Molina Healthcare of California
Provider/Practitioner Manual

Medical Management

UTILIZATION MANAGEMENT

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Utilization Management

Utilization Management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of health care services for Molina Healthcare members. The UM Department also maintains the oversight responsibility for conducting annual assessment and evaluation of IPAs/Medical Groups, with delegated utilization and case management functions.

The UM Department staff are responsible for identification of potential or actual quality of care issues and cases of over or under utilization of health care services for Molina Healthcare members during all components of review and authorization.

The comprehensive methods of review and authorization include the following processes:

Direct Referral

The Direct Referral process allows PCPs to provide direct access to a contracted network specialist. The PCP forwards a copy of the direct referral form and supporting medical records to the contracted network specialist to ensure timely appointments and clarify medical necessity of PCP referral.

(For delegated Medical Groups/IPAs, please refer to your Medical Group/IPA contract for specific requirements for referrals/authorizations)

Admission Review

The Utilization Management Clinical Case Manager obtains telephonic medical record review within twenty four (24) hours of notification of admission (or next business day) to ensure the admission to an acute care hospital is appropriate/medically indicated in accordance with the illness or condition or to confirm information obtained during prior authorization of elective admissions. Admission review is also required on all emergency admissions to determine medical necessity and appropriateness.

Notification of Admissions

All elective and emergency inpatient admissions must be reported to Molina Healthcare within twenty four (24) hours of the admission (or the next business day). These notifications can be submitted by faxing the patient's admission face sheet to:

Molina Healthcare Fax: 1 (866) 472-6303

Concurrent/Continued Stay Review

Concurrent/Continued Stay Review is a process coordinated by the Utilization Management Clinical Case Manager during a member's course of hospitalization to assess the medical necessity and appropriateness of continued confinement at the requested level of care. Hospital UM staff should

call in continued stay updates to:

Molina Healthcare Phone: 1 (800) 526-8196, ext. 126410
Fax: 1 (866) 553-9263

Discharge Planning Review

Discharge planning begins as early as possible during an inpatient admission. Such planning is designed to identify and initiate cost effective, quality driven treatment intervention for post - hospital care needs. It is a collaborative and cooperative effort between the attending Physician, hospital discharge planner, Molina Healthcare Utilization Management staff,; including the Medical Director, ancillary Providers/ Practitioners, and community resources to coordinate care and services.

Retrospective Review

Retrospective Review is a review process performed by the Molina Healthcare UM Medical Claim Review staff, after services have been rendered, to determine:

- If unauthorized services were medically necessary/appropriate.
- If services were rendered at the appropriate level of care and in a timely manner.
- If any quality of care issues exist.
- If Provider/Practitioner claim appeals are in order. The attending physician, and/or hospital/facility is notified in writing of the claim payment determinations via the "Explanation of Benefits."

Ancillary Services (Home Health, Durable Medical Equipment, Hospice)

Referrals for any ancillary services including Home Health; Hospice and Durable Medical Equipment greater than $250 per line item require authorization from the Utilization Management (UM) Department.

(For delegated IPAs/Medical Groups, please refer to your IPA/Medical Group contract for specific requirements for referrals/authorizations)

Skilled Nursing or Rehabilitation Facility Review

When a member is transferred or admitted to a Skilled Nursing Facility (SNF) or Acute Rehab Facility, Molina Healthcare uses Title 22 and/or Medicare SNF criteria and guidelines to determine appropriate level of care. All admissions to SNF and Acute Rehab Facilities require authorization by the Molina Healthcare UM Department.

THE REFERRAL PROCESS

Purpose of Prior Authorization

Prior authorization is designed to promote the medical necessity of service, to prevent unanticipated denials of coverage and to ensure that participating Providers/Practitioners are utilized and that all services are provided at the appropriate level of care for the member's needs.

The following services typically require prior authorization **(for delegated Medical Groups/IPAs, please refer to your Medical Group/IPA contract for specific requirements for referrals/authorizations):**

All Referrals / Service Requests to any Non Contracted Provider – MUST be prior authorized. ***Direct Referrals and Follow Up Consultations to Contracted Specialist for All Ages Do Not Require PA***

Services Requiring Prior Authorization

(For delegated IPAs/Medical Groups, please refer to your IPA/Medical Group Contract for specific requirements for referrals/authorizations.)

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare/Molina Medicare Members. *****Referrals to Network Specialists do not require Prior Authorization*****
Authorization required for services listed below. Pre-Service Review is required for elective services. **Only covered services will be paid. If you are contracted with Molina through an IPA / Medical Group please refer to your IPA / MG Prior Authorization requirements. For San Diego Medi-Cal members age 0 – 17.99 years old please refer to Children's Physicians Medical Group's (CPMG) Prior Authorization requirements.**

- **All Non-Par providers/services:** services, including office visits, provided by non-participating providers, facilities and labs, except professional services related to ER visit, approved Ambulatory Surgical Center or inpatient stay and Women's health/OB services. ER visits do not require PA
- **Alcohol and Chemical Dependency Services** (Medicare & CHIP only)
- **All Inpatient Admissions:** Acute hospital, SNF, Rehab, LTACS, Hospice(notification only)
- **Behavioral Health Services: -** Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), ECT, and > 12 Office Visits/year for adults and 20 Office visits/year for children (Medicare & CHIP only)
- **Cardiac Rehabilitation, Pulmonary Rehabilitation, and CORF (Comprehensive Outpatient Rehab Facility services for Medicare only)**
- **Chiropractic Services** (Benefit only for Sac / San Diego counties – Max. allowable 2 treatments / month) (Healthy Families PA after initial 20 visits benefit)
- **Cosmetic, Plastic and Reconstructive Procedures in any setting:** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, and surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation or dermabrasion, botox injections, etc
- **Dental General Anesthesia for Dental restorations:** 7 years old or older (Not a Medicare covered benefit)
- **Dialysis:** notification only
- **Durable Medical Equipment/Orthotics/Prosthetics:**
  - >$500 allowed amount (paid amount) per line item or >$2000 total
  - All C-PAP and Bi-PAP
  - All customized orthotics, prosthetics, wheelchairs and braces
- **Hearing Aids** – including bone anchored hearing aids (Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462)
- **Enteral Formulas & Nutritional Supplements**
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing NOT related to pregnancy**
- **Home Healthcare: after initial 3 skilled nursing visits**
- **Home Infusion**
- **Outpatient Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, intimal media thickness testing, three dimensional imaging (PA through MedSolutions)
- **Neuropsychological Testing and Therapy**
- **Occupational Therapy, Physical Therapy and Speech Therapy after initial eval plus 6 visits (Home or outpatient setting)**
- **Office-Based Surgical Procedures do not require auth except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** except for see attached**
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Not a Medicare covered benefit)
- **Pregnancy and Delivery:** notification only
- **Sleep Studies**
- **All Specialty Pharmacy including, but not limited to:** Hemophilia drugs**,** Avastin, Enbrel, Lupron, Remicade, Avonex, Interferon, Xolair, Humira, Raptiva, Amevive, Synagis, Synvisc, growth hormone, monoclonal antibody, genomic preparations, etc. (except for specific state regulatory requirements)
- **Solid Organ and Bone Marrow Transplant Services:** including the evaluation (except Cornea transplants)
- **Transportation:** non-emergent ground and air ambulance
- **Unlisted CPT procedures (all),**
  - **miscellaneous codes >$500 billed charges per line item**
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

** **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:**

The following procedures do NOT require PA if performed in a participating ASC or Outpatient Hospital setting:

Appendectomy	44950, 44970
AV Fistula	36831, 36832, 36833
Bladder Tumor	52234, 52235, 52240
Blood Patch	62273
Breast Biopsy	19120
Bronchoscopy	31622, 31623, 31624, 31625, 31626, 31627, 31628, 31629, 31630, 31631, 31632, 31633, 31635, 31636, 31637, 31638, 31640, 31641, 31643, 31645, 31646, 31656
Cardiac Cath	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93530, 93531, 93532, 93533
Cardiovascular Intra-Arterial/Intra-Aortic Catheter	36100, 36120, 36140, 36147, 36148, 36160, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248. Also please note that the following associated Aortography/Angiography procedures do not require authorization as well: 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75791
Cataract	66820, 66821, 66830, 66982, 66983, 66984
Cecostomy tube	49442
Cerclage during Pregnancy	59320
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392
Cystourethroscopy	52270, 52275, 52276, 52265, 52260, 52000,52001, 52005
D&C	58120, 59812, 59820, 59821
Endometrial/Endocervical Sampling (biopsy)	58100
Gastrostomy Tube	49440, 49450, 43760, 43761, 49460
Gastrostomy Tube to Jejunostomy Tube	49446, 49452
GI Endoscopy	43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272
Hardware Removal	20680, 20670

Inguinal Hernia	49505, 49507, 49520, 49521, 49525, 49650, 49651
Jejunostomy Tube	49441, 49451
Lacrimal Duct	68811, 68815, 68816
Lap Cholecystectomy	47563, 47564, 47562
Laryngoscopy	31505, 31510, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31545, 31546, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579
Malignant Lesion	11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11640, 11641, 11642, 11643, 11644, 11646, 17260, 17261, 17262, 17263, 17264, 17266, 17270, 17271, 17272, 17273, 17274, 17276, 17280, 17281, 17282, 17283, 17284, 17286
Orchiopexy	54640
PICC line placement/ replacement	36568, 36569, 36582, 36584, 36589, 36590, 36598
PORT-A-CATH	36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36576, 36578
Sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345
Sterilization*	55250, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58600, 58605, 58611, 58615, 58671, 58940
Tonsillectomy/Adenoidectomy	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836
TURP	52601, 52630
Tympanoplasty/Myringotomy	69420, 69421, 69424, 69433, 69436, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69643, 69644, 69645, 69646

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE/MOLINA MEDICARE

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

All member cases with a potential CCS diagnosis must be referred to CCS paneled practioners and / or facilities. Referrals to non-CCS paneled providers may result in delays in claim payment.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone or fax. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition. Providers can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (800) 526-8196

