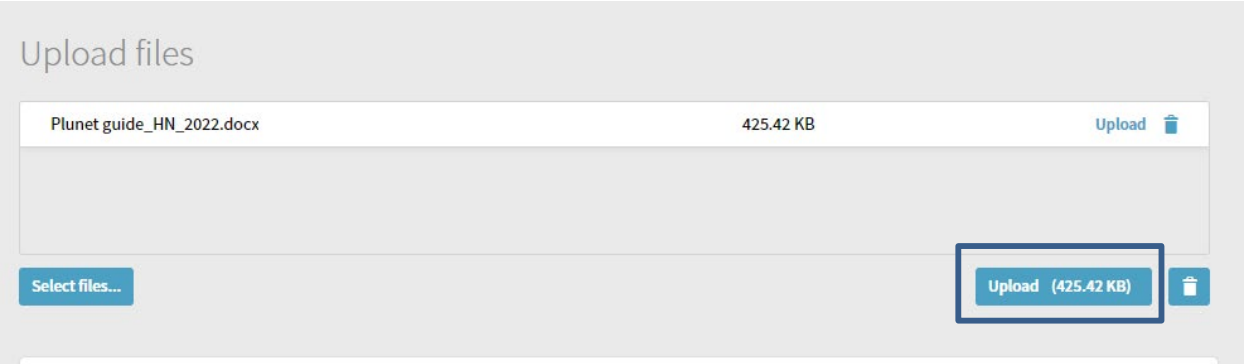

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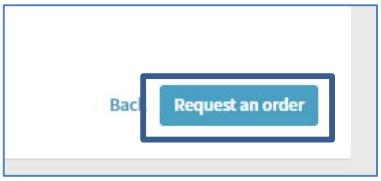

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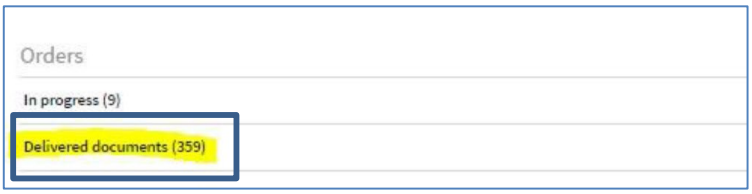

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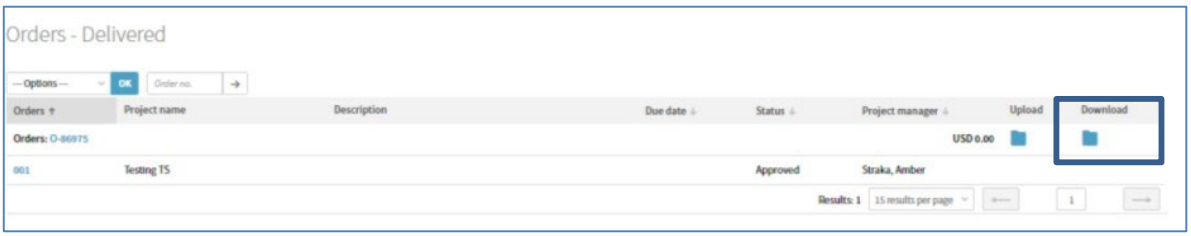

Community Health Plan of Imperial Valley (“CHPIV”) is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

26-378 (3/26)

OFFICE CLEANING SCHEDULE

Facility Cleaning

☐ Occurs Daily by:	
☐ Occurs Weekly by:	
Solutions Used:	
Includes:	☐ Floors
	☐ Exam Tables
	☐ Restrooms
	☐ Furniture
	☐ Dusting entire office

Exam Room/Patient Restroom(if in office) Daily Cleaning:

Solution Used:	
End of Day by:	
As needed during day by	

Biohazardous Spill during Office Hours

Assigned Person:_____

Uses only the Personnel Protection Kit(Spill or Infection control kit)
Places materials in Red Biohazard bag and places in the biohazard storage container.

Cleaning Log/Schedule Year_____

1. All work surfaces and equipment must be cleaned with _____
2. If using 10% Germicidal Bleach solution it must be changed or reconstituted every 24 hours. The date change must be noted on the solution bottle/log.
3. All disinfectant solutions used for cleaning must be approved by the EPA (Environmental Protection Agency), effective in killing HIV/HBV/TB, and used according to the product label for the desired effect.
4. Clean work surfaces and/or equipment before and after each patient use and also on a daily basis.

   Directions

   Staff cleaning work surfaces and equipment must initial the appropriate box (month and day). Staff must initial and sign the bottom of this form to identify the name of the staff member (if using cleaning service same procedure must follow).

LOCATION/ AREA CLEANED: _____

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
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31												

_____ _____ _____

Print Sign Initials

_____ _____ _____

Print Sign Initials

MONTHLY EQUIPMENT, MEDICATION VERIFICATION AND REPLACEMENT LOG

YEAR:_____

Please initial each category as you check the medication and equipment

An initial indicates that the items have been checked, expired medications and lab supplies purged, properly disposed of and replaced.

Month/Day	Meds, etc. In Refrig/Freez	All other meds and samples	Emergency Equipment/ Medication Expiration	Emergency Equipment/ Medication Used and Replaced	Oxygen level, Key, mask and tubing attached	All Lab reagents, hemocults, etc.	All vaccutainer, tubes, culture medium & collection systems	Other
January/								
February/								
March/								
April/								
May/								
June/								
July/								
August/								
September/								
October/								
November/								
December/								

Initials	Signature	Initials	Signature

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____

Visit: ☐ 6 month ☐ 9 month ☐ 12 month ☐ 15 month ☐ 18 month ☐ 24 month ☐ 30 month ☐ 3 year ☐ 4 year ☐ 5 year ☐ 6 year ☐ Other_____

RISK FACTORS

⚠ Mother or primary caregiver had active decay in the past 12 months
☐ Yes ☐ No

- Mother or primary caregiver does not have a dentist
  ☐ Yes ☐ No
- Continual bottle/sippy cup use with fluid other than water
  ☐ Yes ☐ No
- Frequent snacking
  ☐ Yes ☐ No
- Special health care needs
  ☐ Yes ☐ No
- Medicaid eligible
  ☐ Yes ☐ No

PROTECTIVE FACTORS

- Existing dental home
  ☐ Yes ☐ No
- Drinks fluoridated water or takes fluoride supplements
  ☐ Yes ☐ No
- Fluoride varnish in the last 6 months
  ☐ Yes ☐ No
- Has teeth brushed twice daily
  ☐ Yes ☐ No

CLINICAL FINDINGS

⚠ White spots or visible decalcifications in the past 12 months
☐ Yes ☐ No

⚠ Obvious decay
☐ Yes ☐ No

⚠ Restorations (fillings) present
☐ Yes ☐ No

- Visible plaque accumulation
  ☐ Yes ☐ No
- Gingivitis (swollen/bleeding gums)
  ☐ Yes ☐ No
- Teeth present
  ☐ Yes ☐ No
- Healthy teeth
  ☐ Yes ☐ No

ASSESSMENT/PLAN

Caries Risk:
☐ Low ☐ High

Completed:
☐ Anticipatory Guidance
☐ Fluoride Varnish
☐ Dental Referral

Self Management Goals:

☐ Regular dental visits	☐ Wean off bottle	☐ Healthy snacks
☐ Dental treatment for parents	☐ Less/No juice	☐ Less/No junk food or candy
☐ Brush twice daily	☐ Only water in sippy cup	☐ No soda
☐ Use fluoride toothpaste	☐ Drink tap water	☐ Xylitol

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Adapted from Ramos-Gomez FJ, Crystal YO, Ng MW, Crall JJ, Featherstone JD. Pediatric dental care: prevention and management protocols based on caries risk assessment. *J Calif Dent Assoc.* 2010;38(10):746–761; American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. *Pediatrics.* 2003; 122(6):1387–1394; and American Academy of Pediatrics Section of Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. *Pediatrics.* 2003;111(5):1113–1116.

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American Academy of Pediatrics
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Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

National Interprofessional Initiative on Oral Health
engaging clinicians eradicating dental disease

Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment

The Bright Futures/AAP "Recommendations for Preventive Pediatric Health Care," (ie, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://brightfutures.aap.org/clinical_practice.html.

Risk Factors

⚠ Maternal Oral Health

Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. **This child is high risk.**

Maternal Access to Dental Care

Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be if the child has a dentist.

Continual Bottle/Sippy Cup Use

Children who drink juice, soda, and other liquids that are not water, from a bottle or sippy cup continually throughout the day or at night are at an increased risk of caries. The frequent intake of sugar does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing beverages in the child's diet.

Frequent Snacking

Children who snack frequently are at an increased risk of caries. The frequent intake of sugar/refined carbohydrates does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce frequent snacking and choose healthy snacks such as cheese, vegetables, and fruit.

Special Health Care Needs

Children with special health care needs are at an increased risk for caries due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastroesophageal reflux disease and vomiting, attention deficit hyperactivity disorder, and gingival hyperplasia or overcrowding of teeth. Premature babies also may experience enamel hypoplasia.

Protective Factors

Dental Home

According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements

Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page http://aap.org/oralhealth/PracticeTools.html.

Fluoride Varnish in the Last 6 Months

Applying fluoride varnish provides a child with highly concentrated fluoride to protect against caries. Fluoride varnish may be professionally applied and is now recommended by the United States Preventive Services Task Force as a preventive service in the primary care setting for all children through age 5 http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening. For online fluoride varnish training, access the Caries Risk Assessment, Fluoride Varnish, and Counseling Module in the Smiles for Life National Oral Health Curriculum, www.smilesforlifeoralhealth.org.

Tooth Brushing and Oral Hygiene

Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699.

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Clinical Findings

⚠ **White Spots/Decalcifications**
This child is high risk.
White spot decalcifications present—immediately place the child in the high-risk category.

⚠ **Obvious Decay**
This child is high risk.
Obvious decay present—immediately place the child in the high-risk category.

⚠ **Restorations (Fillings) Present**
This child is high risk.
Restorations (Fillings) present—immediately place the child in the high-risk category.

Visible Plaque Accumulation
Plaque is the soft and sticky substance that accumulates on the teeth from food debris and bacteria. Primary care clinicians can teach parents how to remove plaque from the child's teeth by brushing and flossing.

Gingivitis
Gingivitis is the inflamation of the gums. Primary care clinicians can teach parents good oral hygiene skills to reduce the inflammation.

Healthy Teeth
Children with healthy teeth have no signs of early childhood caries and no other clinical findings. They are also experiencing normal tooth and mouth development and spacing.

For more information about the AAP's oral health activities email oralhealth@aap.org or visit www.aap.org/oralhealth.

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OUTPATIENT CALIFORNIA MEDI-CAL AUTHORIZATION FORM

CalViva HEALTH

health net

☐ Request for additional units Existing Authorization Units

Complete and Fax to: 800-743-1655
Transplant Fax: 833-769-1141

☐ **Standard requests: Determination made as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days after the receipt of request.**

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X

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Last Name, First

*Date of Birth (MMDDYYYY)

*Member ID

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider Address

*Fax

City, State, ZIP

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

Servicing Provider Contact Name

Servicing NPI*

Servicing TIN*

Phone

Servicing Provider/Facility Name Address

Fax

City, State, ZIP

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date** OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***End Date** OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

OUTPATIENT SERVICE TYPE*

(Enter the Service type number in the boxes)

199 Adult Day Care
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
290 Hyperbaric Oxygen Therapy -
141 Imaging
112 Nutritional Supplements and/or Services
279 Occupational Therapy Evaluation -
101 Physical Therapy
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation 209 Transplant Surgery
724 Transportation
971 Physical Therapy Evaluation (nonpar only)
127 Speech Therapy Evaluation (nonpar only)
701 Speech Therapy
790 Occupational Therapy

DME
417 Rental
120 Purchase

(Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

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Outpatient Authorization Supplemental Form

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Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL

OUTPATIENT CALIFORNIA MEDI-CAL AUTHORIZATION FORM

health net

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Transplant Fax: 833-769-1141

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112 Nutritional Supplements and/or Services
279 Occupational Therapy Evaluation -
101 Physical Therapy
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation 209 Transplant Surgery
724 Transportation
971 Physical Therapy Evaluation (nonpar only)
127 Speech Therapy Evaluation (nonpar only)
701 Speech Therapy
790 Occupational Therapy

DME
417 Rental
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OUTPATIENT CALIFORNIA HEALTH NET MEDI-CAL AUTHORIZATION FORM

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Palliative and Hospice Care Contracted Provider List

Contracted Providers - Preferred List

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Anchor	1435 N. McDowell Blvd., Ste. 210, Petaluma, CA 94954	North Bay (Sonoma, Marin, Napa, Solano); East Bay (Alameda, Contra Costa); South Bay (San Mateo, San Francisco, Santa Clara, Monterey); San Joaquin, Sacramento, Yolo, El Dorado, Placer, Lake	X	X	415-598-0944 707-321-0046	415-598-0955	www.anchorhpc.com
Community Hospice, Inc., a Californian non-profit corporation	4368 Spyres Way Modesto, CA 95356	San Joaquin Stanislaus, Merced, Calaveras, Mariposa, Tuolumne, and portions of surrounding counties	X	X	209-578-6300	209-541-3280	www.hospiceheart.org
Hinds Hospice	1416 W. Twain Ave, Fresno, CA 93711	Fresno, Merced, Madera, Mariposa	X	X	559-226-5683	559-222-4782	www.hindslifecare.org

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Palliative and Hospice Care Contracted Provider List

Contracted Providers - Preferred List, continued

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Libertana Home Health of Sherman Oaks	5805 Sepulveda Blvd., Ste. 605 Van Nuys, CA 91411	Los Angeles	X	X	818-902-5000 800-750-1444	818-902-5008	www.libertana.com
Lightbridge Hospice, LLC & Palliative Care	6155 Cornerstone Ct. East, Ste. 220 San Diego, CA 92121	San Diego	X	X	858-458-2992	858-362-4027	www.lightbridgehospice.com
Noble Hospice Care, Inc.	6601 Owens Dr., Ste. 245 Pleasanton, CA 94588	Solano, Alameda, San Francisco, San Mateo, Santa Clara, Contra Costa	X	X	925-594-1122	925-520-2411	www.noblehhc.com
Providence Hospice LA County	5315 Torrance Blvd. Torrance, CA 90503	Los Angeles	X	X	800-329-8660	310-424-4228	www.compassus.com
ResolutionCare, PC (Vynca)	1875 S. Grant St., Ste. 760 San Mateo, CA 94403	Humboldt, Mendocino	X	N/A	707-442-5683 888-227-8884	707-442-2006 833-593-2739	www.vyncacare.com
Roze Room Healthcare	2700 E. Foothill Blvd., Ste. 200 Pasadena, CA 91107	Los Angeles, Ventura, San Bernardino	X	X	877-783-0072	818-462-5854 877-783-4783	www.rozeroom.org
Silverado Supportive Care	27710 Jefferson Ave., Ste. 200 Temecula, CA 92590	Los Angeles, San Bernadino, Riverside, San Diego, Orange	X	X	888-491-0049	866-299-8639	www.silveradohospice.com
Snowline Hospice	6520 Pleasant Valley Rd. Diamond Springs, CA 95619	Sacramento, El Dorado, West Slope, Placer, Yolo	X	X	530-621-7820	530-621-4503	www.snowlinehealth.org

Contracted Providers - Preferred List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
The Elizabeth Hospice	800 W. Valley Pkwy., Ste. 100 Escondido, CA 92025	San Diego, Southwest Riverside	X	X	833-349-2052	760-796-3781	www.elizabethhospice.org

Contracted Providers - Secondary List

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Assisted Home Hospice - Northern Hills	10550 Sepulveda Blvd., Ste. 101 Mission Hills, CA 91345	Mission Hills/ Los Angeles	X	X	818-830-5003	818-830-5019	www.assistedcares.com
Assisted Home Hospice - Ventura	4450 Westinghouse St., Ste. 103 Ventura, CA 93003	Ventura	X	X	805-677-7405	805-677-7441	www.assistedcares.com
Assisted Home Hospice - Los Angeles	3731 Wilshire Blvd., Ste. 518 Los Angeles, CA 90010	Los Angeles	X	X	213-355-3511	213-355-3516	www.assistedcares.com
Assisted Home Hospice - Santa Barbara	115 E Micheltorena St., Suite 100 Santa Barbara, CA 93101	Santa Barbara	X	X	805-569-2000	805-722-1459	www.assistedcares.com
Carechoices Hospitc eand Palliative Services, Inc.	20 Corporate Park, Ste. 300 Irvine, CA 92606	Orange	X	X	949-777-8600	949-777-8601	www.carechoices.net
Hoffman Hospice Of The Valley, Inc.	4325 Buena Vista Rd. Bakersfield, CA 93311	Kern, Victorville, Los Angeles	X	X	661-410-1010	661-410-1110	www.hoffmannhospice.org

health net

Palliative and Hospice Care Contracted Provider List

Contracted Providers - Secondary List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Hospice of East Bay	3470 Buskirk Ave. Pleasant Hill, CA 94523	Alameda, Contra Costa, Solano	X	X	925-887-5678	925-887-5679 (Hospice)	www.hospiceeastbay.org
Hospice of East Bay	2849 Miranda Ave. Alamo, CA 94507	Alameda, Contra Costa, Solano	X	X	925-945-8924 925-945-0863	925-852-0010 925-852-0044 (Palliative)	www.hospiceeastbay.org
Skirball - JHA Geriatric Services, Inc., a subsidiary of the Los Angeles Jewish Home	6345 Balboa Blvd., Ste 315 Encino, CA 91316	Los Angeles	X	X	877-774-3040	818-774-3089	www.skirballhospice.org

N/A = Not applicable

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Contracted Providers - Preferred List, continued

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Libertana Home Health of Sherman Oaks	5805 Sepulveda Blvd., Ste. 605 Van Nuys, CA 91411	Los Angeles	X	X	818-902-5000 800-750-1444	818-902-5008	www.libertana.com
Lightbridge Hospice, LLC & Palliative Care	6155 Cornerstone Ct. East, Ste. 220 San Diego, CA 92121	San Diego	X	X	858-458-2992	858-362-4027	www.lightbridgehospice.com
Noble Hospice Care, Inc.	6601 Owens Dr., Ste. 245 Pleasanton, CA 94588	Solano, Alameda, San Francisco, San Mateo, Santa Clara, Contra Costa	X	X	925-594-1122	925-520-2411	www.noblehhc.com
Providence Hospice LA County	5315 Torrance Blvd. Torrance, CA 90503	Los Angeles	X	X	800-329-8660	310-424-4228	www.compassus.com
ResolutionCare, PC (Vynca)	1875 S. Grant St., Ste. 760 San Mateo, CA 94403	Humboldt, Mendocino	X	N/A	707-442-5683 888-227-8884	707-442-2006 833-593-2739	www.vyncacare.com
Roze Room Healthcare	2700 E. Foothill Blvd., Ste. 200 Pasadena, CA 91107	Los Angeles, Ventura, San Bernardino	X	X	877-783-0072	818-462-5854 877-783-4783	www.rozeroom.org
Silverado Supportive Care	27710 Jefferson Ave., Ste. 200 Temecula, CA 92590	Los Angeles, San Bernadino, Riverside, San Diego, Orange	X	X	888-491-0049	866-299-8639	www.silveradohospice.com
Snowline Hospice	6520 Pleasant Valley Rd. Diamond Springs, CA 95619	Sacramento, El Dorado, West Slope, Placer, Yolo	X	X	530-621-7820	530-621-4503	www.snowlinehealth.org

Contracted Providers - Preferred List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
The Elizabeth Hospice	800 W. Valley Pkwy., Ste. 100 Escondido, CA 92025	San Diego, Southwest Riverside	X	X	833-349-2052	760-796-3781	www.elizabethhospice.org

Contracted Providers - Secondary List

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Assisted Home Hospice - Northern Hills	10550 Sepulveda Blvd., Ste. 101 Mission Hills, CA 91345	Mission Hills/ Los Angeles	X	X	818-830-5003	818-830-5019	www.assistedcares.com
Assisted Home Hospice - Ventura	4450 Westinghouse St., Ste. 103 Ventura, CA 93003	Ventura	X	X	805-677-7405	805-677-7441	www.assistedcares.com
Assisted Home Hospice - Los Angeles	3731 Wilshire Blvd., Ste. 518 Los Angeles, CA 90010	Los Angeles	X	X	213-355-3511	213-355-3516	www.assistedcares.com
Assisted Home Hospice - Santa Barbara	115 E Micheltorena St., Suite 100 Santa Barbara, CA 93101	Santa Barbara	X	X	805-569-2000	805-722-1459	www.assistedcares.com
Carechoices Hospitc eand Palliative Services, Inc.	20 Corporate Park, Ste. 300 Irvine, CA 92606	Orange	X	X	949-777-8600	949-777-8601	www.carechoices.net

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Palliative and Hospice Care Contracted Provider List

Hoffman Hospice Of The Valley, Inc.	4325 Buena Vista Rd. Bakersfield, CA 93311	Kern, Victorville, Los Angeles	X	X	661-410-1010	661-410-1110	www.hoffmannhospice.org

Contracted Providers - Secondary List, continued

Provider	Address	County of Service	Contracted for Palliative?	Contracted for Hospice?	Phone Number	Fax Number	Website
Hospice of East Bay	3470 Buskirk Ave. Pleasant Hill, CA 94523	Alameda, Contra Costa, Solano	X	X	925-887-5678	925-887-5679 (Hospice)	www.hospiceeastbay.org
Hospice of East Bay	2849 Miranda Ave. Alamo, CA 94507	Alameda, Contra Costa, Solano	X	X	925-945-8924 925-945-0863	925-852-0010 925-852-0044 (Palliative)	www.hospiceeastbay.org
Skirball - JHA Geriatric Services, Inc., a subsidiary of the Los Angeles Jewish Home	6345 Balboa Blvd. Ste 315 Encino, CA 91316	Los Angeles	X	X	877-774-3040	818-774-3089	www.skirballhospice.org

N/A = Not applicable

Palliative and Hospice Care Contracted Provider List

Contracted Providers - Preferred List

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Anchor	1435 N. McDowell Blvd., Ste. 210, Petaluma, CA 94954	North Bay (Sonoma, Marin, Napa, Solano); East Bay (Alameda, Contra Costa); South Bay (San Mateo, San Francisco, Santa Clara, Monterey); San Joaquin, Sacramento, Yolo, El Dorado, Placer, Lake	X	X	415-598-0944 707-321-0046	415-598-0955	www.anchorhpc.com
Community Hospice, Inc., a Californian non-profit corporation	4368 Spyres Way Modesto, CA 95356	San Joaquin Stanislaus, Merced, Calaveras, Mariposa, Tuolumne, and portions of surrounding counties	X	X	209-578-6300	209-541-3280	www.hospiceheart.org
Hinds Hospice	1416 W. Twain Ave, Fresno, CA 93711	Fresno, Merced Madera, Mariposa	X	X	559-226-5683	559-222-4782	www.hindslifecare.org

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange healthcare services for CHPIV enrollees. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL | health net

Palliative and Hospice Care Contracted Provider List

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N/A = Not applicable

PEDIATRIC HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. Allergies:

Age: _____ Sex: Male Female TB Risk: Y N (1,6,12 months and then annually)

Advanced Directive:18 & older
Y N Date Discussed: Primary Language: Interpreter: Y N Interpreter Name:

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	Newborn-20 years old	Within 120 days of effective date with Plan or effective date with the PCP			
Health Risk Assessment (ACE/PEARLS, or SDOH)**	Newborn-20 years old	Within 120 days of effective date with Plan or effective date with the PCP. Review yearly.			
IHEBA/"Staying Healthy"	Newborn-20 years old	Not mandated but continues to help with obtaining information for certain screenings	Document on Form (IHEBA)		
Well Check Visit	Newborn-20 years old	Per AAP Guidelines			
Alcohol Use Disorder Screening and Behavioral Counseling**	11 and older	Every Well Check Visit. Use CRAFFT, TAPS, etc. If positive refer for counseling and/or treatment			
Anemia Screening	4, 15, 18, 24, 30 months and 3 years old	**Test Serum Hemoglobin at 12 months** Assess annually and document risk after 3 years old.			
Anthropometric Measurements	WHO chart 0-2years CDC growth chart 2 years and older	Every Well Check Visit. Measure and track BMI at each Well Visit. Head circumference-Infant to 24 months			
Anticipatory Guidelines	0-20 years old	Age Appropriate with each Well Check Visit			
Autism Screening**	18 and 24 months	Based on AAP Bright Futures periodicity- **(ex.** SWYC, M-CHAT-R/F, **etc.)**			
Blood Lead Screening	Assess (anticipatory guidance) at 6 months- 72 months	**Blood Lead screening at 12 months and 24 months if no record up to 72 months of age**			
Blood Pressure Screening	3 years and older	Assess at each Well Check Visit			
Dental /Oral Health Assessment	First Health assessment and through age 20	Identify and document dental home-12 months and older is to be referred to a dentist.			
Fluoride Supplementation	6 months-16 years	Assess and provide fluoride supplementation per AAP guidelines (drinking water)			
Fluoride Varnish	Once first tooth has erupted- 5th year birthday	May be applied by PCP or dentist every 3-6 months per AAP			
Depression Screening**	12 years-20 years	Per USPTF guidelines starting at 12 years old at each Well Check Visit (PHQ9A **etc..)**			
Maternal Depression Screening**	Starting at 1 month	Maternal depression screening at 1, 2, 4, and 6-month visits. (Ex. Edinburgh, PHQ 9)			
Developmental Disorder Screening**	Starting at 9 months	Screening at 9th, 18th and 24 or 30 month visit (SWYC, PEDS, ASQ-3 **etc**.)			
Developmental Surveillance Screen	0-20 years old	Every Well Check Visit			
Drug Use Screening/Behavior Counseling**	11-20 years old	Every Well check visit beginning at age 11 (CRAFFT, TAPS **etc..).** If positive refer for counseling and/or treatment			
Dyslipidemia	Risk assessment 2,4,6,8 years	Annual risk screening after 8 years old 9-11 one-time lipid panel and again at 17-21			
Folic Acid Supplementation	Females 12-20 years old	Assess and document at each Well Check Visit			
Hearing Screening	2m-3years non audio 4-20 years old audio	Age-appropriate screen per AAP guidelines Document scores			
Hep B Screening	0-20 years old	Assess with each Well Check Visit, risk assessment			
Hep C Screening	18-20 years old	Assess with each Well Check Visit, risk assessment			
HIV screening	Assess beginning age 11years old	If high risk test and assess yearly. Test once between 15-18 years old. **Assess at each well visit (risk assessment)**			
TB screening	0-20 years old	Assess at 1m,6m,12months old and annually thereafter			

Psychosocial/Behavioral Assessment	0-20 years	Assess and document with each Well Check Visit **(ex.ASQ:SE-2 for 1-72 months, SDQ 2-17yrs, PSC 4-16 yrs, SDOH, etc.)**			
Suicide Risk Assessment**	12-20 years old unless clinically indicated for younger individuals	Assess with each Well Check Visit. Examples are **ASQ Suicide Questions form or PHQ9A.**			
Contraceptive Care/ STI screening on all sexually active adolescents	Assess at 11-20 years old	Assess at each Well Check Visit. Contraceptive, STI screening and counseling (GC, Chlamydia up to age 20)			
Tobacco Product Use: Screening/Prevention/Cessation**	11 years-20 years	Screen at each Well Check Visit **(ex. TAPS, CRAFFT 2.1+ N)**			
Sudden Cardiac Arrest and Sudden Cardiac Death Screening	11 years old -20 years	Assess on each Well Check visit (risk assessment)			
Vision Screening	3-20 years	Age-appropriate screen per AAP			
Immunizations-Documentation Verification (CAIR)/ Immunization Record	0-20 years	Assess each Well Check visit and verify using CAIR 2			

** Must use Validated Screener Form**

HEALTH NET
MEDI-CAL PROGRAM
PERINATAL NOTIFICATION and ASSESSMENT REPORT

Section A ***Basic Information***

Date:
Member Name:
AKA:
Member ID #:
Date of Birth:
Address: City: State: CA Zip: Phone: ( )
Marital Status — Circle One: Single Married Sep Dv Unk
Language
Years of Education — 0 1 2 3 4 5 6 7 8 9 10 11 12 12+
EDC — LMP
Grav: Para: Sab: Tab:
Date Pregnancy Verified:
Date of First Prenatal Care Visit:
OB Provider:
Address City: State: CA Zip:
OB Telephone #: ( )
OB Office Contact:
Comments:

Section B ***Risk Assessment Data***

High Risk Condition *(check if applies)*	**YES**	**NO**
Maternal age 17 years or less		
Maternal age 35 years or more		
Maternal medical or surgical condition		
High blood pressure		
Asthma		
Diabetes		
Physical disabilities (speech, hearing, or vision)		
Genetic disroder(s)		
Eating disorder		
Severe anemia		
Prior hx of PIH (Preg Induced Hypertension)		
Previous pre-term deliveries		
Prior infant/fetal demise		
Hx of C-Section		
Cervical conditions: hx cone biopsy or cerclage		
Placental conditions If yes, what?_____		
Gestational Diabetes		
Referral for Diabetic Care		
Multigestational pregnancy		
Socioeconomic factors which may require referral (Please explain in comments)		
Evidence of family violence		
Psychological conditions		
Noncompliance with therapies or interventions		
Current tobacco use pks/day_____		
Current alcohol use How much?_____		
Substance use		
If yes, name substances(s):		

Section C ***Additional Assessment Report***

Is OB/Gyn CPSP Yes ☐ No ☐ CPSP Offered: Yes ☐ No ☐ Enrolled: Yes ☐ No ☐ If no, why?_____ CPSP services referred to_____	VBAC offered: If Hx of prior C/S Yes ☐ No ☐ If no, why not?_____
	Baby Dr. options provided Yes ☐ No ☐
	Birth control options discussed Yes ☐ No ☐
HIV test offered Yes ☐ No ☐ WIC offered: Yes ☐ No ☐	Method desired (please circle) BTL Oral BCP Depo Other
Plans to breastfeed Yes ☐ No ☐	

Section D ***Postpartum***

Date of Visit: Postpartum complications: Yes ☐ No ☐	Current birth control method:
Tye of complication:	Bonding issues? Yes ☐ No ☐

Please FAX to Perinatal Care Manger within 7 days of first prenatal visit and after each reassessment: (559) 447-6178

Basic Information: ☐ 2nd Trimester ☐
3rd Trimester: ☐ PostPartum: ☐

hcs/periform 1/19/99

High-Risk Pregnancy Referral Form

For provider use only.

Please complete this form for all Health Net members with high-risk pregnancies within 7 days of identification. Fax form to secure fax line at (866) 878-0034. For questions, call (559) 447-6122.

SECTION A: Patient Information

Today's date (MM/DD/YY): _____ID card #/CIN #: _____Date of birth (MM/DD/YY): _____

Last name: _____First name: _____Telephone #: _____

Street address: _____City: _____State: _____ZIP code: _____

Date of last menstrual period: _____Anticipated delivery hospital:_____ Due date (MM/DD/YY): _____

Preferred language spoken: ☐ English ☐ Spanish ☐ Other: _____

Race/ethnicity: ☐ Hispanic/Latino ☐ African American ☐ Asian/Pacific Islander ☐ White ☐ Native American ☐ Other:_____

SECTION B: OB Provider Information

Last name: _____ First name: _____

Street address: _____ Suite #: _____ City: _____ State: _____ ZIP code: _____

Telephone #: _____Tax ID: _____Provider license #: _____

SECTION C: Current Medications

List all current medications:

☐ Prenatal vitamins ☐ Insulin/diabetic medication ☐ Blood pressure medication:_____

☐ Narcotics ☐ Antidepressant/anti-anxiety ☐ Other: _____

SECTION D: Identified Risk

Medical:

☐ Asthma ☐ Currently receiving 17-p injections ☐ Current placental problems

☐ Diabetes ☐ Gestational diabetes ☐ Previous preterm birth (<37 weeks)

☐ Advanced maternal age (>35 years) ☐ Genetic disorder ☐ Previous high-risk pregnancy

☐ History of poor pregnancy outcome ☐ Multifetal pregnancies ☐ Pregnancy-induced hypertension

☐ Stillbirth ☐ Multiple miscarriages ☐ LBW or VLBW

☐ Medications that may affect fetal outcome ☐ Teen pregnancy (<17 years) ☐ Other: _____

Substance Abuse:

☐ Alcohol How many drinks per day?_____ ☐ Tobacco/cigarettes Packs per day? _____

☐ Prescription medications used Name of medication:_____ How often? _____

☐ Street drugs ☐ Marijuana ☐ Other What drug(s)?_____ How often? _____

List any other medical/psychological problems not included above or other issues that may place member at risk:

_____

SECTION E: Referrals Made by OB Office or CPSP Program (indicate location or name of the program)

☐ WIC ☐ Case management_____ ☐ Health plan:_____ ☐ Nutrition counseling_____

☐ Prenatal/parenting/childbirth classes_____ ☐ Glucose monitor with nutritional counseling _____

☐ Smoking cessation_____ ☐ Substance abuse treatment_____ ☐ Psychosocial services_____

Provider comments or suggestions:

_____

_____

Signature and Title: _____ **Date:**_____

To be completed by internal case manager:

DATE CM OPENED: _____ DATE DELIVERED: _____ DATE CM CLOSED: _____

Perinatal Risk Screening Tool

❒ Medi-Cal ❒ Healthy Families ❒ AIM

Name: _____ ID#: _____

Age: _____ Phone #: _____ Service Area: _____

Dates Called: _____ Date Administered: _____

Time Started: _____ Time Stopped:_____ Total Time: _____

Referral Source: _____ Completed By: _____

ACUITY LEVEL: _____

SURVEY NOT COMPLETED DUE TO:

- **❒ Unable to reach member:**
  - **❒ Messages left x3, No call back**
  - **❒ No phone, No record of member at PCP office, No OB information**
  - **❒ Member refused due to:**
- **❒ Member no longer pregnant.**

EDUCATION MATERIAL REQUESTED:

❒ No ❒ Yes ❒ Education Dept. Notified

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
1. When is your baby due?	_____/_____/_____ MM/DD/YY			
2. Who are you seeing for your pregnancy? Telephone:	(_____)_____-_____			
3. When was your first doctor's visit for this pregnancy? a) How many times have you seen your doctor since your first visit? b) When is your next appointment? c) How many appointments have you missed? d) Is there any reason you have problems keeping your appointment? If yes, what is the reason?	___/_____/_____ MM/DD/YY _____/_____/_____ MM/DD/YY	❒ < 2 ❒ N	❒ ≥ 2 ❒ Y	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
4. How many times have you been pregnant? a) How many children do you have? • What are their ages? b) Have you lost or terminated any pregnancies? • How far along were you? c) Have you had any pregnancies that you delivered more than one baby? d) For this pregnancy, do you think you're carrying more than one baby?	**Loss (SAB)** **Terminated (TAB)**	❒ < 5 ❒ < 2 ❒ < 4 ❒ N ❒ N	❒ ≥ 5 ❒ ≥ 2 ❒ ≥ 4 ❒ Y ❒ Y	**Notify CM if pregnancies less than ONE year apart.** **If YES, how many losses?** **If YES, how many terminations?**
5. Were any of your babies born early (before 37 weeks)? If yes, why? • Were you ever treated for or hospitalized for preterm labor? • Have any of your babies needed to stay in the hospital after you went home? If yes, why?		❒ N ❒ N ❒ N	❒ Y ❒ Y ❒ Y	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
6. Have you had any problems with previous pregnancies? Ex: a) Diabetes b) Excessive vomiting requiring intravenous hydration c) High blood pressure d) Bleeding after 12 weeks e) Other		 ❒ N ❒ N ❒ N ❒ N ❒ N	 ❒ Y ❒ Y ❒ Y ❒ Y ❒ Y	**A YES to any condition is considered high risk.**
7. How many of your babies were born by vaginal delivery? a) How many were born by C-Section? b) What type of delivery are you planning for this baby?	 ❒ Vaginal ❒ C-Section	 ❒ < 2	 ❒ ≥ 2	
8. Where are you planning to deliver your baby?	❒ Hospital ❒ Birthing Center ❒ Home			**Confirm use of a contracted facility at the end of the call and forward to CM if using non-contracted facility.**

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
9. Did you have any existing health problems prior to this pregnancy? Ex:				**A YES to any condition is considered HIGH RISK.**
a) Diabetes		❒ N	❒ Y	
b) High Blood Pressure		❒ N	❒ Y	
c) Asthma		❒ N	❒ Y	
d) Kidney Disease		❒ N	❒ Y	
e) Heart Disease		❒ N	❒ Y	
f) Frequent Bladder Infections		❒ N	❒ Y	
g) AIDS or HIV Infection		❒ N	❒ Y	
h) Sexually Transmitted Diseases		❒ N	❒ Y	
i) Surgery of the Uterus		❒ N	❒ Y	
j) Other		❒ N	❒ Y	
10. Have you ever had any problems with depression, anxiety disorders or other mental illness?		❒ N	❒ Y	
11. Have you had any problems or been hospitalized during this pregnancy? Ex:		❒ N	❒ Y	**A YES to any condition is considered HIGH RISK.**
a) Diabetes		❒ N	❒ Y	
b) Excessive vomiting requiring intravenous hydration		❒ N	❒ Y	
c) High blood pressure		❒ N	❒ Y	
d) Bleeding after 12 weeks		❒ N	❒ Y	
e) Other		❒ N	❒ Y	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
12. Is there any family history of babies with physical or mental problems?		❒ N	❒ Y	
13. We need to know if you are taking any other medications:				
a) Please tell us what medication(s) are recommended or prescribed by your doctor including PNV, Folic Acid, and Iron?	❒ NONE	❒ N	❒ Y	
b) Please tell us what over-the-counter drugs are you taking, such as Tylenol, Aspirin, sleeping aids, etc.?	❒ NONE	❒ N	❒ Y	
c) Herbal remedies?	❒ NONE	❒ N	❒ Y	
14. During the past year, have you used any tobacco products?		❒ N	❒ Y	
a) If yes, and you used cigarettes how many packs do you smoke per day?				
b) If you stopped smoking, when did you stop?				
c) Does anyone smoke in your house?	❒ Y ❒ N If YES, see comments			If anyone smokes at home, encourage smoking cessation or smoking outside away from baby.