Important Molina Healthcare/Molina Medicare Information	
Medi-Cal & HF Prior Authorizations: 8:30 a.m. – 5:30 p.m. Phone: 800-526-8196 PA Queue X126400 (PA Manager – Alona Velando X126587) or 562-499-6191 Fax: 800-811-4804 **Pharmacy Authorizations:** 8:00 a.m. – 6:00 p.m. Phone: 888-665-4621 8:30am-5pm Fax: 866-508-6445 **Medicare Prior Authorization:** Phone: 800-526-8196 X129105 Fax: 866-472-0596 **Behavioral Health Authorizations:** **Comprehensive Care – Medicare & Healthy Family LOB - (Sacramento, Riverside, San Bernardino, LA)** Phone: 800-818-7235 Fax: 877-436-3604 **Behavioral Health Associates – San Diego Medicare & Healthy Family LOB** Phone: 619-528-4600 Fax: 619-528-4625	**Member Customer Service Benefits/Eligibility:** Phone: 888-665-4621 Fax: 562-901-9632 TTY/TDD: 800-479-3310 **Medicare Member Customer Service Benefits / Eligibility** Phone: 1-800-665-0898 Fax: 1-801-858-0409 TTY/TDD-1-800-346-4128 **Provider Customer Service:** 7:00 a.m. – 7:00 p.m. Monday - Friday Phone: 888-665-4621 Fax: 562-901-9632 **24 Hour Nurse Advice Line** English: 1 (888) 275-8750 [TTY: 1-866/735-2929] Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703] **Vision Care: March Vision Services** Phone: (888) 493-4070

	Medicare Dental: Avesis Phone: 855-214-6779 **Medicare Hearing Coverage: Avesis** Phone: 800-327-4462 **Medicare Non-emergency transportation coverage: Logisticare** Phone: 866-475-5423

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com

Available features include:

- **Authorization submission and status**
- **Claims submission and status (EDI only)**
- **Download Frequently used forms**
- **Member Eligibility**
- **Provider Directory**
- **Nurse Advice Line Report**

Molina Healthcare does not require prior authorization for the following services:

- Emergency services
- Urgent Care services
- Family planning services
- Treatment of sexually transmitted diseases
- Confidential HIV testing and counseling
- Obstetrical care
- Sensitive and confidential services (e.g. services related to sexual assault, drug and alcohol abuse for children aged 12 and over)
- Therapeutic and elective pregnancy termination
- Annual Well Woman visit
- Optometry and diabetic retinal exam
- Services not listed on the Molina Healthcare Prior Authorization List or listed as not requiring Prior Authorization.

Eligibility

Authorization is based on member eligibility at the time of request and is verified by the Utilization Management staff. Providers / Practitioners are encouraged to verify member eligibility at the time the service is rendered.

Benefits

Benefit coverage for a requested service is verified by the UM staff during the authorization process.

Referral to Non-Participating Providers/Practitioners or Non-Contracted Facilities

Except in true emergencies, Molina Healthcare provides coverage for only those services rendered by contracted Providers/Practitioners and facilities. The exceptions are:

- Molina Healthcare is notified, approves, and authorizes the referral in advance. In these instances, the UM Prior Authorization Department will issue an authorization number for the services to be provided. Prior approval must be obtained by the Provider/Practitioner recommending an out of plan referral before arrangements have been made for those services. To obtain an authorization number, contact the Molina Healthcare UM Outpatient Services/Authorization Department at (800) 526-8196, ext. 126400; Fax (800) 811-4804.

Service Request Form

The Service Request Form must be completed and an authorization obtained for all services described above as requiring prior authorization **before the service is provided**, except in emergencies.

For an authorization to be valid the following conditions must be met:

- The member must be currently enrolled with Molina Healthcare.
- The member must be assigned to the PCP initiating the primary referral.
- The member must receive initial services within ninety (90) days of the authorization date.
- **A Prior Authorization number must be obtained from Molina Healthcare prior to services**

being rendered as described above (except in emergencies).

- Molina Healthcare retains the right to retrospectively review inpatient and specialist claims to identify inappropriate consultations and procedures. The right to deny such consultations and procedures is also reserved.
- All inpatient services must have a prior authorization number which is issued by the Molina Healthcare Utilization Management Department.
- Inpatient Admission Notification **(800) 526-8196, ext. 126410**; Fax **(866) 472-6303**.

Completion of a Service Request Form

- A thoroughly completed Service Request Form is essential to assure a prompt authorization.
  - All shaded areas are to be completed by the referring/ordering entity. **A copy of pertinent clinical notes may be attached and substituted for the Clinical History segment of the Service Request Form.**
  - The form should be transmitted by fax to Molina Healthcare for review by the Utilization Management Department and assignment of an authorization number: **Fax: (800) 811-4804**.
  - To assure maximum benefit from a referral, the PCP must clearly state the purpose of the service request. Patient progress notes, labs, and imaging should be attached to the request.
- Reference the Access to Care Standards Section

PRIOR AUTHORIZATION REQUESTS

Primary Care Practitioners (PCPs)

- The PCP is always the initial source of care for members. A member may see the PCP without a referral and the PCP may perform essential services in the office environment.
- Elective office procedures performed by the PCPs may require authorization.
- Prior Authorization may be required for necessary member services ordered by the PCP which cannot be performed in the office. (Please reference Molina's PA Requirement Matrix)
- If the PCP determines that a specialist is necessary for consultation or care of the patient, the PCP must complete a Referral Form (see below). Prior Authorization is not required for direct referrals and/or follow-up consultations to contracted specialists.
- Referrals are only made to specialists in the Molina Healthcare Network. Exceptions will be made only in rare circumstances and then only with the prior approval of the Molina Medical Director.
- Complete referrals are essential, stating exactly what is to be done and including any clinical information and previous diagnostic testing for the specialty provider's/practitioner's review.
- A system within the PCP's practice should be developed to assure that written responses from specialty referrals are received and incorporated into the Member's medical record, e.g. a Specialty Log.

NOTE: As described in the Benefits and Covered Services Section of this Provider Manual, certain benefits and services are available to members without the necessity of PCP referral, e.g. Obstetrics, Optometry, Family Planning, etc.

LAB REFERRALS

UNILAB/QUEST

Laboratory Services are provided through various methods, depending upon the Provider/Practitioner's or IPA/Medical Group's relationship with the Plan. Refer to the following table for reference when accessing laboratory services for your patients:

	MOLINA HEALTHCARE DIRECT PCP	MOLINA HEALTHCARE DIRECT SPECIALIST	MOLINA HEALTHCARE STAFF MODEL PCP	MOLINA HEALTHCARE PCP THROUGH IPA/MEDICAL GROUP
UNILAB/ QUEST	**X**	**X**	**X**	
FOLLOW IPA REQUIREMENTS				**X**

As outlined in the table above, Molina Healthcare's Direct contracted PCPs, Direct contracted Specialists, and Molina Medical Group Staff Model PCPs must use UNILAB/QUEST for Molina Healthcare members. Providers/Practitioners should direct Molina Healthcare patients to a UNILAB/QUEST draw station. Providers/Practitioners may call UNILAB/QUEST for laboratory pick-up.

All STAT laboratory tests will be picked up as soon as possible and results will be called in or faxed as soon as the tests are completed. Most routine laboratory tests will be processed within forty eight (48) hours. For further information regarding services, draw station locations, supplies, or for answers to technical questions, call UNILAB/QUEST directly.

UNILAB/QUEST
8401 Fallbrook Ave.
West Hills, CA 91304
(818) 996-7300, ext. 2000

SPECIALISTS REFERRALS

- A specialist may see a Molina Healthcare member only upon an initial referral from the member's assigned PCP or as a secondary consultant from the primary referred specialist, except in a Medical Emergency.
- If there is any question regarding the scope of the referral, the PCP should be contacted for

clarification.

- The PCP will specify the type of referral:
  - Consultation for diagnostic purposes
  - Consultation to recommend treatment plan
  - Consultation and request to assume care
- When the member is referred for **"Consultation to Recommend Treatment Plan"** the PCP will specify on the referral form if:
  - The referral is for a consultation visit only, or
  - The referral is for consultation plus one follow-up visit.

  Only those diagnostic procedures, tests, and treatments specifically related to the consultation and not defined in the services/referral guidelines, may be performed by the Specialist.

  This authorization is obtained **directly by the specialist** following Molina Healthcare's prior authorization policies and procedures. Tests, procedures, and treatments must be performed in network facilities. This type of referral is valid for a ninety (90) day period.
- When the member is referred for consultation and subsequent care, the PCP will so specify. For diagnostic procedures and tests which are specifically related to the requested consultation, and which are not listed in the services/referral guidelines, prior authorization is required.

  If the specialist determines that a secondary specialist who is out of the Molina Healthcare Network is required, a Prior Authorization from Molina Healthcare is required.

MOLINA HEALTHCARE is ONLY financially responsible for those services which are Medically Necessary and specified in the Referral/Service Request form by the PCP to Specialist (or Referred Specialist to Secondary Specialist), and have been Prior Authorized by Molina Healthcare.

- Verbal communication from the PCP should be provided on any urgent referrals.
- A written response should be provided to the PCP within three (3) weeks of care for inclusion in the member's medical record.
- **The** Prior Authorization/Referral number must be clearly written on the bill submitted to Molina Healthcare**:**

  MOLINA HEALTHCARE
  200 Oceangate, Suite 100
  Long Beach, CA, 90802
  Attention: Claims Department

If the member is Medicare eligible or has other insurance, submit the claim to that entity first, then to Molina Healthcare with the appropriate EOB.

Prior Authorization Decision Turnaround Time Standards

- Turn-Around-Times for Medical Authorizations:
  - **Emergency Care:** No prior authorization required, Molina Healthcare follows the

reasonable person standard to determine that the presenting complaint might be an emergency.

- **Post Stabilization Care:** Molina Healthcare's Medical Director will respond within thirty (30) minutes of the reported service request or the service is deemed approved.
- **Concurrent Review** of authorization for treatment regimen already in place: Within five (5) working days or less, consistent with the urgency of the Member's medical condition.
- **Retrospective Review:** Retrospective review is completed within thirty (30) calendar days of receiving all pertinent clinical information to make a medical necessity decision.
- **Routine Authorizations:**
  Determinations regarding requests for elective services/procedures are made within five (5) working days of receipt of medical record information required to evaluate medical necessity and appropriateness, but no longer than fourteen (14) calendar days from the receipt of the service request.

The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where:

- The Member or the Member's Provider/Practitioner requests an extension or;
- Molina Healthcare can provide justification upon request of the need for additional information.

- **Expedited Authorizations:**
  - Determinations regarding urgent service/procedures (medically necessary within seventy two (72) hours) are made within three (3) calendar days after receipt of the request for services. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where:
    - The Member or the Member's Provider/Practitioner requests an extension or;
    - Molina Healthcare can provide justification upon request of the need for additional information.
  - The Urgent Service Request designation should only be used if the treatment is required to prevent serious deterioration in the member's health.
  - The Provider/Practitioner will be notified of the decision within twenty four (24) hours of the decision.
  - A list of resources used to make utilization and clinical decisions includes but is not limited to:
    - InterQual
    - MediCal Policies and Procedures
    - Medicare Policies and Procedures
    - Hayes Directory of New Medical Technology
    - American Institute of Preventative Medicine Protocols
    - American College of Obstetrics and Gynecology (ACOG) Guidelines for Perinatal Care

Providers/Practitioners who wish to discuss denial or modification of services may contact the Molina Healthcare Medical Director at (800) 526-8196.

Clinical Criteria used in a denial or modification decision may be requested by calling (800) 526-8196, ext. 126400 for outpatient and ext. 126410 for inpatient.

(UM decision making is based only on appropriateness of care and service and existence of coverage. Molina Healthcare does not specifically reward Providers/Practitioners or other individuals for issuing denials of coverage or service care. Molina Healthcare does not provide financial incentives for UM decision makers and does not encourage decision that result in under utilization.)

Upon approval of the request of a service request, the PCP's office staff will assist the member in scheduling an appointment with the Provider/Practitioner for the member. The PCP or his staff will instruct the member to take a copy of the authorization form and / or number to the requested Provider/Practitioner.

CONTINUITY OF MEMBER CARE

Molina Healthcare and contracted Providers/Practitioners within these networks must ensure that members receive medically necessary health care services in a timely manner without undue interruption.

The cornerstone of continuity of care is the maintenance of a single, confidential medical record for each patient. This record includes documentation of all pertinent information regarding medical services rendered in the Primary Care Practitioner's (PCP) office or other settings, such as, hospital emergency departments, inpatient and outpatient hospital facilities, specialist offices, the patient's home (home health), laboratory and imaging facilities. Molina Healthcare and contracted Providers/Practitioners must have systems in place to ensure the following:

- Maintenance of a confidential medical record.
- Monitoring of patients with ongoing medical conditions.
- Appropriate referral of patients in need of specialty services.
- Documentation of referral services in the member's medical record.
- Forwarding of pertinent information or findings to specialist.
- Entering findings of specialist in the member's medical record.
- Documentation of care rendered in the emergency or urgent care facility in the medical record.
- Documentation of hospital discharge summaries and operative reports in the medical record.
- Coordination of post hospital follow-up, discharge planning, and aftercare.

Molina Healthcare does not provide incentives to Molina Healthcare Staff or its providers for UM decision making.

Routine Medical Care

The member's PCP is responsible for providing routine medical care to members, following up on missed appointments, prescribing diagnostic tests and procedures, referrals, and/or laboratory tests. The PCP also ensures that each newly enrolled member receives an initial health assessment

within ninety (90) days of enrollment.

Each of these items are discussed in more detail within this Manual.

Referrals

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Upon initiation of the referral, the PCP is responsible for initiating the referral tracking system.

Second Medical/Surgical Opinion

A member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- Molina Healthcare members may request a second opinion through their PCP or Molina Healthcare's Member Services Department. Molina Healthcare's Member Services Department will assist the member in coordinating the second opinion request with the member's PCP, specialist, and/or IPA/Medical Group.
- Members assigned to a delegated IPA/Medical Group will have their second opinion request submitted to and reviewed by that IPA/Medical Group's Medical Director.
- Members assigned to a direct contracted PCP or Non-Capitated / UM Delegated Molina Medical Group Staff Model PCP will have their second opinion request submitted to and reviewed by Molina Healthcare's Medical Director.
- Second Opinion requests will be reviewed and provided written approval or denial within forty eight (48) hours of request receipt. In cases where the request identifies an urgent or emergent need, formal approval or denial will be provided within one (1) working day.
- If the request for second medical/surgical opinion is denied, both the member and Provider/Practitioner have the opportunity to appeal the decision through the Member Appeals Process.
- If the requested specialty care Provider/Practitioner or service is not available within the Molina Healthcare network; an approval to an out of network Provider/Practitioner will be facilitated by Molina Healthcare or the IPA/Medical Group's Utilization Management Department.
- Only one request for a second medical/surgical opinion will be approved for the same episode of treatment. This applies to both the in network and out of network requests for second medical/surgical opinion.

Under the authorization process utilized by the Utilization Management Department, any medical or surgical procedure that does not meet medical policy criteria (refer to online InterQual criteria) is reviewed with a Medical Director. The Medical Director may request a second opinion at any time on any case deemed to require specialty practitioner advisor review. **The Utilization Management review criteria specific to the second opinion decision may be obtained upon request to the Utilization Management Department.**

Upon approval of the request for a second medical/surgical opinion, the PCP's office staff will assist

the member in scheduling an appointment with the second opinion Provider/Practitioner for the member. The PCP or his staff will instruct the member to take a copy of the authorization form and pertinent medical records to the second opinion Provider/Practitioner.

CONTINUITY OF CARE – New & Current Members

When Continuity of Care is a result of a Provider / Practitioner Contract Termination:

- Members shall be notified at least thirty (30) calendar days prior to the effective date of a Provider/Practitioner contract termination, or within fourteen (14) calendar days prior to the change in cases of unforeseeable circumstances. In cases of unforeseeable circumstances, the Compliance Department will coordinate with the Regulatory Contract Managers for approval. Molina Healthcare will adhere to the most stringent regulatory standard for all lines of business.
- This policy shall encompass all members assigned to a PCP or that have been treated by a Specialist Provider/Practitioner any time during the eight (8) months preceding the effective termination date, currently in treatment or open authorizations.
- Molina Healthcare shall arrange for, upon request by the member or a Provider/Practitioner on behalf of the member, for continuity of care by a terminated Provider/Practitioner or a Provider/Practitioner that has changed Medical Group/Independent Practitioner Association (IPA) affiliation, who has been providing care for:

Specific Requirements for Serving Molina Healthcare's Medi-Cal-only SPD Members

Newly enrolled SPD Member access to existing out-of-network practitioner / provider: MHC's UM department will ensure continued access for up to 12 months to an out-of-network provider for new SPD members who have an established on-going relationship if there are no quality of care issues with the provider and the provider agrees to accept MHC's contract or Medi-Cal FFS rates, whichever is higher.

Conditions For Continuation of Services:

- *New Medi-Cal only SPD Member who has an ongoing relationship with a non-participating provider; and there are no quality of care issues with the provider and the provider agrees to accept the health plan or Medi-Cal FFS rates; not to exceed 12 months.*
- An acute condition for the duration of the condition. (defined as a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration).
- Serious chronic condition for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, not to exceed 12 months.(defined as a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: (a) persists without full cure or worsens over an extended period of time, and (b) requires ongoing treatment to maintain remission or prevent deterioration.

- Pregnancy condition for the duration of the condition and immediate postpartum period.(A pregnancy is the three (3) trimesters of pregnancy and immediate postpartum period.)
- Terminal Illness for the duration of the condition. (A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.)
- Care of a newborn child who age is between birth and age thirty-six (36) months not to exceed 12 months duration.
- Performance of surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment that is to occur within 180 days.
- Transition to other care for member's who are receiving approved services but whose benefit coverage will end while the members still need the medically necessary care.
- For cases involving an acute condition or a serious chronic condition, Molina Healthcare will continue to provide the member with health care services in a timely and appropriate basis from the terminated Provider/Practitioner or Provider/Practitioner that has changed Medical Group/IPA affiliation, for up to ninety (90) days or a longer period if necessary, for a safe transfer to another Provider/Practitioner as determined by Molina Healthcare's Medical Director, in consultation with the PCP, terminated Provider/Practitioner, and/or the receiving Medical Group/IPA, consistent with good professional practice.
- For cases involving pregnancy, Molina Healthcare shall furnish the member with health care services on a timely and appropriate basis from the terminated Provider/Practitioner or Provider/Practitioner that has changed Medical Group/IPA affiliation, until postpartum services related to the delivery are completed or for a longer period if necessary, for a safe transfer to another Provider/Practitioner as determined by Molina Healthcare's Medical Director, in consultation with the PCP, terminated Provider/Practitioner, and/or the receiving Medical Group/IPA, consistent with good professional practice.
- Continuity of care during an inpatient admission shall be reviewed and determined by Molina Healthcare's Medical Director in consultation with the PCP, terminated Provider/Practitioner, and/or the receiving Medical Group/IPA.
- Continuity of care for outpatient services, outstanding and ongoing authorizations, for a terminated Provider/Practitioner or a Provider/Practitioner that has changed Medical Group/IPA affiliation, shall be reviewed by Molina Healthcare's Medical Director in consultation with the PCP, receiving Medical Group/IPA, and other Providers/Practitioners involved with the patient's care.

SECTION 9: PUBLIC HEALTH COORDINATION AND CASE MANAGEMENT

PUBLIC HEALTH COORDINATION

Molina Healthcare provides a comprehensive case management program to all members who meet the criteria for services. Case Management focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of care. Public health issues are comprehensively managed through Case Management.

Case Management is individualized to accommodate a member's needs. In collaboration with and approval by the member's Primary Care Practitioners (PCP), the Molina Healthcare Case Manager will arrange individual services for members whose needs include ongoing medical care, home health care, hospice care, rehabilitation services, and preventive services. The Molina Healthcare Case Manager is responsible for assessing the member's appropriateness for the Case Management (CM) Program and for notifying the PCP of the evaluation results, as well as making recommendation for a treatment plan.