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
15. In the past year how many alcoholic beverages did you average in a week? a) If yes, when was your last drink? b) If you do not drink, when did you stop?		❒ N	❒ Y	**Any number is considered HIGH RISK.**
16. Have you used recreational drugs in the last year? a) If no, when did you stop? b) If yes, what are you using? c) How often do you use it/them?		❒ N	❒ Y	**Examples: Cocaine, Marijuana, Ecstasy, and Heroin.**
17. Have you been referred to Women, Infants & Children (WIC)?	❒ Y ❒ N			**If NO, instruct to contact local WIC office.**
18. Do you feel you are eating a healthy diet for you and your baby? • If no, why?		❒ Y	❒ N	A healthy diet includes three meals a day with balanced amounts of fish and meats, fruits and vegetables as well as grains or rice.

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
19. How are you planning to feed your baby?	❒ Breast ❒ Bottle ❒ Both			
20. Pregnancy can be a difficult time. Do you feel you have a good support system available from family or friends? • Do you live with baby's father? • Parents • Other adults	(Check ALL that apply) ❒ Y ❒ N ❒ Y ❒ N ❒ Y ❒ N	❒ **Y**	❒ **N**	
21. Do you have any concerns about your safety or the safety of your baby? • If yes why?		❒ **N**	❒ **Y**	
22. Do you have any other concerns? • If yes, what are they?		❒ **N**	❒ **Y**	

Questions	Responses (Information Only)	LOW Risk	HIGH Risk	Comments
23. Are you receiving Comprehensive Perinatal Services Program (CPSP)? a) Was this offered? b) If not offered, would you like to receive CPSP services?	 ❒ Y ❒ N ❒ Y ❒ N	❒ Y	❒ N	**Medi-Cal Only. Do not rate for AIM or HF.**
24. Have you taken any classes related to pregnancy or child rearing? If YES, what have you taken?	❒ If NO, suggest the following: ❒ Breast Feeding ❒ Childbirth ❒ C/S Birth Class ❒ Infant Child Resuscitation ❒ Parenting ❒ Refresher Birth Class ❒ Sibling **FOR AIM MEMBERS:** ❒ Early Pregnancy Class			**For AIM, refer to Car Seat Program.**
25. Do you have a car seat for this baby?		❒ Y	❒ N	
26. Would you like our Health Education department to mail you information on pregnancy or other related health issues?	❒ Y ❒ N			**For Medi-Cal only.**

GUIDELINES TO CARE MANAGEMENT SCORING
(To be completed by the Perinatal Care Manager only.)

Risk Acuity Score: _____ R.N.: _____
(0 – 3)
Date: _____

Acuity Scoring	Category	Desk Top Reference
0	Low Risk	
1	Low/High Risk	
2	Moderate/High Risk	
3	High/High Risk	

CM Notes:

PCP:	
SECTION: Personnel	
POLICY AND PROCEDURE: **Staff Education Training**	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY

That all staff at PCP sites receive education/training regarding safety issues, information on Members' rights and other issues related to clinical procedures. This education/training should take place **initially upon hire, then annually** thereafter for those areas identified with an asterisk on the Checklist.

PROCEDURE:

I. NEW HIRE PROCESS

A. Upon hire, all new employees will receive training on safety, Members' rights and clinical procedures as outlined in the attached checklist.

B. Types of training may include, but is not limited to: new employee orientation, in-service training, instructional videos, educational materials, annual training renewal, etc.

C. Upon completion of each criterion within this education/training, the employee's supervisor will initial the Checklist with the corresponding date of completion. The supervisor's initials indicate the employee either stated or demonstrated an understanding of the education/training provided.

1. When all areas on the Checklist have been completed, the employee and the instructor will sign and date the Checklist, signifying the employee was knowledgeable of all criteria presented by the instructor.

2. A copy of the completed Checklist shall be kept in each employee's file. All records of education/training **need to be kept for three years**. ***Must be available onsite of each office/clinic at time of audit***

D. ANNUAL REVIEW

E. All employees must receive an annual renewal of all training/education identified with an asterisk on the Training Checklist.

F. Follow the same procedure as, described above, for the New Employee.

PCP:	
SECTION: Clinical Services	
POLICY AND PROCEDURE: Pharmaceutical Services	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The site will maintain competent, efficient and ethical Pharmaceutical Services according to state and federal statutes for the health and safety of its patients.

PROCEDURE:

A. Drugs and medication supplies are maintained secure to prevent unauthorized access.
   1. All drugs (including sample and over-the-counter), medication supplies, prescription pads and hazardous substances are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic (CA B&P Code, 4051.3). Keys to the locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32).

   **During business hours, the lockable space may remain unlocked ONLY if there is no access to this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over-the-counter), medication supplies, prescription pads and hazardous substances must be securely locked.

   2. Controlled drugs are stored separately from other drugs, in a secured, lockable space accessible ONLY to authorized personnel (including physicians, dentists, podiatrists, physician assistants, licensed nurses and pharmacists) (Control Substances Act, CFR 1301.75). There is no need for the controlled substances to be double locked.

   **Controlled substances include all Schedule I, II, III, IV and V substances listed in the CA Health and Safety Code, Sections 11053-11058.

   3. A dose-by-dose controlled substance distribution log in maintained, including:
      A. Date
      B. Provider's DEA number
      C. Name of controlled substance
      D. Original quantity of controlled substance
      E. Dose administered, Number of remaining doses
      F. Name of patient receiving controlled substance
      G. Name of authorized person dispensing controlled substance

B. Drugs are handled safely and stored appropriately.

1. Preparation:
   - Drugs are prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.
   - Drugs or medication supplies are considered "adulterated" if it contains any filthy, putrid or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351).
2. Storage:
   - Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs, as these items may potentially cause contamination.
   - Drugs are stored separately from test reagents, germicides, disinfectants and other household substances.
   - Drugs for external use are stored separately from drugs for internal use.
   - Drugs are stored under appropriate conditions of temperature, humidity and light, so that the identity, strength, quality and purity of the drug product are not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30°C (86°F) (Title22, Section 75037(d)).
3. Immunobiologics:
   - Vaccines are placed in a refrigerator or freezer (**not** on the door) immediately upon receipt on site and are stored according to specific instructions in the package insert for each vaccine.
   - Vaccines, such as DTP, DtaP, DT, Td, Hep A, Hep B, Enhanced Inactive Polio (E-IPV), and Pneumococcal, are kept in a refrigerator maintained at 2°- 8°C, or 35°- 46°F (at time of visit). [MMR and varicella are protected from light at all times, and kept cold]. Oral polio vaccine (OPV), MMR, MMRV and varicella vaccines are stored in a freezer maintained at -15°C, or 5°F, or lower (at time of visit). Failure to adhere to recommended specifications for storage and handling immunobiologics could make these products impotent.
   - Refrigerator and freezer temperatures must be checked at least once a day and documented (U.S. Pharmacopeial Convention Regulations and Recommendations). However, the CA DHCS Immunization Branch recommends checking temperatures twice a day, first thing in the morning and last thing at night. (See Attachments)
   - The most current Vaccine Information Statements (VIS) are available from state and local health departments or can be downloaded from the CDC website at www.cdc.gov/nip/publications/VIS or by calling the CDC Immunization Hotline at 800-232-2522.
4. Hazardous substances (Substances that are physical or health hazards):
   - Safety practices on site are followed in accordance with current/updated CAL-OSHA standards.

- The manufacturer's label is not removed from a container as long as the hazardous material (or residues from the material) remains in the container.
- All portable containers of hazardous chemicals and secondary containers (into which hazardous substances are transferred or prepared) require labeling. Hazardous substances are appropriately labeled with the following information:
  a. Identity of hazardous substance
  b. Description of hazard warning: can be words, pictures, symbols
  c. Date of preparation or transfer

  ****Exception:** Labeling is NOT required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. ******
- Site has method(s) in place for drug and hazardous substance disposal. Proper disposal is via the site's contracted/licensed medical waste hauler.

C. Drugs are dispensed according to State and Federal drug distribution laws and regulations.

1. Drug Expiration:
   - There are no expired drugs on site, as they may not be distributed or dispensed.
   - The manufacturer's expiration date must appear on the label of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired.
   - If a drug is reconstituted at the time of dispensing, its label must contain expiration information for both the reconstituted and unconstituted drug.
   - Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas. Must be done AT LEAST monthly. A log is preferred, but it is acceptable to clearly mark the outside of the drug packages with the expiration date.
2. Prescription Labeling
   - All stored and dispensed prescription drugs are appropriately labeled with:
     a. Provider's name
     b. Patient's name
     c. Drug name
     d. Dose
     e. Frequency
     f. Route
     g. Quantity dispensed
     h. Manufacturer's name and lot number

3. Drug Dispensing and Administration
    - Each prescription medication is dispensed in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)).
    - Drug dispensing is in compliance with all applicable State and Federal laws and regulations. Drugs are not offered for sale, charged or billed to Medi-Cal members (Business and Professions Code, Article 13, Section 4193).
    - Drugs are dispensed **ONLY** by a physician, pharmacist or other persons (i.e. NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. **Personnel, such as medical assistants, office managers, and receptionists, DO NOT DISPENSE DRUGS**.
    - California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, Sections 4170,4171).
    - Administration of medications ordered by the licensed practitioner may be completed by the MA using the following procedures:
        - Prepare Medication in a clean area
        - Have the ordering practitioner or another licensed practitioner (i.e. MD, NP, PA, CNM, RN, LVN) verify the medication and dosage prior to administration of the drug.
            - Showing the checking practitioner the bottle or vial and medicine cup or syringe,
            - If the practitioner checking the medication is not the practitioner that ordered the drug show the checking practitioner the patient's chart with the original order.
            - Administer to the patient only after a licensed practitioner has checked the prepared medication.

      Note: No MA may administer any anesthetic agent or any medication mixed with an anesthetic agent (e.g. Rocephin diluted with Xylocaine).

4. Vaccine Information Statements (VIS)
    - Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccines are administered. Health care providers **must** give a copy of the most recent VIS to patients prior to each vaccination dose of DTaP, Td, MMR, IPV, Hep B, Hib, Varicella and Pneumococcal Conjugate. VISs for other vaccines are available through the CDC website referred to previously.

- VIS for distribution to patients are present on site. Site personnel should be able to verbalize standard practices regarding VIS distribution.
- The *date the VIS was given* **and** *the publication date of the VIS* **MUST** be documented in the patient's medical record.

5. Pharmacy:
   - If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy, with a licensed pharmacist monitoring drug distribution and current policies/procedures for drug storage and dispensing.

*****Note: All site review survey deficiencies related to Pharmaceutical Services REQUIRE a corrective action plan. *****

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: □ PCP □ Specialist □ Ancillary	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIORBUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIORBUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

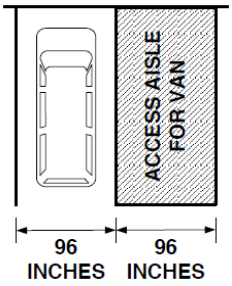
I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

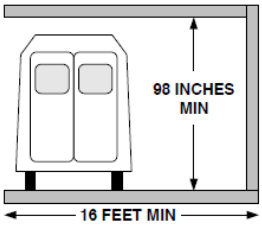
Name: _____ Signature: _____ Date: _____

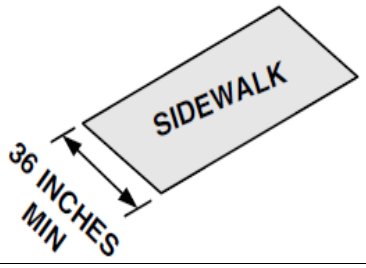
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle. 				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

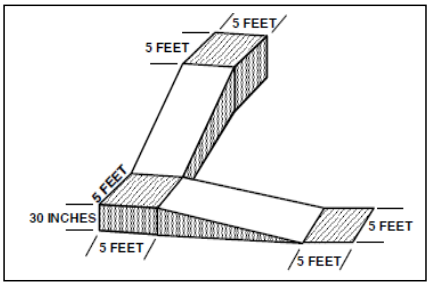
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.				

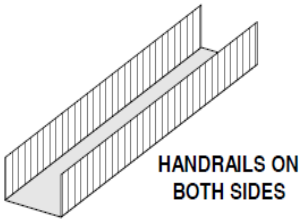
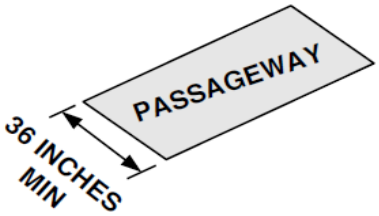
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	**Is VAN accessible parking provided?**	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

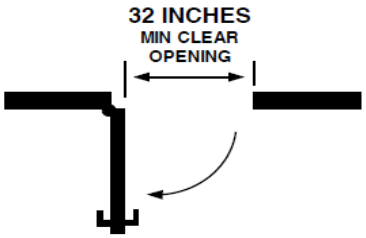
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following:(Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

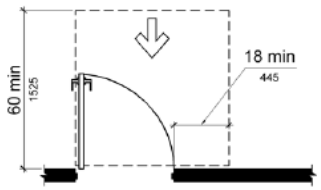
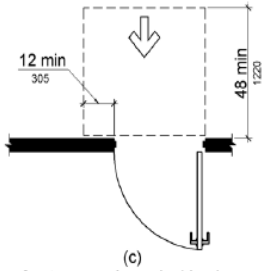
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

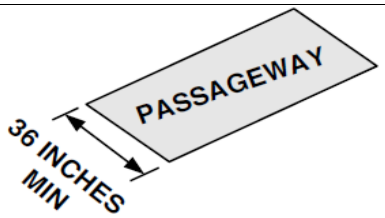
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23 (CE)	**Are all ramps at least 36 inches wide?**	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

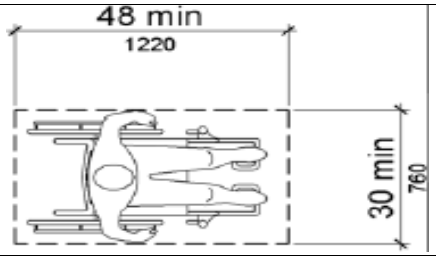
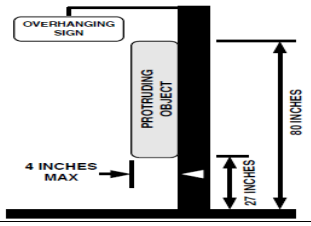
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

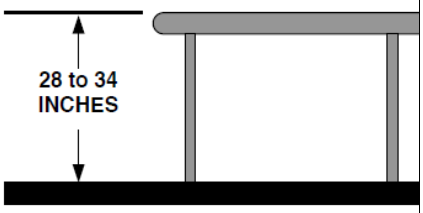
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trashcans, merchandise, etc., located in these areas, they must be removed or relocated.				

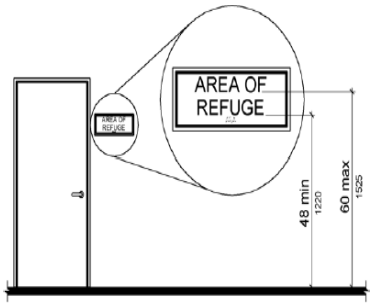
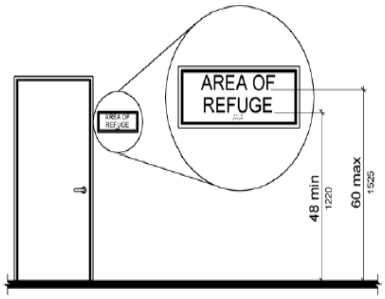
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed fist or fully open hand?Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				

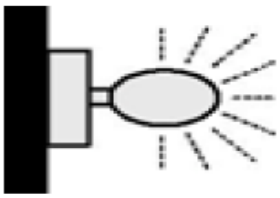
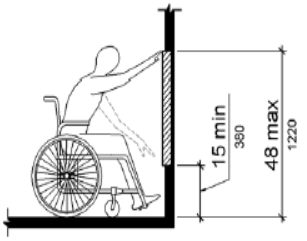
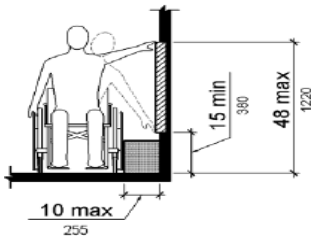
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				
34 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
35	Is the interior accessible routestable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
37 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	If there are no stairs, check NA.				
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	**If a platform lift is used, can it be used without assistance?**	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

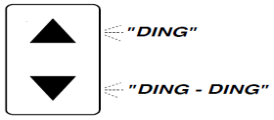
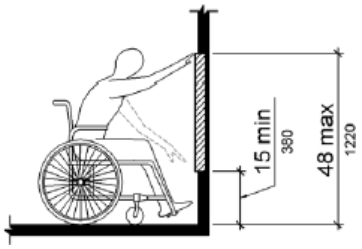
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

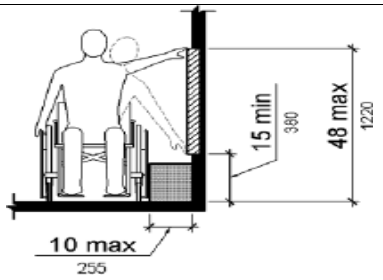
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

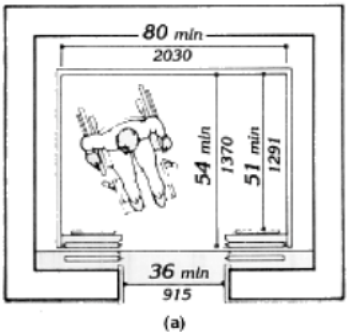
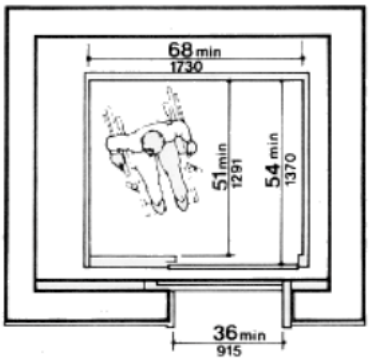
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	Self explanatory.				

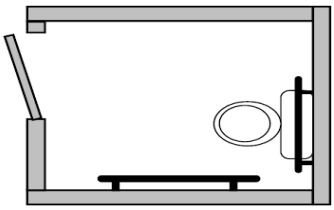
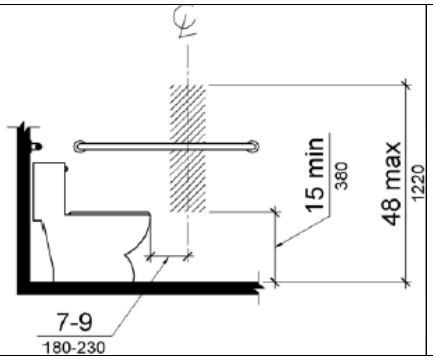
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.  				
55 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**	 				

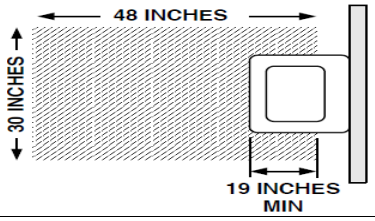
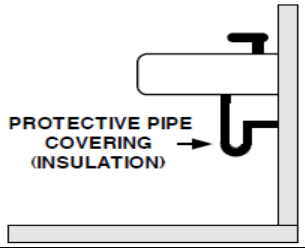
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

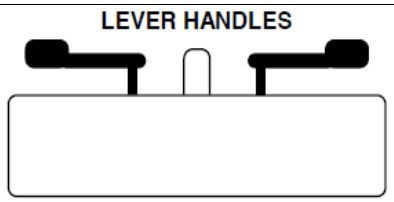
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				

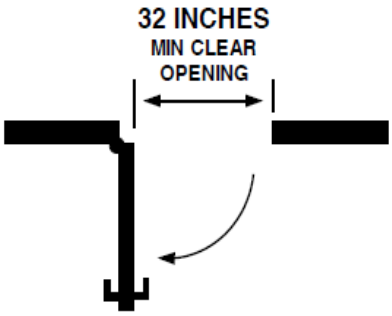
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

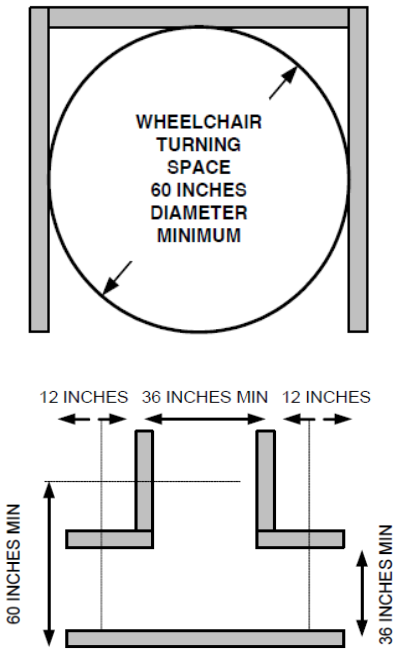
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

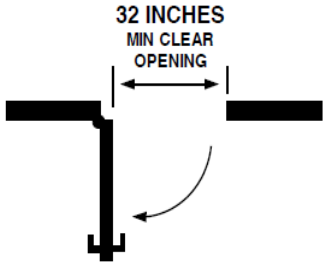
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:** **Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					

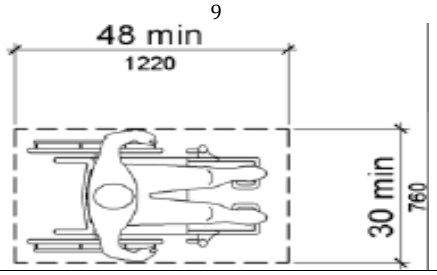
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible.				

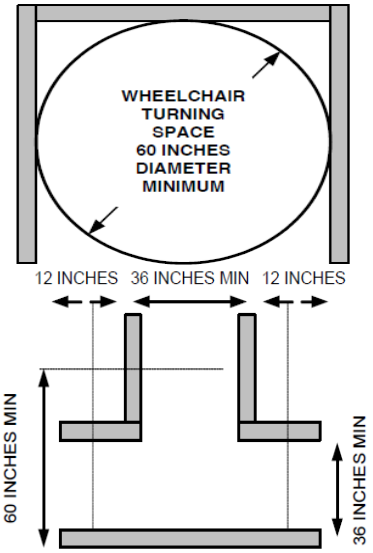
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITHOUT STALLS					
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA. 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
78	Is the space inside the accessible stall clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	**Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**	9 				
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"
© Copyright 2008
Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

Non-Emergency Medical Transportation (NEMT) Request

The Department of Health Care Services (DHCS) requires that a Physician Certification Statement (PCS) form be used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. Health Net requires the submission of this PCS form, signed by a qualified provider when requesting NEMT services.

1. This certification is valid for up to one year from the date of the provider's signature.
2. Please fax the completed and signed form to Health Net at: **Health Net's Care Ride Unit at 833-701-0051**
3. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) **do not require the submission of this form**. Members requesting NMT services should be directed to call Health Net's Customer Service Department **at 800-675-6110 and choose the Transportation option.**
4. Any section marked with an "*" is a mandatory section and must be completed prior to sending to Health Net.
5. Please note, Medi-Cal managed care plans (MCP) are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (wheelchair van).

*Patient Information Required

First name:	Last name:		Date of birth:
ID number / CIN#:			Phone number:
Address:			Caregiver name:
City:	State:	ZIP:	Caregiver phone:

*Requesting Provider Information Required

Provider full name and title (print):		Tax ID:
Phone number:	Fax number:	Provider NPI:

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION and SIGNATURE REQUIRED

No changes can be made by Health Net or the transportation vendor after it has been submitted by the approved provider. Once the PCS form is submitted, neither Health Net nor the transportation vendor can modify without a new PCS form being sent from the physician or other provider.

*Mode of Transportation needed. Check one box below. Refer to page 2 for the medical necessity criteria per mode of transportation

Ambulance type: ☐ Basic Life Support (A0428) ☐ Advance Life Support (A0426) ☐ Specialty Care Transport (A0434)	☐ Litter/gurney van (T2005) If bariatric litter is required, include: Height:____ Weight:____	☐ Wheelchair van (A0130) If bariatric wheelchair is required, include: Height:_____ Weight:_____	☐ Air transport (A0430 or A0431) Requires prior authorization through Health Net

*NEMT Anticipated duration required (based on continued Health Plan eligibility)

Start date: _____ ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (chronic condition only)

*Physical and medical limitations related to this request - Please check ALL items that apply

☐ Behavioral issues ☐ Blind ☐ Dementia ☐ Extensive medical support required (e.g., ventilator, IV, oxygen required) ☐ Hemiplegic ☐ Hemodialysis ☐ High fall risk due to: _____(please specify) ☐ Paraplegic	☐ Other (please specify other functional or physical limitations)

*Diagnosis Information

ICD-10 Codes	1.	2.	3.	4.

***Please CHECK the only approved types of providers that can sign this form:**
This form **must be signed** by a ☐ physician ☐ nurse practitioner ☐ physician assistant ☐ certified nurse midwife ☐ dentist ☐ mental health professional ☐ substance use disorder provider

Certification Statement: As the provider responsible for providing care to the member listed above and responsible for determining medical necessity of transportation consistent with the scope of their practice, by my signature, I certify that medical necessity criteria was used to determine the type of transport being requested.

***Signature and title required:**	**Date:**

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25-183 (2/25)

Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

health net

<u>DO NOT</u> fax this page back to Health Net – Reference sheet only

Mode of transportation	Criteria
Wheelchair van Must meet one (1) of the bulleted criteria	Wheelchair van services are covered when the patient's medical and physical condition: (A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport. (B) 1. Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation. 2. Local educational agency (LEA) specialized medical transportation services shall not be subject to subsection (a)(3)(B)1. (C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (D) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Gurney/Stretcher van/ Litter van Must meet both of the bulleted criteria	Litter van services are covered when the patient's medical and physical condition: (A) 1. Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport. 2. LEA specialized medical transportation services shall not be subject to subsection (a)(2)(A)1. (B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Ambulance levels of service (BLS, ALS SCT) Please select correct ambulance type for the member's condition	(A) **<u>Basic Life Support</u>** 1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation 2. Transfers from an acute care facility to another acute care facility 3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) 4. Transport for members with chronic conditions who require more than 5L of oxygen if monitoring is required 5. Transport from hospital to psychiatric facility (B) **<u>Advanced Life Support</u>** 1. Transport from hospital to hospital with a cardiac monitor (C) **<u>Specialty Care Transport</u>** 1. Transport from hospital to hospital when members require vent, respiratory therapist, or deep suctioning. 2. Transport from hospital to SNF/residence when members require vent, respiratory therapist, or deep suctioning. 3. Transport to an appointment when members require vent, respiratory therapist, or deep suctioning. 4. Transport from hospital to hospital for members that require continuous intravenous medication
Air transport Clinical documentation required	Medical transportation by air is covered under the following conditions: (A) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply: 1. The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1). 2. The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1). (B) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

CalViva HEALTH health net

Non-Emergency Medical Transportation (NEMT) Request

The Department of Health Care Services (DHCS) requires that a Physician Certification Statement (PCS) form be used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. Health Net requires the submission of this PCS form, signed by a qualified provider when requesting NEMT services.

1. This certification is valid for up to one year from the date of the provider's signature.
2. Please fax the completed and signed form to Health Net at: **Health Net's Care Ride Unit at 833-701-0051**
3. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) **do not require the submission of this form**. Members requesting NMT services should be directed to call Health Net's Customer Service Department **at 800-675-6110 and choose the Transportation option.**
4. Any section marked with an "*" is a mandatory section and must be completed prior to sending to Health Net.
5. Please note, Medi-Cal managed care plans (MCP) are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (wheelchair van).

*Patient Information Required

First name:	Last name:		Date of birth:
ID number / CIN#:			Phone number:
Address:			Caregiver name:
City:	State:	ZIP:	Caregiver phone:

*Requesting Provider Information Required

Provider full name and title (print):		Tax ID:
Phone number:	Fax number:	Provider NPI:

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION and SIGNATURE REQUIRED

No changes can be made by Health Net or the transportation vendor after it has been submitted by the approved provider. Once the PCS form is submitted, neither Health Net nor the transportation vendor can modify without a new PCS form being sent from the physician or other provider.

*Mode of Transportation needed. Check one box below. Refer to page 2 for the medical necessity criteria per mode of transportation

Ambulance type: ☐ Basic Life Support (A0428) ☐ Advance Life Support (A0426) ☐ Specialty Care Transport (A0434)	☐ Litter/gurney van (T2005) If bariatric litter is required, include: Height:____ Weight:____	☐ Wheelchair van (A0130) If bariatric wheelchair is required, include: Height:_____ Weight:_____	☐ Air transport (A0430 or A0431) Requires prior authorization through Health Net

*NEMT Anticipated duration required (based on continued Health Plan eligibility)

Start date: _____ ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (chronic condition only)

*Physical and medical limitations related to this request - Please check ALL items that apply

☐ Behavioral issues ☐ Blind ☐ Dementia ☐ Extensive medical support required (e.g., ventilator, IV, oxygen required) ☐ Hemiplegic ☐ Hemodialysis ☐ High fall risk due to: _____(please specify) ☐ Paraplegic	☐ Other (please specify other functional or physical limitations)

*Diagnosis Information

ICD-10 Codes	1.	2.	3.	4.

***Please CHECK the only approved types of providers that can sign this form:**
This form **must be signed** by a ☐ physician ☐ nurse practitioner ☐ physician assistant ☐ certified nurse midwife ☐ dentist ☐ mental health professional ☐ substance use disorder provider

Certification Statement: As the provider responsible for providing care to the member listed above and responsible for determining medical necessity of transportation consistent with the scope of their practice, by my signature, I certify that medical necessity criteria was used to determine the type of transport being requested.

***Signature and title required:**	**Date:**

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. Confidentiality note for fax transmission: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments. If you no longer wish to receive fax notices from Provider Communications, please email us at provider.communications@healthnet.com indicating the fax number(s) covered by your request. We will comply with your request within 30 days or less.
25-184 (2/25)

Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

<u>DO NOT</u> fax this page back to Health Net – Reference sheet only

Mode of transportation	Criteria
Wheelchair van Must meet one (1) of the bulleted criteria	Wheelchair van services are covered when the patient's medical and physical condition: (A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport. (B) 1. Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation. 2. Local educational agency (LEA) specialized medical transportation services shall not be subject to subsection (a)(3)(B)1. (C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (D) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Gurney/Stretcher van/ Litter van Must meet both of the bulleted criteria	Litter van services are covered when the patient's medical and physical condition: (A) 1. Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport. 2. LEA specialized medical transportation services shall not be subject to subsection (a)(2)(A)1. (B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Ambulance levels of service (BLS, ALS SCT) Please select correct ambulance type for the member's condition	(A) **<u>Basic Life Support</u>** 1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation 2. Transfers from an acute care facility to another acute care facility 3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) 4. Transport for members with chronic conditions who require more than 5L of oxygen if monitoring is required 5. Transport from hospital to psychiatric facility (B) **<u>Advanced Life Support</u>** 1. Transport from hospital to hospital with a cardiac monitor (C) **<u>Specialty Care Transport</u>** 1. Transport from hospital to hospital when members require vent, respiratory therapist, or deep suctioning. 2. Transport from hospital to SNF/residence when members require vent, respiratory therapist, or deep suctioning. 3. Transport to an appointment when members require vent, respiratory therapist, or deep suctioning. 4. Transport from hospital to hospital for members that require continuous intravenous medication
Air transport Clinical documentation required	Medical transportation by air is covered under the following conditions: (A) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply: 1. The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1). 2. The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1). (B) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

Non-Emergency Medical Transportation (NEMT) Request

The Department of Health Care Services (DHCS) requires that a Physician Certification Statement (PCS) form be used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. Health Net requires the submission of this PCS form, signed by a qualified provider when requesting NEMT services.

1. This certification is valid for up to one year from the date of the provider's signature.
2. Please fax the completed and signed form to Health Net at: **Health Net's Care Ride Unit at 833-701-0051**
3. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) **do not require the submission of this form**. Members requesting NMT services should be directed to call Health Net's Customer Service Department **at 800-675-6110 and choose the Transportation option.**
4. Any section marked with an "*" is a mandatory section and must be completed prior to sending to Health Net.
5. Please note, Medi-Cal managed care plans (MCP) are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (wheelchair van).

*Patient Information Required

First name:	Last name:		Date of birth:
ID number / CIN#:			Phone number:
Address:			Caregiver name:
City:	State:	ZIP:	Caregiver phone:

*Requesting Provider Information Required

Provider full name and title (print):		Tax ID:
Phone number:	Fax number:	Provider NPI:

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION and SIGNATURE REQUIRED

No changes can be made by Health Net or the transportation vendor after it has been submitted by the approved provider. Once the PCS form is submitted, neither Health Net nor the transportation vendor can modify without a new PCS form being sent from the physician or other provider.

*Mode of Transportation needed. Check one box below. Refer to page 2 for the medical necessity criteria per mode of transportation

Ambulance type: ☐ Basic Life Support (A0428) ☐ Advance Life Support (A0426) ☐ Specialty Care Transport (A0434)	☐ Litter/gurney van (T2005) If bariatric litter is required, include: Height:____ Weight:____	☐ Wheelchair van (A0130) If bariatric wheelchair is required, include: Height:_____ Weight:_____	☐ Air transport (A0430 or A0431) Requires prior authorization through Health Net

*NEMT Anticipated duration required (based on continued Health Plan eligibility)

Start date: _____ ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (chronic condition only)

*Physical and medical limitations related to this request - Please check ALL items that apply

☐ Behavioral issues ☐ Blind ☐ Dementia ☐ Extensive medical support required (e.g., ventilator, IV, oxygen required) ☐ Hemiplegic ☐ Hemodialysis ☐ High fall risk due to: _____(please specify) ☐ Paraplegic	☐ Other (please specify other functional or physical limitations)

*Diagnosis Information

ICD-10 Codes	1.	2.	3.	4.

***Please CHECK the only approved types of providers that can sign this form:**
This form **must be signed** by a ☐ physician ☐ nurse practitioner ☐ physician assistant ☐ certified nurse midwife ☐ dentist ☐ mental health professional ☐ substance use disorder provider

Certification Statement: As the provider responsible for providing care to the member listed above and responsible for determining medical necessity of transportation consistent with the scope of their practice, by my signature, I certify that medical necessity criteria was used to determine the type of transport being requested.

***Signature and title required:**	**Date:**

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.
CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by phone or by return fax and destroy this transmission, along with any attachments. If you no longer wish to receive fax notices from Provider Communications, please email us at provider.communications@healthnet.com indicating the fax number(s) covered by your request. We will comply with your request within 30 days or less.
26-380 (3/26)

Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

DO NOT fax this page back to Health Net – Reference sheet only

Mode of transportation	Criteria
Wheelchair van Must meet one (1) of the bulleted criteria	Wheelchair van services are covered when the patient's medical and physical condition: (A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport. (B) 1. Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation. 2. Local educational agency (LEA) specialized medical transportation services shall not be subject to subsection (a)(3)(B)1. (C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (D) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Gurney/Stretcher van/ Litter van Must meet both of the bulleted criteria	Litter van services are covered when the patient's medical and physical condition: (A) 1. Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport. 2. LEA specialized medical transportation services shall not be subject to subsection (a)(2)(A)1. (B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
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Air transport Clinical documentation required	Medical transportation by air is covered under the following conditions: (A) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply: 1. The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1). 2. The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1). (B) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

PCP:	Page 1 of 2
SECTION: Personnel	
POLICY AND PROCEDURE: Staff Qualifications	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
All professional health care personnel must have current California licenses and certifications and must be qualified and trained for assigned responsibilities.

PROCEDURE:
I. HEALTH CARE LICENSE AND CERTIFICATION REQUIREMENTS

A. All medical professional licenses and certifications must be current and issued from the appropriate agency to practice in California. Copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.

Medical Professional	License/Certification	Issuing Agency
Certified Nurse Midwife	RN License and Nurse-Midwife certificate	CA Board of Registered Nursing
Certified Radiological Technologist (CRT)	CRT Certificate	CA Department of Public Health (Radiological Branch)
Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate, DEA Registration	Osteopathic Medical Board of CA, Drug Enforcement Administration
Licensed Vocational Nurse (LVN)	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
Nurse Practitioner (NP)	RN License with NP Certification and Furnishing Number	CA Board of Registered Nursing
Pharmacist (Pharm.D)	Pharmacist License	CA State Board of Pharmacy
Physician/Surgeon (MD)	Physician's & Surgeon's Certificate, DEA Registration	Medical Board of CA, Drug Enforcement Administration
Physician's Assistant (PA)	PA License	Physician Assistant Examining Committee / Medical Board of CA
Radiological Technician	Limited Permit	CA Department of Health Care Services (Radiological Branch)
Registered Dietitian	RD Registration Card	Commission on Dietetic Registration
Registered Nurse	RN license	CA Board of Registered Nursing

II. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license type, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

III. TRAINING OF SITE PERSONNEL

A. Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

B. Provider and staff must be able to demonstrate operation of medical equipment used in their scope of work.

Notice To Consumers Regulation

Effective June 27, 2010, a new regulation, mandated by Business and Professions Code section 138, will go into effect requiring physicians in California to inform their patients that they are licensed by the Medical Board of California, and include the board's contact information. The information must read as follows.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

The purpose of this new requirement (Title 16, California Code of Regulations section 1355.4) is to inform consumers where to go for information or with a complaint about California medical doctors.