The Case Manager works in conjunction with the PCP, the member, the member's family, other Providers/Practitioners, etc., to coordinate and implement the individualized treatment plan of members placed in the CM Program.

Referral to Medical Case Management

Members with high-risk medical conditions may be referred by their PCP or specialty care Provider/Practitioner to Molina Healthcare's Case Management Program. The Case Manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist Providers/Practitioners, ancillary Providers/ Practitioners, the Local Health Department, and other community resources.

Members with the following conditions are potential cases and should be referred to the Molina Healthcare Case Management Program for evaluation:

- California Children's Services (CCS) eligible cases
- High-Risk Pregnancy
- Catastrophic Medical Conditions (HIV, Neoplasms, Organ/Tissue Transplants, Multiple Trauma)
- Chronic Illness (Asthma, Diabetes, ESRD)
- Preterm Births
- High-Technology home care requiring more than two (2) weeks of treatment
- Members requiring care and services "carved out" from coverage by Molina Healthcare due to contractual arrangements
- Member accessing Emergency Room services inappropriately
- Comprehensive Perinatal Services Program (CPSP)
- Members receiving care in non-contracted facilities as a result of an emergency admission.

PCP RESPONSIBILITIES IN CASE MANAGEMENT REFERRALS

The member's PCP is the primary leader of the health team involved in the coordination and direction of care services for the member. The Molina Healthcare Case Manager provides the PCP with reports, updates, and information regarding the member's progress through the case management plan.

The PCP is responsible for the provision of preventive services and for the primary medical care of members eligible for or requiring "carved out" services. The PCP is responsible for early identification of members eligible for "carved out" services and for referrals to Molina Healthcare's Case Management Program and specialist/ancillary Providers/Practitioners.

Referrals to Case Management may be made by PCPs, other Providers/Practitioners, hospital UR/DC staff, ancillary Providers/Practitioners, Local Health Department resources, the Molina Healthcare Medical Director, and UM staff.

- Molina Healthcare adheres to Case Management Society of America (CMSA) Standards of Practice Guidelines in its execution of the program.
- The Molina Healthcare Case Manager, in conjunction with the PCP and other Providers/Practitioners, develops and implements a care plan appropriate to the member's medical needs.
- Case Management services are not delegated to IPAs or medical groups. Molina Healthcare's Medical Case Manager retains sole responsibility for authorization and implementation of these services. IPAs/Medical Groups are required to refer known or potential cases appropriate for Case Management to Molina Healthcare. The referral may be made by telephone or facsimile.

The CM Program is based on a member advocacy philosophy designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The Molina Healthcare Case Manager receives referrals from and/or communicates and interfaces with Local Health Department representatives to coordinate responsibilities (per "Agreement" terms) for the following services/programs:

- Mental Health
- Waiver Programs
- Direct Observed Therapy for TB
- Family Planning
- Sexually Transmitted Disease
- HIV
- CHDP (immunizations)
- WIC
- CCS
- CPSP
- Refugee Health Programs
- Developmental Disabilities Services (DDS)
- Early Start Program
- The Case Manager collaborates with all resources involved and develops a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes.

- The Case Manager, Providers/Practitioners, and the member are jointly responsible for implementing the plan of care.
- The Case Manager monitors and communicates the progress of the implemented plan of care to all involved resources.
- The Case Manager serves as a coordinator of and resource to Team Members throughout the implementation of the plan and makes revisions in the plan as suggested and needed.
- The Case Manager coordinates appropriate educational sessions through Molina Healthcare's Health Education Department and encourages the member's role in self-help.

Progress toward the member's achievement of treatment plan goals is monitored in order to determine an appropriate time for the member's discharge from the Case Management Program.

Health Education and Preventive Care Programs

Molina Healthcare's Health Education and Preventive Care Programs will be incorporated into the member's case management plan as programs are available to address the member's health care needs. Primary prevention programs may include nutrition, exercise, smoking cessation, stress reduction, and wellness. The Case Management staff will work closely with the Health Education staff to coordinate education services.

Referrals to State or County Case Management Programs

When a member is identified as being eligible for a County or State supported health care program, a Molina Healthcare Case Manager may assist the PCP to ensure timely referral to the appropriate program. The PCP, with the patient's/family's approval, makes the referral to the program. The PCP will coordinate primary medical care services for members who are eligible.

Referrals to Molina Healthcare Case Management

Referrals to Molina Healthcare Case Management may be made by contacting:

Molina Healthcare Case Management
Telephone 1-800-526-8196, Ext. 127604
Fax (888) 273-1735

WOMEN'S AND ADULT HEALTH SERVICES, INCLUDING PREVENTIVE CARE

PREGNANCY AND MATERNITY CARE

All pregnant and postpartum women must be offered access to the Comprehensive Perinatal Services Program (CPSP) or equivalent services. This includes the multi-disciplinary integration of health education, nutrition, and psychosocial assessments. In addition, pregnant and postpartum women have access to medical/obstetrical care, genetic counseling, case coordination/case management, individualized care plan (ICP) development with updates, trimester reassessments, and postpartum assessment to include health education, nutrition and psychosocial assessments, and medical/obstetrical care to both the common and identified high-risk pregnancy/postpartum member within sixty (60) days postpartum.

Provider/Practitioner Responsibilities

OB care Providers/Practitioners are strongly encouraged to be CPSP certified or have a formal relationship with a CPSP certified Provider/Practitioner for the provision of CPSP support services. All pregnant members shall be referred and assigned to CPSP certified Providers/Practitioners for CPSP services, whenever possible. The CPSP Providers/Practitioners shall be involved with the following:

- Integration of clinical health education, nutrition, and psychosocial assessment
- Medical obstetrical care, genetic counseling, and case coordination/management
- Use of appropriate documentation and care planning tools
- Submission of encounter and outcomes data

CPSP Certified Providers/Practitioners of Perinatal Services

- CPSP Certified Providers/Practitioners shall be responsible for providing and complying with all CPSP service requirements for their pregnant and postpartum members up to sixty (60) days after delivery.
- CPSP Certified Providers/Practitioners shall be responsible for complying with Molina Healthcare's policy and procedure and Comprehensive Perinatal Services Program (CPSP) requirements and standards including: use of appropriate assessment, documentation, and care planning tools; submission of reporting forms (i.e. Pregnancy Notification Report).
- All CPSP Providers/Practitioners will receive information on how to obtain copies of CPSP's "Steps to Take" materials which provides information helpful to staff members to effectively assess, provide intervention for common pregnancy conditions and

discomforts, and how to appropriately refer pregnant members.

Non-CPSP Certified Providers/Practitioners of Perinatal Services

Non-CPSP Providers/Practitioners **must** comply with Molina Healthcare policy and procedures and standards including:

- Use of appropriate assessment, documentation, and care planning tools
- Submission of reporting forms (e.g. PNR)
- Employment of appropriate, qualified staff (e.g. CPHW)

Molina Healthcare's Perinatal Services Staff may also perform audits/reviews on, but not limited to, the following:

- Member satisfaction questionnaire;
- Member complaints;

Molina Healthcare and the Local Health Departments shall provide a consolidated effort to promote, encourage, and assist all Non-CPSP Providers/Practitioners in obtaining CPSP certification through the Department of Health Care Services. Molina Healthcare and the Local Health Department shall provide ongoing support to all Molina Healthcare contracted CPSP certified Providers/Practitioners.

Non-CPSP certified Providers/Practitioners may choose to outsource CPSP services. Molina Healthcare Perinatal Services Staff shall provide technical assistance to Non-CPSP Providers/Practitioners in referring members to appropriate facilities (clinics, hospitals, etc.) as necessary. Non-CPSP certified Providers/Practitioners may refer their high-risk pregnancies to Molina Healthcare's Motherhood Matters Program.

For more information on how to become a DHCS certified CPSP Provider/Practitioner, call the appropriate CPSP Program Coordinator:

Riverside (951) 358-5260

San Bernardino (909) 388-5751

Sacramento (916) 875-6171

Los Angeles (213) 639-6427

San Diego (619) 542-4053

Authorization

- Prior authorization or approval certification for either the OB or CPSP services provided for pregnant or postpartum members (defined as up to sixty (60) days after delivery) is not required.
- Members may see any qualified contracted Provider/Practitioner, including their PCP, an obstetrician/gynecologist, or a nurse midwife for prenatal care, (Note: members in capitated IPA/Medical Groups must obtain an obstetrical Provider/Practitioner within their IPA/Medical Group).

Member Participation

Prior to the administration of any assessment, drug, procedure, or treatment, the member must be informed of the following:

- Potential risks or hazards which may adversely affect her or her unborn infant during pregnancy, labor, birth, or postpartum.
- Alternative therapies available to her.
- The member has a right to consent to or refuse the administration of any assessment, drug, procedure, test, or treatment. The refusal of any Molina Healthcare member to participate in CPSP must be documented in the member's medical record by the Provider/Practitioner or Perinatal Support Staff offering the CPSP service. Member participation is strongly encouraged, but is voluntary.

Perinatal Support Staff as defined in this document includes:

- Certified Nurse Midwives
- Registered Nurse Practitioners (Family and/or Pediatric)
- Physician Assistants
- Registered Nurses
- Social Workers
- Psychologist • Dietitians
- Health Educators
- Child Birth Educators
- Comprehensive Perinatal Health Workers (CPHW)
- Medical Groups
- Medical Clinics
- Hospitals
- Birthing Centers
- Case Manager

PREVENTIVE CARE

Molina Healthcare requires contracted Providers/Practitioners of Perinatal Services to adhere at minimum to the current American College of Obstetrics and Gynecologists (ACOG) Standards, current edition.

Molina Healthcare Prenatal Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the ACOG, U.S. Preventive Services Task Force, the American Academy of Family Physicians, and others. They are updated annually. The Prenatal PHG is available on the Molina Healthcare webpage at www.molinahealthcare.com.

You may request a copy by contacting Provider Services at (888) 665-4621.