- Physicians may provide this notice by one of three methods:
- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font. (See link "Sign for printing", below, to print the actual notice.)
- Including the notice in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician is licensed and regulated by the board.
- Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

For more information, please contact Frank Miller, at frank.miller@mbc.ca.gov or (916) 263-2480.
Sign for printing: http://www.mbc.ca.gov/licensee/notice_to_consumers_regulation_Sample_sign.pdf

PCP:	Page 1 of 2
SECTION: Infection Control	
POLICY AND PROCEDURE: Standard and Universal Precautions	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:

Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel will apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

PROCEDURE:

I. HAND WASHING FACILITIES

A. Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030).

B. Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995).

II. ANTISEPTIC HAND CLEANER

A. Antimicrobrial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

III. WASTE DISPOSAL CONTAINER

A. Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children.

IV. ISOLATION PROCEDURES

A. Personnel are able to demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient.

Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Do not photocopy this form. The information contained is confidential and peer-review protected.

Check one:

☐ Medical/physical medicine PQIs (Complete all fields and forward immediately **via secure fax: 877-808-7024**)
☐ Behavioral health PQIs (Complete all fields and forward immediately **via secure email: pqi@healthnet.com**)

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

Important

The PQI Referral Form is a confidential document used by the Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to CalViva Health enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner.

Refer issues identified as *member appeals* or *member grievances* to the Member Appeals and Grievances Department for appropriate case handling and resolution.

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

Referral Content

1. All the fields on the PQI form are **required** fields.
2. Use the fillable PDF form to complete the PQI referral. Do not fax a handwritten PQI referral form. Handwritten PQI forms will be returned to originator for proper re-submission.
3. All sections of the PQI referral must be completed.
4. The form should be completed as follows:
    a) Referral source - Include referral date, first and last name of the associate completing the referral, contact information (telephone number, fax number) and the name of the associate who identified the PQI. If same as the referred by, enter *same as referred by* in this section.
    b) Member demographics – Include member first and last name, member ID, member's current primary care physician (PCP) and the associated participating physician group (PPG).
    c) PQI Event Dates / Filed Against Details – Include date of event, first and last name of practitioner that PQI is filed against (if same as PCP, re-enter PCP and PPG name here) and practitioner's office location. If hospital, please include name of hospital and location. Provide an admission date. Indicate the type of PQI using the check box items provided on the PQI referral. In the description of event field, describe event(s) chronologically, including dates, provider or practitioner names, specify any equipment or medication involved, quote relevant statements made by the provider or others and provide a complete explanation describing the potential deviation in the standard of care.
5. Complete and submit this report directly within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
6. Incomplete referral forms are returned to the associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

REFERRAL SOURCE

Referral date: _____

Referred by *(First, Last Name)*: _____

Identified by *(First, Last Name)*: _____

Phone number: _____

Fax number: _____

MEMBER DEMOGRAPHICS

Member name *(Last, First, MI)*: _____

ID#: _____

Current primary care physician (PCP): _____

Current participating physician group (PPG): _____

PQI EVENT DATES

Date(s) of PQI event: _____

Admission date: _____

Prior admission dates (if applicable): _____

_____

FILED AGAINST DETAILS:

Provider/Practitioner name: *(First, Last or name of facility)*: _____

Associated Provider/Practitioner PPG: _____

Provider/Practitioner location: _____

Provider/Practitioner NPI#: _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Surgical events:

- ☐ **Surgery on wrong body part**
- ☐ **Surgery on wrong patient**
- ☐ **Wrong surgical procedures on a patient**
- ☐ **Foreign object retained after surgery**
- ☐ Anesthesia adverse event
- ☐ **Surgery with post-operative/intra-operative death in a normal healthy patient**
- ☐ Acute MI or CVA within 48 hours after elective surgery
- ☐ Cardiac or respiratory arrest in the operating room (OR)
- ☐ Unplanned return to OR, unplanned removal, injury or repair of an organ
- ☐ Other (explain) _____

Surgical site/post-operative infections:

- ☐ **Mediastinitis after coronary artery bypass graft (CABG)**
- ☐ **Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)**
- ☐ **Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip**
- ☐ Other (explain) _____

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Patient death/disability:

- ☐ Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- ☐ Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- ☐ Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended
- ☐ Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- ☐ Unexpected death (Please explain) _____

Patient issue:

- ☐ Member leaves against medical advice (AMA) when there is a potential for serious adverse event(s)
- ☐ Patient suicide attempt or serious injury to self while in treatment
- ☐ Other (explain) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Hospital-acquired (nosocomial) infections:

- ☐ **Catheter-associated urinary tract infection (UTI)**
- ☐ **Vascular catheter-associated Infection**
- ☐ Other (explain)_____

Deep vein thrombosis or pulmonary embolism following orthopedic procedures:

- ☐ **Total knee replacement**
- ☐ **Total hip replacement**
- ☐ Other (explain) _____

Falls (with trauma):

- ☐ **Fractures**
- ☐ **Dislocations**
- ☐ **Intracranial injuries**
- ☐ Other (explain)_____

Injury:

- ☐ **Crushing injuries**
- ☐ **Burns**
- ☐ **Electric shock**
- ☐ Other (explain) _____

Manifestations of poor glycemic control:

- ☐ **Diabetic ketoacidosis**
- ☐ **Nonketotic hyperosmolar coma**
- ☐ **Hypoglycemic coma**
- ☐ **Secondary diabetes with ketoacidosis**
- ☐ **Secondary diabetes with hyperosmolarity**

Obstetrics:

- ☐ Nonmedically indicated (elective) delivery less than 39 weeks gestational age
- ☐ Newborn Apgar < 4 at 1 minute or < 6 at 5 minutes

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Admission/readmission/discharge:

- ☐ Unexpected / unanticipated readmission within 30 days to acute level of care with same or similar diagnosis or as a complication of the previous admission
- ☐ Unplanned admission following diagnostic test or outpatient procedure
- ☐ Neurological deficit present at discharge not present on admit
- ☐ Delay in transfer/treatment or discharge – which results in a poor outcome to the member or additional costs to the plan
- ☐ Delayed diagnosis or missed diagnosis – resulting in adverse member outcome or extended hospital stay
- ☐ **Infant discharged to the wrong person**

Outpatient/ambulatory care:

- ☐ Breach of member confidentiality or ethics concern/violation
- ☐ Abnormal diagnostic study not followed up appropriately where the potential for adverse outcome exists
- ☐ Inattention to or lack of appropriate follow-up of consultant's major recommendations without appropriate rationale
- ☐ Practitioner's failure to follow-up on any member's significant complaint or physical finding within a reasonable period of time
- ☐ Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
- ☐ Hospitalization resulting from inappropriate drug therapy

Other:

- ☐ Pressure ulcer stages III & IV occurring after hospital admission
- ☐ Air embolism
- ☐ Blood transfusion incompatibility
- ☐ Any substandard care with the potential for harm to the member (please explain fully) _____
- ☐ Member refused to file a grievance
- ☐ Grievance withdrawal
- ☐ Other (select only when no other selection is applicable and explain fully) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS	BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Behavioral health:

- ☐ Inadequate assessment
- ☐ Inadequate treatment strategy or intervention
- ☐ Quality of patient relationship with provider appears very poor
- ☐ Inadequate discharge planning or follow-up
- ☐ Failure to utilize appropriate collateral contacts and/or coordinate care
- ☐ Lack of timely intervention that doesn't involve medication
- ☐ Patient's condition requires medication evaluation, but no referral was made
- ☐ Incident of drug/alcohol use in a facility
- ☐ Incident of possession of a weapon in a facility
- ☐ Situation where provider/facility acted in such a way as to create potential safety concerns
- ☐ Patient assaulting or causing serious injury to other or other criminal activity
- ☐ Use of restrictive interventions (seclusion, restraints, isolation) inconsistent with accepted standards and regulations
- ☐ Clinical risk inadequately assessed or managed
- ☐ Medication error, incident or concern
- ☐ Alleged abuse of child, adolescent or elder not reported to appropriate authorities

Description of event:
Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary – must be typed, not handwritten):

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Do not photocopy this form. The information contained is confidential and peer-review protected.

Check one:

☐ Medical/physical medicine PQIs (Complete all fields and forward immediately **via secure fax: 877-808-7024**)
☐ Behavioral health PQIs (Complete all fields and forward immediately **via secure email: pqi@healthnet.com**)

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

Important

The PQI Referral Form is a confidential document used by the Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to Community Health Plan of Imperial Valley enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner.

Refer issues identified as *member appeals* or *member grievances* to the Member Appeals and Grievances Department for appropriate case handling and resolution.

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

Referral Content

1. All the fields on the PQI form are **required** fields.
2. Use the fillable PDF form to complete the PQI referral. Do not fax a handwritten PQI referral form. Handwritten PQI forms will be returned to originator for proper re-submission.
3. All sections of the PQI referral must be completed.
4. The form should be completed as follows:
    a) Referral source - Include referral date, first and last name of the associate completing the referral, contact information (telephone number, fax number) and the name of the associate who identified the PQI. If same as the referred by, enter *same as referred by* in this section.
    b) Member demographics – Include member first and last name, member ID, member's current primary care physician (PCP) and the associated participating physician group (PPG).
    c) PQI Event Dates / Filed Against Details – Include date of event, first and last name of practitioner that PQI is filed against (if same as PCP, re-enter PCP and PPG name here) and practitioner's office location. If hospital, please include name of hospital and location. Provide an admission date. Indicate the type of PQI using the check box items provided on the PQI referral. In the description of event field, describe event(s) chronologically, including dates, provider or practitioner names, specify any equipment or medication involved, quote relevant statements made by the provider or others and provide a complete explanation describing the potential deviation in the standard of care.
5. Complete and submit this report directly within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
6. Incomplete referral forms are returned to the associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

REFERRAL SOURCE

Referral date: _____

Referred by *(First, Last Name)*: _____

Identified by *(First, Last Name)*: _____

Phone number: _____

Fax number: _____

MEMBER DEMOGRAPHICS

Member name *(Last, First, MI)*: _____

ID#: _____

Current primary care physician (PCP): _____

Current participating physician group (PPG): _____

PQI EVENT DATES

Date(s) of PQI event: _____

Admission date: _____

Prior admission dates (if applicable): _____

_____

FILED AGAINST DETAILS:

Provider/Practitioner name: *(First, Last or name of facility)*: _____

Associated Provider/Practitioner PPG: _____

Provider/Practitioner location: _____

Provider/Practitioner NPI#: _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Surgical events:

- ☐ **Surgery on wrong body part**
- ☐ **Surgery on wrong patient**
- ☐ **Wrong surgical procedures on a patient**
- ☐ **Foreign object retained after surgery**
- ☐ Anesthesia adverse event
- ☐ **Surgery with post-operative/intra-operative death in a normal healthy patient**
- ☐ Acute MI or CVA within 48 hours after elective surgery
- ☐ Cardiac or respiratory arrest in the operating room (OR)
- ☐ Unplanned return to OR, unplanned removal, injury or repair of an organ
- ☐ Other (explain) _____

Surgical site/post-operative infections:

- ☐ **Mediastinitis after coronary artery bypass graft (CABG)**
- ☐ **Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)**
- ☐ **Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip**
- ☐ Other (explain) _____

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Patient death/disability:

- ☐ Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- ☐ Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- ☐ Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended
- ☐ Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- ☐ Unexpected death (Please explain) _____

Patient issue:

- ☐ Member leaves against medical advice (AMA) when there is a potential for serious adverse event(s)
- ☐ Patient suicide attempt or serious injury to self while in treatment
- ☐ Other (explain) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Hospital-acquired (nosocomial) infections:

- ☐ **Catheter-associated urinary tract infection (UTI)**
- ☐ **Vascular catheter-associated Infection**
- ☐ Other (explain)_____

Deep vein thrombosis or pulmonary embolism following orthopedic procedures:

- ☐ **Total knee replacement**
- ☐ **Total hip replacement**
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Falls (with trauma):

- ☐ **Fractures**
- ☐ **Dislocations**
- ☐ **Intracranial injuries**
- ☐ Other (explain)_____

Injury:

- ☐ **Crushing injuries**
- ☐ **Burns**
- ☐ **Electric shock**
- ☐ Other (explain) _____

Manifestations of poor glycemic control:

- ☐ **Diabetic ketoacidosis**
- ☐ **Nonketotic hyperosmolar coma**
- ☐ **Hypoglycemic coma**
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Obstetrics:

- ☐ Nonmedically indicated (elective) delivery less than 39 weeks gestational age
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- ☐ Neurological deficit present at discharge not present on admit
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Outpatient/ambulatory care:

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- ☐ Hospitalization resulting from inappropriate drug therapy

Other:

- ☐ Pressure ulcer stages III & IV occurring after hospital admission
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- ☐ Alleged abuse of child, adolescent or elder not reported to appropriate authorities

Description of event:
Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary – must be typed, not handwritten):

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

Potential Quality Issue (PQI) Referral Form

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6. Incomplete referral forms are returned to the associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

Referral Source

Referral date:_____

Referred by *(First, Last Name)*: _____

Identified by *(First, Last Name)*: _____

Phone number: _____

Fax number: _____

Member Demographics

Member name *(Last, First, MI)*: _____

ID#: _____

Current primary care physician (PCP): _____

Current participating physician group (PPG): _____

PQI Event Dates

Date(s) of PQI event:_____

Admission date:_____

Prior admission dates (if applicable): _____

_____

Filed Against Details:

Provider/Practitioner name: *(First, Last or name of facility)*: _____

Associated Provider/Practitioner PPG: _____

Provider/Practitioner location: _____

Provider/Practitioner NPI#:_____

HAC/HCAC, OPPC, SRAE, & and other PQI Indicators

Surgical events:

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- ☐ **Foreign object retained after surgery**
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- ☐ Unplanned return to OR, unplanned removal, injury or repair of an organ
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- ☐ **Mediastinitis after coronary artery bypass graft (CABG)**
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Bolded text indicates HAC/HCAC, OPPC or SRAE

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- ☐ Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
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Other:

- ☐ Pressure ulcer stages III & IV occurring after hospital admission
- ☐ Air embolism
- ☐ Blood transfusion incompatibility
- ☐ Any substandard care with the potential for harm to the member (please explain fully) _____
- ☐ Member refused to file a grievance
- ☐ Grievance withdrawal
- ☐ Other (select only when no other selection is applicable and explain fully) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS	BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Behavioral health:

- ☐ Inadequate assessment
- ☐ Inadequate treatment strategy or intervention
- ☐ Quality of patient relationship with provider appears very poor
- ☐ Inadequate discharge planning or follow-up
- ☐ Failure to utilize appropriate collateral contacts and/or coordinate care
- ☐ Lack of timely intervention that doesn't involve medication
- ☐ Patient's condition requires medication evaluation, but no referral was made
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- ☐ Incident of possession of a weapon in a facility
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- ☐ Patient assaulting or causing serious injury to other or other criminal activity
- ☐ Use of restrictive interventions (seclusion, restraints, isolation) inconsistent with accepted standards and regulations
- ☐ Clinical risk inadequately assessed or managed
- ☐ Medication error, incident or concern
- ☐ Alleged abuse of child, adolescent or elder not reported to appropriate authorities

Description of event:
Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary – must be typed, not handwritten):

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Prescription Drug Prior Authorization or Step Therapy Exception Request Form (No. 61-211) Contact Information

Please use the **Prescription Drug Prior Authorization or Step Therapy Exception Request form (No. 61-211)** when submitting prior authorization requests for prescription drugs. The form is attached below and is available on the Health Net* provider library under "Forms and References" at:

- Medi-Cal: https://providerlibrary.healthnetcalifornia.com/medi-cal/forms.html/HMO
- HMO: https://providerlibrary.healthnetcalifornia.com/hmo/forms.html/
- PPO: https://providerlibrary.healthnetcalifornia.com/ppo/forms.html

Requests made with incorrect forms will be returned to the provider or facility for resubmission.

When submitting a form for Health Net members, please note the contact information differs based on the type of prior authorization request being made.

Prior authorization contact information: Commercial (HMO and PPO)

Prior authorization type	Contact	Fax	Phone
Pharmacy and self-injectable requests	**Pharmacy services**	866-399-0929	800-548-5524 Option 2
Physician-administered medications	**Pharmacy services**	844-235-5090	800-867-6564 Option 2

Prior authorization contact information: Medi-Cal

Prior authorization type	Contact	Fax	Phone
Self-administered medication requests	**Medi-Cal Rx**	800-869-4325	800-977-2273
Physician-administered medications	**Pharmacy services**	833-953-3436	800-867-6564 Option 2

*Health Net of California, Inc. and Health Net Community Solutions, Inc. are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/medical group name: _____ **Plan/medical group phone number:** _____

Plan/medical group fax number: _____ **Non-urgent** ☐ **Exigent circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA).**

Member Information

First name:	Last name:	MI:	Phone number:	
Address:	City:		State:	ZIP Code:
Date of birth:	☐ Male ☐ Female	Circle the unit of measure Height (in/cm):____ Weight (lb/kg):____	Allergies:	
Member's authorized representative (if applicable):		Authorized representative phone number:		

Insurance Information

Primary insurance name:	Member ID number:
Secondary insurance name:	Member ID number:

Prescriber Information

First name:	Last name:	Specialty:	
Address:	City:	State:	ZIP Code:
Requestor (if different than prescriber):	Office contact person:		
National provider identifier (NPI) (individual):	Phone number:		
Drug enforcement administration (DEA) (if required):	Fax number (in HIPAA compliant area):		
Email address:			

Medication/Medical and Dispensing Information

Medication name:

☐ New therapy ☐ Renewal ☐ Step therapy exception request
If Renewal: Date Therapy Initiated: Duration of therapy (specific dates):

How did the member receive the medication?
☐ Paid under Insurance Name:_____ Prior auth number (if known):_____
☐ Other (explain):

Dose/strength:	Frequency:	Length of therapy/number refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration location:
☐ Member's home ☐ Long term care
☐ Physician's office ☐ Home care agency ☐ Other (explain):_____
☐ Ambulatory infusion center ☐ Outpatient hospital care

Revised 7/2025 Form 61-211

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Member name:	ID number:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request.

1. Has the member tried any other medications for this condition? ☐ **Yes (if yes, complete below)** ☐ **No**

Medication/therapy (Specify drug name and dosage)	**Duration of therapy** (Specify dates)	**Response/reason for failure/allergy**

2. List diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step-therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber signature or electronic ID verification:_____ **Date**:_____

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Plan/Insurer Use Only: Date/time request received by plan/insurer:_____ Date/time of decision_____

Fax number_____

☐ Approved ☐ Denied Comments/information requested: _____

Prescription Drug Prior Authorization or Step Therapy Exception Request Form (No. 61-211) Contact Information

Please use the **Prescription Drug Prior Authorization or Step Therapy Exception Request form (No. 61-211)** when submitting prior authorization requests for prescription drugs. The form is attached below and is available on the Health Net* provider library under "Forms and References" at: https://providerlibrary.healthnetcalifornia.com/medi-cal/forms.html. Requests made with incorrect forms will be returned to the provider or facility for resubmission.

When submitting a form for CalViva Health members, please note the contact information differs based on the type of prior authorization request being made.

Prior authorization contact information: CalViva Health

Prior authorization type	Contact	Fax	Phone
Self-administered medication requests	**Medi-Cal Rx**	800-869-4325	800-977-2273
Physician-administered medications	**Pharmacy services**	833-953-3436	800-867-6564 Option 2

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/medical group name: _____ **Plan/medical group phone number:** _____

Plan/medical group fax number: _____ **Non-urgent** ☐ **Exigent circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA).**

Member Information

First name:	Last name:	MI:	Phone number:	
Address:	City:		State:	ZIP Code:
Date of birth:	☐ Male ☐ Female	Circle the unit of measure Height (in/cm):_____ Weight (lb/kg):____	Allergies:	
Member's authorized representative (if applicable):		Authorized representative phone number:		

Insurance Information

Primary insurance name:	Member ID number:
Secondary insurance name:	Member ID number:

Prescriber Information

First name:	Last name:	Specialty:	
Address:	City:	State:	ZIP Code:
Requestor (if different than prescriber):	Office contact person:		
National provider identifier (NPI) (individual):	Phone number:		
Drug enforcement administration (DEA) (if required):	Fax number (in HIPAA compliant area):		
Email address:			

Medication/Medical and Dispensing Information

Medication name:

☐ New therapy ☐ Renewal ☐ Step therapy exception request
If Renewal: Date Therapy Initiated: Duration of therapy (specific dates):

How did the member receive the medication?
☐ Paid under Insurance Name:_____ Prior auth number (if known):_____
☐ Other (explain):

Dose/strength:	Frequency:	Length of therapy/number refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration location:
☐ Member's home ☐ Long term care
☐ Physician's office ☐ Home care agency ☐ Other (explain):_____
☐ Ambulatory infusion center ☐ Outpatient hospital care

Revised 7/2025 Form 61-211

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Member name:	ID number:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request.

1. Has the member tried any other medications for this condition? ☐ **Yes (if yes, complete below)** ☐ **No**

Medication/therapy (Specify drug name and dosage)	**Duration of therapy** (Specify dates)	**Response/reason for failure/allergy**

2. List diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step-therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber signature or electronic ID verification:_____ **Date**:_____

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Plan/Insurer Use Only: Date/time request received by plan/insurer:_____ Date/time of decision_____

Fax number_____

☐ Approved ☐ Denied Comments/information requested: _____

Prescription Drug Prior Authorization or Step Therapy Exception Request Form (No. 61-211) Contact Information

Please use the **Prescription Drug Prior Authorization or Step Therapy Exception Request form (No. 61-211)** when submitting prior authorization requests for prescription drugs. The form is attached below and is available on the Health Net* provider library under "Forms and References" at: https://providerlibrary.healthnetcalifornia.com/medi-cal/forms.html. Requests made with incorrect forms will be returned to the provider or facility for resubmission.

When submitting a form for Community Health Plan of Imperial Valley members, please note the contact information differs based on the type of prior authorization request being made.

Prior authorization contact information: Community Health Plan of Imperial Valley

Prior authorization type	Contact	Fax	Phone
Self-administered medication requests	**Medi-Cal Rx**	800-869-4325	800-977-2273
Physician-administered medications	**Pharmacy services**	833-953-3436	800-867-6564 Option 2

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

26-382 (3/26)

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/medical group name: _____ **Plan/medical group phone number:** _____

Plan/medical group fax number: _____ **Non-urgent** ☐ **Exigent circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA).**

Member Information

First name:	Last name:	MI:	Phone number:	
Address:	City:		State:	ZIP Code:
Date of birth:	☐ Male ☐ Female	Circle the unit of measure Height (in/cm):____ Weight (lb/kg):____	Allergies:	
Member's authorized representative (if applicable):		Authorized representative phone number:		

Insurance Information

Primary insurance name:	Member ID number:
Secondary insurance name:	Member ID number:

Prescriber Information

First name:	Last name:	Specialty:	
Address:	City:	State:	ZIP Code:
Requestor (if different than prescriber):	Office contact person:		
National provider identifier (NPI) (individual):	Phone number:		
Drug enforcement administration (DEA) (if required):	Fax number (in HIPAA compliant area):		
Email address:			

Medication/Medical and Dispensing Information

Medication name:

☐ New therapy ☐ Renewal ☐ Step therapy exception request
If Renewal: Date Therapy Initiated: Duration of therapy (specific dates):

How did the member receive the medication?
☐ Paid under Insurance Name:_____ Prior auth number (if known):_____
☐ Other (explain):

Dose/strength:	Frequency:	Length of therapy/number refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration location:
☐ Member's home ☐ Long term care
☐ Physician's office ☐ Home care agency ☐ Other (explain):_____
☐ Ambulatory infusion center ☐ Outpatient hospital care

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Member name:	ID number:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization or step-therapy exception request.

1. Has the member tried any other medications for this condition? ☐ **Yes (if yes, complete below)** ☐ **No**

Medication/therapy (Specify drug name and dosage)	**Duration of therapy** (Specify dates)	**Response/reason for failure/allergy**

2. List diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step-therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber signature or electronic ID verification:_____ **Date**:_____

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Plan/Insurer Use Only: Date/time request received by plan/insurer:_____ Date/time of decision_____

Fax number_____

☐ Approved ☐ Denied Comments/information requested: _____

PCP:	Page 1 of 3
SECTION: Preventive Services	
POLICY AND PROCEDURE: Preventive Services: Screening and Equipment	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:

Preventive health care services and health appraisal examinations are provided on a periodic basis for detection of asymptomatic diseases. Examination equipment, appropriate for primary care services is required to be available at the Primary Care Physician office site.

PROCEDURE:

The following equipment shall be maintained onsite and will be appropriate to the population served.

A. Examination table: the examination table has a protective barrier to cover the exam table surface that is changed between patient contact. The exam table is in "good repair". "Good repair" means clean and well maintained in proper working order.

B. Scales: Precise, reproducible measurements required correct equipment, which is maintained and regularly checked (per manufacturer recommendations or at least annually), for proper functioning and accuracy.

- **Infant scales** are marked and accurate to increments of one (1) ounce or less, and have a capacity of at least 35 pounds. Infant and children are weighed undressed or wearing minimal indoor clothing. If the child resists to the extent that he/she cannot be weighed accurately, document in the medical record that the child resisted and the weight measurement is imprecise.

- **Standing floor scales** are marked and have accurate to increments of one-fourth (¼) pound or less with a capacity of at least 300 pounds.

- **Balance beam or electronic scales** are appropriate for clinic use.

- **Electronic or digital scales** have automatic zeroing and lock-in weight features.

- **Spring balance scales (e.g. bathroom scales) are UNSATISFACTORY** for clinical use.

C. Measuring stature devices: includes length, height and head circumference

- Rigid 90° right angle headboard block that is perpendicular to the recumbent measurement surface or vertical to the wall mounted standing measurement surface.
- Flat, paper or plastic non-stretchable tape or yardstick marked to one-eighth inch (1/8 or 1 mm) or less. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement.
- Non-flexible footboard at 90° right angle perpendicular to the recumbent measurement surface or a flat floor surfaces for standing. Adult scale height measuring devices are unacceptable.
- **Head circumference** measurement uses a non-stretchable tape measuring device marked to (1/8 or 1 mm) or less (up to 24 months of age).

D. Basic exam equipment available for use in exam rooms:

- Thermometers: oral and/or tympanic
- Stethoscope and sphygmomanometer with various sized cuffs (e.g., child, adult, obese/thigh)
- Percussion hammer
- Tongue blades
- Patient gowns are appropriate to the population served on site.
- Ophthalmoscope
- Otoscope with adult and pediatric ear speculums

E. Vision testing:

- **Eye charts:** both literate (e.g. Snellen) and illiterate (e.g. "E" chart, "kindergarten" chart, Allen Picture Card Test) eye charts are available.
- **Heel lines** are aligned with the center of the eye chart at a distance of 10 or 20 feet depending on whether the chart is for 10 foot or 20 foot distance. Eye charts are located in an area with adequate lighting and at height appropriate to patient (adjustable).

- **Eye "occluders"** that are disposable (e.g. Dixie cups or tongue blades with back-to-back stickers) are acceptable. Non-disposable occluders are disinfected between patients.

F. Audiometric testing:

- **Tester will assess the testing room for noise level** prior to the start of testing. To ensure the testing room is quiet enough to perform the hearing screening.

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Under 1 Month Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Newborn Hearing Screen Results ☐ Pass ☐ Refer

Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

OB/GYN Provider:
Post-Partum Appointment Date:

Cord	☐ Absent ☐ Present ☐ Redness/swelling ☐ Yellow drainage

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Nutrition	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal (2-4 hours) ☐ Abnormal	
Sleeping Position	☐ Supine ☐ Prone ☐ Side	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Born to HBV+ parents
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Childhood hearing impairment	☐ Other:	
Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social -0p of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Maternal Depression Score: _____	☐ EPDS, ☐ PHQ-9, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Prone, lifts head briefly	☐ Turns head side to side	☐ Responds to sound
☐ Moro reflex	☐ Blinks at bright light	☐ Keeps hands in a fist

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions No cleft lip or palate	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Name: DOB: MR#:

Assessment

Plan

Referrals		
☐ WIC	☐ Audiologist	☐ Optometrist / Ophthalmologist
☐ Maternal Behavioral Health	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders		
☐ Hep B vaccine	☐ Newborn metabolic screen	☐ Obtain newborn hospital records & hearing screen results
☐ Hep B Panel (if at risk)	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed) Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:		
Diet, Nutrition & Exercise		
☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Colic
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear-facing Infant car seat	☐ Stimulation from hanging objects & bright colors
☐ Call MD for fever	☐ Choking hazards	☐ Family spacing
☐ Family support, social interaction & communication	☐ Never shake baby	☐ Physical growth
☐ Signs of maternal depression	☐ Matches / burns	☐ Stools
☐ Post-Partum Checkup	☐ Violence prevention, gun safety	☐ Sneezing
☐ Hot liquid away from baby	☐ Poison control phone number	☐ Hiccups
☐ Effects of passive smoking	☐ Smoke detector	☐ Bathing
☐ Skin cancer prevention	☐ Hot water temp < 120° F	☐ Circumcision care
☐ Sleeping position	☐ Drowning / tub safety	☐ Cord care
Next Appointment		
☐ At 2 months old	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Screening tools (TB, HEP B, Maternal Depression, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)
☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

1 to 2 Months Old	Actual Age: Date:		
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Newborn Hearing Screen Results ☐ Pass ☐ Refer

Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

OB/GYN Provider:
Post-Partum Appointment Date:

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Born to HBV+ parents
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Other:		
Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Maternal Depression Score: _____	☐ EPDS, ☐ PHQ-9, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Prone, lifts head 45°	☐ Vocalizes (cooing)	☐ Grasps rattle
☐ Kicks	☐ Follows past midline	☐ Smiles responsively (social)

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Present and equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Comprehensive Health Assessment Form

Name: DOB: MR#:

Assessment

Plan

Referrals		
☐ WIC	☐ Dietician / Nutritionist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Optometrist / Ophthalmologist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders		
☐ DTaP	☐ IPV	☐ CBC / Basic metabolic panel
☐ Hep B vaccine	☐ PCV	☐ Hct / Hgb
☐ Hib	☐ Rotavirus	☐ ECG ☐ COVID 19 test
☐ Hep B Panel (if at risk)	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed) Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:		
Diet, Nutrition & Exercise		
☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Signs of hunger
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear-facing Infant car seat	☐ Childcare plan
☐ Call MD for fever	☐ Choking hazards	☐ Crying
☐ Hot liquid burns	☐ Never shake baby	☐ Family spacing
☐ Signs of maternal depression	☐ Matches / burns	☐ Sibling and family relationships
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Diaper rash	☐ Poison control phone number	☐ Bathing
☐ Skin cancer prevention	☐ Smoke detector	☐ Sleeping position
☐ Crying	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / tub safety	☐ Thumb sucking
Next Appointment		
☐ At 4 months old	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Screening tools (TB, HEP B, Maternal Depression, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)
☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

3 to 4 Months Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Delivery	☐ Vaginal ☐ C-Section Complications ☐ Yes ☐ No	

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Born to HBV+ parents
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Drivers of health (SDOH)**	☐ Unremarkable for social driverd of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Maternal Depression Score: _____	☐ EPDS, ☐ PHQ-9, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ Other:	☐	☐

Growth and Development		
☐ Head steady when sitting	☐ Squeals or coos	☐ Orients to voices
☐ Eyes follow 180°	☐ Rolls form stomach to back	☐ Brings hands together
☐ Grasps rattle	☐ Gums objects	☐ Laughs aloud

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Present and equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment Form

Name: DOB: MR#:

Subjective / Objective

Assessment

Plan

Referrals		
☐ WIC	☐ Dietician / Nutritionist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Optometrist / Ophthalmologist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders		
☐ COVID 19 vaccine	☐ Influenza vaccine	☐ CBC / Basic metabolic panel
☐ DTaP	☐ IPV	☐ Hct / Hgb
☐ Hep B vaccine (if not up to date)	☐ PCV	☐ PPD skin test ☐ QFT
☐ Hib	☐ Rotavirus	☐ ECG ☐ COVID 19 test
☐ DTaP	☐ IPV	☐ Iron-fortified formula ☐ Iron supplements
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed) Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:		
Diet, Nutrition & Exercise		
☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Signs of hunger
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Childcare plan
☐ Signs of maternal depression	☐ Choking hazards	☐ Rolling
☐ Family support, social interaction & communication	☐ Storage of drugs / toxic chemicals	☐ Family spacing
☐ Effects of passive smoking	☐ Matches / burns	☐ Sibling and family relationships
☐ Skin cancer prevention	☐ Violence prevention, gun safety	☐ Physical growth
☐ Sleeping position	☐ Poison control phone number	☐ Reaching for objects
☐ No bottle in bed	☐ Smoke detector	☐ Bathing
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Minor illness care	☐ Drowning / pool fence	☐ Teething
Next Appointment		
☐ At 6 months old	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Screening tools (TB, HEP B, Maternal Depression, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)
☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: DOB: MR#:

5 to 6 Months Old	Actual Age: Date:		
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Fluoride Use	Drinks fluoridated water or takes supplements: ☐Yes ☐No	
Fluoride Varnish	Applied to teeth within last 6 months: ☐ Yes ☐ No	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Born to HBV+ parents
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Other:		
Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Blood Lead Education (Start at 6 months)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Maternal Depression Score: _____	☐ EPDS, ☐ PHQ-9, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ No head lag when pulled to sitting	☐ Sits briefly alone	☐ Orients to bell
☐ Bears weight on legs	☐ Rolls both ways	☐ Bangs small objects on surface
☐ Reaches for objects	☐ Gums objects	☐ Babbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	Present, grossly normal, No visible cavities	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, Thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment Form

Name: DOB: MR#:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ Dentist	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ IPV	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PCV	☐ Hct / Hgb
☐ Hep A vaccine (if high risk)	☐ Rotavirus	☐ PPD skin test ☐ QFT
☐ Hep B vaccine	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Hib	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ ECG ☐ COVID 19 test
☐ Influenza vaccine	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Introduction to solids	☐ Fortified Infant Cereals	☐ Start solid foods one at a time
☐ Breastfeeding / formula	☐ No cow's milk	☐ Start feeder cup

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Blocks
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Repetitive games
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Caution with strangers	☐ Poison control phone number	☐ Bathing
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Signs of maternal depression	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ At 9 months old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, HEP B, Maternal Depression, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

7 to 9 Months Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable			
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: ☐ Vaginal ☐ C-section Complications: ☐ Yes ☐ No Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No			
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV ☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other:			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Sleep	☐ Normal ☐ Abnormal		
Sleep Position	☐ Supine ☐ Prone ☐ Side		
Fluoride Use	Drinks fluoridated water or takes supplements: ☐Yes ☐No		
Fluoride Varnish	Applied to teeth within last 6 months: ☐ Yes ☐ No		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Born to HBV+ parents	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs	
☐ Other:			
Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Blood Lead Education (At each Well Visit)	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder (At 9 months) Score:_____	☐ ASQ-3, ☐ SWYC, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Sits without support	☐ Transfers object hand to hand	☐ Looks for toy dropped
☐ Begins to crawl	☐ Rolls over	☐ Says "mama" or "dada"
☐ Pulls to stand	☐ Feeds self, cracker	☐ Scribbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	Present, grossly normal, No visible cavities	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment Form

Name: DOB: MR#:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if high risk)	☐ Hct / Hgb
☐ Hep A vaccine (if high risk)	☐ PCV (if not up to date)	☐ Lipid panel (if high risk)
☐ Hep B vaccine	☐ Rotavirus Requires 2-3 doses, depends on manufacturer	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine (Requires two doses by 2 years old)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ ECG ☐ COVID 19 test
☐ IPV	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Introduction to meats & proteins	☐ Fortified Infant Cereals	☐ Mashed table food
☐ Whole grains / iron-rich foods	☐ Finger foods	☐ Start feeder cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Allow to feed self
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Understands "no" but not discipline
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Childcare plan	☐ Poison control phone number	☐ Decreased appetite
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ At 12 months old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, HEP B, Developmental D/O, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment

10 to 11 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Psychosocial & Behavioral Assessment, Family/ Social Factors	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Pulls self to standing	☐ Walks with help	☐ Drop object in cup
☐ Stands holding on	☐ Plays pat-a-cake	☐ Says "mama" or "dada"
☐ Thumb-finger grasp	☐ Holds cup to drink	☐ Scribbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Name: DOB:

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if high risk)	☐ Hct / Hgb (at 12 months)
☐ Hep A vaccine (if high risk)	☐ PCV (if not up to date)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead (at 12 months)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Introduction to meats & proteins	☐ Weaning breastfeeding	☐ Mashed table food
☐ Whole grains / iron-rich foods	☐ Finger foods	☐ Start feeder cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Allow to feed self
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Looks in mirror
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Caution with strangers	☐ Poison control phone number	☐ Decreased appetite
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Revised 6/1/22

Comprehensive Health Assessment Form

Name: DOB: MR#:

12 to 15 Months Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No Fluoride varnish applied in last 6 months: ☐Yes ☐ No	
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 30 min/day) ☐ Active (> 30 min/day)	
Sleep	☐ Regular ☐ Sleep regression ☐Nighttime fears	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Born to HBV+ parents
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead Test Test at 12 months and Educate at each well visit	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Walks alone well	☐ Three-word vocabulary	☐ Stacks two-block tower
☐ Stoops and recovers	☐ Plays pat-a-cake	☐ Says "mama" or "dada"
☐ Takes lids off containers	☐ Feeds self	☐ Scribbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment Form

Name: DOB: MR#:

Subjective / Objective

Assessment

Plan

Referrals		
☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders		
☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP	☐ MMR	☐ Hct / Hgb (at 12 months)
☐ Hep A vaccine (Requires one dose between 12 & 23 months)	☐ PCV	☐ Lipid panel (if high risk)
☐ Hep B vaccine	☐ Varicella	☐ PPD skin test ☐ QFT
☐ Hib	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Blood Lead (at 12 months)	☐ ECG ☐ COVID 19 test
☐ IPV	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed) Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:		
Diet, Nutrition & Exercise		
☐ Relaxed atmosphere / Avoid rushing while eating	☐ Vegetables, fruits	☐ Table food
☐ Whole grains / iron-rich foods	☐ Encourage solids	☐ Using cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear facing toddler car seat	☐ Feeding self
☐ Routine dental care	☐ Choking hazards	☐ Simple games
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Temper tantrum
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Family play
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Treatment of minor cuts
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training
Next Appointment		
☐ In 3 months	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)
☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

16 to 23 Months Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See WHO Growth Chart)	**Vital Signs**	
Head Circumference		Temp	
Length		Pulse	
Weight		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No Fluoride varnish applied in last 6 months: ☐Yes ☐ No	
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 30 min/day) ☐ Active (> 30 min/day)	
Sleep	☐ Regular ☐ Sleep regression ☐ Nighttime fears	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Autism Disorder (At 18 months) Score: ___	☐ SWYC, ☐ M-CHAT, ☐ Other:	☐	☐
Blood Lead Education (At each Well Visit)	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder (At 18 months) Score: _____	☐ ASQ-3, ☐ SWYC, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Walks alone fast	☐ 7 to 20-word vocabulary	☐ Stacks three-block tower
☐ Climbs	☐ Names 5 body parts	☐ Says "mama" or "dada"
☐ Kicks a ball	☐ Indicates wants by pointing and pulling	☐ Sips from cup, a little spillage

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities & grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg length equal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: DOB: MR#:

Subjective / Objective

Assessment

Plan

Referrals		
☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders		
☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed) Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:		
Diet, Nutrition & Exercise		
☐ Relaxed atmosphere / Avoid rushing while eating	☐ Vegetables, fruits	☐ Caloric balance
☐ Whole grains / iron-rich foods	☐ Switch to low-fat milk	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles
Accident Prevention & Guidance		
☐ Lead poisoning prevention	☐ Rear facing toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Parallel peer play
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training
Next Appointment		
☐ At 2 years old	☐ RTC PRN	☐ Other:

Documentation Reminders		
☐ Screening tools (TB, Autism, Developmental D/O, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Length, Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)
☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

2 Years Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Allergies / Reaction		Temp	
Height		Pulse	
Weight		Resp	
BMI Value		BMI %	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No Fluoride varnish applied in last 6 months: ☐Yes ☐ No	
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)	
Sleep Pattern	☐ Regular ☐ Sleep regression ☐ Nighttime fears	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	

Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Autism Disorder Score: _____	☐ ASQ-3, ☐ SWYC, ☐ M-CHAT, ☐ Other:	☐	☐
Blood Lead Test Test at 24 months and Educate at each well visit	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder Score: _____	☐ ASQ-3, ☐ SWYC, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Runs well, walks up and down	☐ Identifies 5 body parts	☐ Helps around the house
☐ Jumps off the ground with both feet	☐ Plays hide and seek	☐ Stacks three-block tower
☐ Puts 2 or more words together	☐ Kicks and throws a ball	☐ Handles spoon well
☐ 7 to 20-word vocabulary	☐ Name at least 1 color	☐ Puts on simple clothes

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead (at 2 yrs old)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Caloric balance
☐ Whole grains / iron-rich foods	☐ Switch to low-fat milk	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt / Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Parallel peer play
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ At 30 months old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Autism, Developmental D/O, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

30 Months Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Allergies / Reaction		Temp	
Height		Pulse	
Weight		Resp	
BMI Value		BMI %	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No Fluoride varnish applied in last 6 months: ☐Yes ☐ No	
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)	
Sleep Pattern	☐ Regular ☐ Sleep regression ☐ Night time fears	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	

Psychosocial / Behavioral **Social Drivers of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead Education (At each Well Visit)	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder Score: ____	☐ ASQ-3, ☐ SWYC, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Balances on each foot, 1 second	☐ Eats independently	☐ Helps in dressing
☐ Uses 3-word sentences	☐ Goes up stairs alternating feet	☐ Draws a single circle
☐ Plays with other children	☐ Knows age, sex, first, & last name	☐ Cuts with scissors

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐

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Comprehensive Health Assessment Form

Name: DOB: MR#:

Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PPSV	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt /Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ At 3 years old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Developmental D/O, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

3 Years Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Height		Temp	
Weight		BP	
BMI Value		Pulse	
BMI %		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: ☐ Non coop		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV
☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History	
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No Fluoride varnish applied in last 6 months: ☐Yes ☐ No
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:
Appetite	☐ Good ☐ Fair ☐ Poor
Elimination	☐ Normal ☐ Abnormal
Has WIC	☐ Yes ☐ No
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Determinants of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead Education (At each Well Visit)	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development		
☐ Balances on each foot, 1 second	☐ Eats independently	☐ Helps in dressing
☐ Uses 3-word sentences	☐ Goes up stairs alternating feet	☐ Draws a single circle
☐ Plays with several children	☐ Knows age, sex, first, & last name	☐ Cuts with scissors

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PPSV	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs (0.25 mg/0.50 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ School lunch program

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt /Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ At 4 years old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

4 to 5 Years Old	Actual Age:	Date:	
Sex at Birth	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Height		Temp	
Weight		BP	
BMI Value		Pulse	
BMI %		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: ☐ Non coop		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Birth Weight: _____ Birth Length: _____ Gestational Age: _____
Delivery: ☐ Vaginal ☐ C-section
Complications: ☐ Yes ☐ No
Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ Asthma ☐ Cancer ☐ DM ☐ Dialysis ☐ Heart Disease
☐ HEP B ☐ HEP C ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures
☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Current Medications/Vitamins: ☐ See Medication List

Interval History	
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No Fluoride varnish applied in last 6 months: ☐Yes ☐ No
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:
Appetite	☐ Good ☐ Fair ☐ Poor
Elimination	☐ Normal ☐ Abnormal
Has WIC	☐ Yes ☐ No
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Determinants of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Blood Lead Education (At each Well Visit)	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development / School Progress **Grade:** _____		
☐ Hops on one foot	☐ Counts four pennies	☐ Copies a square
☐ Catches, throws a ball	☐ Knows opposites	☐ Recognizes 3-4 colors
☐ Plays with several children	☐ Knows name, address, & phone number	☐ Holds crayon between finger and thumb

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PCV13 (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis at 5 years
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs (0.25 mg/0.50 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ School lunch program

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

6 to 8 Years Old	Actual Age: Date:		
Sex at Birth	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Height		Temp	
Weight		BP	
BMI Value		Pulse	
BMI %		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: ☐ Non coop		
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable			
Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No			
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other:			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements: ☐Yes ☐No		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs	
☐ Anemia	☐ Other:		
Psychosocial / Behavioral **Social Determinants of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development / School Progress **Grade:** _____		
☐ Rides bicycle	☐ Knows right from left	☐ Reads for pleasure
☐ Ties shoelaces	☐ Draws person with 6 parts including clothing	☐ Tells time
☐ Rules and consequences	☐ Independence	☐ Prints first name

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities & grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐
Subjective / Objective		

Name: DOB: MR#:

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dietician / Nutritionist	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A (if not up to date)	☐ Tdap (≥7 yrs)	☐ Lipid panel (if high risk)
☐ Hep B (if not up to date)	☐ Varicella (if not up to date)	☐ PPD skin test (if high risk) ☐ QFT (if high risk)
☐ IPV (if not up to date)	☐ Blood Lead (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Routine dental care	☐ Use of social media	☐ Peer pressure
☐ Lead Poisoning Prevention	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Non-violent conflict resolution	☐ Physical growth
☐ Form caring & supportive relationships with family & peers	☐ Safety helmet ☐ Seat belt	☐ Daily mindful movements
☐ Early Sex education	☐ Limit screen time	☐ Puberty
☐ Smoking/vaping use/exposure	☐ Skin cancer prevention	☐ Bedtime

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

9 to 12 Years Old	Actual Age: Date:		
Sex at Birth	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Height		Temp	
Weight		BP	
BMI Value		Pulse	
BMI %		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ 9-10 Yrs Old: Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ ≥11 Yrs Old: Responded at ≤ 25 dB at 1000-8000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: ☐ Non coop		
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable			
Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No			
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other:			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements:☐Yes ☐No		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):		☐ Menorrhagia	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:	

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Determinants of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: ____ (Starting at 11 yrs old)	☐ CRAFFT, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____ (Starting at 12 yrs old)	☐ PHQ-9A, ☐ Other:	☐	☐
Drug Misuse Score: _____ (Starting at 11 years old)	☐ CRAFFT, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Starting at 11 yrs old)	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ PEARLS, ☐ PEARLS-12&UP ☐ SDOH, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ PEARLS, ☐ PEARLS-12&UP ☐ SDOH, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections (Starting at 11 yrs old)	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest (Start at 11 yrs old)	☐ SCD, ☐ H&P, ☐ Other:	☐	☐
Suicide (Starting at 12 yrs old)	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development / School Progress **Grade:** _____		
☐ School achievement	☐ Performs chores	☐ Plays / listens to music
☐ School attendance	☐ Exhibit compassion & empathy	☐ Reads for pleasure
☐ Cause and effect are understood	☐ Participates in organized sports / social activities	☐ Demonstrate social & emotional competence (including self-regulation)
☐ Caring & supportive relationships with family & peers	☐ Adheres to predetermined rules	☐ Knows right from left

Comprehensive Health Assessment Form

Name: DOB: MR#:

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Tdap	☐ CBC/Basic metabolic panel
☐ Hep B vaccine (if not given previously)	☐ Varicella (if not up to date)	☐ Hct / Hgb (yearly if menstruating)
☐HPV vaccine (if not up to date – requires 2-3 doses between 9-12 yrs)	☐ Hep B Panel (if not up to date)	☐ Lipid panel (once between 9-11 yrs)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (11 to 12 yrs)	☐ HIV (if high risk) ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social media use	☐ Peer pressure
☐ Signs of depression (suicidal ideation)	☐ Avoid risk-taking behavior	☐ Independence
☐ Mental health (emotional support)	☐ Gun safety	☐ Personal development
☐ Form caring & supportive relationships with family & peers	☐ Non-violent conflict resolution	☐ Physical growth
☐ Early Sex education / Safe sex practices	☐ Safety helmet	☐ Mindful of daily movements
☐ Skin cancer prevention	☐ Seat belt	☐ Puberty
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Bedtime

Tobacco Use / Cessation Exposed to 2nd hand smoke ☐ Yes ☐ No

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

13 to 16 Years Old	Actual Age: Date:		
Sex at Birth	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Height		Temp	
Weight		BP	
BMI Value		Pulse	
BMI %		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: ☐ Non coop		
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable			
Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No			
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other:			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No Drinks fluoridated water or takes supplements:☐Yes ☐No		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):		☐ Menorrhagia	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:	

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Determinants of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: ____	☐ CRAFFT, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ-9A, ☐ Other:	☐	☐
Drug Misuse Score: ____	☐ CRAFFT, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test at least once starting at 15 yrs old)	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ SCD, ☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development / School Progress **Grade:** _____		
☐ School achievement	☐ Performs chores	☐ Plays / listens to music
☐ School attendance	☐ Learns new skills	☐ Reads
☐ Understands parental limits & consequences for unacceptable behavior	☐ Participates in organized sports / social activities	☐ Uses both hands independently
☐ Ability to get along with peers	☐ Learns from mistakes & failures, tries again	☐ Preoccupation with rapid body changes

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest/Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Varicella (if not up to date)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Lipid panel (if high risk)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV (if high risk) ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social Media Use	☐ Goals in life
☐ Signs of depression (suicidal ideation)	☐ Avoid risk-taking behavior	☐ Independence
☐ Mental health (emotional support)	☐ Gun safety	☐ Personal development
☐ Intimate partner violence	☐ Violent behavior	☐ Academic or work plans
☐ Sex education (partner selection)	☐ Safety helmet	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Mindful of daily movements
☐ Skin cancer prevention	☐ Motor vehicle safety (no texting & driving)	☐ Physical growth
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Sexuality

Tobacco Use / Cessation Exposed to 2nd hand smoke ☐ Yes ☐ No

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

17 to 20 Years	Actual Age: Date:		
Sex at Birth	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake	(See CDC Growth Chart)	**Vital Signs**	
Height		Temp	
Weight ☐ Significant loss/gain: ___lbs		BP	
BMI Value		Pulse	
BMI %		Resp	
Allergies / Reaction			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: ☐ Non coop		
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable			
Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No			
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No		
Advance Directive Info given/discussed	☐ Yes ☐ Refused Starting at 18 years old		
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other: Functional Limitations (check all that apply): ☐ Unremarkable ☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care			
Current Medications/Vitamins: ☐ See Medication List ☐ Taking 0.4 to 0.8 mg of folic acid daily (females of reproductive age)			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):	G P A	☐ Menorrhagia	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:	

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 yrs
☐ Anemia	☐ Other:	
Psychosocial / Behavioral **Social Determinants of Health (SDOH)**	☐ Unremarkable for social drivers of health ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: _____	☐ CRAFFT, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ-9A, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ CRAFFT, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ PEARLS, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Psychosocial / Behavioral	☐ SDOH, ☐ PEARLS, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ SCD, ☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Growth and Development / School Progress **Grade:** _____		
☐ Hobbies / work	☐ Plays sports	☐ Plays / listens to music
☐ School achievement / attendance	☐ Acts responsibly for self	☐ Takes on new responsibility
☐ Improved social skills; maintains family relationships	☐ Sets goals & works towards achieving them	☐ Preparation for further education, career, marriage & parenting

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Normal	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist/ Ophthalmologist	☐ Dietician/ Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Hep B Panel (at least once ≥18 yrs)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (at least once ≥18 yrs)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Rx for folic acid 0.4-0.8mg daily (females)	☐ Lipid panel (once between 17-21 yrs)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV (if high risk) ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test

☐ Tdap	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed)

Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social media use	☐ Transitioning to adult provider
☐ Routine dental care	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development & goals in life
☐ Intimate partner violence	☐ Violent behavior	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt / Safety Helmet	☐ Testicular self-exam
☐ Skin cancer prevention	☐ Motor vehicle safety (no texting & driving)	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Mental health (emotional support)	☐ Prenatal care / encourage breastfeeding

Tobacco Use / Cessation Exposed to 2nd hand smoke ☐ Yes ☐ No

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member/parent refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

21 to 39 Years: Female at Birth	Actual Age: Date:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake		**Vital Signs**	
Allergies / Reaction		Temp	
Height		BP	
Weight ☐ Significant loss/gain: _____lbs		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease
☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease
☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Functional Limitations (check all that apply): ☐ Unremarkable
☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care

Current Medications/Vitamins: ☐ See Medication List
☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)

Education (last grade completed): _____
Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
LMP: ☐ Pregnant	G P A	☐ Menorrhagia
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Intimate Partner Violence	In the last 12 months: Has anyone physically hurt you? ☐ Yes ☐ No Has anyone insulted or humiliated you? ☐ Yes ☐ No Has anyone threatened you? ☐ Yes ☐ No Has anyone screamed or cursed at you? ☐ Yes ☐ No	
Last PAP/HPV	Date: ☐ WNL	
Social Determinants of Health (SDOH)	☐ Unremarkable for social drivers of health ☐ Changes since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Stressors (mental illness, alcohol/drugs, violence/abuse)	

Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:
Family History	☐ None	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Hip fracture
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History and Dates	☐ None	☐ See CAIR
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Tdap:
☐ COVID Booster(s):	☐ MMR:	☐ Varicella:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ SDOH, ☐ HITS, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ TAPS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear, Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐

Name: DOB: MR#:

Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Varicella (if not up to date)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ HPV vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Low to moderate dose statin
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV (if high risk) ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Pneumococcal (if high risk)	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose / HbA1C
☐ Tdap	☐ Bone Density Test	☐ PAP ☐ HPV
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Routine dental care	☐ Gun safety	☐ Personal development
☐ Signs of depression (suicidal ideation)	☐ Violent behavior	☐ Goals in life
☐ Intimate partner violence	☐ Mindful of daily movements	☐ Family support, social interaction & communication
☐ Diabetes management	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Skin cancer prevention	☐ Safety helmet	☐ Breastfeeding
☐ Smoking/vaping use/exposure	☐ ASA use	☐ Sex education (partner selection)

Tobacco Use / Cessation

☐ Never smoked or used tobacco products
☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____
☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____
Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

21 to 39 Years: Male at Birth	Actual Age: Date:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake		**Vital Signs**	
Allergies / Reaction		Temp	
Height		BP	
Weight ☐ Significant loss/gain: ___lbs		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No
Advance Directive Info given/discussed	☐ Yes ☐ Refused

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease
☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease
☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Functional Limitations (check all that apply): ☐ Unremarkable
☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care

Current Medications/Vitamins: ☐ See Medication List

Education (last grade completed): _____
Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Social Determinants of Health (SDOH)	☐ Unremarkable for social drivers of health ☐ Changes since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Stressors (mental illness, alcohol/drugs, violence/abuse)	
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:
Family History	☐ None	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Other:

Immunization History / Date	☐ None	☐ See CAIR
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Tdap:
☐ COVID Booster(s):	☐ MMR:	☐ Varicella:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ TAPS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐

Name: DOB: MR#:

Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Varicella (if not up to date)	☐ Hct / Hgb ☐ Lipid panel
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Low to moderate dose statin
☐ Influenza vaccine	☐ Hep C Antibody test (if high risk)	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ Chlamydia ☐ Gonorrhea	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ HIV (if high risk) ☐ Herpes	☐ ECG ☐ COVID 19 test
☐ Pneumococcal (if high risk)	☐ Syphilis ☐ Trichomonas	☐ Fasting plasma glucose ☐ HbA1C
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes Management	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Family support, social interaction & communication
☐ Skin cancer prevention	☐ Safety helmet	☐ Testicular self-exam
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Sex education (partner selection

Tobacco Use / Cessation

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem/Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: DOB: MR#:

40 to 49 Years: Female at Birth	Actual Age: Date:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake		**Vital Signs**	
Allergies / Reaction		Temp	
Height		BP	
Weight ☐ Significant loss/gain: _____lbs		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable			
Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No			
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other: Functional Limitations (check all that apply): ☐ Unremarkable ☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Education (last grade completed): _____ Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
LMP:	G P A	☐ Menorrhagia ☐ Menopause	
Hysterectomy	☐ Partial ☐ Total		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Intimate Partner Violence	In the last 12 months: Has anyone physically hurt you? ☐ Yes ☐ No Has anyone insulted or humiliated you? ☐ Yes ☐ No Has anyone threatened you? ☐ Yes ☐ No Has anyone screamed or cursed at you? ☐ Yes ☐ No		
Last PAP/HPV	Date: ☐ WNL		
Last Mammogram	Date: ☐ WNL		
Last Colonoscopy	Date: ☐ WNL		

Social Determinants of Health (SDOH)	☐ Unremarkable for social drivers of health ☐ Changes since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Stressors (mental illness, alcohol/drugs, violence/abuse)	
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:
Family History	☐ None	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Hip fracture
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History / Date	☐ None	☐ ☐ See CAIR
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Tdap:
☐ COVID Booster(s):	☐ MMR:	☐ Varicella: ☐ Exempt (DOB < 1980 & non-healthcare worker)
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Breast Cancer (Starting at 40 yrs old)	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ SDOH, ☐ HITS, ☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ TAPS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ HIV (if high risk) ☐ Herpes	☐ CXR ☐ Urinalysis
☐ Pneumococcal (if high risk)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose ☐ Oral glucose tolerance
☐ Varicella (if not up to date)	☐ gFOBT or Fit ☐ Colonoscopy	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster (if high risk)	☐ PAP ☐ HPV	☐ Bone Density Test ☐ Mammogram
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Skin cancer prevention	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work activities
☐ Intimate partner violence	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Sex education (partner selection)	☐ Seat belt	☐ Self-breast exam
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Safety helmet	☐ Aging process
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Perimenopause education

Tobacco Use / Cessation

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

40 to 49 Years: Male at Birth	Actual Age: Date:	
Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:	
Intake		**Vital Signs**
Allergies / Reaction		Temp
Height		BP
Weight ☐ Significant loss/gain: _____lbs		Pulse
BMI Value		Resp
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable		
Country of Birth: ☐ US ☐ Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No		
Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No	
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused	
Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List ☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease ☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease ☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months ☐ Other: Functional Limitations (check all that apply): ☐ Unremarkable ☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care		
Current Medications/Vitamins: ☐ See Medication List		
Education (last grade completed): _____ Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:		
Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last Colonoscopy	Date: ☐ WNL	
Social Determinants of Health (SDOH)	☐ Unremarkable for social drivers of health ☐ Changes since last visit (move, job, death) ☐ Problems with housing/food/employment/transportation ☐ Stressors(mental illness, alcohol/drugs, violence/abuse)	
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Other:

Immunization History / Date	☐ None	☐ See CAIR
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Tdap:
☐ COVID Booster(s):	☐ MMR:	☐ Varicella: ☐ Exempt (DOB < 1980 & non-healthcare worker)
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ TAPS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ/uncircumcised, testes in scrotum Prostate Exam / Rectal	☐

Courtesy of Anthem Blue Cross - Revised 05/06/24

Name: DOB: MR#:

Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal vaccine	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ HbA1C	☐ Fasting plasma glucose
☐ Zoster	☐ PSA	☐ Oral glucose tolerance test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Testicular self-exam
☐ Smoking/vaping use/exposure	☐ Skin cancer Prevention	☐ Routine dental care

Tobacco Use / Cessation

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

50+ Years: Female at Birth	Actual Age:	Date:	
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake		**Vital Signs**	
Allergies / Reaction		Temp	
Height		BP	
Weight ☐ Significant loss/gain: _____lbs		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease
☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease
☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Functional Limitations (check all that apply): ☐ Unremarkable
☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care

Current Medications/Vitamins: ☐ See Medication List

Education (last grade completed): _____
Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
LMP:	G P A	☐ Menorrhagia ☐ Menopause
Hysterectomy	☐ Partial ☐ Total	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last PAP/HPV	Date:	☐ WNL
Last Mammogram	Date:	☐ WNL
Last Colonoscopy	Date:	☐ WNL
Social Determinants of Health (SDOH)	☐ Unremarkable for social drivers of health ☐ Changes since last visit (move, job, death) ☐ Problems with housing, food, employment, transportation ☐ Stressors (mental illness, alcohol/drugs, violence/abuse)	

Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:
Family History	☐ None	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Hip fracture
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Zoster:
☐ COVID Booster(s):	☐ MMR: ☐ Exempt (DOB <1957 & non-healthcare worker)	☐ Varicella: ☐ Exempt (non-healthcare worker)
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Breast Cancer	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Cognitive Health (Start at 65 yrs old) Score: ____ *May be used as member risk assessment	☐ MINI-COG, ☐ AD8, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ ACEs ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ TAPS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep C Antibody test (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Chlamydia ☐ Gonorrhea	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ HIV (if high risk) ☐ Herpes	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Pneumococcal	☐ Rx for folic acid 0.4-0.8mg daily	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Varicella (if not up to date)	☐ PAP ☐ HPV	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster ☐ Hep B Panel (if high risk)	☐ Mammogram ☐ Bone Density Test	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ ASA use	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Goals in life	☐ Aging process
☐ Diabetes management	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Perimenopause education

Tobacco Use / Cessation

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Comprehensive Health Assessment Form

Name: **DOB:** **MR#:**

50+ Years: Male at Birth	Actual Age: Date:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Name of Interpreter:		
Intake		**Vital Signs**	
Allergies / Reaction		Temp	
Height		BP	
Weight ☐ Significant loss/gain: _____lbs		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): ☐ Unremarkable

Country of Birth: ☐ US ☐ Other: _____
At least 1 parent born in Africa, Asia, Pacific Islands: ☐ Yes ☐ No

Dental Home	Dental visit within past 12 months: ☐ Yes ☐ No
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused

Chronic Problems/Significant Conditions: ☐ None ☐ See Problem List
☐ Asthma ☐ Cancer ☐ Depression ☐ DM ☐ Dialysis ☐ Heart Disease
☐ HEP B ☐ HEP C ☐ High Cholesterol ☐ HIV ☐ HTN ☐ Liver Disease
☐ Seizures ☐ STI ☐ Uses DME ☐ ≥ 2 ER visits in 12 months
☐ Other:

Functional Limitations (check all that apply): ☐ Unremarkable
☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care

Current Medications/Vitamins: ☐ See Medication List

Education (last grade completed): _____
Health education preference: ☐ Verbal ☐ Visual ☐ Multimedia ☐ Other:

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last Colonoscopy	Date: ☐ WNL	
Social Drivers of Health (SDOH)	☐ Unremarkable for social drivers of health ☐ Changes since last visit (move, job, death) ☐ Problems with housing/food/employment/transportation ☐ Stressors(mental illness, alcohol/drugs, violence/abuse)	
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs-Current ☐ IV Drugs-Past Hx	☐ Other:

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease / HTN	☐ Lives/lived with someone HBV+	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Zoster:
☐ COVID Booster(s):	☐ MMR: ☐ Exempt (DOB <1957 & non-healthcare worker)	☐ Varicella: ☐ Exempt (non-healthcare worker)
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Abdominal Aortic Aneurism	☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Cognitive Health (Start at 65 yrs old) Score: _____ *May be used as member risk assessment	☐ MINI-COG, ☐ AD8, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression Score: _____	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse Score: _____	☐ TAPS, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	☐ CDC HEP Risk, ☐ H&P, ☐ Other:	☐	☐
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Member Risk Assessment	☐ SDOH, ☐ ACEs, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ TAPS, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Gums	Pink, no bleeding/inflammation/lesions	☐

Courtesy of Anthem Blue Cross - Revised 05/06/24

Name: DOB: MR#:

Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ /uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV (if high risk) ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Zoster	☐ AAA Ultrasound (65 to 75 who have ever smoked >100 cigarettes in lifetime)	☐ HbA1C ☐ PSA
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Diabetes management	☐ Violent behavior	☐ Goals in life
☐ Sex education (partner selection)	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Smoking/vaping use/exposure	☐ Seat belt	☐ Testicular self-exam
☐ Routine dental care	☐ Safety helmet	☐ Aging process

Tobacco Use / Cessation

☐ Never smoked or used tobacco products

☐ Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

☐ Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: ☐ Cigarettes ☐ Chewing tobacco ☐ Vaping products ☐ Other:

☐ Advised to quit smoking	☐ Discussed smoking cessation medication	☐ Discussed smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

☐ Member refused the following screening/orders:

Courtesy of Anthem Blue Cross - Revised 05/06/24

Primary language spoken_____
Needs interpreter YES _____ NO _____

Primary language spoken_____
Needs interpreter YES _____ NO _____

Primary language spoken_____
Needs interpreter YES _____ NO _____

Primary language spoken_____
Needs interpreter YES _____ NO _____

Primary language spoken_____
Needs interpreter YES _____ NO _____

PCP:	
SECTION: Personnel	
POLICY AND PROCEDURE: **Prior Authorization/Referrals**	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
To ensure that referrals for specialty care and medical procedures are processed in a timely manner, the site will have a process for the timely processing of internal and external referrals, consultant reports and diagnostic test results.

PROCEDURE:
I. REFERRAL FORMS

A. The staff has an organized, timely referral system clearly evident for making and tracking referrals, physician review of reports, and providing and/or scheduling follow-up care.
   - Appropriate referral forms shall be available at the Primary Care Physician site. The practitioner shall complete the referral form and attach all relevant medical information. Refer to the attached Health Plan specific referral forms.

B. Primary Care Physician offices are required to maintain a "Referral Tracking Log" or an appropriate tickler system. Refer to the referral tracking log attached.
   - The PCP must ensure timely receipt of the specialist's report or medical procedure report.
   - **Reports must be in the patient's medical record within thirty (30) days from the date of the procedure or appointment. If the PCP site has not received the report within 30 days, the PCP/staff will contact the specialist or procedure site to request a copy of the report.**
   - Document results of follow up actions

C. The PCP shall ensure that referral informational resources, i.e. Health Plan Specialty and Network Directory, are readily available for use by site personnel.

The following elements should be included within the referral system:
- Patient Name
- Date of Referral
- Referral Type
- Appointment Date
- Appointment Kept or Failed
- Date Report Received
- Physician Follow-up/Documentation

D. Site staff should be able to demonstrate (e.g., “walk through”) the office referral process from beginning to end.

PROVIDER*Update*

CONTRACTUAL | DECEMBER 19, 2024 | UPDATE 24-1316 | 6 PAGES

New Prior Authorization Changes, Effective March 1, 2025

Learn which drugs have been added, changed or removed for medical benefit medications

View the tables below for prior authorization (PA) requirement changes for the Los Angeles County Department of Health Services (LA-DHS) participating physician groups (PPGs), hospitals and clinics. These changes apply to outpatient pharmaceuticals (submitted under the medical benefit).

Supplemental form for outpatient PA requests

A supplemental form is now available with the Outpatient Prior Authorization Form that you can complete and use when an authorization request involves more than four procedure codes. This page is optional. It does not need to be included with outpatient PA requests with four codes or less.

You can access the Outpatient Prior Authorization Form, which now includes the supplemental form, on Health Net's Prior Authorization web page at https://bit.ly/HN-Prior-Auth. You can also access the form in the Medi-Cal Provider Library under *Forms and References*.

PA additions, changes and deletions

The below PA requirement changes are for Health Net's Medi-Cal fee-for-service physicians and other providers.

Outpatient pharmaceuticals (submitted under medical benefit)

Additions, effective March 1, 2025

The following require PA.

Requirement	Code and description
Amtagvi™	N/A, unclassified.
Gazyva®	J9301, injection, obinutuzumab, 10 mg
Hepzato®	J9248, Injection, melphalan (hepzato), 1 mg
Lymphir™	N/A, unclassified
Niktimvo™	N/A, unclassified

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups
- Hospitals/Clinics
- Ancillary Providers
- Behavioral Health Providers

LINES OF BUSINESS:

- Medi-Cal
  - Los Angeles (LA-DHS)

PROVIDER SERVICES

provider_services@healthnet.com

Medi-Cal (including CS and ECM providers) – 800-675-6110

Behavioral Health providers – 844-966-0298

PROVIDER PORTAL

provider.healthnetcalifornia.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

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Changes, effective March 1, 2025

The following are changes to existing PA requirements.

Requirement	Code and description	Comments
Camcevi®	J1952, leuprolide injectable, camcevi, 1 mg	No longer requires PA for urology/oncology.
Eligard®	J9217, leuprolide acetate (for depot suspension), 7.5 mg.	Remove PA exclusion for oncology/ urology. Now requires PA for all physicians and other providers.
Fensolvi®	J951, Injection, leuprolide acetate (for depot suspension), 0.25 mg	Remove PA exclusion for oncology/ urology. Now requires PA for all physicians and other providers.
Leuprolide Acetate	J1950, Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Remove PA exclusion for oncology/ urology. Now requires PA for all physicians and other providers.
Lupron®	J1954, Injection, leuprolide acetate (for depot suspension) (Cipla), 7.5 mg	Remove PA exclusion for oncology/ urology. Now requires PA for all physicians and other providers.
Octagam®	J1568 Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg	Added to list for clarification; existing requirement: Immune globulin agents
Panzyga®	J1576 Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Added to list for clarification; existing requirement: Immune globulin agents
Tecelra®	N/A, unclassified	Added to list for clarification; existing requirement: Gene therapy CAR-T.
Tremfya®	J1628, Injection, guselkumab, 1 mg	Added to list for clarification; existing requirement: self-injectable.
Zoladex®	J9202, Goserelin acetate implant, per 3.6 mg	Remove PA exclusion for oncology/ urology. Now requires PA for all physicians and other providers.

Deletions, effective March 1, 2025

The following no longer require PA.

Requirement	Code and description	Comments
Bethkis®, Katabis®, TOBI®	J7682, Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligrams	Tobramycin (inhaled) agents

Requirement	Code and description	Comments
Gamastan® SD	J1560, Injection, gamma globulin, intramuscular, over 10 cc	Discontinued, Immune globulin agent
Uptravi®	No code, unclassified	Pulmonary arterial hypertension (PAH) agent

New CPT and HCPCS codes, effective October 1, 2024

The below procedures, services (including durable medical equipment (DME)) and outpatient pharmaceuticals require PA per new CPT and HCPCS codes issued by the Centers for Medicare & Medicaid Services (CMS).

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Code	Description	Category
C9169	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 mcg	Outpatient Pharmaceuticals (Part B Medications): Anktiva®
C9170	Injection, tarlatamab-dlle, 1 mg	Outpatient Pharmaceuticals (Part B Medications): Imdelltra™
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose	Outpatient Pharmaceuticals (Part B Medications): Beqvez™
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	DME – Items with a total Medi-Cal purchase price greater than $1,500
E0683	Nonpneumatic, nonsequential, peristaltic wave compression pump	DME – Items with a total Medi-Cal purchase price greater than $1,500
E0715	Intravaginal device intended to strengthen pelvic floor muscles during Kegel exercises	Reconstructive and cosmetic surgery, services and supplies
E0721	Transcutaneous electrical nerve stimulator, stimulates nerves in the auricular region	Neuro and spinal cord stimulators
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application	Neuro and spinal cord stimulators
E0743	External lower extremity nerve stimulator for restless legs syndrome, each	Neuro and spinal cord stimulators

Code	Description	Category
E0767	Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories	Experimental
J0175	Injection, donanemab-azbt, 2 mg	Outpatient Pharmaceuticals (Part B Medications): Kisunla™
J9329	Injection, tislelizumab-jsgr, 1 mg	Outpatient Pharmaceuticals (Part B Medications): Tevimbra®
L1006	Scoliosis orthosis (SO), sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	Custom Orthotics
L8720	External lower extremity sensory prosthesis, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg	Prosthetics
0476U	Drug metabolism, psychiatry (e.g., major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis and reported phenotypes	Genetic Testing
0477U	Drug metabolism, psychiatry (e.g., major depressive disorder, general anxiety disorder, ADHD, schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis, including impacted gene-drug interactions and reported phenotypes	Genetic Testing
0478U	Oncology (non-small cell lung cancer), DNA and RNA, digital PCR analysis of nine genes (EGFR, KRAS, BRAF, ALK, ROS1, RET, NTRK 1/2/3, ERBB2, and MET) in formalin-fixed paraffin-embedded (FFPE) tissue, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and reported as actionable detected variants for therapy selection	Genetic Testing
0479U	Tau, phosphorylated, pTau217	Genetic Testing
0480U	Bacteria, Viruses, Fungus, and Parasite Metagenomic Sequencing, Spinal Fluid (MSCSF), Mayo Clinic, Laboratory Developed Test	Genetic Testing
0486U	Oncology (pan-solid tumor), next-generation sequencing analysis of tumor methylation markers present in cell-free circulating tumor DNA, algorithm reported as quantitative measurement of methylation as a correlate of tumor fraction	Genetic Testing

Code	Description	Category
0487U	Oncology (solid tumor), cell-free circulating DNA, targeted genomic sequence analysis panel of 84 genes, interrogation for sequence variants, aneuploidy-corrected gene copy number amplifications and losses, gene rearrangements, and microsatellite instability	Genetic Testing
0493U	Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA	Genetic Testing
0496U	Oncology (colorectal), cell-free DNA, eight genes for mutations, seven genes for methylation by real-time RT-PCR, and four proteins by enzyme-linked immunosorbent assay, blood, reported positive or negative for colorectal cancer or advanced adenoma risk	Genetic Testing
0497U	Oncology (prostate), mRNA gene-expression profiling by real-time RT-PCR of six genes (FOXM1, MCM3, MTUS1, TTC21B, ALAS1, and PPP2CA), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a risk score for prostate cancer	Genetic Testing
0498U	Oncology (colorectal), next- generation sequencing for mutation detection in 43 genes and methylation pattern in 45 genes, blood, and formalin-fixed paraffin-embedded (FFPE) tissue, report of variants and methylation pattern with interpretation	Genetic Testing
0499U	Oncology (colorectal and lung), DNA from formalin-fixed paraffin-embedded (FFPE) tissue, next-generation sequencing of eight genes (NRAS, EGFR, CTNNB1, PIK3CA, APC, BRAF, KRAS, and TP53), mutation detection	Genetic Testing
0500U	Autoinflammatory disease (VEXAS syndrome), DNA, UBA1 gene mutations, targeted variant analysis (M41T, M41V, M41L, c.118-2A>C, c.118-1G>C, c.118-9_118-2del, S56F, S621C)	Genetic Testing
0501U	Oncology (colorectal), blood, quantitative measurement of cell-free DNA (cfDNA)	Genetic Testing
0503U	Neurology (Alzheimer disease), beta amyloid (A1340, A1342, A1342/40 ratio) and tau-protein (ptau217, np-tau217, ptau217/np-tau217 ratio), blood, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry (LC-MS/MS), algorithm score reported as likelihood of positive or negative amyloid plaques	Genetic Testing
0506U	Gastroenterology (Barrett's esophagus), esophageal cells, DNA methylation analysis by next-generation sequencing of at least 89 differentially methylated genomic regions, algorithm reported as likelihood for Barrett's esophagus	Genetic Testing

Code	Description	Category
0507U	Oncology (ovarian), DNA, whole- genome sequencing with 5-hydroxymethylcytosine (5hmC) enrichment, using whole blood or plasma, algorithm reported as cancer detected or not detected	Genetic Testing
0508U	Transplantation medicine, quantification of donor-derived cell-free DNA using 40 single-nucleotide polymorphisms (SNPs), plasma, and urine, initial evaluation reported as percentage of donor-derived cell-free DNA with risk for active rejection	Genetic Testing
0509U	Transplantation medicine, quantification of donor-derived cell-free DNA using up to 12 single-nucleotide polymorphisms (SNPs) previously identified, plasma, reported as percentage of donor-derived cell-free DNA with risk for active rejection	Genetic Testing
0516U	Drug metabolism, whole blood, pharmacogenomic genotyping of 40 genes and CYP2D6 copy number variant analysis, reported as metabolizer status	Genetic Testing
Q5135	Injection, tocilizumab-aazg (Tyenne®), biosimilar, 1 mg	Outpatient Pharmaceuticals (Part B Medications): Tyenne
Q5136	Injection, denosumab-bbdz (Jubbonti®/Wyost®), biosimilar, 1 mg	Outpatient Pharmaceuticals (Part B Medications): Jubbonti/Wyost

Additional information

If you have questions regarding the information contained in this update, contact the Health Net Medi-Cal Provider Services Center at 800-675-6110. Behavioral health providers can call 844-966-0298.