Perinatal Services Available to Members and Providers/Practitioners

- The Molina Healthcare UM Department shall be responsible for reviewing all referrals and treatment authorization requests for Perinatal Services of Molina Healthcare members where prior authorization is required. Please refer to Molina Healthcare's Prior Authorization list in the Utilization Management Section.

Frequency Scheduling of Perinatal Visits/Re-Assessments

Molina Healthcare Providers/Practitioners shall follow ACOG's Guidelines for Perinatal Care regarding the frequency of visits/reassessments: Uncomplicated Pregnancy

- Every four (4) weeks for the first twenty eight (28) weeks
- Every two (2) three (3) weeks until the thirty sixth (36th) week
- After the thirty sixth (36th) week, then weekly until delivery
- Postpartum, three (3) eight (8) weeks after delivery

Complicated/High-risk Pregnancy

- Frequency as determined by the member's Provider/Practitioner or Perinatal Support Staff according to the nature and severity of the pregnant member identified risk(s)
- Women with medical or obstetrical risks may require closer surveillance than the ACOG recommendations

Biochemical Lab Studies

The Perinatal Support Staff shall ensure the following biochemical lab studies are completed as part of the member's initial risk assessment:

- Urinalysis, including microscopic examination and infection screen
- Hemoglobin/Hematocrit
- Complete Blood Count
- Blood Group, ABO and RH type
- Antibody screen
- Rubella antibody titer
- Syphilis screen (VDRL/RPR)
- Gonorrhea culture
- Chlamydia culture
- Urinary Ketones
- Serum Albumin
- Hepatitis B virus screen
- Cervical Cytology
- Tuberculosis testing

- Hemoglobin electrophoresis
- Blood volume
- One hour glucose screen
- Screening for Genetic Disorders

The Perinatal Support Staff shall ensure all pregnant members who have a history of one (1) or more of the following shall have genetic disorder screening performed as part of the member's initial risk assessment and are referred to a genetic counseling center or genetic specialist, as appropriate:

- Advanced maternal age (35 years of age or older)
- Previous offspring with chromosomal aberration
- Chromosomal abnormality in either parent
- Family history of a sex-linked condition
- Inborn errors of metabolism
- Neural tube defects
- Hemoglobinopathies
- Ancestry indicating risk for Tay-Sachs, Phenylketonia (PKU), Alpha or Beta Thalassemia, Sickle Cell Anemia, and Galactosemia

The Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment and document in the member's Individualized Care Plan. Upon the Provider/Practitioner's recommendations and member consent, the appropriate procedure(s) shall be performed (i.e. amniocentesis). The Provider/Practitioner shall give results of procedure(s) to the member . Appropriate follow-up intervention shall occur, as necessary

INITIAL COMBINED PRENATAL RISK ASSESSMENT/REASSESSMENT OF THE PREGNANT MEMBER OVERVIEW

The Initial Combined Prenatal Risk Assessment/Re-Assessment is a combined risk assessment which includes medical/obstetrical, psychosocial, nutritional, and health educational components.

Perinatal Support Staff Responsibilities

Perinatal Support Staff shall be responsible for assessing and evaluating the following:

- Member's Prenatal Assessment Profile.
- Women's Food Frequency Questionnaire.
- Prenatal Weight Gain Grid - Nutritional Assessment.
- Psychosocial and Health Education assessment of the pregnant member.

- Individualized Care Plan, as appropriate, utilizing the following initial prenatal assessment tools.
- Perinatal Support Staff shall report all relevant information obtained during their assessments/ reassessments to the Provider/Practitioner and document in the member's record.
- Prenatal Assessment Profile shall be available in threshold language for the specific geographic areas of membership.
- Perinatal Support Staff shall be available to assist member in completion of Prenatal Assessment Profile if member is unable to complete independently.
- Perinatal Support Staff signature shall be required if assistance was provided to member for completion of Prenatal Assessment Profile.
- Perinatal Support Staff shall review member's response to the Prenatal Assessment Profile, identify, and discuss any responses that could indicate a potential risk.
- Perinatal Support Staff shall assign a risk status of "High, Medium, or Low" for each answer on the Prenatal Assessment Profile as determined by the member's response.
- Perinatal Support Staff **must** initiate appropriate interventions in response to the member's identified and assigned risk status from the Prenatal Assessment Profile

NUTRITIONAL ASSESSMENT/REASSESSMENT - WOMEN'S FOOD FREQUENCY QUESTIONNAIRE

- Re-caps the member's food intake for the prior twenty four (24) hours to determine pregnant member's current nutritional status.
- Women's Food Frequency Questionnaire shall be available in threshold languages for the specific geographic areas of membership. Perinatal Support Staff shall be available to assist member in completion of Women's Food Frequency Questionnaire if member is unable to complete independently.
- Perinatal Support Staff shall review member's response to the Women's Food Frequency Questionnaire and discuss any responses that could indicate a barrier to adequate nutritional intake (i.e. alcohol/tobacco or drug use; infant feeding problems; or socioeconomic factors potentially affecting dietary intake). Member will be evaluated for the WIC Program, Food Stamps, etc. Member must be referred to the WIC Program within four (4) weeks of the first prenatal visit. The Perinatal Support Staff shall initiate appropriate interventions in response to the member's identified nutritional risk status. The Perinatal Support Staff shall utilize relevant information obtained from the Women's Food Frequency Questionnaire to assist in the development of the member's Individualized Care Plan.

ANTHROPOMETIC ASSESSMENT - PRENATAL WEIGHT GAIN GRID

- The Perinatal Support Staff shall obtain the member's weight (in pounds) at the initial prenatal assessment and plot on the DHCS-approved Prenatal Weight Gain Grid.
- The Perinatal Support Staff shall obtain a new weight at each perinatal assessment

and plot accordingly on the Prenatal Weight Gain Grid. The Perinatal Support Staff shall compare the current weight and the total amount gained with the gain expected for the member. The Perinatal Support Staff shall consider the results of weight assessment and results of the dietary and clinical assessments to determine appropriate nutritional interventions.

- The Perinatal Support Staff shall initiate appropriate interventions in response to the member's identified risk status regarding weight.

PSYCHOSOCIAL ASSESSMENT/RE-ASSESSMENT

The Perinatal Support Staff shall be responsible for the Psychosocial Assessment/Re-assessment which includes:

- Current living status
- Personal adjustment and acceptance of pregnancy (e.g. Is this a wanted or unwanted pregnancy?)
- Substance use/abuse
- Member's goals for herself in this pregnancy
- Member's education, employment, and financial material resources
- Relevant information from the medical history, including physical, emotional, or mental disabilities
- Experience within the health care delivery system and/or any prior pregnancy

HEALTH EDUCATION ASSESSMENT/REASSESSMENT

The Perinatal Support Staff shall be responsible for the Health Education Assessment/Re-assessment which includes:

- Member and family/support person(s) available to member
- Motivation to participate in health education plans
- Disabilities which may affect learning
- Member's expressed learning needs and identified learning needs related to diagnostic impressions, problems, and risk factors
- Primary languages spoken and written
- Education and current reading level
- Current health practices (i.e. member's religious/cultural influences potentially affecting the member's perinatal health)
- Evaluation of mobility and residency. Transportation assistance shall be considered when the resources immediately available to the maternal, fetal, or neonate member are not adequate to deal with the actual or anticipated condition
- Evaluation for level of postpartum self-care, infant care to include immunizations and car seat safety

Provider/Practitioner's Responsibilities

Provider/Practitioner shall be responsible for the completion of the medical/obstetrical assessment portion of the initial combined prenatal risk assessment of the pregnant member and may utilize any of the following perinatal assessment forms:

- POPRAS
- Hollister
- ACOG

A copy of the Provider/Practitioner's completed perinatal assessment form, (POPRAS, Hollister or ACOG), **must** be forwarded to the hospital identified for member's delivery by the member's thirty fifth (35th) week of gestation. Provider/Practitioner shall direct members with identified risks to hospitals with advanced obstetrical and neonatal units.

Provider/Practitioner's Medical/Obstetrical Assessment includes:

- History of previous Cesarean Sections
- Operations on the uterus or cervix
- History of premature onset of labor
- History of spontaneous or induced abortion
- Newborn size; small or large for gestational age
- Multiple gestation
- Neonatal morbidity
- Fetal or neonatal death
- Cardiovascular disease
- Urinary tract disorders
- Metabolic or endocrine disease
- Chronic pulmonary disease
- Neurological disorder
- Psychological illness
- Sexually transmitted diseases
- Identification of medication taken which may influence/affect health status
- HIV/AIDS Risk assessment/testing and counseling (Senate Bill 899) **must** be offered to all pregnant members at initial prenatal assessment. Documentation in member's

medical record **must** include that assessment, testing, and counseling was offered.

- Documentation **must** include if member "accepted" or "refused" risk assessment, testing, or counseling.
- Blood Pressure

Provider/Practitioner **must** initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment phase. This includes health education, nutrition, and psychosocial assessment, and document in the member's Individualized Care Plan, accordingly.

Perinatal Support Staff Responsibilities Second (2nd) and Third (3rd) Trimester Re-assessments of the Pregnant Member

- Perinatal Support Staff shall utilize the Combined second (2nd) and third (3rd) Trimester Re-Assessment Forms to ensure a continuous, comprehensive assessment of the member's status in each trimester and shall update the member's Individualized Care Plan, accordingly
- Anthropometric Assessment - Prenatal Weight Gain Grid.
- Perinatal Support Staff shall obtain the member's weight (in pounds) at each trimester reassessment and plot on the Prenatal Weight Gain Grid.
- Perinatal Support Staff shall compare the total amount gained since the prior assessment against the weight gain expected for the member.
- Perinatal Support Staff shall consider the results of weight assessment and dietary and clinical assessments to determine appropriate nutritional interventions.

Provider/Practitioner's Responsibilities - Second (2nd) and Third (3rd) Trimester Re-assessment of the Pregnant Member

- During the second (2nd) and third (3rd) trimester re-assessment phase, the Provider/ Practitioner shall be responsible to update the POPRAS, Hollister, or ACOG form, to ensure the continuous, comprehensive assessment of the member's medical/obstetrical health status.
- The POPRAS, Hollister, or ACOG form was initiated by the Provider/Practitioner at the initial combined risk assessment phase and the same medical/obstetrical assessment form shall be utilized throughout the member's second (2nd) and third (3rd) trimester reassessment phases.
- The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the Provider/Practitioner completed the previous assessment; the information obtained by the Provider/Practitioner shall be utilized to update the member's Individualized Care Plan, accordingly.