BE INFORMED

If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment pursuant to Section 1704.7 of the California Health & Safety Code.

The information about methods of treatment was developed by the State Department of Health Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures.

INFÓRMESE

Si es usted un paciente que está recibiendo tratamiento contra cualquier forma de cáncer de próstata, o en la etapa prévia a una biopsia por cáncer prostático, su médico o cirujano está urgido dar a usted un sumario escrito de los métodos alternativos de tratamiento disponibles considerados eficaces. Esto es en cumplimiento con la Sección 1704.7 del Código de Salud y Seguridad del Estado de California.

La información sobre los métodos de tratamiento fueron desarrollados por los Servicios de Salud del Estado de California para informar a los pacientes sobre las ventajas y desventajas, riesgos y descripciones de los procedimientos.

通知

如果你是前列癌病患者或如要进行前列腺癌的切片測驗，按照加省衛生安全規則第 1704.7 部份，你的醫生必要向你提供一份有關各種有效治療的報告書。

各種治療的資料是由國家衛生服務局所提供，來使病人知道各種不同治療的好處、壞處、危險和治療的程序。

Provider Dispute Resolution Request

CalViva Health

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-888-893-1569.
- Mail the completed form to the following address.
  CalViva Health Provider Disputes and Appeals Unit
  PO Box 989881
  West Sacramento, CA 95798-9881

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

21-226a/FRM047531EC00 (3/21)

CalViva Health Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-888-893-1569.
- Mail the completed form to the following address.
  CalViva Health Provider Disputes and Appeals Unit
  PO Box 989881
  West Sacramento, CA 95798-9881

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

21-226a/FRM047531EC00 (3/21)

Provider Dispute Resolution Request

Community Health Plan of Imperial Valley (CHPIV)

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 888-893-1569.
- Mail the completed form to the following address.

  Community Health Plan of Imperial Valley Provider Disputes and Appeals Unit
  PO Box 989881
  West Sacramento, CA 95798-9881

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal entrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health net Community Solutions, Inc. is a subsidiary of Health Het, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

26-383 (3/26)

Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 888-893-1569.
- Mail the completed form to the following address.
  Community Health Plan of Imperial Valley Provider Disputes and Appeals Unit
  PO Box 989881
  West Sacramento, CA 95798-9881

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
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11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

23-610 (7/23)

Provider Dispute Resolution Request

Commercial and Medi-Cal

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

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21-225a/FRM047551EC00 (3/21)

Commercial and Medi-Cal Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

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PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

21-225a/FRM047551EC00 (3/21)

Provider Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 833-719-3921.**

*Required Field

Member Information

***Member ID #:**

First Name:

Last Name:

***Birth Date MMDDYYYY:**

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

***First and Last Name:**

Phone Number: *TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

***Member ID #:**

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

- ☐ Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)
- ☐ Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
- ☐ Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
- ☐ Member does not have any current physical, behavioral, or social drivers of health needs
- ☐ Other

Please explain

Previous Pregnancy History (Please check all that apply)

- ☐ History of preterm delivery
- ☐ History of C-Section
- ☐ History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)
- ☐ Member does not have any previous pregnancy conditions
- ☐ Other

Please explain

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25-546 (5/25)
Re. 04 18 2024
X-PNP-5986

Provider Notification of Pregnancy

CalViva HEALTH health net

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 833-719-3921.**

*Required Field

Member Information

***Member ID #:**

First Name:

Last Name:

***Birth Date MMDDYYYY:**

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

***First and Last Name:**

Phone Number: *****TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

***Member ID #:**

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

- ☐ Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)
- ☐ Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
- ☐ Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
- ☐ Member does not have any current physical, behavioral, or social drivers of health needs
- ☐ Other

Please explain

Previous Pregnancy History (Please check all that apply)

- ☐ History of preterm delivery
- ☐ History of C-Section
- ☐ History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)
- ☐ Member does not have any previous pregnancy conditions
- ☐ Other

Please explain

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

25-547 (5/25)
Re. 04 18 2024
X-PNP-5986

Community Health Plan OF IMPERIAL VALLEY | MEDI-CAL | health net

Provider Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 833-719-3921.**

*Required Field

Member Information

***Member ID #:**

First Name:

Last Name:

***Birth Date MMDDYYYY:**

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

***First and Last Name:**

Phone Number: *TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

***Member ID #:**

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

- ☐ Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)
- ☐ Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
- ☐ Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
- ☐ Member does not have any current physical, behavioral, or social drivers of health needs
- ☐ Other

Please explain

Previous Pregnancy History (Please check all that apply)

- ☐ History of preterm delivery
- ☐ History of C-Section
- ☐ History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)
- ☐ Member does not have any previous pregnancy conditions
- ☐ Other

Please explain

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV members. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

26-384 (3/26)
Re. 04 18 2024
X-PNP-5986

PCP:	
SECTION: Office Management	
POLICY AND PROCEDURE: **Provision of Services 24 Hours a Day**	Approved date: _____ Approved by: _____ Effective date: _____ Revised by: _____ Revised by: _____

POLICY:
The site will have a provision for appropriate, coordinated health care services twenty-four hours a day, seven days a week

PROCEDURE:

A. The staff will ensure that current clinic office hours are posted within the office or readily available upon request.

B. The PCP will ensure that current site-specific resource information is available to site personnel about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care.

C. Medi-Cal and Cal MediConnect participating providers must offer hours of operation to Medi-Cal and CalMediConnect members that are no less than hours of operation offered to patients from other lines of business, or to Medi-Cal Fee-for-Service (FFS) beneficiaries.

D. The staff will be able to contact the PCP (or covering physician) at all times via telephone, cell phone or pager.

Radiologic Health Branch
Contact Information
February 2014

OFFICE	ADDRESS	TELEPHONE NUMBER	FAX NUMBER
Radiologic Health Branch Sacramento	**MAILING ADDRESS:** Department of Public Health Radiologic Health Branch P.O. Box 997414, MS 7610 Sacramento, CA 95899-7414 **PHYSICAL ADDRESS (for FEDEX, UPS, etc.):** Department of Public Health Radiologic Health Branch 1500 Capitol Avenue, 5th Floor, MS 7610 Sacramento, CA 95814-5006	(916) 327-5106	(916) 440-7999
Radiologic Health Branch Richmond	850 Marina Bay Parkway, Bldg. P, 1st Floor Richmond, CA 94804	(510) 620-3416	(510) 620-3874
Radiologic Health Branch Brea	500 S. Kraemer Blvd, Brea, CA 92821 Radioactive Materials (RAM), Suite 235 X-ray (Region 2*), Suite 235 X-ray (Region 5*), Suite 225	RAM (714) 524-1409 X-ray (714) 524-4450 X-ray (714) 524-5681	RAM (714) 524-1908 X-ray (714) 524-1908 X-ray (714) 524-5682
Radiologic Health Branch Los Angeles County	Radiation Management 3530 Wilshire Boulevard, 9th Floor Los Angeles, CA 90010	(213) 351-7897	(213) 351-2718
Radiologic Health Branch San Diego County	**MAILING ADDRESS:** County of San Diego Dept of Envr Health, Radiological Health Program 5500 Overland Ave, Ste 110 MS O-560 San Diego, CA, 92123	(858) 694-3621	(858) 694-3629

***Region 2 serves the following counties:**
Fresno, Inyo, Kern, Kings, Madera, Mariposa, Mono, Monterey, San Benito, San Luis Obispo, Santa Barbara, Tulare, Ventura.

***Region 5 serves the following counties:**
Imperial, Orange, Riverside, San Bernardino.

PCP:	Page 1 of 3
SECTION: Clinical Services	
POLICY AND PROCEDURE: Radiology Services	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The site will meet California DHCS Radiological inspection and safety regulations by ensuring that radiation is used safely and effectively, individuals are protected from unnecessary radiation exposure and that environmental quality is preserved and maintained (17 CCR §30255, §30305, §30404, §30405).

PROCEDURE:

A. Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.

1. If no current inspection report on site, there is either a:
    - Short Form Sign-off Sheet (issued for minimal problems that are easily corrected) **or**
    - Notice of Violation Form (issued if there are more serious violations) **with** an approval letter for a corrective action plan form the CA Radiologic Health Branch.

2. Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115).
    - Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.
    - High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years.
    - Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment use, and likelihood of radiation exposure.

- DEXAscanner equipment: According to the CA Radiological Branch, a lead apron/shield and gonad shields are usually not required. The CA Radiologic Health Branch (RHB) has additional requirements . such as, the registration of the DEXAscanner and use of dosimeter badges. Ref: CCR Title 17 Sections 30111, 30305, 30404.
- If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch.

B. The following documents are <u>posted</u> on site:

1. Current copy of Title 17 with a posted notice about availability of Title 17 and its location.
2. "Radiation Safety Operating Procedures" posted in a highly visible location.
3. "Notice to Employees Poster" posted in highly visible location.
4. "Caution, X-Ray" sign posted on or next to door of each room that has X-Ray equipment.
5. Physician Supervisor/Operator certificate posted and within current expiration date.
6. Technologist certificate posted and within current expiration date.
    - If there are a large number of technicians, a list of names, license numbers and expiration dates may be substituted.
    - The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates.
    - The "Limited Permit" limits the technician to one of the 10 X-ray categories specified on the limited certificate: Chest, Dental Laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-Ray bone densitometry.

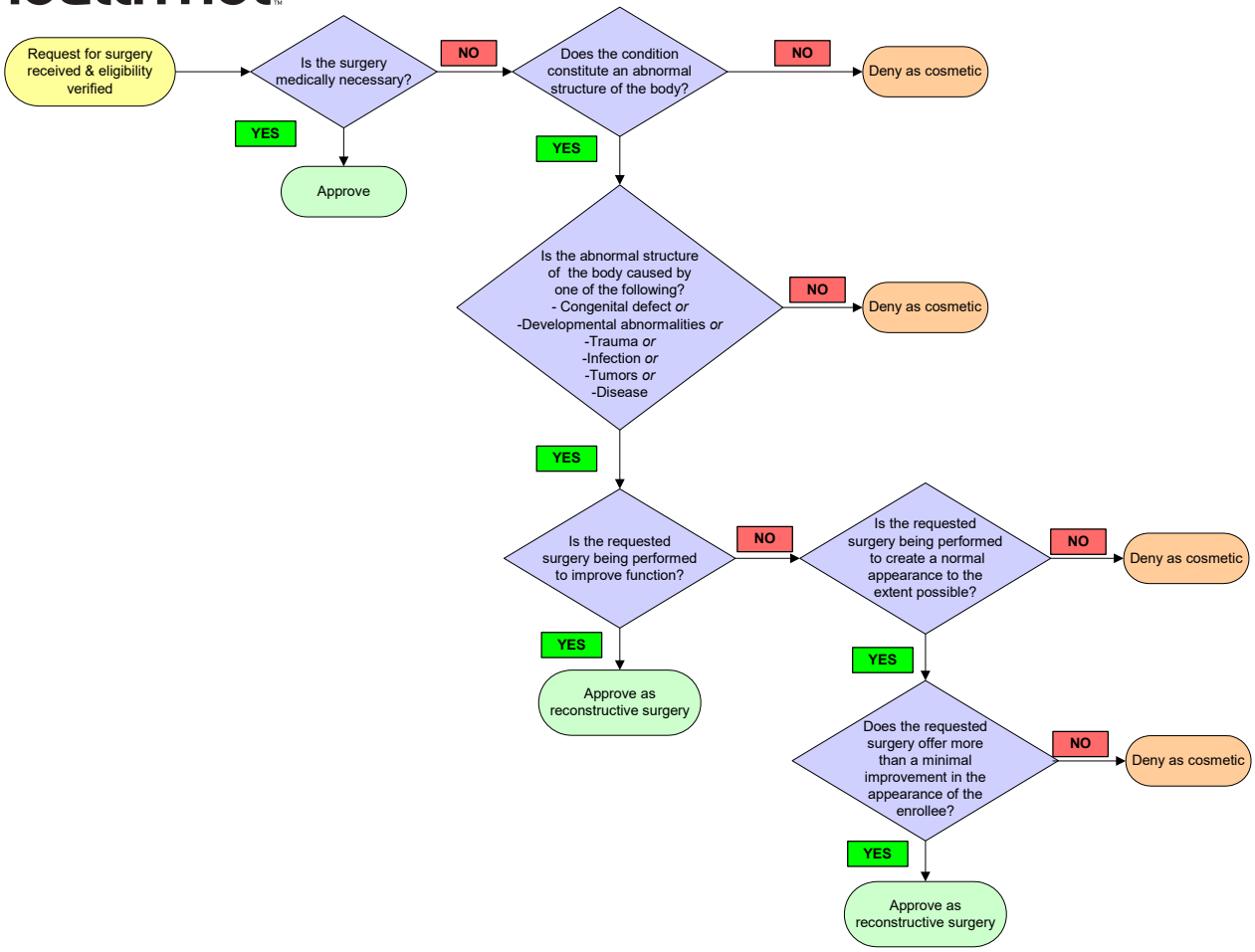
C. The following radiological protective equipment is present on site:

1. Operator protection devices: radiologic equipment operator must use lead apron or lead shield.
2. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.

<u>Notes</u>:

- The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Health Care Services enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines.
- For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CA DHCS Radiologic Health Branch (Compliance Unit) General Information (daytime hours) at (916) 327-5106.

Reconstructive Surgery Decision Tree



RED FLAGS FOR ALCOHOL/DRUG ABUSE

Observable

1. Tremor/perspiring/tachycardia
2. Evidence of current intoxication
3. Prescription drug seeking behavior
4. Frequent falls; unexplained bruises
5. Diabetes, elevated BP, ulcers; non-responsive to treatment
6. Frequent hospitalizations
7. Inflamed, eroded nasal septum
8. Dilated pupils
9. Track marks/injection sites
10. Gunshot/knife wound
11. Suicide talk/attempt; depression
12. Pregnancy (screen all)

Laboratory

1. MCV - over 95
2. MCH - High
3. GGT - High
4. SGOT - High
5. Bilirubin - High
6. Triglycerides - High
7. Anemia
8. Positive UA for illicit drugs

QUESTIONS TO ASK PATIENT

C 1. Have you ever felt you should ***Cut Down*** on your drinking or drug use?

A 2. Have people ***Annoyed*** you by criticizing or complaining about your drinking or drug use?

G 3. Have you ever felt bad or ***Guilty*** about your drinking or drug use?

E 4. Have you ever had a drink or drug in the morning ***(Eye Opener)*** to steady your your nerves or to get rid of a hangover?

5. Do you use any drugs other than those prescribed by a physician?
6. Has a physician ever told you to cut down or quit use alcohol or drugs?
7. Has your drinking/drug use caused family, job or legal problems?
8. When drinking/using drugs have you ever had a memory loss (blackout)?

REFERRAL, CONSULTS, DIAGNOSTIC TESTING TICKLER LOG

Date	Patient Name	Refer To	Appointment Date	Report Received	Calls to Specialist/Lab, X-Ray, Etc.	Results of Follow-Up Action

Instructions: When the physician orders a procedure, test or consultation, enter the date, patient's name, the referred to office and the date of the appointment. When the report of the ordered services is received, enter the date received. If the report is not received within 2 weeks of the scheduled date of the ordered service, call the provider of the service to inquire about the results report and document the call(s). Record results of actions taken to obtain reports.

Refrigerator Temperature Log

MONTH & YEAR	REFRIGERATOR LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
Example	8:00 a.m.	NN		4.3	2.4	5.7	
	4:00 p.m.	NN	✔	7.6	4.0	9.1	12345
1	a.m.						
	p.m.						
2	a.m.						
	p.m.						
3	a.m.						
	p.m.						
4	a.m.						
	p.m.						
5	a.m.						
	p.m.						
6	a.m.						
	p.m.						
7	a.m.						
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	p.m.						
9	a.m.						
	p.m.						
10	a.m.						
	p.m.						
11	a.m.						
	p.m.						
12	a.m.						
	p.m.						
13	a.m.						
	p.m.						
14	a.m.						
	p.m.						
15	a.m.						
	p.m.						

Notes: _____

Instructions

Keep refrigerator in OK range.

Check temperatures twice a day.

1. Fill out month, year, refrigerator ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/fridge ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name:

_____

Signature:_____

Date: ___/___/___

Staff Na mes and Initials:

_____

_____

_____

VFC

Refrigerator Temperature Log

MONTH & YEAR	REFRIGERATOR LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
16	a.m.						
	p.m.						
17	a.m.						
	p.m.						
18	a.m.						
	p.m.						
19	a.m.						
	p.m.						
20	a.m.						
	p.m.						
21	a.m.						
	p.m.						
22	a.m.						
	p.m.						
23	a.m.						
	p.m.						
24	a.m.						
	p.m.						
25	a.m.						
	p.m.						
26	a.m.						
	p.m.						
27	a.m.						
	p.m.						
28	a.m.						
	p.m.						
29	a.m.						
	p.m.						
30	a.m.						
	p.m.						
31	a.m.						
	p.m.						

Notes: _____

Instructions

Keep refrigerator in OK range.

Check temperatures twice a day.

1. Fill out month, year, refrigerator ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/fridge ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name: _____

Signature: _____
Date: ___/___/___
Staff Na mes and Initials: _____

Refrigerator Temperature Log

MONTH & YEAR	REFRIGERATOR LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
Example	8:00 a.m.	NN		40.5	38.1	43.7	
	4:00 p.m.	NN	✔	37.4	33.0	39.2	12345
1	a.m.						
	p.m.						
2	a.m.						
	p.m.						
3	a.m.						
	p.m.						
4	a.m.						
	p.m.						
5	a.m.						
	p.m.						
6	a.m.						
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7	a.m.						
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	p.m.						
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	p.m.						
12	a.m.						
	p.m.						
13	a.m.						
	p.m.						
14	a.m.						
	p.m.						
15	a.m.						
	p.m.						

Notes: _____

Instructions

Keep refrigerator in OK range.

Check temperatures twice a day.

1. Fill out month, year, freezer ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/fridge ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name:

_____

Signature:_____

Date: ___/___/___

Staff Na mes and Initials:

_____

_____

_____

VFC

Refrigerator Temperature Log

MONTH & YEAR	REFRIGERATOR LOCATION/ID	VFC PIN

DAY OF MONTH	TIME	INITIALS	ALARM	CURRENT	MIN	MAX	SHOTS ID
16	a.m.						
	p.m.						
17	a.m.						
	p.m.						
18	a.m.						
	p.m.						
19	a.m.						
	p.m.						
20	a.m.						
	p.m.						
21	a.m.						
	p.m.						
22	a.m.						
	p.m.						
23	a.m.						
	p.m.						
24	a.m.						
	p.m.						
25	a.m.						
	p.m.						
26	a.m.						
	p.m.						
27	a.m.						
	p.m.						
28	a.m.						
	p.m.						
29	a.m.						
	p.m.						
30	a.m.						
	p.m.						
31	a.m.						
	p.m.						

Notes: _____

Instructions

Keep refrigerator in OK range.

Check temperatures twice a day.

1. Fill out month, year, freezer ID, and PIN.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Report excursion to SHOTS at MyVFCvaccines.org.
5. Record assigned SHOTS ID.
6. Ensure data logger is in place and recording.

Supervisor's Review

When log is complete, check all that apply:

- ☐ Month/year/fridge ID/PIN are recorded.
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files for all the days on this log to find any missed excursions. Date downloaded: ___/___/___
- ☐ Any excursions were reported to SHOTS at MyVFCvaccines.org.
- ☐ We understand that falsifying this log is grounds for vaccine replacement and termination from the VFC Program.

On-Site Supervisor's Name:

_____

Signature:_____

Date: ___/___/___

Staff Na mes and Initials:

_____

_____

_____

VFC

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! =Report immediately by telephone (designated by a ♦ in regulations).
† =Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ =Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
=All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae,* invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

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* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

Request for PCP/PPG Change Form

☐ **Health Net** ☐ **Molina**

New PCP Name:	
Location:	
License/ Clinic#:	
PPG Name:	
Reason For request:	

	Member's Name	Date of Birth	CIN#
1			
2			
3			

Please check Yes or No:	Yes	No
Is the member currently hospitalized?		
Is the member in her 3rd trimester of pregnancy?		
Did the member receive any services with the assigned PCP/PPG?		
Is the member currently receiving treatment?		
Is the member scheduled to receive future treatment (surgery, specialist care, etc.)?		
Has the member recently delivered a baby within the past 60 days?		
Does the member have an infant less than 60 days old who is currently in the hospital?		
Did the member receive any services in the emergency room?		

Please read Disclaimer:
Any prior authorizations submitted to or approved by the existing PCP/PPG will no longer be valid with the new PCP/PPG.
If a member becomes hospitalized prior to the effective date of change, the member will be changed back to existing PCP/PPG until the episode of care is complete.
If the mother of a newborn request a PCP/PPG change prior to her first post-partum visit, (which usually occurs within 40 days of delivery), the change cannot be processed. (Only exception is if the requested PCP is in the same PPG).

Member's Signature: _____

Member's Address: _____

Member's Phone #: _____

Name of Staff Member Completing Transfer: _____

Staff Member's Phone #: _____ Ext. #:_____ Fax #: _____

Additional Information: _____

(Please check ☑one)

Today's Date: _____/____/____ ☐ **Fax** ☐ **E-mail** Effective Date: _____/____/_____

OFFICE USE:

Date change entered: _____/_____/_____ **Rep's Name:** _____

Fax request to: Health Net
Medi-Cal Member Services
(800) 281-2999 or (844) 837-5947
Email request to
SHPPROVIDERREQUEST@healthnet.com

Forma para Solicitar cambio de Doctor/Grupo Medico

Por favor elija su Plan de Salud: ☐ **Health Net** ☐ **Molina**

Nombre del Nuevo Doctor Primario:	
Número de identificación del Medico:	
Dirección del Doctor Primario:	
Grupo Medico:	
Escriba la razón pare el cambio:	

Nombre Y Apellido	**Fecha de Nacimiento**	**CIN#**
1.		
2.		
3.		

Por favor Marque "Si" o "No" en las siguientes preguntas:	**SI**	**NO**
¿Se encuentra el afiliado actualmente hospitalizado?		
¿Está la afiliada en su tercer trimestre de embarazo?		
El afiliado ha recibido servicios médicos con su doctor primario o con un doctor afiliado a su grupo medico?		
¿Está el afiliado recibiendo algún tratamiento médico actualmente?		
Esta el afiliado programado para recibir algún tratamiento médico futuro como una cirugía o visitas al especialista?		
El afiliado tiene un Nuevo bebe de menos de 60 días de nacido y que está internado en algún hospital actualmente?		

Por favor lea la declaración detalladamente:
Cualquier autorización previa sometida o aprobada por el doctor primario o grupo medico al que este asignado actualmente no será válido con el nuevo doctor primario o grupo médico.
Si el miembro se encuentra hospitalizado en el día efectivo del cambio, el cambio será anulado y se mantendrá con el mismo doctor primario y grupo medico hasta que el tratamiento de cuidado sea completado.
Si tiene un recién nacido y solicita un cambio de doctor primario y grupo médico y no ha completado su cuidado postnatal, que usualmente se completa entre los 40 días después del parto, el cambio no podrá ser procesado. La única excepción seria si cambia con un doctor primario dentro del mismo grupo médico.

Firma del afiliado: _____

Domicilio del afiliado: _____

Nombre del Represéntate que completa la forma: _____

Número de teléfono del Representante:_____ Ext: _____ Numero de Fax: _____

Información Adicional: _____

Fecha de hoy: / /____ ¿Como fue enviado? **(Marque ☑ uno)** ☐ Fax ☐ Correo Electrónico
Fecha efectiva:_____/____/_____

Internal Use Only

Date Change Entered:

Coordinator's Name:

Por Favor envié por Fax
Atención: Health Net
Medi-Cal Member Services
Fax#: 1-(844) 837-5947
Correo Electrónico a:
SHPROVIDERREQUEST@healthnet.com

Request for PCP/PPG Change Form

New PCP Name:	
Location:	
License/ Clinic#:	
PPG Name:	
Reason For request:	

	Member's Name	Date of Birth	CIN#
1			
2			
3			

Please check Yes or No:	Yes	No
Is the member currently hospitalized?		
Is the member in her 3rd trimester of pregnancy?		
Did the member receive any services with the assigned PCP/PPG?		
Is the member currently receiving treatment?		
Is the member scheduled to receive future treatment (surgery, specialist care, etc.)?		
Has the member recently delivered a baby within the past 60 days?		
Does the member have an infant less than 60 days old who is currently in the hospital?		
Did the member receive any services in the emergency room?		

Please read Disclaimer:
Any prior authorizations submitted to or approved by the existing PCP/PPG will no longer be valid with the new PCP/PPG.
If a member becomes hospitalized prior to the effective date of change, the member will be changed back to existing PCP/PPG until the episode of care is complete.
If the mother of a newborn request a PCP/PPG change prior to her first post-partum visit, (which usually occurs within 40 days of delivery), the change cannot be processed. (Only exception is if the requested PCP is in the same PPG).

Member's Signature: _____

Member's Address: _____

Member's Phone #: _____

Name of Staff Member Completing Transfer: _____

Staff Member's Phone #: _____ _____ Ext. #: _____ Fax #: _____ _____

Additional Information: _____

(Please check ☑one)

Today's Date: _____/____/____ ☐ **Fax** ☐ **E-mail** Effective Date: _____/____/_____

OFFICE USE:

Date change entered: _____/_____/_____ **Rep's Name: _____**

Fax request to: CalViva Health
Medi-Cal Member Services
1-(844) 837-5947
Email request to:
SHPPROVIDERREQUEST@healthnet.com

Forma para Solicitar cambio de Doctor/Grupo Medico

Por favor elija su Plan de Salud: ☐ **CalViva Health**

Nombre del Nuevo Doctor Primario:	
Número de identificación del Medico:	
Dirección del Doctor Primario:	
Grupo Medico:	
Escriba la razón pare el cambio:	

Nombre Y Apellido	**Fecha de Nacimiento**	**CIN#**
1.		
2.		
3.		

Por favor Marque "Si" o "No" en las siguientes preguntas:	**SI**	**NO**
¿Se encuentra el afiliado actualmente hospitalizado?		
¿Está la afiliada en su tercer trimestre de embarazo?		
El afiliado ha recibido servicios médicos con su doctor primario o con un doctor afiliado a su grupo medico?		
¿Está el afiliado recibiendo algún tratamiento médico actualmente?		
Esta el afiliado programado para recibir algún tratamiento médico futuro como una cirugía o visitas al especialista?		
El afiliado tiene un Nuevo bebe de menos de 60 días de nacido y que está internado en algún hospital actualmente?		

Por favor lea la declaración detalladamente:
Cualquier autorización previa sometida o aprobada por el doctor primario o grupo medico al que este asignado actualmente no será válido con el nuevo doctor primario o grupo médico.
Si el miembro se encuentra hospitalizado en el día efectivo del cambio, el cambio será anulado y se mantendrá con el mismo doctor primario y grupo medico hasta que el tratamiento de cuidado sea completado.
Si tiene un recién nacido y solicita un cambio de doctor primario y grupo médico y no ha completado su cuidado postnatal, que usualmente se completa entre los 40 días después del parto, el cambio no podrá ser procesado. La única excepción seria si cambia con un doctor primario dentro del mismo grupo médico.

Firma del afiliado: _____

Domicilio del afiliado: _____

Nombre del Represéntate que completa la forma: _____

Número de teléfono del Representante:_____ Ext: _____ Numero de Fax: _____

Información Adicional: _____

Fecha de hoy: / /____ ¿Como fue enviado? **(Marque ☑ uno)** ☐ Fax ☐ Correo Electrónico
Fecha efectiva:____/____/____

Internal Use Only

Date Change Entered:

Coordinator's Name:

Por Favor envié por Fax
Atención: CalViva Health
Medi-Cal Member Services
Fax#: 1-(844) 837-5947
Correo Electrónico a:
SHPPROVIDERREQUEST@healthnet.com

PCP/PPG Change Request Form

☐ Community Health Plan of Imperial Valley (CHPIV)

New PCP Name:	
Location:	
License/ Clinic#:	
PPG Name:	
Reason For request:	

	Member's Name	Date of Birth	CIN#
1			
2			
3			

Please check Yes or No:	Yes	No
Is the member currently hospitalized?		
Is the member in her 3rd trimester of pregnancy?		
Did the member receive any services with the assigned PCP/PPG?		
Is the member currently receiving treatment?		
Is the member scheduled to receive future treatment (surgery, specialist care, etc.)?		
Has the member recently delivered a baby within the past 60 days?		
Does the member have an infant less than 60 days old who is currently in the hospital?		
Did the member receive any services in the emergency room?		

Please read Disclaimer:
Any prior authorizations submitted to or approved by the existing PCP/PPG will no longer be valid with the new PCP/PPG.
If a member becomes hospitalized prior to the effective date of change, the member will be changed back to existing PCP/PPG until the episode of care is complete.
If the mother of a newborn request a PCP/PPG change prior to her first post-partum visit, (which usually occurs within 40 days of delivery), the change cannot be processed. (Only exception is if the requested PCP is in the same PPG).

Member's Signature: _____

Member's Address: _____

Member's Phone #: _____

Name of Staff Member Completing Transfer: _____

Staff Member's Phone #: _____ Ext. #:_____ Fax #: _____

Additional Information: _____

(Please check ☑one)

Today's Date: ____/____/____ ☐ **Fax** ☐ **E-mail** Effective Date: ____/____/____

OFFICE USE:

Date change entered: ____/____/____ **Rep's Name:** _____

Fax request to: CHPIV
Member Services
(844) 837-5947
Email request to
SHPPROVIDERREQUEST@healthnet.com

Forma para Solicitar cambio de Doctor/Grupo Medico

Por favor elija su Plan de Salud: ☐ **Community Health Plan of Imperial Valley**

Nombre del Nuevo Doctor Primario:	
Número de identificación del Medico:	
Dirección del Doctor Primario:	
Grupo Medico:	
Escriba la razón pare el cambio:	

Nombre Y Apellido	**Fecha de Nacimiento**	**CIN#**
1.		
2.		
3.		

Por favor Marque "Si" o "No" en las siguientes preguntas:	**SI**	**NO**
¿Se encuentra el afiliado actualmente hospitalizado?		
¿Está la afiliada en su tercer trimestre de embarazo?		
El afiliado ha recibido servicios médicos con su doctor primario o con un doctor afiliado a su grupo medico?		
¿Está el afiliado recibiendo algún tratamiento médico actualmente?		
Esta el afiliado programado para recibir algún tratamiento médico futuro como una cirugía o visitas al especialista?		
El afiliado tiene un Nuevo bebe de menos de 60 días de nacido y que está internado en algún hospital actualmente?		

Por favor lea la declaración detalladamente:
Cualquier autorización previa sometida o aprobada por el doctor primario o grupo medico al que este asignado actualmente no será válido con el nuevo doctor primario o grupo médico.
Si el miembro se encuentra hospitalizado en el día efectivo del cambio, el cambio será anulado y se mantendrá con el mismo doctor primario y grupo medico hasta que el tratamiento de cuidado sea completado.
Si tiene un recién nacido y solicita un cambio de doctor primario y grupo médico y no ha completado su cuidado postnatal, que usualmente se completa entre los 40 días después del parto, el cambio no podrá ser procesado. La única excepción seria si cambia con un doctor primario dentro del mismo grupo médico.

Firma del afiliado: _____

Domicilio del afiliado: _____

Nombre del Represéntate que completa la forma: _____

Número de teléfono del Representante:_____ Ext: _____ Numero de Fax: _____

Información Adicional: _____

Fecha de hoy: / /____ ¿Como fue enviado? **(Marque ☑ uno)** ☐ Fax ☐ Correo Electrónico
Fecha efectiva:_____/____/_____

Internal Use Only

Date Change Entered:

Coordinator's Name:

Por Favor envié por Fax
Atención: CHPIV
Medi-Cal Member Services
Fax#: 1-(844) 837-5947
Correo Electrónico a:
SHPPROVIDERREQUEST@healthnet.com

SAMPLE

Sample Site Evacuation Plan

Draw diagram of your office with clearly marked exits and evacuation route

Sharps Injury Log

The following information, if known or reasonably available, should be documented within 14 working days of the date on which each exposure incident was reported.

1. Date and time of the exposure incident: _____
2. Date of exposure incident report: _____ Report written by: _____
3. Type and brand of sharp involved: _____
4. Description of exposure incident:
   - Job classification of exposed employee: _____
   - Department or work area where the incident occurred: _____
   - Procedure being performed by the exposed employee at the time of the incident: _____
     _____
   - How the incident occurred: _____
   - Body part(s) involved: _____
   - Did the device involved have engineered sharps injury protection? Yes (✓) _____ No (✓) _____
   - Was engineered sharps injury protection on the sharp involved? Yes (✓) _____ No (✓) _____

If Yes	If No
A. Was the protective mechanism activated at the time of the exposure incident? Yes ____ No ____ B. Did the injury occur before, during, or after the mechanism was activated? _____ _____ Comments: _____ _____ _____	A. Does the injured employee believe that a protective mechanism could have prevented the injury? Yes ____ No ____

   - Does the exposed employee believe that any controls (e.g., engineering, administrative, or work practice) could have prevented the injury? Yes (✓) _____ No (✓) _____
   - Employee's opinion: _____
     _____
     _____
     _____
5. Comments on the exposure incident (e.g., additional relevant factors involved): _____
   _____
   _____
   _____
6. Employee interview summary: _____
   _____
   _____
   _____
7. Picture(s) of the sharp(s) involved (please attach if available).

PCP:	
SECTION: Access/Safety	
POLICY AND PROCEDURE: **Site Accessibility by Individuals with Physical Disabilities**	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Site shall be accessible and useable by individuals with physical disabilities. The site will meet city, county and state building structure and access ordinances for persons with physical disabilities as well as meet the California Department of Health Care Services Medi-Cal Managed Care Division Physical Accessibility Review Survey (PARS).

PROCEDURE:

I. ACCOMODATIONS

Accessibility levels and elements are made available to members on the health plan website and in provider directories. Access is Basic or Limited with element summary for: Parking, Exterior Building, Interior Building, Restroom, Exam Room, and Medical Equipment such as accessible scale and hi-lo exam table.

A. The site shall maintain the following safety accommodations seniors and persons with disabilities.
    1. Designated disabled parking space near the primary entrance.
        a. Are there accessible parking spaces provided in off-street parking and the correct number of accessible parking spaces provided.
        b. Do curbs on the route from off-street public parking have curb ramps at the parking and drop-off location?
        c. Is VAN accessible parking provided or available.
        d. Staff will assist disabled members who choose to continue to seek care at the site, in spite of accessibility, and will meet any disabled member at the scheduled time/place and assist the member at a meeting point as near as possible to an entrance agreed upon.
    2. An exterior route to the main entrance from accessible parking, public transportation, and public sidewalks will include:
        a. A curb ramp if the accessible route crosses a curb.
        b. The accessible route is at least 36 inches wide, is stable, firm, and slip resistant, and free of grates, gaps, and openings greater than ½ inch wide and over ¼ inch deep.
    3. Pedestrian ramps will be maintained. (Any path is considered a ramp if the slope is greater than a one foot rise in twenty feet of horizontal run).
        a. Each run (leg) of the ramp is no longer than 30 feet between landings.

   b. Handrails are provided on both sides of the ramp, between 34 and 38 inches above the ramp surface if it is longer than six feet.
   c. Level landings at the top and bottom of all ramps will be maintained clear of any obstruction and staff are responsible for clearing any obstruction noted.
4. The building entrance shall be made accessible to the disabled or another accessible entrance shall be made available.
   a. The main entrance door is at least 32 inches wide when opened to 90 degrees.
   b. Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, a person using a walker or other mobility devices, to open the door safely and independently.
5. If there is an interior route (from the building entrance to the clinic/office entrance, to the registration counter/window, or through the clinic/office to areas that patients could go) is the accessible route:
   a. At least 36 inches wide
   b. There are handrails on each side of the stairs on the accessible route.
   c. A platform lift (if available) can be used without assistance.
6. Passenger elevator will be maintained in working condition for multi-level floor accommodation and will be available for use during business hours. If elevator(s) are present, is the elevator:
   a. Equipped with both visible and audible door opening/closing and floor indicators.
   b. There are raised letter and Braille sign on each side of each elevator jamb.
   c. The hall call buttons for the elevator are no higher than 48 inches from the floor.
   d. The elevator car is large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit (floor area is at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide).
   e. The buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons.
7. The patient restroom(s) will be accessible to physically disabled individuals. Staff may make a reasonable alternative available to the member as needed. Alternatives may include: directing or accompanying the member to a nearby disabled – accessible restroom, physically assisting the member in the smaller restroom, or, providing a urinal, bedpan or commode, and sanitary supplies, as acceptable to the member. An accessible restroom shall:
   a. Provide grab bars, one on the wall behind the toilet and one on the wall next to the toilet.

b. Toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high.
c. Space is provided in front of the sink to allow wheelchair users to park in front of the sink that is 30 inches wide and 48 inches deep.
d. Faucet handles are operable with one hand and without grasping, pinching, or twisting.
e. The restroom doorway has a minimum clear opening of 32 inches with the door open at 90 degrees.
f. Restrooms with stalls has a 60-inch diameter turning circle or a 60-inch x 60 inch "T" shaped space inside the restroom to allow a wheelchair or scooter to turn around.