- Provider/Practitioner's medical/obstetrical assessment of the member's health status shall include, but not be limited to:
  - Blood pressure, weight, uterine size, fetal heart rate, presence of any edema, and Leopold's maneuvers.
  - After quickening, the Provider/Practitioner shall inquire and instruct member on completing fetal kick count after twenty eight (28) weeks gestation.
  - Education and counseling on signs and symptoms of preterm labor and appropriate actions to take.
- Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the member's trimester re-assessment phase and document in the member's Individualized Care Plan, accordingly.

Combined Postpartum Assessment for the Member

PROVIDER/PRACTITIONER'S RESPONSIBILITIES POSTPARTUM PHASE

- Provider/Practitioner's postpartum assessment should occur within twenty one (21) - fifty six (56) days post delivery. Time frames for postpartum assessment may be modified if warranted by the specific needs of the postpartum member.
- Postpartum access two (2) weeks post C-section falls outside of this requirement.
- Provider/Practitioner shall be responsible for assessing the member's current medical/obstetrical health status by referencing the POPRAS, Hollister, or ACOG form which was initiated by the Provider/Practitioner at the initial prenatal risk assessment phase and updated with assessment information obtained during the second (2nd) and third (3rd) trimester re-assessment phases to ensure a continuous assessment of the postpartum member. The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the previous member assessment; information obtained by the Provider/Practitioner shall be utilized to update the member's Individualized Care Plan accordingly.
- Provider/Practitioner must initiate appropriate interventions in response to any problems/risks/needs identified during the member's postpartum phase and document in the member's Individualized Care Plan, accordingly.

Perinatal Support Staff Responsibilities - Postpartum Phase (three (3) to eight (8) weeks after delivery):

- Perinatal Support Staff shall utilize the Combined Postpartum Assessment Form to provide for a comprehensive assessment of the postpartum member in the following areas and update the member's Individualized Care Plan.
- Anthropometic Assessment - Prenatal Weight Gain Grid. Perinatal Support Staff shall obtain the member's postpartum weight (in pounds) and plot on the Prenatal Weight Gain Grid. Perinatal Support Staff shall consider the results of the weight, dietary, and clinical assessments to determine the appropriate nutritional interventions.

- Nutritional Assessment - Women's Food Frequency Questionnaire. Member shall complete the Women's Food Frequency Questionnaire that re-caps the food intake for the prior twenty four (24) hours to determine nutritional status and any potential economic barriers to adequate nutrition for the member and infant. Member to be evaluated for the WIC Program, Food Stamps, etc. Perinatal Support Staff shall counsel breast-feeding mothers on dietary needs of breast-feeding and management of specific breast-feeding problems i.e. address member's individual concerns and needs, refer high-risk members for appropriate intervention.

Health Education Assessment

- Perinatal Support Staff shall evaluate the member's level of health education regarding postpartum self-care and infant care and safety to include car seat, immunizations, breast-feeding, and well-child care (CHDP). Perinatal Support Staff shall identify those health education behaviors, which could promote risk to the postpartum member or the infant.
- Perinatal Support Staff shall discuss and counsel the postpartum member on smoking cessation, substance and alcohol use, family planning and birth control methods, and provide information on Family Planning Centers, as appropriate.
- Perinatal Support Staff shall identify goals to be achieved via health education interventions.
- Perinatal Support Staff to discuss importance of referral of infant for CHDP exam, immunizations, and well-child care.
- Perinatal Support Staff shall educate the member on how to enroll the newborn in the Plan and how to select a PCP for the newborn.

Psychosocial Assessment

- Perinatal Support Staff shall identify psychosocial behaviors which could promote a risk to the postpartum member or the infant.
- Perinatal Support Staff shall identify and support any strengths and habits oriented towards optimal psychosocial health.
- Perinatal Support Staff shall identify goals to be achieved via psychosocial interventions.
- Perinatal Support Staff **must** initiate appropriate interventions in response to any problems, needs, or risks identified in the member's postpartum phase and document in the member's Individualized Care Plan, accordingly.

Complicated/High-risk Pregnancy - Identification and Interventions

- Early identification of complicated/high-risk pregnancy is critical to minimizing maternal and neonatal morbidity.
- Both Providers/Practitioners and Perinatal Support Staff shall be responsible for identifying the complicated/high-risk pregnancy and providing the appropriate

intervention(s).

- Referrals to physician specialists; i.e. Perinatal Specialist, Neonatal Specialist.
- Coordinating with other appropriate medically necessary services.
- Coordinating with appropriate support services/agencies.
- Referrals to the Local Health Department support agencies.
- Coordinating with Molina Healthcare Perinatal Services Staff for appropriate interventions and follow-up.
- Coordinating with Molina Healthcare Medical Case Manager for appropriate interventions and follow-up through the Case Coordination/Management process of Perinatal Services.

Individualized Care Plans (ICPs)

- All pregnant members, regardless of risk status, must have an ICP.
- ICPs must be initiated at first prenatal visit.
- ICPs must be reviewed and revised accordingly, each trimester at the minimum, throughout the

  pregnancy and postpartum phases, by the Provider/Practitioner and the Perinatal Support Staff members.

ICPs must address/document the following four (4) components:

- Nutritional Assessment
- Psychosocial Assessment
- Health Education Assessment
- Medical/Obstetrical Health Status Assessment

ICPs documentation within the four (4) component areas must address the following:

- Nutritional Assessment: Prevention and/or resolution of nutritional problems. Support and maintenance of strengths and habits oriented toward optimal nutritional status and goals to be achieved via nutritional interventions.
- Psychosocial Assessment: Prevention and/or resolution of psychosocial problems. Support and maintenance of strengths in psychosocial functioning and goals to be achieved via psychosocial interventions.
- Health Education Assessment: Health education strengths, prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk reduction behaviors, goals to be achieved via health education

interventions and health education interventions based on identified needs, interests, and capabilities.

- Medical/Obstetrical Health Status Assessment: Continuous evaluation of the member's medical and obstetrical health status.

ICPs must be developed from multidisciplinary information obtained and interventions initiated resulting from, but not limited to, the following:

- Prenatal Assessment profile;
- Women's Food Frequency Questionnaire;
- Prenatal Weight Gain Grid;
- Providers/Practitioners assessment to include Medical/Obstetrical Health status;
- Providers/Practitioners second (2nd) and third (3rd) Trimester re-assessment to include Medical/Obstetrical Health status; and
- Perinatal Support Staff's individualized review of member and their Psychosocial, Health Education, and Nutritional Assessment results.

ICPs shall serve as an effective tool for the ongoing coordination and dissemination of information on the pregnant member's perinatal care throughout all phases of the pregnancy and postpartum (i.e. initial visit, all trimester reassessments and postpartum). For any of the multidisciplinary Perinatal Support Staff or Provider/Practitioner involved with the member, ICPs shall serve as an identification source/summary of prioritized problems, needs, or risk conditions as identified.

- ICPs must be created and individualized for each pregnant member.
- ICPs must be created in conjunction with the pregnant member.
- ICP must clearly define who is responsible for implementing the proposed interventions and the timeframes.

MOLINA HEALTHCARE'S MOTHERHOOD MATTERS PREGNANCY PROGRAM

Motherhood Matters Pregnancy Program encompasses clinical case management, member outreach, and member and Provider/Practitioner education. The Perinatal Case Management staff works closely with the Provider/Practitioner community in the identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program comprises multi-departmental activities to ensure the coordination and delivery of comprehensive services to participating members. The main focus of the program is on member outreach to identify pregnant women and the subsequent provision of risk assessment, education, and case management services. Members receive incentives for participating in the program.

Motherhood Matters program does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to

the members. **For members who are receiving CPSP services at the time of entry into Motherhood Matters, the program will serve as back-up and additional support resource.**

Goals of Motherhood Matters Pregnancy Program

The goals of pregnancy management program are to:

- Improve Molina Healthcare's knowledge of newly pregnant members, or members newly accessing prenatal care.
- Identify all pregnant members as early as possible in the course of their pregnancy.
- Improve the rate of screening pregnant members for potential risk factors by the administration of initial and subsequent assessments.
- Provide education services to all pregnant members and their families.
- Refer members at high-risk for poor pregnancy outcome to perinatal case management
- Provide coordinated, integrated, continuous care across a variety of settings.
- Actively involve Providers/Practitioners, members, families, and other care providers in the planning, provision, and evaluation of care.
- Meet patients', families' and Providers/Practitioners' expectations with pregnancy care.
- Improve the quality of information collection and statistical analysis; in order to assess the effectiveness of the program and to project future needs.
- Monitor program effectiveness through the evaluation of outcomes.

Eligibility Criteria for Program Participation and Referral Source

Eligibility Criteria

Motherhood Matters is a population based pregnancy program, which includes all pregnant females of any age. To participate in the program, the member is Medi-Cal eligible and enrolled with Molina Healthcare and resides in San Bernardino, Riverside, Sacramento, or San Diego Counties.

Referral Source

Potential participants may be identified from a number of sources including, but not limited to:

- **Physician referral (Pregnancy Notification Report Form ("PNR" Form)**
  Providers/Practitioners are required to notify Molina Healthcare within seven (7) days of a positive pregnancy test by faxing a completed PNR form to Molina Healthcare's Motherhood Matters Pregnancy Program at **(562) 499-6105**. If you have any questions, or need some assistance, contact Molina Healthcare's Motherhood Matters Program at (877) 665-4628.