8. Accessible patient exam/treatment room(s) has a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop.
9. PCP sites that have accessible medical equipment shall have:
    a. Height adjustable exam table(s) that lowers to between 17 inches and 19 inches from the floor to the top of the cushion.
    b. Space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table.
    c. There is a 60-inch diameter turning circle or a 60-inch x 60 inch "T" shaped space so that a wheelchair or scooter user can make a 180 degree turn.
    d. A weight scale within the medical office is available with a platform to accommodate a wheelchair or scooter and the patient.

II. CHANGES IN ACCESS/AVALABILITY

A. Notification
    1. If at any time the site becomes inaccessible to physically disabled individuals, all contracted health plans will be notified in writing.

Download this topic [PDF]

Ultraviolet (UV) Radiation

What is UV radiation?

Ultraviolet (UV) radiation is a form of electromagnetic radiation that comes from the sun and man-made sources like tanning beds and welding torches.

Radiation is the emission (sending out) of energy from any source. There are many types of radiation, ranging from very high-energy (high-frequency) radiation – like x-rays and gamma rays – to very low-energy (low-frequency) radiation – like radio waves. UV rays are in the middle of this spectrum. They have more energy than visible light, but not as much as x-rays.

There are also different types of UV rays, based on how much energy they have. Higher-energy UV rays are a form of *ionizing radiation*. This means they have enough energy to remove an electron from (ionize) an atom or molecule. Ionizing radiation can damage the DNA (genes) in cells, which in turn may lead to cancer. But even the highest-energy UV rays don't have enough energy to penetrate deeply into the body, so their main effect is on the skin.

UV radiation is divided into 3 main groups:

- **UVA rays** have the least energy among UV rays. These rays can cause skin cells to age and can cause some indirect damage to cells' DNA. UVA rays are mainly linked to long-term skin damage such as wrinkles, but they are also thought to play a role in some skin cancers.
- **UVB rays** have slightly more energy than UVA rays. They can damage the DNA in skin cells directly, and are the main rays that cause sunburns. They are also thought to cause most skin cancers.
- **UVC rays** have more energy than the other types of UV rays. Fortunately, because of this, they react with ozone high in our atmosphere and don't reach the ground, so they are not normally a risk factor for skin cancer. But UVC rays can also come from some man-made sources, such as arc welding torches, mercury lamps, and UV sanitizing bulbs used to kill bacteria and other germs (such as in water, air, food, or on surfaces).

How are people exposed to UV radiation?

Sunlight

Sunlight is the main source of UV radiation, even though UV rays make up only a small portion of the sun's rays. Different types of UV rays reach the ground in different amounts. About 95% of the UV rays from the sun that reach the ground are UVA rays, with the remaining 5% being UVB rays.

The strength of the UV rays reaching the ground depends on a number of factors, such as:

- **Time of day:** UV rays are strongest between 10 am and 4 pm.
- **Season of the year:** UV rays are stronger during spring and summer months. This is less of a factor near the equator.

- **Distance from the equator (latitude):** UV exposure goes down as you get farther from the equator.
- **Altitude:** More UV rays reach the ground at higher elevations.
- **Clouds:** The effect of clouds can vary, but what's important to know is that UV rays can get through to the ground, even on a cloudy day.
- **Reflection off surfaces:** UV rays can bounce off surfaces like water, sand, snow, pavement, or even grass, leading to an increase in UV exposure.
- **Contents of the air:** Ozone in the upper atmosphere, for example, filters out some UV radiation.

The amount of UV exposure a person gets depends on the strength of the rays, the length of time the skin is exposed, and whether the skin is protected with clothing or sunscreen.

Man-made sources of UV rays

People can also be exposed to man-made sources of UV rays. These include:

- **Sunlamps and sunbeds (tanning beds and booths):** The amount and type of UV radiation someone is exposed to from a tanning bed (or booth) depends on the specific lamps used in the bed, how long a person stays in the bed, and how many times the person uses it. Most modern UV tanning beds emit mostly UVA rays, with the rest being UVB.
- **Phototherapy (UV therapy):** Some skin problems (such as psoriasis) are helped by treatment with UV light. For a treatment known as PUVA, a drug called a psoralen is given first. The drug collects in the skin and makes it more sensitive to UV. Then the patient is treated with UVA radiation. Another treatment option is the use of UVB alone (without a drug).
- **Black-light lamps:** These lamps use bulbs that give off UV rays (mostly UVA). The bulb also gives off some visible light, but it has a filter that blocks most of that out while letting the UV rays through. These bulbs have a purple glow and are used to view fluorescent material. Bug-zapping insect traps also use "black light" that gives off some UV rays, but the bulbs use a different filter that causes them to glow blue.
- **Mercury-vapor lamps:** Mercury-vapor lamps can be used to light large public areas such as streets or gyms. They do not expose people to UV rays if they are working properly. They are actually made up of 2 bulbs: an inner bulb that emits light and UV rays, and an outer bulb that filters out the UV. UV exposure can only occur if the outer bulb is broken. Some mercury-vapor lamps are designed to turn themselves off when the outer bulb breaks. The ones that don't have this feature are only supposed to be installed behind a protective layer or in areas where people wouldn't be exposed if part of the bulb breaks.
- **High-pressure xenon and xenon-mercury arc lamps, plasma torches, and welding arcs:** Xenon and xenon-mercury arc lamps are used as sources of light and UV rays for many things, such as UV "curing" (of inks, coatings, etc.), disinfection, to simulate sunlight (to test solar panels, for example), and even in some car headlights. Most of these, along with plasma torches and welding arcs, are mainly of concern in terms of workplace UV exposure.

Does UV radiation cause cancer?

Most skin cancers are a result of exposure to the UV rays in sunlight. Both basal cell and squamous cell cancers (the most common types of skin cancer) tend to be found on sun-exposed parts of the body, and their occurrence is typically related to lifetime sun exposure. The risk of melanoma, a more serious but less common type of skin cancer, is also related to sun exposure, although perhaps not as strongly. Skin cancer has also been linked to exposure to some man-made sources of UV rays.

What do studies show?

Many studies have found that **basal and squamous cell skin cancers** are linked to certain behaviors that put people in the sun, as well as a number of markers of sun exposure, such as:

- Spending time in the sun for recreation (including going to the beach)

- Spending a lot of time in the sun in a swimsuit
- Living in an area that gets a lot of sunlight
- Having had serious sunburns in the past (with more sunburns linked to a higher risk)
- Having signs of sun damage to the skin, such as liver spots, actinic keratoses (rough skin patches that can be precancerous), and solar elastosis (thickened, dry, wrinkled skin caused by sun exposure) on the neck

Studies have also found links between certain behaviors and markers of sun exposure and **melanoma of the skin**, including:

- Activities that lead to "intermittent sun exposure," like sunbathing, water sports, and taking vacations in sunny places
- Previous sunburns
- Signs of sun damage to the skin, such as liver spots, actinic keratoses, and solar elastosis

Because UV rays don't penetrate deeply into the body, they wouldn't be expected to cause cancer in internal organs, and most research has not found such links. However, some studies have shown possible links to some **other cancers**, including Merkel cell carcinoma (a less common type of skin cancer) and melanoma of the eye.

Studies have found that people who use **tanning beds (or booths)** have a higher risk of skin cancer, including melanoma and squamous and basal cell skin cancers. The risk of melanoma is higher if the person started indoor tanning before age 30 or 35, and the risk of basal and squamous cell skin cancer is higher if indoor tanning started before age 25.

What do expert agencies say?

In general, the American Cancer Society does not determine if something causes cancer (that is, if it is a carcinogen), but we do look to other respected organizations for help with this. Based on the available evidence, several expert agencies have evaluated the cancer-causing nature of UV radiation.

The **International Agency for Research on Cancer (IARC)** is part of the World Health Organization (WHO). One of its major goals is to identify causes of cancer. Based on the available data, IARC has made the following determinations:

- **Solar radiation** is *carcinogenic to humans*.
- **Use of UV-emitting tanning devices** is *carcinogenic to humans*.
- **UV radiation (including UVA, UVB, and UVC)** is *carcinogenic to humans*.

The **National Toxicology Program (NTP)** is formed from parts of several different US government agencies, including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). The NTP has made the following determinations:

- **Solar radiation** is *known to be a human carcinogen*.
- **Exposure to sunlamps or sunbeds** is *known to be a human carcinogen*.
- **Broad-spectrum UV radiation** is *known to be a human carcinogen*.
- **UVA radiation** is *reasonably anticipated to be a human carcinogen*.
- **UVB radiation** is *reasonably anticipated to be a human carcinogen*.
- **UVC radiation** is *reasonably anticipated to be a human carcinogen*.

(For more information on the classification systems used by these agencies, see Determining if Something Is a Carcinogen.)

What about tanning beds?

Some people think that getting UV rays from tanning beds is a safe way to get a tan, but this isn't true.

Both **IARC** and **NTP** classify the use of UV-emitting tanning devices (including sunlamps and tanning beds) as carcinogenic to humans.

The **US Food and Drug Administration (FDA),** which refers to all UV lamps used for tanning as "sunlamps," requires them to carry a label that states, "Attention: This sunlamp product should not be used on persons under the age of 18 years."

The FDA also requires that user instructions and sales materials directed at consumers (including catalogs, specification sheets, descriptive brochures, and webpages) carry the following statements:

- Contraindication: This product is contraindicated for use on persons under the age of 18 years.
- Contraindication: This product must not be used if skin lesions or open wounds are present.
- Warning: This product should not be used on individuals who have had skin cancer or have a family history of skin cancer.
- Warning: Persons repeatedly exposed to UV radiation should be regularly evaluated for skin cancer.

The FDA has also proposed a new rule to ban the use of indoor tanning devices by anyone under age 18, to require tanning facilities to inform adult users about the health risks of indoor tanning, and to require a signed risk acknowledgment from all users. Some US states have already banned indoor tanning by all people younger than 18, while others have banned use by younger teens and children.

Are there any other health issues related to UV radiation?

In addition to **skin cancer**, exposure to UV rays can cause other health problems:

- UV rays, either from the sun or from artificial sources like tanning beds, can cause **sunburn**.
- Exposure to UV rays can cause **premature aging of the skin** and **signs of sun damage** such as wrinkles, leathery skin, liver spots, actinic keratosis, and solar elastosis.
- UV rays can also cause **eye problems**. They can cause the cornea (on the front of the eye) to become inflamed or burned. They can also lead to the formation of cataracts (clouding of the lens of the eye) and pterygium (tissue growth on the surface of the eye), both of which can impair vision.
- Exposure to UV rays can also **weaken the immune system**, so that the body has a harder time fending off infections. This can lead to problems such as reactivation of herpes triggered by exposure to the sun or other sources of UV rays. It can also cause vaccines to be less effective.

Some people are more sensitive to the damaging effects of UV radiation. Some medications can also make you more sensitive to UV radiation, making you more likely to get sunburned. And certain medical conditions can be made worse by UV radiation.

UV rays and vitamin D

Your skin makes vitamin D naturally when it is exposed to UV rays from the sun. How much vitamin D you make depends on many things, including how old you are, how dark your skin is, and how strong the sunlight is where you live.

Vitamin D has many health benefits. It might even help lower the risk of some cancers. At this time, doctors aren't sure what the optimal level of vitamin D is, but a lot of research is being done in this area.

Whenever possible, it's better to get vitamin D from your diet or vitamin supplements rather than from exposure to UV rays. Dietary sources and vitamin supplements do not increase skin cancer risk, and are typically more reliable ways to get the amount you need.

Can I avoid exposure to UV radiation?

UV rays in sunlight

It's not possible (or healthy) to avoid sunlight completely, but there are ways to help ensure you're not getting too much sun:

- If you're going to be outside, simply **staying in the shade**, especially during midday hours, is one of the best ways to limit your UV exposure from sunlight.
- Protect your skin with **clothing** that covers your arms and legs.
- Wear a **hat** to protect your head, face, and neck.
- Wear **sunglasses** that block UV rays to protect your eyes and the skin around them.
- Use **sunscreen** to help protect skin that isn't covered with clothing.

For more information, see How Do I Protect Myself from Ultraviolet (UV) Rays?

The US Centers for Disease Control and Prevention (CDC) has also recommended ways for communities to help prevent skin cancer by reducing sun exposure, including educational interventions in schools and providing shade at schools, recreational sites, and work sites.

Artificial sources of UV rays

Many people believe the UV rays of **tanning beds** are harmless. This is not true. The best thing to do is to not use tanning beds (or booths).

People who may be exposed to **artificial sources of UV at their job** should follow appropriate safety precautions, including using protective clothing and UV shields and filters.

Additional resources

Along with the American Cancer Society, other sources of information include:

American Academy of Dermatology
Toll-free number: 1-888-462-3376 (1-888-462-DERM)
Website: www.aad.org/public

Environmental Protection Agency
Website: www.epa.gov/sunsafety

National Cancer Institute
Toll-free number: 1-800-422-6237 (1-800-4-CANCER); TYY: 1-800-332-8615
Website: www.cancer.gov

Skin Cancer Foundation
Toll-free number: 1-800-754-6490 (1-800-SKIN-490)
Website: www.skincancer.org

**Inclusion on this list does not imply endorsement by the American Cancer Society.*

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OBTAINABLE FROM YOUR MEDICAL SUPPLY COMPANY

Infection Control Kit
This kit contains:
- 1 pair Latex Free Gloves
- 1 Disposable Coverall
- 1 Bouffant Cap
- 2 Antiseptic Bacterial Wipes
- 1 Red Polybag w/tie
- 1 fluid Resistant Mask w/Face Shield
- 1 Biohazard Label 2" x 2"
- Fits 5'6" to 5'10" 135-210 lbs

Deluxe Infection Control Kit
The Deluxe Infection Control Kit includes:
- 1 bouffant cap
- 1 pair gloves
- 1 fluid-resistant mask/eyeshield attached (Safety Shield Combo Mask)
- 1 fluid-impervious gown with full back

Bloodborne Pathogen Protection and Cleanup Kit
Ideal for compliance to OSHA Bloodborne Pathogen Standards. The cabinet is made of plastic. MSDS sheets are included as well as individual component boxes for Personal Protection and Cleanup Kit.

> **Personal Protection Pack** contains 1 disposable hospital gown, 1 pair of booties, 2 antiseptic towelettes (non-alcohol), 1 bouffant cap, 1 pair of nitrile gloves and 1 eye and face shield/splash mask combination.
>
> **Spill Cleanup Pack** contains 1 EPA registered disinfectant, 8oz pack of absorbent powder, scoop and spatula, 1 pack of paper towels, 2 biohazard bags, 2 antiseptic towelettes (non-alcohol) and 1 pair of nitrile gloves.

Medi-Cal Managed Care Facility Site Requirement
Provider and Staff Education Checklist

Clinic Name _____

Employee Name: _____ , Title _____

ANNUAL STAFF EDUCATION IS COMPLETED FOR THE FOLLOWING TOPICS ***DENOTES ANNUAL EDUCATION**	**EDUCATION FORMAT: INSERVICE or SELF-LEARNING MATERIALS**	**EDUCATION UPON HIRE DATE**	**ANNUAL RE-EDUCATION DATES AND STAFF INTIALS (IN BOXES BELOW)** *1.* *2.* *3.*		
Infection Control/Universal Precautions*					
Blood Borne Pathogens Exposure Prevention*					
Biohazardous Waste Handling*					
MA Skill Based Training *					
STAFF EDUCATION FOR FOLLOWING TOPICS IS COMPLETED UPON HIRE AND THEN AS NEEDED			**RE-EDUCATION DATES AND INITIALS**		
Fire Safety/Prevention					
Emergency non-medical procedures					
Emergency medical procedures					
Child/Elder Abuse/Domestic Violence Reporting					
Patient Confidentiality					
Informed Consent, including human sterilization					
Prior authorization Requests/Referral Process			.		
Grievance/Complaint Procedure			.		
Sensitive Services/Minors Rights					
Health Plan Referral Process/Procedure/Resources					
Member's Rights					
Cultural and Linguistics					
Disability Rights and Provider Obligations					

PCP:	Page 1 of 2
SECTION: Personnel	
POLICY AND PROCEDURE: Staff Qualifications	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
All professional health care personnel must have current California licenses and certifications and must be qualified and trained for assigned responsibilities.

PROCEDURE:
I. HEALTH CARE LICENSE AND CERTIFICATION REQUIREMENTS

A. All medical professional licenses and certifications must be current and issued from the appropriate agency to practice in California. Copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.

Medical Professional	License/Certification	Issuing Agency
Certified Nurse Midwife	RN License and Nurse-Midwife certificate	CA Board of Registered Nursing
Certified Radiological Technologist (CRT)	CRT Certificate	CA Department of Public Health (Radiological Branch)
Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate, DEA Registration	Osteopathic Medical Board of CA, Drug Enforcement Administration
Licensed Vocational Nurse (LVN)	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
Nurse Practitioner (NP)	RN License with NP Certification and Furnishing Number	CA Board of Registered Nursing
Pharmacist (Pharm.D)	Pharmacist License	CA State Board of Pharmacy
Physician/Surgeon (MD)	Physician's & Surgeon's Certificate, DEA Registration	Medical Board of CA, Drug Enforcement Administration
Physician's Assistant (PA)	PA License	Physician Assistant Examining Committee / Medical Board of CA
Radiological Technician	Limited Permit	CA Department of Health Care Services (Radiological Branch)
Registered Dietitian	RD Registration Card	Commission on Dietetic Registration
Registered Nurse	RN license	CA Board of Registered Nursing

II. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license type, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

III. TRAINING OF SITE PERSONNEL

A. Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

B. Provider and staff must be able to demonstrate operation of medical equipment used in their scope of work.

Notice To Consumers Regulation

Effective June 27, 2010, a new regulation, mandated by Business and Professions Code section 138, will go into effect requiring physicians in California to inform their patients that they are licensed by the Medical Board of California, and include the board's contact information. The information must read as follows.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

The purpose of this new requirement (Title 16, California Code of Regulations section 1355.4) is to inform consumers where to go for information or with a complaint about California medical doctors.

- Physicians may provide this notice by one of three methods:
- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font. (See link "Sign for printing", below, to print the actual notice.)
- Including the notice in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician is licensed and regulated by the board.
- Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

For more information, please contact Frank Miller, at frank.miller@mbc.ca.gov or (916) 263-2480.
Sign for printing: http://www.mbc.ca.gov/licensee/notice_to_consumers_regulation_Sample_sign.pdf

Signature Page

(Please post on left-hand side of each Medical Record)

Please Write Initials or Signature as Typically Signed	Print Name in Full (First Name, Last Name, Title)

Getting Your Child Tested For Lead

WHY YOUR CHILD SHOULD BE TESTED FOR LEAD

Lead poisoning can make it hard for your child to learn, pay attention, or behave and may cause long-term health problems. Children may not look or act sick. Having your child tested for lead is the only way to know if there is lead in your child's body.

Ask your child's doctor for a blood lead test at one and two years old if your child is in a program such as **Medi-Cal, CHDP[1], WIC[2], Head Start, or other similar programs**. If your child is not in one of these programs, ask your child's doctor about their risk of lead exposure.

CHILDREN ARE AT A HIGHER RISK FOR LEAD EXPOSURE IF THEY:

- **Live** in a house or building built before 1978 or near a source of lead air emissions such as highways, industrial sites, general aviation airports, recycling sites.
- **Consume or come in contact with** certain foods, spices, traditional remedies, dishware or other products.
- **Spend time** outside the U.S.
- **Have a sibling with** an elevated blood lead level.
- **Have a family member who works with lead** such as construction or painting or has hobbies that involve lead such as stained glass, fishing, pottery, firearms, antiques.

For a list of lead sources, ask your doctor or visit: tinyurl.com/CLPPB-SOURCES

[1] CHDP is the Child Health and Disability Prevention Program
[2] WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children

WHAT TO EXPECT: BLOOD LEAD TESTING FOR YOUR CHILD

1. The test may be done at your child's doctor's office or at a laboratory.
2. There are two methods of collecting blood for lead testing: capillary or venous. Capillary tests typically use blood taken from your child's finger. Venous tests use blood from a vein in your child's arm.
3. Depending on the result, your child's doctor may order additional tests. Follow-up blood lead tests must be venous.

For more information visit:
www.cdph.ca.gov/programs/clppb
or contact your local Childhood Lead Poisoning Prevention Program:

CDPH California Department of PublicHealth

CLPPB 8/23

What are some sources of lead?

Talk to your health care provider if you or your child comes in contact with any of these possible sources of lead.

Possible Sources of Lead	What You Can Do...
♦ Old paint inside or outside the home (most lead paint is in homes built before 1978)	♦ Move cribs, high chairs, and playpens away from cracked or peeling paint. ♦ Do not allow children to chew on windowsills or other painted surfaces. ♦ Call local lead poisoning prevention program (tinyurl.com/CLPPP-LIST) about testing paint for lead.
♦ Dust on windowsills, floors, and toys	♦ Wet mop floors and wet wipe windowsills and other surfaces. ♦ Wash toys often. ♦ Wash children's hands before eating and sleeping.
♦ Dirt outside the home	♦ Cover bare dirt with stones, grass, plants or gravel. ♦ Wipe shoes or take them off BEFORE going in the house.
♦ Drinking Water (tinyurl.com/EPA-LEAD-H20)	♦ For cooking or drinking, let water run until cold before using. ♦ Do not use a water crock unless it has been tested and found to be lead free.
♦ Take-home exposure from shoes/clothing/hair if family member works around lead on the job or at home, such as auto repair, metalworking, and battery or scrap metal recycling.	♦ Shower and change clothes BEFORE coming home from work, if possible, and BEFORE holding your child. Remove work clothes and shoes and store them in a plastic bag. Wash work clothes separately from other clothes.
♦ Some dishes or pots that are worn or antique, from a discount or flea market, made of crystal, handmade, or made outside the USA	♦ Call local lead poisoning prevention program (tinyurl.com/CLPPP-LIST) for more information about testing dishes and pots for lead.
Traditional remedies, such as: ♦ Azarcon and Greta – orange or yellow powder ♦ Paylooah – red powder ♦ Some Ayurvedic or traditional Chinese remedies	♦ Do not let anyone give "natural" or traditional remedies to your child without talking to your health care provider first.
Some traditional cosmetics and other substances applied to the skin, such as: ♦ Surma ♦ Kohl ♦ Sindoor	♦ Do not use these products on your child. ♦ Call local lead poisoning prevention program (tinyurl.com/CLPPP-LIST) about testing traditional cosmetics, ritual powders, and other substances applied to the skin.
Altars for religious ritual containing: ♦ Ritual powders ♦ Brass and some other metal, ceramic, or painted items	♦ Place altars with these types of items where your child can't get to them. ♦ Don't let your child handle or mouth these items. ♦ Use separate cleaning supplies to clean these items.
Some costume jewelry, amulets, and keys	♦ Do not allow your child to play with, mouth or touch these items.
Some foods and spices, such as: ♦ Some candies (especially imported) ♦ Chapulines (grasshopper snacks) ♦ Some imported spices, such as turmeric, chili powder, Khmeli Suneli ♦ Game meat containing lead shot	♦ Be aware of foods and spices that might contain lead. ♦ Offer your child meals and snacks including a variety of vegetables, fruit, legumes, seeds, nuts, whole grains, unprocessed meats, and dairy products or dairy substitutes without added sugar.
Other items, such as: ♦ Fishing sinkers, bullets, pellets, and solder ♦ Some art supplies and sewing chalk	♦ Keep these items away from your child. ♦ Wash hands well after touching these items. ♦ Do not heat, melt, cast or file any metal items at home.
Spends time at firing ranges	♦ Children and adolescents who spend time at firing ranges should be tested for lead. ♦ Use lead free ammunition. ♦ Do not eat or drink at a firing range. ♦ After shooting, immediately wash your hands and face with soap and water. ♦ Change clothes and shoes before going home / Wash those clothes separately.
Retained bullets and shrapnel	♦ Consult with your health care provider about ongoing testing and monitoring.
Lives or spends time near: ♦ Major roadways or freeways ♦ A former or current lead or steel smelter, or a foundry or industrial facility that historically emitted or currently emits lead ♦ A general aviation airport used by small aircraft	♦ Tell your health care provider if your child lives or spends time near these types of roadways or facilities. ♦ Do not let your child play or spend time near these types of roadways or facilities.

Haciendo Una Prueba De Plomo A Su Hijo

POR QUÉ SU HIJO DEBERÍA HACERSE LA PRUEBA DE PLOMO

El envenenamiento por plomo puede dificultar que su hijo aprenda, preste atención o se comporte y puede causar problemas de salud a largo plazo. Es posible que los niños no se vean ni actúen enfermos. Hacer que su hijo se haga una prueba de plomo es la única manera de saber si hay plomo en el cuerpo de su hijo.

Pídale al médico de su hijo una prueba de plomo en la sangre a los años de edad si su hijo está en un programa como **Medi-Cal, CHDP[1], WIC[2], Head Start u otros programas similares**. Si su hijo no está en uno de estos programas, pregúntele al médico de su hijo sobre su riesgo de exposición al plomo.

LOS NIÑOS ESTÁN EN MAYOR RIESGO PARA LA EXPOSICIÓN AL PLOMO SI ELLOS:

- **Vive** en una casa o edificio construido antes de 1978 o cerca de una fuente de emisiones de plomo al aire, como carreteras, sitios industriales, aeropuertos de aviación, sitios de reciclaje.
- **Consumir o entrar en contacto con** determinados alimentos, especies, remedios tradicionales, vajillas u otros productos.
- **Pasar tiempo** fuera de los EE. UU.
- **Tener un hermano con** un nivel elevado de plomo en la sangre.
- **Tener un familiar que trabaje con plomo** como la construcción o la pintura o tiene pasatiempos que involucran plomo como vidrieras, pesca, cerámica, armas de fuego, antigüedades.

Para obtener una lista de fuentes de plomo, consulte a su médico o visita: tinyurl.com/CLPPB-SOURCES

[1] CHDP es el Programa de Salud Infantil y Prevención de Discapacidades
[2] WIC es el Programa Especial de Nutrición Suplementaria para Mujeres, Bebés y Niños

QUÉ ESPERAR: ANÁLISIS DE PLOMO EN SANGRE PARA SU HIJO

1. La prueba se puede hacer en su consultorio del médico del niño o en unlaboratorio.

2. Hay dos métodos de recolección de sangre para la prueba de plomo: capilar o venosa. Las pruebas capilares suelen utilizar sangre extraída del dedo de su hijo. Pruebas venosas usar sangre de una vena en su brazo del niño.

3. Según el resultado, el médico de su hijo puede ordenar pruebas adicionales. Sangre de seguimiento las pruebas de plomo deben ser venosas.

Para más información visite:
www.cdph.ca.gov/programs/clppb
o comuníquese con su Líder de Niñez local Programa de Prevención de Envenenamiento:

CDPH California Department of PublicHealth

CLPPB 8/23

¿Cuáles son algunas fuentes de plomo?

Hable con su proveedor de atención médica si usted o su hijo entran en contacto con cualquiera de estas posibles fuentes de plomo.

Posibles Fuentes de Plomo	Qué Puedes Hacer...
♦ Pintura vieja dentro o fuera de la casa (la mayoría de la pintura con plomo se encuentra en casas construidas antes de 1978)	♦ Aleje las cunas, las sillas altas y los corralitos de la pintura agrietada o descascarada. ♦ No permita que los niños mastiquen los alféizares de las ventanas u otras superficies pintadas. ♦ Llame al programa local de prevención del envenenamiento por plomo (tinyurl.com/CLPPP-LIST) para analizar la pintura para detectar plomo.
♦ Polvo en alféizares, pisos y juguetes	♦ Moje los pisos de trapeador y limpie húmedamente los alféizares de las ventanas y otras superficies. ♦ Lave los juguetes con frecuencia. ♦ Lávese las manos de los niños antes de comer y dormir.
♦ Suciedad fuera de la casa	♦ Cubra la tierra desnuda con piedras, hierba, plantas o grava. ♦ Limpie los zapatos o quíteselos ANTES de entrar a la casa.
♦ Agua potable (tinyurl.com/EPA-LEAD-H20)	♦ Para cocinar o beber, deje correr el agua hasta que se enfríe antes de usarla. ♦ No use una vasija de agua a menos que haya sido probada y se haya encontrado que no contiene plomo.
♦ Exposición a casa de zapatos/ropa/cabello si un miembro de la familia trabaja alrededor del plomo en el trabajo o en casa, como reparación de automóviles, metalurgia y reciclaje de baterías o chatarra.	♦ Dúchese/bañarse y cámbiese de ropa ANTES de llegar a casa del trabajo, si es posible, y ANTES de cargar a su hijo.Quítese la ropa y los zapatos de trabajo y guárdelos en una bolsa de plástico.Lave la ropa de trabajo por separado de otras prendas.
♦ Algunos platos o ollas que están desgastados o antiguos, de un descuento o mercado de pulgas, hechos de cristal, hechos a mano o hechosfuera de los EE.UU.	♦ Llame al programa local de prevención del envenenamiento por plomo (tinyurl.com/CLPPP-LIST) para obtener más información sobre cómo analizar platos y ollas para detectar plomo.
Remedios tradicionales, tales como: ♦ Azarcon y Greta – polvo naranja o Amarillo ♦ Paylooah – polvo rojo ♦ Algunos remedios Ayurvédicos o tradicionales Chinos	♦ No permita que nadie le dé remedios "naturales" o tradicionales a su hijo sin hablar primero con su proveedor de atención médica.
Algunos cosméticos tradicionales y otras sustancias aplicadas a la piel, tales como: ♦ Surma ♦ Kohl ♦ Sindoor	♦ No use estos productos en su hijo. ♦ Llame al programa local de prevención del envenenamiento por plomo (tinyurl.com/CLPPP-LIST) para probar cosméticos tradicionales, polvos rituales y otras sustancias aplicadas a la piel.
Altares para rituales religiosos que contienen: ♦ Polvos rituales ♦ Latón y algunos otros artículos de metal, cerámica o pintados	♦ Coloque altares con este tipo de artículos donde su hijo no pueda alcanzarlos. ♦ No permita que su hijo manipule o hable con estos artículos. ♦ Use productos de limpieza separados para limpiar estos artículos.
Algunas bisuterías, amuletos y llaves	♦ No permita que su hijo juegue, entre la boca o toque estos artículos.
Algunos alimentos y especias, tales como: ♦ Algunos dulces (especialmente importados) ♦ Chapulines (bocadillos de saltamontes) ♦ Algunas especias importadas, como la cúrcuma, chile en polvo, Khmeli Suneli ♦ Carne de caza que contiene perdigones de plomo	♦ Tenga cuidado con los alimentos y especias que pueden contener plomo. ♦ Ofrezca a su hijo comidas y refrigerios que incluyen una variedad de verduras, frutas, legumbres, semillas, nueces, granos enteros, carnes sin procesar y productos lácteos o sustitutos lácteos sin azúcar añadido.
Otros artículos, tales como: ♦ Plomos de pesca, balas, perdigones y soldadura ♦ Algunos suministros de arte y tiza de costura	♦ Mantenga estos artículos alejados de su hijo. ♦ Lávese bien las manos después de tocar estos artículos. ♦ No caliente, derrita, funda ni lima ningún artículo metálico en casa.
Pasa tiempo en los campos de tiro	♦ Los niños y adolescentes que pasan tiempo en los campos de tiro deben someterse a pruebas de plomo. ♦ Use municiones sin plomo. ♦ No coma ni beba en un campo de tiro. ♦ Después de disparar, lávese inmediatamente las manos y la cara con agua y jabón. ♦ Cámbiese de ropa y zapatos antes de irse a casa / Lave esa ropa por separado.
Balas retenidas y metralla	♦ Consulte con su proveedor de atención médica sobre las pruebas y el monitoreo continuos.
Vive o pasa tiempo cerca: ♦ Carreteras principales o autopistas ♦ Una fundición de plomo o acero anterior o actual, o una fundición o instalación industrial que históricamente emitió o actualmente emite plomo ♦ Un aeropuerto de aviación general utilizado por aviones pequeños	♦ Coméntele a su proveedor de atención médica si su hijo vive o pasa tiempo cerca de este tipo de carreteras o instalaciones. ♦ No permita que su hijo juegue o pase tiempo cerca de este tipo de carreteras o instalaciones.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
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Louise R. Bailey, MEd, RN, Executive Officer

AN EXPLANATION OF STANDARDIZED PROCEDURE REQUIREMENTS FOR NURSE PRACTITIONER PRACTICE

Standardized Procedures are authorized in the Business and Profession Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulation (CCR 1480). Standardized procedures are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine. Standardized procedures must be developed collaboratively by nursing, medicine, and administration in the organized health care system where they will be utilized. Because of this interdisciplinary collaboration for the development and approval, there is accountability on several levels for the activities to be performed by the registered nurse, nurse practitioner.

Organized health care systems includes health facilities, acute care clinics, home health agencies, physician's offices and public or community health services. Standardized procedures means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions.

The organized health care system including clinics, physician's offices (inclusive of sites listed above) must develop standardized procedures permitting registered nurse, nurse practitioner to perform standardized procedure functions. A registered nurse, nurse practitioner may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedure; and **must provide the system with satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform the functions.**

A nurse practitioner is a registered nurse who possesses additional preparation and skill in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforming to the Board standards as specified in CCR 1484 (Standards of Education).

The Board of Registered Nursing has set educational standards for nurse practitioner certification which must be met in order to "hold out" as a nurse practitioner. Nurse practitioners who meet the education standards and are certified by the BRN are prepared to provide primary health care, (CCR 1480 b), that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.

Scope of Medical Practice

The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissue** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these functions by a registered nurse, nurse practitioner requires a standardized procedure.

Standardized Procedure Guidelines.

The Board of Registered Nursing and the Medical Board of California jointly promulgated the following guidelines. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.

(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training, and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. If a RN or NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the Board of Registered Nursing.

Standardized procedures which reference textbooks and other written resources in order to meet the requirements of Title 16, CCR Section 1474 (3), must include book (specify edition) or article title, page numbers and sections. Additionally, the standards of care established by the sources must be reviewed and authorized by the registered nurse, physician and administrator in the practice setting. A formulary may be developed and attached to the standardized procedure. Regardless of format used, whether a process protocol or disease-specific, the standardized procedure must include all eleven required elements as outlined in Title 16, CCR Section 1474.

SUGGESTED FORMAT FOR STANDARDIZED PROCEDURES

I. POLICY

1. Function(s): (2)*
2. Circumstances under which R.N. may perform function: (2)
   a. Setting (9)
   b. Supervision (7)
   c. Patient Conditions
   d. Other

II. PROTOCOL (3)

1. Definitions
2. Data base
   a. Subjective
   b. Objective
3. Diagnosis
4. Plan
   a. Treatment
   b. Patient conditions requiring consultation (8)
   c. Education - patient/family
   d. Follow up
5. Record keeping (10)

III. REQUIREMENTS FOR REGISTERED NURSE: (4)(5)

1. Nurse practitioner education program, specialty
2. Advance level training
3. Experience as a nurse practitioner
4. National Certification in a specialty
5. Method of initial and continuing evaluation of competence

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

1. Method: (Title 16, CCR Section 1474(a))
2. Review schedule (11)
3. Signatures of authorized personnel approving the standardized procedure, and dates: (1)
   a. Nursing
   b. Medicine
   c. Administration

V. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES (6)

1.
2.

*** Numbers in parentheses correspond to Board of Registered Nursing guideline numbers in Title 16, CCR Section 1474.**

EXAMPLE A (Process Protocol)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

General Policy Component

I. Development and Review

A. All standardized procedures are developed collaboratively and approved by the Interdisciplinary Practice Committee (IDPC) whose membership consists of nurse practitioners, nurses, physicians, and administrators and must conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. All standardized procedures are to be kept in a manual which includes dated, signed approval sheets of the persons covered by the standardized procedures.

C. All standardized procedures are to be reviewed every three years and as practice changes by the IDPC.

D. All changes or additions to the standardized procedures are to be approved by the IDPC accompanied by a dated and signed approval sheet.

II. Scope and Setting of Practice

A. Nurses may perform the following functions within their training specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to Specialty Clinics when indicated).