- Members self-referral
- Member Services (as a result of member outreach calls)
- Utilization Management (as a result of authorization requests or triage service calls)
- Quality Improvement (as a result of various reports submitted monthly by IPAs/Medical Groups)
- Pharmacy utilization data (prenatal vitamin prescriptions)
- Nurse Advice Line referrals
- Laboratory Data

Program Components

1. *Assessment and Referral*

Following an initial health assessment performed by the Motherhood Matters Coordinator, the risk factors are scored and based on the assessment outcome pregnant members are risk--stratified into two levels:

I. Normal pregnancy - No identified risks

II. High risk pregnancy - Risk factors identified

Perinatal Case Management staff reviews all level II members for actual or potential at risk pregnancy. High-risk indicators include, but are not limited to:

- Age under 18 or over 35
- Unstable or high-risk social situation (inadequate shelter or nutrition; abuse)
- History of prior cesarean section
- Current or past gestational diabetes or other medical co-morbidity
- History of repeated spontaneous abortion
- History of preterm labor or premature birth
- History of fetal demise, stillbirth, or other poor pregnancy outcome
- Smoking, alcohol, drug, or other substance abuse
- History of behavioral health problems

Members who are positive for any of the above indicators, or have other indications as determined, remain in prenatal case management for detailed assessment and further evaluation and intervention(s), as appropriate. Regardless of the type or absence of identified risk, all pregnant members are provided pregnancy related education services.

Following the completion of initial assessment, subsequent trimester specific assessments are conducted throughout the pregnancy. A postpartum assessment is completed one (1) to five (5) weeks after the delivery.

2. *Health Education within the Case Management Program*

The Motherhood Matters coordinators mail educational modules each trimester throughout

the pregnancy, including the postpartum period. Special materials are provided to teenagers and those assessed as non-English readers. All program participant mailings are documented in the appropriate medical management system. For those participants with identified risks that can be addressed through educational intervention, additional member education services may be provided by a health educator and/or social worker within the Care Management team. Participants identified with nutritional risk, may also include a comprehensive nutrition assessment and the development of a meal plan by a Registered Dietitian.

3. *High-risk Case Management*

The case management of high-risk pregnancy incorporates an intensive process of case assessment, planning, implementation, coordination, and evaluation of services required to facilitate an individual with high-risk obstetrical conditions through the health care continuum. The program consists of a comprehensive approach toward evaluating the member's overall care plan through an assessment and treatment planning process. The case management process comprises case triage and collaboration with treating physician(s), ancillary and other Providers/Practitioners, and development of an individual care plan.

Perinatal case management registered nurses, in conjunction with the treating physician, coordinate all health care services. This includes the facilitation of appropriate specialty care referrals, coordination of home health and DME service, and referral to support groups/social services within the member's community. Molina Healthcare's case managers work closely with Public Health Programs to ensure timely and appropriate utilization of available services (e.g. WIC) and may include California Children's Services for members under age 21. Additionally, case managers coordinate services with the Comprehensive Perinatal Services Program in cases where the member is already receiving such services.

To ensure timely follow-up with the Provider/Practitioner, the database supporting the program has the capability to generate reminders for call backs for trimester specific assessments, prenatal visits, postpartum visits, and well-baby check ups.

4. *Provider Education*

To ensure consistency in the approach of treating high-risk pregnancy, Molina Healthcare has developed clinical guidelines and pathways, with significant input from practicing obstetricians. While the guidelines originate from nationally recognized sources, their purpose is to serve as a starting point for Providers/Practitioners participating in health management systems program. They are meant to be adapted to meet the needs of members with high-risk pregnancies, and to be further refined for individual patients, as appropriate. The guidelines are distributed to Molina Healthcare network participating obstetrical Providers/Practitioners. Other methods of distribution and updating are via *Just the Fax* weekly electronic publications, continuing medical education programs, quarterly physician newsletter, and individual Provider/Practitioner contact.

New Member Outreach

Information introducing Molina Healthcare's Motherhood Matters Perinatal Services Program, that emphasizes early entry into the program, is included in Molina Healthcare's Welcome Package.

- The Welcome Package shall be mailed to all new Molina Healthcare members or responsible party within seven (7) days of enrollment.
- Annually updated Evidence of Coverage shall be mailed to all Molina Healthcare members or responsible party.
- Enrollment Counselors inquire if any members of the household are pregnant during the new member outreach call. Pregnant women are referred directly to the Motherhood Matters Program staff.
- The Welcome Package shall be printed/distributed in appropriate threshold languages for Molina Healthcare members.

Focused Reviews/Studies

All compliance monitoring and oversight activities are undertaken with the goal of assisting and enabling the perinatal Provider/Practitioner to provide care and services that meet or exceed community/professional standards, Department of Health Care Services (DHCS) contractual requirements, and National Committee for Quality Assurance (NCQA) standards and that health care delivery is continuously and measurably improved in both the inpatient and outpatient/ambulatory care setting.

- **Focused Reviews/Studies**
  Obstetricians with five (5) or more deliveries require a Prenatal/OB medical record review once every three (3) years. The performance goal is 85% or above for the following categories: Format and documentation; OB/CPSOP Guidelines (Perinatal Preventive Criteria); and Continuity and Coordination of Care. Audit results are reported to the Quality Improvement Committee.
- **Grievances and Survey**
  - The QI Department utilizes Provider/Practitioner and member surveys to assess compliance with Plan standards.
  - The QI Department investigates, monitors, and provides follow-up to Provider/Practitioner and member grievances involving potential clinical quality issues.

Findings are reported to the individual Provider/Practitioner, the Clinical Quality Management Committee, the Quality Improvement Committee, and/or the Credentials Committee as appropriate.

NURSE MIDWIFE SERVICES

Defined by Title 22, nurse midwife services are permitted under state law and are covered when provided by a Certified Nurse Midwife (CNM). Molina Healthcare will provide access to and reimbursement for CNM services under state law. Federal guidelines have been established and members have the right to access CNM services on a self-referral basis.

Covered Services

All eligible Molina Healthcare members are eligible to receive the following limited care and

services from a CNM:

- Mothers and newborns through the maternity cycle of pregnancy
- Labor
- Birth
- Immediate postpartum period, not to exceed six (6) weeks

The CNM services must be provided within seven (7) calendar days of request, based on the severity of the member's condition.

Procedure

Referral to a contracted CNM may be made by either a Primary Care Practitioner (PCP) or by the member requesting the services.

- Minors may access a CNM in accordance with Molina Healthcare Policy and Procedure, Confidential Access to Service for Minors, or applicable policy.
- The CNM will work under the direction of a supervising Provider/Practitioner as defined by law.

Notification

Members are notified of the availability of CNM services through their PCP or OB/GYN Providers/Practitioners. Members are also notified of availability of services through the Evidence of Coverage, which is distributed at the time of enrollment and annually thereafter.

Providers/Practitioners may receive additional information regarding CNMs by contacting Molina Healthcare's Provider Services Department.

Supervising Providers/Practitioners

Supervising Providers/Practitioners will submit claims directly to Molina Healthcare, in accordance with Molina Healthcare Policy and Procedure, Payment of Claims, or applicable policy. This instruction also addresses the appeal process for denial of claims. (Also see Claims Section)

The CNM will be credentialed through the credentialing and re-credentialing process of allied health Providers/Practitioners at Molina Healthcare or subcontracted affiliated plan.

INDIVIDUAL CARE PLAN (ICP)

INSTRUCTIONS

The Sample Individualized Care Plan (ICP) Problem and Intervention List have been developed to assist you in the development of members ICP Not all possible problems and interventions are listed. Please refer to "Steps to Take" and "Sample Problems" list for assistance in developing and documenting additional problems and interventions.

OBSTETRICAL

	Problems	Interventions
1.	Grav: _____ Para: ____ SAB:_____ TAB:_____	Educ re: importance of early prenatal care, following all MD instructions & take prenatal vitamins as prescribed. Clt will keep all OB appts & deliver healthy baby by: _____/EDC
2a.	Urinary Tract Infection (UTI)	Educ on ↑ risk of PTL; S&S of PTL. Clt will have no reoccurrence of UTI, state 4 S&S of PTL and deliver a healthy baby by_____/EDC.
2b.	Urinary Tract Infection (UTI)	Educ clt on ↑ risk of PTL. Clt will comply & complete all medications prescribed by MD.
3.	Preterm Labor (PTL)	Educ re: S&S of PTL; ↑ fluid intake & limiting physical activity. Clt will state 3 S&S of PTL and describe action to take if she experiences symp
4.	History of preterm birth (PTL)	Educ re: PTL, following all MD instructions. Clt will state 3 S&S of PTL and notify MD immediately if S&S occur through: _____/EDC
5.	Multi –gestational Pregnancy	Educ re: Warning S&S of PTL, following all MD instructions. Clt will comply with all MD instructions and deliver baby close to full term.
6a.	Hyperemesis Gravidarum	Educ clt on certain foods to avoid. Evaluate weight loss and adequacy of daily food intake. Clt will state 4 foods she should avoid by_____.
6b.	Hyperemesis Gravidarum	Educ clt. Refer immediately to MD or RD. Clt will comply with all MD instructions and follow-up with referral to RD by: _____

OBSTRETICAL (continued)		
	Problems	**Interventions**
7.	Gestational Diabetes	Clt will follow diet and/or insulin regime per MD instructions. Clt will comply with Gest Diabetes instructions and maintain WNL blood sugar levels through EDC.
8a.	Maternal Age > 35 yrs old	Edu clt on ↑ genetic risks to baby. Clt will discuss genetic testing with OB, by: _____.
8b.	Maternal Age > 16 yrs old	Educ & discuss ↑ risks to baby. Clt will keep all OB appt & follow all MD instructions through EDC _____.
9.	Substance Abuse in Pregnancy	Educ on effects of substance use. Clt will stop all substance use, maintain abstinence and deliver drug-free baby by _____/ EDC.
10.	Placenta Previa	Educ re: PTL & follow all MD instructions. Clt will follow all MD instructions & deliver a healthy term infant by _____/EDC.
11.	Currently on Medication	Discuss possible effects of drug use. CTL will discuss prescription with OB, cont to take medication as prescribed notify MD of any changes through: _____/EDC.
12.	Pregnancy Induced Hypertension (PIH)	Educ re: S&S of PIH. Clt will state 2 S&S of PIH and notify MD immediately if symp occur through: _____/EDC.