B. Standardized procedure functions, such as managing medication regimens, are to be performed in (list area, i.e., short appointment clinic). Consulting physicians are available to the nurses in person or by telephone.

C. Physician consultation is to be obtained as specified in the individual protocols and under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

2. Acute decompensation of patient situation.

3. Problem which is not resolving as anticipated.

4. History, physical, or lab findings inconsistent with the clinical picture.

5. Upon request of patient, nurse, or supervising physician.

III. Qualifications and Evaluations

A. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner Program, and be certified as a Nurse Practitioner by the California Board of Registered Nursing.

B. Evaluation of nurses' competence in performance of standardized procedure functions will be done in the following manner:

1. **Initial:** at 3 months, 6 months and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.

2. **Routine:** annually after the first year by the nurse manager through feedback from colleagues, physicians, and chart review.

3. **Follow-up:** areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

IV. Authorized Nurse Practitioners

List each

V. Protocols

The standardized procedure protocols developed for use by the nurses are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: management of acute/episodic conditions, trauma, chronic conditions, infectious disease contacts, routine gynecological problems, contraception, health promotion exams, and ordering of medications.

STANDARDIZED PROCEDURES FOR NURSE PRACTITIONERS

Revised Spring

Interdisciplinary Practice Committee

(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date

STANDARDIZED PROCEDURES

Management of Common Primary Care Conditions

I. Policy

A. As described in the General Policy Component.

B. Covers only those registered nurses as identified in General Policy Component.

II. Protocol

A. **Definition:** This protocol covers the management of common primary care conditions seen in the outpatient setting, such as eczema, headaches, acne, fatigue syndromes, allergic rhinitis, and low pain.

B. **Database** - Nursing Practice
(Perform usual total nursing assessment to establish data base).

C. **Treatment Plan** - Medical Regimen

1. **Diagnosis**
   a. Most consistent with subjective and objective findings expected by patient. If diagnosis is not clear, assessment to level of surety plus differential diagnosis.
   b. Assessment of status of disease process when appropriate.

2. **Treatment** - (Common nursing functions)
   a. Further lab or other studies as appropriate.
   b. Physical therapy if appropriate.
   c. Diet and exercise prescription as indicated by disease process and patient condition.
   d. Patient education and counseling appropriate to the disease process.
   e. Follow-up appointments for further evaluation and treatment if indicated.
   f. Consultation and referral as appropriate.

3. **Physician Consultation:** As described in the General Policy Component.

4. **Referral to Physician or Specialty Clinic:** Conditions for which the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation.

5. **Furnishing Medications** - (Medical Regimen)
Follow furnishing protocol, utilizing formulary.

PROTOCOL: DRUGS AND DEVICES

Definition: This protocol covers the management of drugs and devices for women of all ages presenting to _____ clinic. The nurse practitioner may initiate, alter, discontinue, and renew medication included on, but not limited to the attached formulary. All Schedule I and Schedule II drugs are excluded.

Subjective Data: Subjective information will include but is not limited to:

1. Relevant health history to warrant the use of the drug or device.
2. No allergic history specific to the drug or device.
3. No personal and/or family history which is an absolute contraindication to use the drug or device.

Objective Data: Objective information will include but is not limited to:

1. Physical examination appropriate to warrant the use of the drug or device.
2. Laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.

Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.

Plan: Plan of care to monitor effectiveness of any medication or device.

Patient Education: Provide the client with information and counseling in regard to the drug or device. Caution client on pertinent side effects or complications with chosen drug or device.

Consultation and/or Referral: Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.

REFERENCES: PDR '94 50th Edition (list page)
Primary Care Medicine, 3rd Edition, Chapter (list), pp. (list)
Handbook of Gynecology and Obstetrics, 3rd Edition, Chapter (list), pp. (list)

FORMULARY

To include but not limited to those medications listed below:

Antibiotic: Ampicillin, Penicillin, Amoxicillin, Dicloxacillin, Augmentin, Keflex, Tetracycline, Noroxin, Minocin, Vibramycin, Benemid, Macrodantin, Erythromycin, Rocephin, Gantrisin, Trimethoprim/sulfamethoxazole, Nitrofurantoin, Nalidixic acid.

Antidiarrheal: Imodium, Donnagel

Antiemetic: Trans-derm V, Compazine, Phenergan, Tigan

Antifungal: Mycostatin oral suspension/tablets, Nizoral, Monistat, Femstat, Terazol, Gyne-Lotrimin

Antiviral: Zovirax ointment/capsules, Podophyllin 25-75%, Trichloroacetic acid

Antiparasite: Flagyl/Protostat, Kwell lotion/shampoo, RID lotion, Eurax cream

Biologic: RhoGAM, HypRho-D

Chemotherapeutic: 5FU for vaginal or vulvar use

Devices: Diaphragm, cervical cap, IUD, pessary, Norplant

Diuretic: Spironolactone, Dyazide

Hormone: All oral contraceptives, progesterone preparations, Estrogen (Premarin, Estinyl, Delestrogen, Estrovis, Estrace), Estraderm, Protestins (Aygestin, Provera, Micronor, Nor QD, Ovrette), Estrogen vaginal creams (Premarin, Estrace)

Local anesthetic: Xylocaine Jel 2%, Xylocaine 1% injection

Nonsteroidal Anti-inflammatory: Anaprox, Anaprox DS, Suprol, Motrin, Ponstel, Naprosyn, Rufen

Over the counter: Spermicidal agents, cold & cough preparations (non-narcotic), laxatives, stool softeners, antacids, antiflatulents, analgesics, prostaglandin inhibitors, topicals, vitamin/mineral, antihistamines, decongestants, hemorrhoidal/antidiarrheal.

Rectal:	Anusol HC, Wyanoids
Thyroid:	Synthroid, Armour thyroid tablets
Urinary analgesic:	Pyridium
Vaginal:	All appropriate antifungals, Aminocervical cream, Acijel, Betadine, Triple Sulfa cream, Estrogen cream.
Vitamin/Mineral:	Prenatal vitamins, iron pill

EXAMPLE B (Disease Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

DEPARTMENT:_____ FACILITY:_____

POLICY

I. FUNCTIONS NURSE PRACTITIONERS MAY PERFORM:

Provide care for patients with acute conditions as covered in attached protocol (see sample attached) and furnish non-controlled drugs and devices to essentially healthy patients.

II. CIRCUMSTANCES UNDER WHICH NURSE PRACTITIONERS MAY PERFORM THESE FUNCTIONS:

A. May furnish non-controlled drugs and devices under standardized procedures under the supervision of a designated physician (or designee).

B. Applies to nurse practitioners working in (indicate departments involved).

III. EXPERIENCE, TRAINING AND/OR EDUCATION REQUIRED OF THE NURSE PRACTITIONER:

Maintains a current California license to practice as an RN, is certified by the State of California as a Nurse Practitioner, has met all the requirements for and has a current Furnishing Number issued by the Board of Registered Nursing. Is oriented to the facility.

IV. METHOD OF INITIAL AND CONTINUED EVALUATION OF COMPETENCE:

General competency is initially evaluated during the probationary period through a proctoring process by the supervising physician. The registered nurse is assigned to and is supervised by a designated physician who is responsible to annually evaluate appropriateness of practice and clinical decision making. A QA review process is established to assure that compliance to standards relating to important aspects of care are maintained.

V. DOCUMENTATION

Documentation required is outlined in each protocol. Patient specific documentation is entered into the patient's medical record.

DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

I. THIS STANDARDIZED PROCEDURE WAS:

Developed by the supervising physician, or designee, and the Nurse Practitioner. Approved by the department Chief, Director of Nursing Practice, Physician-in-Chief or designees, and Medical Group Administrator.

II. THIS STANDARDIZED PROCEDURE WILL BE REVIEWED AT LEAST ANNUALLY.

REVISION DATED _____ REVIEWED DATED _____
_____ _____
_____ _____

III. THE STANDARDIZED PROCEDURE WAS APPROVED BY:

MEDICINE _____ DATE_____
(Chief of Department)

MEDICINE _____ DATE_____
(PIC/Designee)

NURSING _____ DATE_____
(Director of Nursing Practice)

ADMINISTRATION _____ DATE_____
(Medical Group Administrator)

IV. PRACTITIONERS FUNCTION UNDER THIS STANDARDIZED PROCEDURE:

Current list of authorized personnel are on file in the office of the Medical Group Administrator and department manager.

PROTOCOLS (List those applicable)

I.E., Urinary Tract Infection (see attached).
Respiratory tract infection
Otitis Media
Vaginitis

References: List

URINARY TRACT INFECTION PROTOCOL: INITIAL VISIT

I. RATIONALE

This protocol will assist in the differentiation between pyelonephritis and urinary tract symptoms sufficiently to eradicate the symptoms per se rather than attempt to eradicate any bacteriuria that may or may not be present. The design of the protocol for UTI encompasses these principles.

II. SYMPTOMS

A. CYSTITIS

1. FEMALE PATIENTS

Order a STAT CVMS UA for female patients with any of the following symptoms;

a. Dysuria
b. Frequency
c. Urgency
d. Inability to empty bladder completely

2. Male patients

Male patients with any of the above symptoms should be seen by an M.D., not by a NP, unless they have a urethral discharge (possible VD - follow VD protocol).

B. PYELONEPHRITIS

1. In addition to the above symptoms, patients with pyelonephritis may have:
   a. Fever greater than 100.0 F. or
   b. Flank pains, or
   c. Chills, or
   d. Nausea, vomiting or abdominal pain.
2. Continue with protocol through the physical exam with these patients, but then consult supervising physician before deciding on treatment.

III. HISTORY

A. Consult supervising physician if patient has:
   1. A history of kidney problems, or
   2. Is currently pregnant. To ascertain this, always ask for LMP date and record for all female patients.
   3. Diabetes or insulin.
   4. Three or more UTIs in past 12 months

B. Continue with UTI protocol, but also refer patient to GYN if history of:
   1. Vaginal discharge, or
   2. Perineal inflammation.

IV. PHYSICAL EXAM

A. Perform the following examinations:
   1. Abdominal
   2. CVA
   3. Temperature

B. Consult supervising physician if findings of:
   1. Fever greater than 100.0 F. or
   2. CVA tenderness.

V. LAB TESTS

INITIAL URINALYSIS

A. Consult supervising physician if:
   1. Casts
   2. RBCs or protein are positive (without associated WBC abnormality).

B. If UA shows 10 or more WBCs/hpf and patient is symptomatic, give patient antibiotic prescription as described in the treatment section.

C. If UA revealed 0-10 WBCs, review symptoms. If the symptoms are definite and very severe, treat with antibiotics; if symptoms are vague and poorly defined, then give patient symptomatic treatment as described in the treatment section and consider referral to GYN for pelvic.

D. Should the initial UA be "positive": (defined in guidelines below), then give patient a repeat UA slip for the abnormality found with instructions to have that UA one week following completion of treatment.

Positive UA findings are defined as:

Casts: any except occasional hyaline or rare granular
RBCs > 3 (if not menstruating) and WBC < 5
Protein > trace and WBC < 5

VI. TREATMENT

ANTIBACTERIAL TREATMENT

To be given if initial UA reveals 10 or more WBC/hpf, or in any case where symptoms are severe, even if UA revealed, WBC/hpf.

A. Prescribe appropriate antibiotic drug (see p.6)

B. Instruct patient to call in if symptoms do not subside within 72 hours. If patient does call back, information for treatment failure instructions.

SYMPTOMATIC TREATMENT

To be given only if initial UA reveals, 10WBC/Hpf, and patient has minimal or uncertain symptoms. Consider GYN referral for pelvic.

A. Prescribe either Propantheline 15 mg #20 sig: 1-2 QID prn or Belladonna with Pb tabs #15, sig: 1 tab QID prn.
B. Instruct patient to call in if symptoms persist beyond 72 hours or if symptoms worsen at any time.

VII. REPEAT URINALYSIS (CVMS)

A. Consult supervising physician if UA shows casts.
B. If repeat UA confirms abnormality (protein and/or RBC as listed below) refer to Proteinuria and/or Hematuria protocols.

Positive UA findings are defined as:
Casts: any, except occasional hyaline or rare granular
RBCs >3 (if not menstruating) and WBC <5
Protein > trace and WBC <5

UTC PROTOCOL: ANTIBIOTIC TREATMENT

A. If organism found in patient's urine is not listed in the table below, consult supervising physician for treatment.

B. If this is the first antibiotic course (initial visit), assume E coli and use the first listed drug to which patient is not allergic, as listed for E coli in the drug table below.

C. If this is a second antibiotic course (treatment failure), go to the first drug for the organism listed that is not the same as that previously used and to which the patient is not allergic. If the patient is allergic to all drugs listed, consult supervising physician for treatment.

D. Prescribe according to the prescription table which follows:

1. If symptoms have been present within the past 48 hours, use 1 dose treatment.
2. If symptoms have been present longer than 48 hours, use 5-day treatment.
3. If symptoms persists after treatment with first drug, repeat UA and culture and consult supervising physician.

UTI PROTOCOL: TREATMENT FAILURE

If the patient calls in with persisted or recurrent symptoms after the first course of antibiotic treatment, obtain a CVMS urine specimen for UA and culture and sensitivity.

If the UA is negative, wait for the culture results before treating. If the UA is positive, treat with the next drug listed on the Antibiotic Prescription Table and review treatment choice when the culture and sensitivity results are available.

If culture is positive and patients symptoms are improving, stay with the same antibiotic. If not responding after 3 days, switch to a new antibiotic based on culture sensitivity.

Adapted from protocol developed by: _____, NP

_____, MD

(List names of nurse practitioners and physicians who developed the standardized procedure, including the protocol section).

ANTIBIOTIC PRESCRIPTION TABLE

ORGANISM	DRUG
E. Coli Proteus mirabilis	Septra DS, Amoxicillin Macrodantin, Keflex
Aerobacter Klebsiella	Septra DS, Macrodantin Keflex, Ciprofloxacin
Enterococcus	Ampicillin *Consult MD if allergic
Pseudomonas	Ciprofloxacin (Usually not seen in out-patient setting)

DOSAGES

SEPTRA DS	#3 PO at once or 1 bid x 5 days
AMOXICILLIN	500mg 3gms PO at once or 250mg 1 tid x 5 days
MACRODANTIN	100mg qid x 5 days
KEFLEX	250mg qid x 5 days
CIPROFLOXACIN	250mg qid x 5 days

EXAMPLE C (Procedure Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedure for Dispensing by Registered Nurse

I. Policy

A. Drugs and devices listed in the agency formulary and prescribed by a lawfully authorized prescriber may be dispensed.
B. Setting - Adult Clinic.
C. Supervision - None required at the time of dispensing.

II. Protocol

A. Data Base
1. No patient or family history contraindications.
2. Agency required tests and procedures relative to the drug or device being dispensed demonstrate no contraindications.

B. Action
1. Affix label which contains information that follows.
a. Agency name, address and telephone number.
b. Patient's name.
c. Name of the prescriber and initials of the dispenser.
d. Date dispensed.
e. Trade or generic name of dispensed drug.
f. Quantity and strength of dispensed drug.
g. Directions for use of dispensed drug.
h. Expiration date of the drug's effectiveness.
2. Affix any appropriate auxiliary labels.
3. Use child proof containers.
4. Provide patient with appropriate information including:
- directions for taking the drug;
- what to do and whom to contact if side effects occur;
- common side effects;
- possible serious or harmful effects of the drug; and
- any manufacturer-prepared information required by the FDA.

C. Record Keeping - Document in the patient record:
1. Name, dosage, route and amount of the drug dispensed.
2. Lot number and manufacturer's name.
3. Other information, including patient instructions given.
4. Complete information in the pharmacy dispensing log.

D. Consultation - Contact the prescriber if the item is not listed in the agency formulary for RN dispensing or regarding contraindications.

III. Requirements for Registered Nurses

A. Education, training and experience: successful completion of the agency's in-service program on dispensing.

B. Initial evaluation: Demonstration of competency in skill performance to the satisfaction of the Pharmacy Director.

C. On-going evaluation - Monthly random record review by the pharmacist and an annual performance appraisal including observation of dispensing.

IV. Development and Approval of the Standardized Procedure

This standardized procedure was approved by the following:

NURSING_____ DATE _____

MEDICINE_____ DATE _____

PHARMACY_____ DATE _____

ADMINISTRATION _____ DATE _____

The standardized procedure will be reviewed annually.

V. RNs authorized to perform the procedure.

1. _____ DATE _____

2._____ DATE _____

PCP:	Page 1 of 2
SECTION: Infection Control	
POLICY AND PROCEDURE: Standard and Universal Precautions	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:

Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel will apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

PROCEDURE:

I. HAND WASHING FACILITIES

A. Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030).

B. Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995).

II. ANTISEPTIC HAND CLEANER

A. Antimicrobrial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

III. WASTE DISPOSAL CONTAINER

A. Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children.

IV. ISOLATION PROCEDURES

A. Personnel are able to demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient.

State Health Programs Provider Inquiry Spreadsheet

Patient's Name	DOB	Id #	DOS	Billed Amt	Paid Amt	Paid Date	Chk #	HealthNet Comments

Please fax the Claim status list to:
Attn. Glenda H
Fax #: (818) 676 5387 or (818) 676-5161

STERILIZATION PROCEDURES LOG

Date: _____ Facility: _____

							Female Patients			Male Patients	
	Patient Name	Medical Record Number	Date of Procedure	Medi-Cal	Comm	Records Rec'd	Tubal Lig	Hyster	Other	Vasec-tomy	Other
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
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18											
19											

Information Bulletin

SB 697 – Frequently Asked Questions

Overview

SB 697 (Chapter 707, Statutes of 2018) became effective on January 1, 2020 and made numerous changes to the Physician Assistant Practice Act (Act), which provides for licensure and regulation of physician assistants by the Physician Assistant Board (Board). Generally, the new law removes requirements that the medical record identify the responsible supervising physician and surgeon, removes requirements that the physician be physically available to the physician assistant for consultation, removes requirements for review and countersignature of patient medical records, and removes requirements that written guidelines for adequate supervision be established. The new law instead authorizes a physician assistant to perform medical services authorized by the Act if certain requirements are met, including that the medical services are rendered pursuant to a practice agreement, as defined, and the physician assistant is competent to perform the medical services.

The Act now requires that a practice agreement between a physician assistant and a physician and surgeon meet specified requirements, including that the agreement have policies and procedures to ensure adequate supervision of the physician assistant, including, but not limited to, appropriate communication, availability, consultations, and referrals between a physician and surgeon and the physician assistant in the provision of medical services. In addition, a practice agreement must establish policies and procedures to identify a physician and surgeon (with privileges to practice in that hospital) who is supervising a physician assistant rendering services in a general acute care hospital.

The prior law authorized a physician assistant, under the supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device, subject to specified requirements. The new law authorizes a physician assistant to furnish or order a drug or device subject to specified requirements, including that the furnishing or ordering be in accordance with the practice agreement and consistent with the physician assistant's educational preparation or for which clinical competency has been established and maintained, and that the physician and surgeon be available by telephone or other electronic communication method at the time the physician assistant examines the patient.

The Act now authorizes the physician assistant to furnish or order Schedule II or III controlled substances in accordance with the practice agreement or a patient-specific order approved by the treating or supervising physician and surgeon and requires completion of a controlled substances course by the PA's next renewal if the PA is

authorized by a practice agreement to furnish Schedule II controlled substances and if the PA has a DEA registration.

In addition, the new law provides that any reference to a "delegation of services agreement" in any other law means "practice agreement," as defined. The Act now provides that supervision does not require the supervising physician and surgeon to be physically present, but does require adequate supervision as agreed to in the practice agreement and does require that the physician and surgeon be available by telephone or other electronic communication method at the time the physician assistant examines the patient. However, the Act also prohibits this provision from being construed as prohibiting the Board from requiring the physical presence of a physician and surgeon as a term or condition of a PA's reinstatement, probation, or imposing discipline.

For more detailed information and to review the exact text of this new legislation, a copy of SB 697 is included with this information bulletin at:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB697.

The Board is providing the following information in response to questions received:

Practice Agreement

1. **What is a practice agreement?**

   The practice agreement replaces the delegation of services agreement. The practice agreement is a written agreement developed through collaboration among one or more physicians and surgeons ("physician") and one or more physician assistants (PA). The practice agreement defines the medical services the PA is authorized to perform pursuant to Business and Professions Code (BPC) section 3502 and grants approval for the physicians and surgeons on the staff of an "organized health care system"[1] to supervise one or more PAs in an organized health care system. (See BPC, § 3501, subd. (k).).

   The practice agreement must include provisions that address the following:

   (1) The types of medical services a physician assistant is authorized to perform,
   (2) Policies and procedure to ensure adequate supervision of the PA,
   (3) The methods for continuing evaluation of the competency and qualifications of the PA,

[1] Under the new law, an "organized health care system" includes a licensed clinic, an outpatient setting, a health facility, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services (see BPC, § 3501, subd. (j)).

(4) The furnishing or ordering of drugs or devices by a PA pursuant to Section 3502.1 (see answer to Question No. 5); and,
(5) Any additional provisions agreed to by the PA and the supervising physician. (See BPC, § 3502.3, subd. (a)(1).)

The practice agreement must be signed by the PA and one or more physicians or a physician who is authorized to approve the practice agreement on behalf of the staff of the physicians on the staff of an organized health care system. (See BPC, § 3502.3, subd. (a)(2).)

2. Will the Board be publishing a sample/template practice agreement on its website?

No, not at this time. Further, the law does not require the Board to approve practice agreements. (BPC, § 3502.3, subd. (a)(5).)

3. Can an existing delegation of services agreement be used instead of a practice agreement?

Yes. Any delegation of services agreement in effect prior to January 1, 2020 shall be deemed to meet the requirements of BPC Section 3502.3. (See BPC, § 3502.3, subd. (a)(3).)

4. **What Medical Services is a PA authorized to perform?**

A PA is authorized to perform those medical services described in the practice agreement. The PA must also have the competency to perform the medical services, and the PA's education, training, and experience must have prepared the PA to render the services. (See BPC, § 3502, subd. (a).)

Finally, in addition to any other practices that meet the criteria set forth in the Act or the Board's or the Medical Board of California's regulations, a practice agreement may authorize a PA to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 of the Act (particularly competency, education training, and experience), or the practice agreement.

(2) For individuals receiving home health services or personal care services, after consultation with a supervising physician, approve, sign, modify, or add to a plan of treatment or plan of care.

(3) After performance of a physical examination by the PA under the supervision of a physician, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. (See BPC, § 3502.3, subd. (b).)

Prescriptions

5. Are protocols and formularies for controlled substances required?

No. However, there are still criteria that need to be met to authorize a PA to furnish a controlled substance. A PA may furnish or order only those Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act that have been agreed upon in the practice agreement, and consistent with the PA's educational preparation or for which clinical competency has been established and maintained. With respect to Schedules II or III controlled substances, the practice agreement or a patient-specific order approved by the treating or supervising physician can authorize the PA to furnish a Schedule II or III controlled substance. (See BPC, § 3502.1, subds. (a), (d)(1), and (d)(2).)

A practice agreement authorizing a PA to order or furnish a drug or device shall specify all of the following:

(1) which PA or PAs may furnish or order a drug or device,
(2) which drugs or devices may be furnished or ordered,
(3) under what circumstances a drug or device will be furnished,
(4) the extent of physician supervision,
(5) the method of periodic review of the PA's competence, including peer review,
(6) review of the practice agreement (BPC, § 3502.1, subd. (b)(1); and,
(7) if the practice agreement authorizes the PA to furnish a Schedule II controlled substance, the practice agreement shall address the diagnosis of the illness, injury, or condition for which the PA may furnish the Schedule II controlled substance. (See BPC, § 3502.1, subd. (b)(2).)

To furnish any drug or device, the PA must have also completed a course in pharmacology that meets the requirements contained in section 1399.530 of Title 16 of the California Code of Regulations as that provision read on June 7, 2019. (See BPC, § 3502.1, subd. (e)(1).) For PAs that are authorized through a practice agreement to furnish Schedule II controlled substances, completion of a controlled substance education course is now mandatory, as described below.

6. Is the Controlled Substance Education Course required?

Yes. A PA who holds an active license, who is authorized through a practice agreement to furnish Schedule II controlled substances, who is registered with the U.S. Drug Enforcement Administration (DEA), and who has not completed a one-time course in compliance with sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations as those provisions read on June 7, 2019, shall complete, as part of their continuing education requirements, a course that

covers Schedule II controlled substances and the risks of addiction associated with their use, based on standards developed by the Board. Therefore, if a PA who holds an active license has not yet completed the required course, the PA needs to complete the course before renewing their license. (See BPC, § 3502.1, subd. (e)(3).)

7. Can a PA furnish or order Schedule II or III controlled substances?

Yes. A PA may furnish or order Schedule II or III controlled substances in accordance with the practice agreement or a patient-specific order approved by the treating or supervising physician. (See BPC, § 3502.1, subd. (d)(2).) However, continuing education and practice agreement requirements also need to be met to maintain compliance with the Act (see answers to Question Nos. 5 and 6 above).

8. Is supervising physician contact information required on PA prescriptions?

No. PA prescription pads are no longer required to list the name, address, and telephone number of their supervising physician. Further, a PA's drug order that is authorized to be issued under the Act must be treated in the same manner as a prescription of a supervising physician, and the signature of a PA on a drug order issued in accordance with the Act is deemed to be the signature of a prescriber for purposes of the Business and Professions Code and the Health and Safety Code. (See BPC, § 3502.1, subd. (g).)

<u>Supervision</u>

9. Are PAs required to identify their supervising physician for each episode of care in the patient's medical record?

Not anymore. The legislation removed the requirement that each episode of care for a patient identify the physician responsible for the supervision of the physician assistant. (See BPC, § 3502, as amended.)

10. Does the supervising physician still need to review or countersign my charts?

No. Unless the practice agreement requires it, the supervising physician no longer must review or countersign the medical records of a patient treated by a PA. The Board may, as a condition of probation or reinstatement of a licensee, require the review or countersignature of records of patients treated by a PA for a specified duration. (See BPC, § 3502, subd. (c).)

11. What are the Responsibilities of a Supervising Physician?

Under the new law, a supervising physician must provide adequate supervision of a PA as agreed to in the practice agreement. A supervising physician need not be physically present while the PA provides medical services but must be available by telephone or other electronic communication method at the time the PA examines the patient. (See BPC, § 3501, subd. (f)(1)(A)-(B).) However, the Board may require the physical presence of the supervising physician as a term or condition of a PA's reinstatement, probation, or imposing discipline. (See BPC, § 3501, subd. (f)(2).)

Supervision means that a physician oversees and accepts responsibility for the medical services provided by the PA. (See BPC, § 3501, subd. (f)(1).) While the PA is also no longer an agent of the supervising physician, the PA and the supervising physician can agree via practice agreement, that the PA is designated as an agent of the supervising physician. (See BPC, § 3502.3, subd. (a)(4).)

If rendering services in a general acute care hospital as defined in Health and Safety Code section 1250, the PA must be supervised by a physician who has privileges to practice in that hospital. Within a general acute hospital, the practice agreement shall establish policies and procedures to identify a physician who is supervising the PA. (See BPC, § 3502, subd. (f).)

However, amendments to the new law did not change the following requirements for physician supervision:

> (a) a physician assistant licensed by the board shall be eligible for employment or supervision by a physician who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision.
>
> (b) Except as provided in Business and Professions Code section 3502.5 (state of war or emergency), a physician shall not supervise more than four physician assistants at any one time.
>
> (c) The Medical Board of California may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon from supervising physician assistants outside of the field of specialty of the physician and surgeon. (See BPC, § 3516.)

Miscellaneous

12. Can a PA now own a majority share in a medical practice?

No. The new law did not change the Moscone-Knox Professional Corporation Act's ban on the owning of a majority of shares of a professional medical corporation. Under this prohibition a PA cannot own more than 49% of a professional medical corporation. (See Corp. Code, § 13401.5, subd. (a)(7).)

DELEGATION OF SERVICES AGREEMENT
BETWEEN
A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT

Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, "a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

The following document is a sample Delegation of Services Agreement (DSA) to assist you with meeting this legal requirement. This sample DSA is provided for information purposes; feel free to duplicate or modify it as appropriate and consistent with the law.

If you choose not to use the sample DSA, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are **not** required to submit it to the Physician Assistant Board. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Board who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant's license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT BOARD

SAMPLE

DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT_____
(Name)

Physician assistant, graduated from the _____
(Name of PA Training Program)

physician assistant training program on _____.
(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on _____.
(Date)

He/she was first granted licensure by the Physician Assistant Board on _____, which expires on _____, unless renewed.
(Date) (Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (b), (c), (d), (e), (f), (g) and (h) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the PA and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

_____

_____

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

_____

_____

The PA is authorized to perform the following therapeutic procedures:

_____

_____

The PA is authorized to assist in the performance of the following therapeutic procedures:

_____

_____

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

_____

_____

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized Schedule(s). The PA has taken and passed the drug course approved by the Board on _____ (attach certificate). DEA #:_____.
Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval (circle authorized Schedule(s). DEA #:_____.

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

_____
(List Types of Patients and Situations)

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. _____ YES _____ NO

The PA may also enter a drug order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at _____ and, in _____ hospital(s) and
(Address / City) (Address / City)
_____ skilled nursing facility (facilities) for care of
(Name of Facility)
patients admitted to those institutions by physician(s) _____ .
(Name/s))

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The _____ emergency room at _____
(Name of Hospital) (Phone Number)
is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.
Notify _____ at _____ immediately
(Name of Physician) (Phone Number/s))
(or within _____ minutes).

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_____ _____
Date Physician's Signature (Required)

_____
Physician's Printed Name

_____ _____
Date Physician Assistant's Signature (Required)

_____
Physician Assistant's Printed Name

SAMPLE ONLY

(c) The requirement that the physician assistant be supervised by, or work in collaboration with, a licensed physician and surgeon.

(Amended by Stats. 2018, Ch. 92, § 2 (SB 1289), eff. January 1, 2019.)

§ 3502.2. Physical Examinations

Notwithstanding any other provision of law, a physician assistant may perform the physical examination and any other specified medical services that are required pursuant to Section 2881 of the Public Utilities Code and Sections 44336, 49406, 49423, 49455, 87408, 87408.5, and 87408.6 of the Education Code, practicing in compliance with this chapter, and may sign and attest to any certificate, card, form, or other documentation evidencing the examination or other specified medical services.

(Added by Stats. 2010, Ch. 512, § 2 (SB 1069), eff. January 1, 2011.)

§ 3502.3. Practice Agreement

(a) (1) A practice agreement shall include provisions that address the following:

(A) The types of medical services a physician assistant is authorized to perform.

(B) Policies and procedures to ensure adequate supervision of the physician assistant, including, but not limited to, appropriate communication, availability, consultations, and referrals between a physician and surgeon and the physician assistant in the provision of medical services.

(C) The methods for the continuing evaluation of the competency and qualifications of the physician assistant.

(D) The furnishing or ordering of drugs or devices by a physician assistant pursuant to Section 3502.1.

(E) Any additional provisions agreed to by the physician assistant and physician and surgeon.

(2) A practice agreement shall be signed by both of the following:

(A) The physician assistant.

(B) One or more physicians and surgeons or a physician and surgeon who is authorized to approve the practice agreement on behalf of the staff of the physicians and surgeons on the staff of an organized health care system.

(3) A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.

(4) A practice agreement may designate a PA as an agent of a supervising physician and surgeon.

(5) Nothing in this section shall be construed to require approval of a practice agreement by the board.

(b) Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(3) After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

(c) This section shall not be construed to affect the validity of any practice agreement in effect prior to the effective date of this section or those adopted subsequent to the effective date of this section.

(Amended by Stats. 2019, Ch. 707, § 5 (SB 697), eff. January 1, 2020.)

PCP:	
SECTION: Personnel	
POLICY AND PROCEDURE: **Child Abuse Reporting**	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
Health care practitioners who have knowledge of or observe a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report the suspected incident of abuse or neglect to a "child protective agency".

PROCEDURE:

I. Reporting

A. The report must be made to a "child protective agency". A child protective agency is a county welfare or probation department or a police or sheriffs department (P.C. 11165.9, P.C. 11166[a])

1. Written reports must be submitted on a Department of Justice form – Form SS 8572 (DOJ SS 8572) which can be requested from your local child protective agency

2. A report must be made **immediately (or as soon as possible) by phone**

3. **A written report must be forwarded to the child protective agency within 36 hours of receiving the information regarding the incident**

4. A single report may be made if two or more persons have knowledge of suspected child abuse or neglect

5. Have the following information ready to report:
   - Name of reporter
   - Name and present location of the child
   - Nature and extent of the injury, and any evidence of prior abuse
   - Any other information, including what led you to suspect child abuse, if requested by the child protective agency (P.C. § 11167 [a])

6. **Failure to make a required report is a misdemeanor punishable by up to six months in jail and/or up to a $1,000 fine (P.C. 1172[e]). Persons who fail to report can also be subject to a civil lawsuit, and found liable for damages, especially if the child-victim or another child is further victimized because of the failure to report**

II. Indicators of Abuse

A. Physical Abuse

1. Physical Indicators of Physical Abuse
   - Fractures, lacerations, bruises that cannot be explained, or explanations which are improbable given the extent of the injury
   - Burns (cigarette, rope, scalding water, iron, radiator)
   - Infected burns, indicating delay in seeking treatment
   - Facial injuries (black eyes, broken jaw, broken nose, bloody nose, bloody or swollen lips) with implausible or nonexistent explanations
   - Subdural hematomas, long-bone fractures, fracture in different states of healing
   - Pattern of bruising (e.g., parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time

2. Behavioral Indications of Physical Abuse
   - Hostile, aggressive, verbally abusive towards others
   - Fearful or withdrawn behavior
   - Self-destructive (self-mutilates, bangs head, etc.)
   - Destructive (breaks windows, sets fires, etc.)
   - Out-of-control behavior (seems angry, panics, easily agitated)
   - Frightened of going home, frightened of parents/caretakers or, at the other extreme, is overprotective of parent(s) or caretaker(s)
   - Attempts to hide injuries; wears excessive layers of clothing, especially in hot weather
   - Difficulty sitting or walking
   - Clingy, forms indiscriminate attachments
   - Apprehensive when other children cry
   - Wary of physical contact with adults
   - Exhibits drastic behavioral changes in and out of parental/caretaker presence
   - Suffers from seizures or vomiting
   - Exhibits depression, suicide attempts, substance abuse, or sleeping and eating disorders

B. Sexual Abuse

1. Physical Indicators of Sexual Abuse; the following may be indicative of sexual abuse:
   - Wears torn, stained, or bloody underclothing
   - Physical trauma or irritation to the anal/genital area (pain, itching, swelling, bruising, bleeding, laceration, abrasions), especially if injuries are unexplained or there is an inconsistent explanation

- Knowledge of a child's history of previous or recurrent injuries/diseases
- Swelling or discharge from vagina/penis
- Visible lesions around mouth or genitals
- Complaint of lower abdominal pain
- Painful urination, defecation
- Sexually transmitted diseases
- Difficulty in walking or sitting due to genital or anal pain
- Psychosomatic symptoms (stomachaches, headaches)

2. Behavioral Indicators of Sexual Abuse
   - Sexualized behavior (has precocious knowledge of explicit sexual behavior and engages self or others in overt or repetitive sexual behavior)
   - Compulsive indiscreet masturbation
   - Excessive curiosity about sexual matters or genitalia (self or others)
   - Unusually seductive with classmates, teachers and other adults
   - Excessive concern about homosexuality, especially by boys

3. Behavioral Indicators of Sexual Abuse in Younger Children; the following may be exhibited by younger children who are experiencing sexual abuse:
   - Wetting pant, bed wetting or fecal soiling
   - Eating disturbances such as overeating, under eating
   - Fears or phobias
   - Compulsive behavior
   - School problems or significant change in school performance (attitude and grades)
   - Age-inappropriate behavior, including pseudomaturity or regressive behavior such as bed wetting or thumb sucking
   - Inability to concentrate
   - Drastic behavior changes
   - Speech disorders
   - Frightened of parent/caretaker or of going home

4. Behavioral Indicators of Sexual Abuse in Older Children and Adolescents; the following are behaviors that may be exhibited by older children and adolescents who are experiencing sexual abuse:
   - Withdrawal, clinical depression, apathy, chronic fatigue
   - Overly compliant behaviors
   - Poor hygiene or excessive bathing
   - Poor peer relations and social skills; inability to make friends; non-participation in sports and social activities
   - Acting out; running away; aggressive, antisocial, or delinquent behavior

- Alcohol or drug abuse
- Prostitution or excessive promiscuity
- School problems, frequent absences, sudden drop in school performance
- Refusal to dress to physical education
- Fearfulness of showers or restrooms; of home life, as demonstrated by arriving at school early or leaving late; of going outside or participating in familiar activities; of males (in cases of male perpetrator and female victim)
- Self-consciousness of body beyond that expected for age
- Sudden acquisition of money, new clothes, or gifts with no reasonable explanation
- Suicide attempt, self-mutilation, or other-destructive behavior
- Crying without provocation
- Setting fires
- Pseudo-mature (seems mature beyond chronological age)
- Eating disorders

C. Neglect
   1. Physical Indicators of Neglect; Neglect may be suspected when one or more of the following conditions exist:
      - Failure to thrive – the child fails to gain weight at the expected rate for a normal child
      - Malnutrition or poorly balanced diet (bloated stomach, extremely thin, dry, flaking skin, pale, fainting)
      - Inappropriate dress for weather
      - Dirty unkempt, extremely offensive body odor
      - Unattended medical or dental conditions (e.g., infections, impetigo)
      - Evidence of poor or inadequate supervision for the child's age
   2. Behavioral Indicators of Neglect
      - Clingy or indiscriminate attachment
      - Depressed, withdrawn, or apathetic
      - Antisocial or destructive behavior
      - Fearfulness
      - Substance abuse
      - Speech, eating, or habit disorders (biting, rocking, whining)
      - Often sleepy or hungry
      - Brings only candy, chips, and soda for lunch or consistently "forget" to bring food

III. Definitions

A. Physical abuse: characterized by physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, biting, burning, or otherwise harming a child. Any injury resulting from physical punishment that requires medical treatment is considered outside the realm of normal disciplinary measures.

B. Neglect: the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

C. Severe neglect: the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or heath is endangered, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

D. Sexual abuse: refers to sexual assault or sexual exploitation

1. Sexual assault includes rape, statutory rape, rape in concert, incest, sodomy, and lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation. It includes, but is not limited to, all of the following:
   - Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen
   - Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person
   - Any intrusion by one person into the genital or anal opening of another person, including the use of any object for this purpose, excepting acts performed for a valid medical reason
   - The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, excepting acts that may reasonably be construed to be normal caretaker responsibilities; interaction with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose
   - The intentional masturbation of the perpetrator's genitals in the presence of a child (P.C. 11165.1[b])

2. Sexual exploitation refers to any of the following:
   - Depicting a minor engaged in obscene acts in violation of law; preparing, selling, or distributing obscene matter that depicts minors; employment of minor to perform obscene acts

- Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assists other to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. "Person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution
- Any person who depicts a child in, or who knowingly develops, duplicates, prints or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3 (P.C. 11165.1[c])

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (4/1/09)

STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER ☐ M ☐ F	4. SAFE PHONE NUMBER ( )

5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – **NO P.O. Box)** City State Zip

6. PATIENT SPEAKS ENGLISH ☐ Y ☐ N – Identify language spoken: _____	7. DATE AND TIME OF INJURY Date: Time: ☐ am ☐ pm ☐ Unknown

8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: ☐

9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY

12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis. ☐ ADDITIONAL PAGES ATTACHED

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: Time: ☐ am ☐ pm

15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )

18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )

22. EMPLOYER'S ADDRESS (Number and Street) City State Zip

23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE

25. HEALTH PRACTITIONER'S SIGNATURE:	26. DATE SIGNED:

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (rev 4/09)

STATE OF CALIFORNIA

Instructions To The Health Practitioner

Penal Code Section 11160 *mandates* the following regarding suspicious injuries:

- Internal procedures established to facilitate reporting and apprise supervisors and administrators of reports shall be consistent with the reporting requirements of PC Section 11160. The internal procedures shall not require any employee who must make a report to disclose his or her identity to the employer.
- Report suspicious injuries to your local law enforcement agency by telephone **immediately**, or as soon as practically possible.
- Submit the required completed written report to your local law enforcement agency *within two working days of discovering a suspicious injury,* whether or not:
  1. The person has expired;
  2. The injury was a factor contributing to the person's death; or
  3. Evidence of the conduct of the perpetrator is discovered during an autopsy.
- Use this standard form or a form, developed and adopted by another state agency, that otherwise fulfills the requirements of this form, (see "Exceptions to using this form" below).
- Two or more health practitioners with knowledge of a suspicious injury may mutually select a team member to make the telephone report and one written report signed by the selected team member. A team member who knows that the selected team member has not made the telephone call or submitted the written report shall make the report(s).
- No supervisor or administrator shall impede or inhibit the required reporting duties, and no person making a report pursuant to this section shall be subject to any sanction for making the report.

Exceptions To Using This Form

Other state reporting mandates pre-empt the use of this form to report suspicious injuries, as follows:

Incident	Form	Source of Form
Physical Child Abuse	SS 8572	Call California Department of Justice at (916) 227-3285.
Dependent Adult / Elder Abuse	SOC 341	Online: http://www.dss.cahwnet.gov/pdf/SOC341.pdf or contact your local County Adult Protective Services Dept.
Sexual Assault – Adult*	CalEMA 2-923*	Online: www.CalEMA.ca.gov under Plans and Publications or call Cal EMA at (916) 324-9100.
Sexual Assault – Child*	CalEMA 2-925* CalEMA 2-930*	

*Use these forms to conduct a forensic examination of the victim. Otherwise, use this Suspicious Injury Report form.

Definitions

Health Practitioner – Provides medical services to a patient for a physical condition that he/she reasonably suspects is a suspicious injury as listed below, and is employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department.

Suspicious Injury – Includes any wound or other physical injury that either was:

- Inflicted by the injured person's own act or by another where the injury is by means of a firearm, OR
- Is suspected to be the result of *assaultive or abusive conduct* inflicted upon the injured person.

Injury – Shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

Assaultive / Abusive Conduct – includes committing, or an attempt to commit, any of the following Penal Code violations:

- Abuse of spouse or cohabitant
- Aggravated mayhem
- Administering controlled substances or anesthetic to aid in the commission of a felony
- Assault with a stun gun or taser
- Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury
- Assault with intent to commit mayhem, rape, sodomy, or oral copulation
- Battery
- Child abuse or endangerment (including Statutory Rape)
- Elder abuse
- Incest
- Lewd and lascivious acts with a child
- Murder
- Manslaughter
- Mayhem
- Oral copulation
- Procuring any female to have sex with another man
- Rape
- Sexual battery
- Sexual penetration
- Sodomy
- Spousal rape
- Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure
- Torture CAL

T-ACE

(T = tolerance A = annoyed C = cut down E = eye-opener)

The T-Ace questions take approximately one minute to ask and represent the first validated sensitive screen for risk-drinking appropriate for routine use in obstetric-gynecologic practice.

Scoring: T = 2 points, A = 1 point, C = 1 point, E = 1 point.
A total score of 2 or more indicates positive screening.

T How many drinks does it take to make you feel high (TOLERANCE)?

A Have people ANNOYED you by criticizing your drinking?

C Have you felt you ought to CUT DOWN on your drinking?

E Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE-OPENER)?

TB (Tuberculosis) Risk Assessment

*** You (your child) may be at increased risk for TB if you answer YES to any of the following questions:**	Date / /	Date / /	Date / /	Date / /
1. Do you have a family member or close contact with history of confirmed or suspected TB?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Do you (does your child) live in an "out of home" placement facility?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Do you (does your child) have a history of confirmed or suspected HIV infection?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Do you (does your child) live with any individual who is HIV positive?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you been, or do you (does your child) live with any individual who has been incarcerated in the last 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you (does your child) live among, or are you (is he/she) frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

* A person who is at increased risk for TB should have a yearly TB test.
(All children are tested routinely for TB at 4-5 years, 13-16 years, regardless of risk)

Name:_____ Date:_____

Evaluando el Riesgo de Poder Contraer "TB" (Tuberculosis)

*** Sus hijos pueden tener un riesgo muy alto de poder contraer "TB" si contesta en informa afirmativa a cualquiera de las siguientes preguntas:**	Fecha / /	Fecha / /	Fecha / /	Fecha / /
1. Existe algun contacto cercano o algun miembro de la familia que haya sido declardo enfermo de TB o que se sospeche tener esta enfermedad?	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐
2. Cuando emigraron a este pais lo hicieron de Asia, Africa, America Central de Sudamerica? (en estas reginoes del mundo existe un porcentaje muy alto de este enfermedad)	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐
3. Acaso ested (o su hijo/a) se encuentra viviendo temporalmente en un hogar o local sostenido por el gobierño o asistencia social?	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐
4. Acaso ested (o su hijo/a) haya sido, diagnosticado(a) con algun tipo de infeccion como el sida?	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐
5. Acaso ested (o su hijo/a) haya sido declardo positivo con el examen del sida?	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐
6. Acaso ested (o su hijo/a) vive con adultos que hayan estado presos or cualquier motivo en los ultimos 5 anos?	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐
7. Acaso ested (o su hijo/a) vive o se asocia frecuentemente con personas que viven en las calles, que sean trabajadores temporales del campo, utilicen drogas ilicitas inyectables o que residan en asilos o en hospitals de convalescencia?	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐	Si ☐ No ☐

*****Cualquir persona que tiene un alto riesgo de contraer /tb debe hacerse el examen de la tuberculosis cara año, (se les examina los 4 y 5 años y de los 13 a 16 años)

¡Recuerde que este examen es muy sencillo y pareciera que esta recibiendo una vacuan pero debe ser revisado por personal medico en un periodo de 2 a 3 dias, este proceso es muy importante y no debe olivarse, de otra manera el examen no tiene validez alguna!

Nombre:_____ Fecha:_____

Health Net Transplant Performance Centers

UPDATED: 11/13/25

Center FACILITIES NOT LISTED ARE NON-PAR. FOR NON-PAR RE-DIRECT OR REQUEST LOA	Transplant	Type	Wellcare California (Medicare) [Legacy Wellcare - CareCentral]	Wellcare by Health Net (Medicare) [Legacy Health Net - Trucare]	Line of Business UC B&G	GROUP HMO, POS Tier 1	PPO/EPO	OOS PPO	MEDI-CAL	AMBETTER HMO / PPO
California Pacific Medical Center - San Francisco	Kidney	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Cellic	X - Cellic	X - Cellic	X - Cellic	CIGNA NETWORK EFF 11/1/23	X - Cellic	X - Cellic
	Kidney-Pancreas (DHCS Adult)	Adult		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Pancreas	Adult (Medicare Certified)		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Liver-Kidney	Adult		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Heart (DHCS Adult)	Adult (Medicare Certified)		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
Cedars-Sinai Medical Center - Los Angeles	Lung - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Does not participate in LOB. No LOA required.	Non-Par	Non-Par	Non-Par	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD; LOA req'd.	NON-PAR
	Heart (DHCS Adult)	Adult (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Kidney	Adult / Pediatric (Medicare Certified Adult/Ped)			X - HN	X - HN	X - HN			X - OPTUM
	Liver - (DHCS Adult)	Adult (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Blood / Marrow (DHCS Adult)	Adult			X - HN	X - HN	X - HN			NON-PAR
		Autologous								
		Allogeneic Related & Unrelated								
Children's Hospital and Research Ctr at Oakland "Publicly know as UCSF Benioff Children's Hospital Oakland"	Blood / Marrow (DHCS PED)	Autologous	n/a	n/a	X - Optum	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	X-Covered under MOT agreement effective 1/1/22	X - OPTUM
		Allogeneic Related			X - Optum	X - Optum	X - Optum			
Children's Hospital of Los Angeles	Heart (DHCS Ped)	Pediatric (Medicare Certified)	n/a	n/a	X - HN	X - HN	X - HN	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Req'd.	X - OPTUM
	Intestinal (DHCS Ped)	Pediatric (Medicare Certified)			Non-Par	Non-Par	Non-Par			NON-PAR
	Liver - (DHCS Ped)	Pediatric (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Kidney	Pediatric (Medicare Certified)			X - HN	X - HN	X - HN			X - OPTUM
	Blood / Marrow (DHCS PED)	Pediatric			X - HN	X - HN	X - HN			X - OPTUM
		Autologous								
		Allogeneic Related & Unrelated								
Children's Hospital of Orange County - Orange	Blood / Marrow (DHCS PED)	Pediatric	n/a	n/a	X - HN	X - HN	X - HN	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Req'd.	X - OPTUM
		Autologous				X - HN	X - HN			
		Allogeneic Related & Unrelated				X - HN	X - HN			
City of Hope - Duarte	Blood / Marrow (DHCS Adult/Ped)	Pediatric	PPG Delegation for Transplant Auth; LOA Req'd	X - Cellic	X - Cellic	X - Cellic	X - Cellic	CIGNA NETWORK EFF 11/1/23	X - Cellic	X - Cellic
		Adult		X - Cellic	X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
Loma Linda University Medical Center - Loma Linda	Blood / Marrow (DHCS PED)	Pediatric	PPG Delegation for Transplant Auth; LOA Req'd	Does not participate in LOB - no LOA req'd	Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Required.	Non-Par (SCA Required)
	Heart (DHCS Adult/Ped)	Pediatric (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Kidney	Adult (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Pediatric (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Kidney-Pancreas (DHCS Adult)	Adult			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Pediatric			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Liver - (DHCS Adult)	Adult (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Pediatric			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
		Adult (Medicare Certified)			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
	Pancreas	Pediatric			Non-Par (SCA Required)	Non-Par (SCA Required)	Non-Par (SCA Required)			Non-Par (SCA Required)
Lucile Packard Children's Hospital	Heart (DHCS Ped)	Pediatric (Medicare Certified)	n/a	n/a	X - Cellic	X - Cellic	X - Cellic	CIGNA NETWORK EFF 11/1/23	X - Cellic	X - Cellic
	Intestinal (DHCS Ped)	Pediatric (Medicare Certified)			SCA REQD	SCA REQD	SCA REQD		X - Cellic	SCA REQD
	Heart-Lung	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Kidney	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Liver - (DHCS Ped)	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Lung - (DHCS Ped)	Pediatric (Medicare Certified)			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
	Blood / Marrow (DHCS PED)	Pediatric			X - Cellic	X - Cellic	X - Cellic		X - Cellic	X - Cellic
		Autologous								
		Allogeneic Related & Unrelated								
Rady Childrens Hospital	Heart - (DHCS Ped)	Pediatric (Medicare Certified)	n/a	n/a	X - Optum	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. No LOA req'd.	X - OPTUM
	Kidney	Pediatric (Medicare Certified)			X - Optum	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS PED)	Pediatric			X - Optum	X - Optum	X - Optum			X -OPTUM
		Autologous								
		Allogeneic Related & Unrelated								
Scripps Health - San Diego	Kidney	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Optum	X - Optum	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. No LOA required.	X - OPTUM
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Liver	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Pancreas	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS Adult)	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
		Autologous								
		Allogeneic Related & Unrelated								

Health Net Transplant Performance Centers

UPDATED: 11/13/25

Center FACILITIES NOT LISTED ARE NON-PAR. FOR NON-PAR RE-DIRECT OR REQUEST LOA	Transplant	Type	Wellcare California (Medicare) [Legacy Wellcare - CareCentral]	Wellcare by Health Net (Medicare) [Legacy Health Net - Trucare]	UC B&G	Line of Business GROUP HMO, POS Tier 1	PPO/EPO	OOS PPO	MEDI-CAL	AMBETTER HMO / PPO
Sharp Healthcare System	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - HN	X - HN	X - HN	X - HN	CIGNA NETWORK EFF 11/1/23	X - HN Agreement	X - OPTUM
	Kidney	Adult (Medicare Certified)		X - HN	X - HN	X - HN	X - HN		X - HN Agreement	X - OPTUM
Stanford University Hospital - Palo Alto	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Celtic	X - Celtic	X - Celtic	X - Celtic	CIGNA NETWORK EFF 11/1/23	X - Celtic	X - Celtic
	Heart-Lung	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney-Pancreas	Adult		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Lung - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Pancreas after Kidney TP	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Blood / Marrow (DHCS Adult)	Adult Autologous Allogeneic Related & Unrelated		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
Sutter Medical Center Sacramento	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Does not meet Celtic criteria	Does not meet Celtic criteria	Does not meet Celtic criteria	Does not meet Celtic criteria	CIGNA NETWORK EFF 11/1/23	X - Celtic	Does not meet Celtic Criteria
	Blood / Marrow (DHCS Adult)	Adult Allogeneic Adult Autologous		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
UC Davis - Sacramento	Kidney	Adult Cadaveric & Adult Living (Medicare Certified)	PPG Delegation for Transplant Auth.	X - Optum	X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	X - HN Agreement, not covered under MOT	X - OPTUM
	Liver (DHCS Adult)	Adult (Medicare Certified)		X- HN effective 2/21/24	Non-Par	Non-Par	Non-Par		Covered under MOT agreement effective 8/8/24	Non-Par
	Blood / Marrow (DHCS Adult)	Adult Autologous Allogeneic Related & Unrelated		X - Optum X - Optum X - Optum	X - HN X - HN X - Optum	X - Optum X - Optum X - Optum	X - Optum X - Optum X - Optum		Covered under the MOT Agreement effective 1/1/22	X - OPTUM
UC San Diego - San Diego	Kidney	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Optum	X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	X - HN Agreement	X - OPTUM
	Heart - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - HN	X - Optum	X - Optum		Covered under the MOT Agreement effective 1/1/22	X - OPTUM
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - HN	X - Optum	X - Optum			X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)		X - Optum	X - HN	X - Optum	X - Optum			X - OPTUM
	Heart-Lung	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Liver	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Pancreas	Adult		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)		X - Optum	X - Optum	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS Adult)	Adult Autologous Allogeneic Related & Unrelated		X - Optum	X - HN	X - Optum	X - Optum			X - OPTUM
UCSF - SAN FRANCISCO	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Non-Par	Canopy Members: X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Covered under the MOT Agreement effective 1/1/22	X - OPTUM
	*Heart-Lung	Pediatric		Non-Par	Canopy Members: X - HN	Non-Par	Non-Par			NON-PAR
		Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric		Non-Par	Canopy Members: X - HN	Non-Par	Non-Par			NON-PAR
	Kidney	Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum		X - HN	X - OPTUM
		Pediatric (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum		X - HN	X - OPTUM
	Kidney-Pancreas (DHCS Adult)	Adult		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum		Covered under the MOT Agreement effective 1/1/22	X - OPTUM
	Liver - (DHCS Adult/Ped)	Pediatric		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
		Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
	Kidney-Liver	Adult/Pediatric		Non-Par	X - Optum	X - Optum	X - Optum			X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM
	*Pancreas Autologous Islet Cell	Adult		Non-par	Canopy Members: X - HN	Non-Par	Non-par			NON-PAR
	Blood / Marrow (DHCS Adult/Ped)	Adult Pediatric Autologous Allogeneic Related & Unrelated		Non-Par	Canopy Members: X - HN	X - Optum	X - Optum			X - OPTUM

Health Net Transplant Performance Centers

UPDATED: 11/13/25

Center FACILITIES NOT LISTED ARE NON-PAR. FOR NON-PAR RE-DIRECT OR REQUEST LOA	Transplant	Type	Wellcare California (Medicare) [Legacy Wellcare - CareCentral]	Wellcare by Health Net (Medicare) [Legacy Health Net - Trucare]	Line of Business UC B&G	GROUP HMO, POS Tier 1	PPO/EPO	OOS PPO	MEDI-CAL	AMBETTER HMO / PPO
Ronald Reagan UCLA Medical Center	Heart - (DHCS Adult/Ped)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd**	Does not participate in LOB, no LOA required	X - HN	X - Optum	X - Optum	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Required.** LOA's will only be granted if the member is an existing Continuity of Care patient.	X - OPTUM
		Pediatric (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Kidney	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Heart-Lung	Adult (Medicare Certified)			X - Optum	X - Optum	X - Optum			X - OPTUM
	Kidney-Pancreas	Adult			X - HN	X - Optum	X - Optum			X - OPTUM
	Liver - (DHCS Adult/Ped)	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Pancreas	Adult (Medicare Certified)			X - HN	X - Optum	X - Optum			X - OPTUM
	Small Bowel - (DHCS Adult)	Adult (Medicare Certified Adult & Ped)			X - HN	X - Optum	X - Optum			X - OPTUM
	Blood / Marrow (DHCS Adult/Ped)	Adult			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric								
		Autologous								
		Allogeneic Related & Unrelated								
	Liver-Kidney	Adult			X - HN	X - Optum	X - Optum			X - OPTUM
		Pediatric			X - HN	X - Optum	X - Optum			X - OPTUM
Keck Hospital of USC	Heart - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	X - Celtic	X - Celtic	X - Celtic	X - Celtic	CIGNA NETWORK EFF 11/1/23	LOA	X - Celtic
	Heart-Lung	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Liver - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney-Liver	Adult		X - Celtic	X - Optum	X - Optum	X - Optum		X - Celtic	X - OPTUM
	Lung - (DHCS Adult)	Adult (Medicare Certified)		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Kidney-Pancreas	Adult		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
	Blood / Marrow (DHCS Adult)	Adult		X - Celtic	X - Celtic	X - Celtic	X - Celtic		X - Celtic	X - Celtic
UC Irvine - Irvine NON-PARTICIPATING	Kidney - (DHCS Adult)	Adult (Medicare Certified)	PPG Delegation for Transplant Auth; LOA Req'd	Does not participate in LOB; no LOA required	Non-Par	Non-Par	Non-Par	CIGNA NETWORK EFF 11/1/23	Non-par for LOB. Must be DHCS Approved program, CTU review req'd. Provider req'd to accept 100% MCD. LOA Required.	X - Optum
	Pancreas - (DHCS Adult)	Adult (Medicare Certified)			Non-Par	Non-Par	Non-Par			X - Optum
	Kidney-Pancreas (DHCS Adult)	Adult			Non-Par	Non-Par	Non-Par			X - Optum
	Blood / Marrow - (DHCS Adult)	Adult			Non-Par	Non-Par	Non-Par			Non-par

Abbreviations

[1]DHCS = Department of Health Care Services
[2]LOB = Line of business
[3]HN = Health Net
[4]CTU = Centralized Transplant Unit
[5]MCD = Medicaid
[6]LOA = Letter of Agreement
[7]n/a = not applicable
[8]MOT Agreement = Major Organ Transplant Agreement
[9]SCA = Single Case Agreement

Color Legend

Blue = Separates the listed centers
Orange = Non-participating (non-par) providers
Yellow = Column K shows yellow for Optum to differentiate from orange for non-par.

PCP:	
SECTION: Office Management	
POLICY AND PROCEDURE: Triage	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
The site shall have sufficient health care personnel to provide timely, appropriate health care services. Triage is the sorting and classification of information to determine priority of need and proper place of treatment. Telephone triage is the system for managing telephone callers during and after office hours.

PROCEDURE:

A. The PCP will ensure that appropriate personnel handle emergent, urgent and medical advice telephone calls. This includes licensed medical personnel such as a CNM, NP, RN or PA. LVN's cannot perform triage independently (MCPB letter 92-15). LVNs and unlicensed personnel such as medical assistants may provide patient information or instructions only as authorized by the physician (Title 16, 1366b)

B. Staff will ensure that a telephone answering machine, voice mail system or answering service is utilized whenever office staff does not directly answer phone calls.

The practitioner is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- ***This message should be in the threshold languages for the office.***

- Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision

regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

C. Staff will ensure that the telephone answering service, recorded telephone information, and recording devices are periodically checked and updated (see suggested scripts as seen in section 18 of this manual).

- Health Plans encourage answering services follow these steps when receiving a call:
  - Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
  - Question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
  - Contact the on-call physician with the facts as stated by the member.
  - After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted

TUBERCULOSIS SUSPECT CASE REPORT

Patient_____
Address_____
_____
Phone ( )_____

Reported by_____
_____
_____
Phone ( )_____

DOB:_____/_____/_____ Sex: M__ F__

Social Security Number_____-_____-_____
Employer/School_____
If under 18, list parent name and DOB:
_____

Hospital/Clinic of Dx_____
Medical Record Number_____
Treating Physician_____
Phone_____
Consulting Physician_____
Phone_____

Skin Test (PPD) Date_____/_____/_____ Reading___mm X___mm Anergic Y___ N___ Unk___

Chest X-ray Date_____/_____/_____ Impresssion_____
_____

Pulmonary TB_____ Extra Pul. TB_____ Site_____ Date of Diagnosis____/_____/____

If Pul TB, check symptons: cough_____ sputum production_____ hemoptysis_____
night sweats_____ wt. loss_____(lbs)

Past history of TB treatment Y_____ N_____ If yes, where & when_____

Other medical conditions relevant to diagnosis_____

BACTERIOLOGY

Specimen Number	Specimen Date	Specimen Type	Smear AFB - or +	Culture M. Tb - or +

Lab Name:
Account Number:

MEDICATION

Medication	Dose	Start Date

Allergies:

HIV Status_____Psychosocial History_____
_____

Additional Comments_____
_____

Date Reported _____/_____/_____ Recorded by _____

TUBERCULOSIS SUSPECT CASE REPORT
Tulare County Department of Health Services

Within 24 hours of diagnosis or suspicion of TB, complete Part I and II and FAX to TCDHS TB Division – FAX: (559) 685-4786

PART I: PATIENT/FACILITY INFORMATION

Date: ___/___/___

Name: _____ **Alias:** _____
LAST FIRST MI LAST FIRST MI

Address prior to admission: _____
STREET CITY ZIP CODE COUNTY

Sex: _____ **Age:** _____ **DOB:** _____ **Phone: ( )** _____

Race/Ethnicity:
___ White, non-Hispanic
___ Black, non-Hispanic
___ Hispanic
___ Native American/Alaskan American
___ Asian/Pacific Islander (specify) _____
___ Other (specify) _____

Name and Address of Workplace: _____

Social Security #: _____

Primary Language if other than English: _____

Medical Record #: _____

Chemically dependent? ___ Yes (specify drug): _____ ___ No **Homeless?** ___ Yes ___ No
AIDS? ___ Yes ___ No (HIV + TB = AIDS)

History of medical noncompliance? ___ Yes ___ No ___ Unk **DOT Anticipated?** ___ Yes ___ No ___ Unk
Person to notify in case of emergency: NAME: _____ **PHONE:** ( )
Legal guardian or contact person (if applicable): NAME: _____ **PHONE:** ( )
FACILITY NAME: _____ **Admission Date:** ___/___/___
Attending Physician: _____ **PHONE:** ( )

PART II: CLINICAL FINDINGS

Date of Symptom Onset: ___/___/___ **Date of Diagnosis:** ___/___/___ **Weight:** _____ **lbs.**

Site: ___ Pulmonary ___ Laryngeal ___ Extrapulmonary (specify) _____

Prior TB drug treatment? ___ Yes ___ No ___ Unknown
If yes, prior TB drug resistance? ___ Yes ___ No ___ Unknown
Prior TB drug adherence? ___ Yes ___ No ___ Unknown

INITIAL SYMPTOMS:
Cough sputum production?
___ Yes ___ No ___ Unknown

Last CXR: ___/___/___

Most recent PPD: ___/___/___ **Reaction:** _____ mm
Last prior PPD: ___/___/___ **Reaction:** _____ mm
Anergic test? ___/___/___ **Reaction:** _____ mm

Results:
___ Normal
___ Abnormal (noncavitary)
___ Abnormal(cavitary)

BACTERIOLOGY: **(Include all specimens collected during current admission)**

Date (Month/Day/Year)	Source	AFB Smear Results	AFB Culture Results	Laboratory

Initial Drug Regimen (circle drugs) **INH RIF PZA EMB Other (specify)** _____ **Date Started:** _____
Form Completed by: _____ **Phone:** _____

"TWEAK" TEST

Do you drink alcoholic beverages? If you do, please take our "TWEAK" test.

T	**Tolerance:** How many drinks can you "hold"? (Record number of drinks in box at right)	☐
	(For the next questions, check box at right for "yes" answers)	☐
W	Have close friends **Worried or Complained** about your drinking in the past year?	☐
E	**Eye Opener:** Do you sometimes take a drink in the morning when you first get up?	☐
A	**Amnesia** (Blackouts): Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	☐
K(C)	Do you sometimes feel the need to Cut Down on your drinking?	☐

To score the test, a seven-point scale is used. The tolerance question scores two points if a woman reports she can "hold" more than five drinks without passing out, and a positive response to the worry question scores two points. Each of the last three questions scores one point for positive responses. A total score of three or more points indicates the woman is likely to be a heavy/problem drinker.

For more information on screening, write: Marcia Russell, Ph. D., Research Institute on Addictions, 1021 Main Street, Buffalo, New York, 14203, or telephone (716) 887-2507.

Clorox Regular Bleach

Overview:

Size/Count 60.0 oz.

- Kills 99.9% of common household germs
- Patented whitest whites technology
- Not harmful to septic systems

Q. What organisms does Clorox® Regular-Bleach kill?

A. **Bacteria**
Staphylococcus aureus (Staph.)
Salmonella choleraesuis
Pseudomonas aeruginosa
Streptococcus pyogenes (Strep.)
Escherichia coli O157:H7 *(E. coli)*
Shigella dysenteriae
Methicillin Resistant Staphylococcus aureus (MRSA)

Fungi
Trichophyton mentagrophytes (can cause Athlete's Foot)
Candida albicans (a yeast)

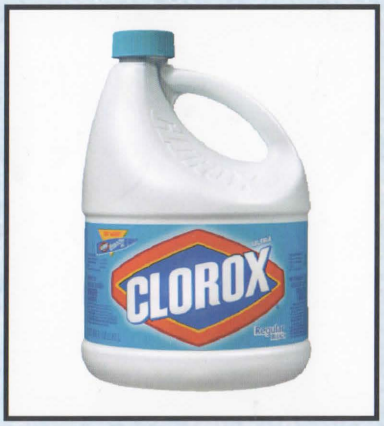
Viruses
Rhinovirus Type 17 (a type of virus that can cause colds)
Influenza A (Flu virus)
Hepatitis A virus
Rotavirus
Respiratory Syncytial Virus (RSV)
HIV-1 (Human Immunodeficiency Virus)*
Herpes simplex Type 2
Rubella virus
Adenovirus Type 2
Cytomegalovirus

Understanding Bleach

Recognizing The Differences Between Germicidal, Laundry & Cheap Bleach

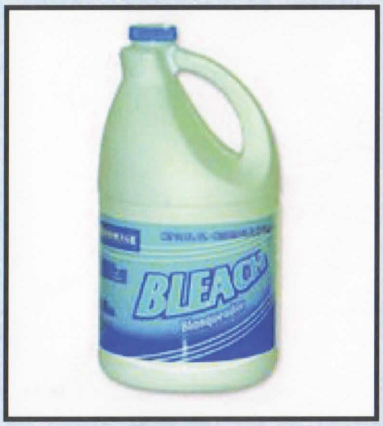
Clorox Germicidal Bleach

- Highest sodium hypochlorite concentration (6.15%)
- Lowest pH / Significantly shorter contact times for surface disinfection vs. cheap bleach
- Disinfects, sanitizes and deodorizes hard, non-porous surfaces
- EPA-registered disinfectant
- Reliable packaging and profitable distribution
- 100+ Sole Source Bleach distributors and counting…



Clorox Liquid Bleach

- Higher sodium hypochlorite concentration (6.0%)
- Higher pH / Longer contact times for surface disinfection
- Includes patented additive that keeps metals and minerals found in water and body soil from discoloring fabrics over time
- Special additive creates improved whitening power
- EPA-registered disinfectant
- Reliable packaging and profitable distribution



Cheap Bleach

- Low sodium hypochlorite concentration (5.25%)
- Highest pH / Longest contact times for surface disinfection
- Unreliable packaging and unprofitable distribution

Call 888-797-7225 or your Clorox Sales Rep for more details.

CLOROX
PROFESSIONAL PRODUCTS
DIVISION

PCP:	Page 1 of 2
SECTION: Personnel	
POLICY AND PROCEDURE: Unlicensed Personnel	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:
All professional health care personnel must be qualified and trained for assigned responsibilities.

PROCEDURE:

I. MEDICAL ASSISTANTS

A. Medical Assistants (MA) are unlicensed health personnel who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician. The licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA.

B. Training may be administered under a licensed physician; or under a RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation must be maintained on-site and include the following:

- Diploma or certification from an accredited training program/school, or
- Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature.

II. MEDICATIONS

A. Unlicensed staff must have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work.
    - Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally, or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or simple injection.
    - The pre-labeled medication container must be shown to the licensed person prior to administration.

- To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training hours established in CCR, Title 16, Section 1366.1.
- An MA may administer injections of scheduled drugs, including narcotic medications, only if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular.
- Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia.
- The supervising physician must specifically authorize all medications administered by an MA by means of a specific written or standing order prepared by the supervising physician.

III. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and title/practitioner's license type, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

IV. TRAINING OF SITE PERSONNEL

A. Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

Site personnel are qualified and trained for assigned responsibilities

Provider and staff must be able to demonstrate operation of medical equipment used in their scope of work.

Trainings: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection.

Staff shall follow procedures for confirming the correct patient, correct medication, correct dosage, and correct route prior to administration. **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.**

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered		
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of <u>Denial and Modification</u> to Practitioner and Member**
	request for service **Additional information <u>incomplete or not received</u>** • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial	 <u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None Specified	exceed 28 calendar days from the receipt of the request for service <u>Practitioner</u>: Within 2 working days of making the decision <u>Member:</u> Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request	Within 72 hours of receipt of the request	<u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None specified	<u>Practitioner</u>: Within 2 working days of making the decision <u>Member</u>: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or	**Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered		

<u>Working day(s):</u> mean State calendar (State Appointment Calendar, Standard 101) working day(s).

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
health or ability to attain, maintain or regain maximum function. • Additional clinical information required	• Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest **Additional information received** • If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision Member: None specified Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination **CA H&SC 1367.01 (h)(2)**		
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may chose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request **Note:** If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of <u>Denial and Modification</u> to Practitioner and Member**
Post-Service - Extension Needed • Additional clinical information required	**Additional clinical information required (AKA: deferral)** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request		
	Additional information received • If requested information <u>is received</u>, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information	<u>Member & Practitioner</u>: None specified	<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination
	<u>Additional information incomplete or not received</u> • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information	<u>Member & Practitioner</u>: None Required	<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination
Hospice - Inpatient Care	Within 24 hours of receipt of request	<u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None Specified	<u>Practitioner</u>: Within 2 working days of making the decision <u>Member</u>: Within 2 working days of making the decision

<u>Working day(s):</u> mean State calendar (State Appointment Calendar, Standard 101) working day(s).

State of California—Health and Human Services Agency

California Department of Public Health
California WIC Program

WIC REFERRAL FOR POSTPARTUM / BREASTFEEDING WOMAN

Health Care Provider:
Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate

WOMAN'S CURRENT (After Delivery)

Height _____ ins.
Weight _____ lbs.
____ /____ /____ Measurement date

Hemoglobin _____ gm/dl.
and/or
Hematocrit _____ %
____ /____ /____ Blood test date

PREGNANCY OUTCOME

____ /____ /____ Delivery date

	Full-Term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth	Sex	Birth weight	Birth length
1.	❒	❒	❒	❒	❒			
2.	❒	❒	❒	❒	❒			

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

❒ C-Section
❒ Diabetes
❒ Hypertension
❒ Tuberculosis
____+PPD ____INH

❒ Other conditions occurring during this pregnancy or delivery (specify): _____

❒ Other current or historical medical conditions (specify): _____

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS / COMMENTS:

LOCAL WIC AGENCY

Name of physician / health care provider / group / clinic

Telephone number:

IMPORTANT: Must be signed by health care provider Date

The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

PM 247 (10/09)

OSP 09 116409

YOU DESERVE
to be your very best!

Your body makes new cells every day—blood, skin, hair, nails and others.

Folic acid is a B vitamin that is needed to make new cells. It is found in some multivitamins and foods labeled as enriched.

MAKE GOOD HEALTH a habit for LIFE!

Start today.

Start a healthy habit. Get 400 micrograms of folic acid every day!

Take a multivitamin with 400 micrograms (mcg) of Folic Acid daily.

An easy way to be sure you're getting enough folic acid is to take a daily multivitamin with folic acid in it. Most multivitamins have all the folic acid you need. If you get an upset stomach from taking a multivitamin, try taking it with meals or just before bed. If you have trouble taking pills, you can try a multivitamin that is gummy or chewable. Also be sure to take it with a full glass of water.

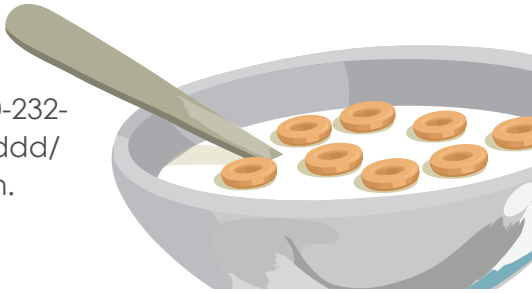
Eat right by choosing food rich in folate.

Folic acid has been added to foods such as enriched breads, pastas, rice and cereals. Check the Nutrition Facts Label on the food packaging. A serving of some cereals has 100% of the folic acid that you need each day.

In addition to getting **400 mcg of folic acid** from supplements and fortified foods, it is important to eat a diet rich in folate. Folate is a form of the B vitamin folic acid. It is found naturally in some foods, such as leafy, dark green vegetables, citrus fruits and juices, and beans.

You never know when you might become pregnant. Having enough folic acid in your body before you become pregnant and during early pregnancy helps prevent some birth defects of the brain and spine. Be ready when the time comes!

For More Information – Call 1-800-CDC-INFO (800-232-4636), visit CDC's website at www.cdc.gov/ncbddd/folicacid, or ask your doctor for more information.



CS247351-A

Workplace Violence Protocol

I. Any staff member involved in an exchange with a patient or other visitor, which he/she perceives to be escalating will:

   a. ask the visitor to remain calm. If the discussion continues to escalate he/she will notify the supervisor/practitioner.

   b. ensure the safety of staff, patients and visitors.

   c. if alone in the office, ask the visitor to leave.

   d. if the situation continues to escalate, the visitor does not leave, or at any time the staff member feels threatened, **dial 911** to summon police.

II. Any staff member who witnesses violence in the office will:

   a. immediately dial 911.

   b. notify the supervisor/practitioner.

Employee Alarm System:

Type of system (please circle or write in): verbal (if 10 employees or less), fire pull, alarm button or pull string in each room, code words, distinct sound/signal (silent alarm, paging system), panic button, and/or other_____.

APPROVED BY: Dr. _____ Date: _____