HEALTH EDUCATION		
	Problems	**Interventions**
1a.	Lacks knowledge of birth control methods	Clt will receive edu/inf. Clt will verbalize 3 methods available to her & choose a BC method to use by postpartum exam.
1b.	Lacks knowledge of birth control	Clt will receive educ/info on available BC methods. Clt will state her plans for future child bearing & describe any BC method she would consider using by:_____
2a.	Unsure of Infant Feeding method	Educ on methods. Clt will decide on method by: _____
2b	Lacks knowledge of Infant feeding methods	Educ on methods. Clt will state 3 advantages each to breastfeeding & and make a choice on how to feed newborn by _____
3b.	Lacks knowledge of labor & delivery Unaware of signs & symptoms of Labor	Educ on S&S of labor, stages of labor. Will refer to classes. Clt will attend at least I class & state 3 S&S Labor by EDC.
3c.	No Labor Plan developed	Educ on S&S of labor. Clt will identify labor support person & transportation plans to & from hospital by: _____
4a.	Current Tobacco Use: _____ Cigs/day	Educ Clt will identify 3 risks of smoking; will consider quitting and /or reduce use to _____ cigs/day by: _____
4b.	Current Tobacco Use: _____ Cigs/day	Educ Clt will consider quitting and /or reduce use to _____cigs/day by:_____
5a.	**History of Sexuality Transmitted Infections (STI)**	**Educ clt on STI's. Clt will state 3 symp and be able to discuss how to prevent infections by:_____**
5b.	Lacks knowledge of Sexuality Transmitted Infections (STI)	Educ on types of STI's. Clt will have ↑ understanding of STI & how to prevent infection by: _____
5c.	Lacks knowledge of Sexuality Transmitted Infections (STI)	Educ on types of STI's Clt will state 3 STI's, & ways to prevent infections by: _____.

HEALTH EDUATION (continued)

	Problems	Interventions
6.	Lacks Knowledge of Kick Counts	Educ on importance of conducting kick-counts daily per protocol. Clt will perform kick-counts daily from 28 wks GA & will notify MD of any ↓ movement until delivery.
7.	Lacks knowledge and/or Resources for Infant Car Seat Safety	Educ clt on legal requirements and proper car safety. Refer to low –cost community resources. Clt will describe proper installation of car seat & obtain infant car seat by: _____/EDC.
8.	Lack of exercise	Educ. Clt will discuss exercise plan with OB and will begin, if appropriate, exercise routine by: _____

Nutrition

	Problems	Intervention
1.	Inadequate dietary intake	Educ on proper nutrition. Clt will ↑ intake to meet daily food guide recommendations by: _____.
2.	Inadequate Weight Gain	Educ on proper nutrition. Clt will ↑ food intake to meet daily food guide recommendations by: _____
3.	Excessive dietary intake	Educ on proper nutrition. Clt will ↓ make to meet daily food guide recommendations by: _____
4a.	Excessive Weight Gain	Educ re: risk/problems of excessive wt gain. Will refer clt to RD for nutritional consult. Clt will keep RD appt & adopt healthful eating behavior by; _____
4b.	High intake of fats	Educ on proper nutrition. Clt will ↓ intake to meet daily food guide recommendations by: _____
4c.	High intake of sweets and /or junk food	Educ on proper nutrition. Clt will ↓ intake to meet daily food guide recommendations by:_____
5.	Client IS receiving WIC	Clt will cont to receive WIC& maintain adequate dietary intake through preg and post period.

Nutrition (continued)		
	Problems	**Interventions**
6.	Client is NOT receiving WIC	Clt will receive WIC by: _____ & maintain adequate dietary intake through preg & postp.
7.	Caffeine intake: _____ servings /day	Educ clt on risks of caffeine intake. Clt to ↓ or stop all caffeine intake by:_____
8.	Prenatal Vitamins- non complaint in taking daily	Explore with clt reasons for non-compliance. Educ on importance of taking prenatal vits. Clt will resolve issues of noncompliance; will take vits as prescribed through: _____/EDC
9a.	Anemia, unable to or unwilling to take iron supplement due to discomfort	Educ on importance of taking iron supplements. Clt will use alternative method of taking supplements. ↑ Hct and Hgb levels by: _____.
9b.	Anemia, Poor Dietary Intake	Educ on importance of dietary intake that is rich in Iron and B12. Refer to RD Clt will ↑ dietary intake & comply with RD's recommendations by: _____
10a.	Pica-_____	Educ on possible problems from Pica, with OB, refer to RD. Clt will refrain from eating non-foods and comply with eating healthy substitutes by _____.
10b.	Pica- _____	Educ on possible problems from Pica, Encourage clt to talk about feelings & reasons for craving _____. Clt will refrain from (state item that clt is craving) eating non-foods and comply with eating healthy substitutes by: _____

PSYCHOSOCIAL		
Problems		Interventions
1a. 1b.	History of substance abuse History of substance abuse	Educ on the effects of substance abuse, comply with services provider by _____ (Name of Agent/Provider) Clt will maintain abstinence & deliver health neg tox-screen baby by EDC.

2a. 2b.	Hx of _____SAB,_____TAB; Did NOT receive counseling Hx of _____SAB, _____ TAB; Received counseling	Explore feelings related to _____ (SAB/TAB) Will seek support and begin work through issues. Referred to Social Worker, Clt will follow through with counseling appt. Explore feelings related to _____ (SAB/TAB) Clt coping well & has resolved feelings. Declines counseling at this time. Clt will request assistance, as needed through EDC.

3.	Teen Pregnancy	Clt will attend High School Teen Mother Program. Clt will complete school & recv parenting educ through EDC.

4.	Age discrepancy between Minor client and FOB	Will file a CAR ASAP & follow-up with action taken by Soc Svc By:_____

5.	Clt & FOB unsure of relationship	Clt having differences with relationship. Differences to be resolved & clt will request assistance/referral to SW, as needed, through EDC and postp period

6a. 6b.	FOB Incarcerated, Plan on maintaining relationship FOB incarcerated: Not being responsible for client & baby	Clt coping well without FOB; Clt & FOB will maintain a healthy relationship upon his release from jail. Will explore and make decisions re: the relationship. Clt will make a healthy choice for self and baby.

7.	Dropped out High School	Discussed returning to school. Will refer to teen

		program Clt to explore options and request info from school district by: _____/ Clt. Will return & complete school

PSYCHOSOCIAL (continued)

	Problems	Interventionss
8a.	History of Abuse	Will explore issues related to abuse. Refer to SW as needed throughout EDC and post period.
8b.	History of Abuse	Clt received counseling & coping well. Clt will express feelings and thoughts & request as needed through EDC and post period.

9.	History of Depression	Refer to SW as appropriate. Clt will express feelings and request assistance as needed through EDC and postp period

10.	History of Domestic Violence	Refer to SW as appropriate. Clt to request assistance, as needed through EDC and postp period.

11.	Low income. Unaware of community resources	Clt will be referred and follow through with local community agencies, Request help as needed through EDC.

12.	No experiences with US Health Care System	Educ. Discuss concerns and/or fears with US Health Care. Clt will request assistance, as needed through EDC and Postp period

Glossary

Term	Definitions
Alc	Alcohol
BC	Birth Control
CAR	Child Abuse Report
Clt	Client
Cont(d)	Continue(d)
EDC	Expected Date of Confinement
Educ	Educate, Education
FOB	Father of Baby
Gest Diabetes	Gestational Diabetes
Grav	Gravida
Hct	Hematocrit
Hgb	Hemoglobin
Info	Information
L&D	Labor & Delivery
Para	Parity
PIH	Pregnancy Induced Hypertension
Postp	Postpartum
PTL	Preterm Labor
RD	Registered Dietician
Recv	Receive
S&S	Signs and Symptoms
SAB	Spontaneous Abortion
Soc Svc	Social Services
STD	Sexually Transmitted Diseases
SW	Social Worker
Symp	Symptoms
TAB	Therapeutic Abortion
Tox-screen	Toxicology Screen
Vits	Vitamins
WNL	Within Normal Limits

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

The Women, Infants & Children (WIC) Supplemental Food Program provides an evaluation and, if appropriate, a referral for pregnant, breast-feeding, or postpartum women or parents or guardians of a child under 5 years of age. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under 5 years of age with a medical/nutritional need.

Program Services

WIC participants receive a packet of food vouchers each month, which they can redeem at the local retail market of their choice, for supplemental food such as milk, eggs, cheese, cereal, and juice. WIC participants attend monthly nutrition and health education classes and receive individual nutrition counseling from registered dieticians and nutrition program assistance. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breast-feeding.

Policy

As part of the initial evaluation, Provider/Practitioners will document the referral of pregnant, breast-feeding, or postpartum women or a parent/guardian of a child under age 5 to the WIC program. Evidence of the referral will be documented in the member's medical record. Children will be screened for nutritional problems at each initial, routine, and periodic examination. Children and women, who are pregnant, postpartum, and breast-feeding will be referred to the local WIC supplemental-food program. Follow-up of WIC referrals will be completed and documented at each subsequent periodic visit.

Identifying Eligible Members

Members are eligible for WIC services if they meet one (1) of the following criteria:

- Pregnant woman
- Breast-feeding woman (up to one (1) year after childbirth)
- Postpartum woman (up to six (6) months after childbirth)
- Child under age 5 years who is determined to be at nutritional risk by a health professional

To maintain eligibility, members must also:

- Receive regular medical checkups
- Meet income guidelines
- Reside in a local agency service area

Referrals to WIC

PCPs are responsible for referring eligible members to WIC programs, providing required

documentation with each referral, and coordinating follow-up care. Upon request of the PCP, Molina Healthcare will assist in the coordination of the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals to WIC services must be made on one (1) of the following forms:

- PM-160, CHDP Form
- PM-247, WIC Pediatric Referral Form
- PM-247A, WIC Referral for Pregnant Women Form
- Nutritional Questionnaire
- Provider/Practitioner Prescription Pad

Federal WIC regulations require hemoglobin or hematocrit test values at initial enrollment and when participants are re-certified. These biochemical values are used to assess eligibility for WIC program benefits. Children will be referred to WIC for the following conditions:

- Anemia - Please refer to the Pediatric and Child Health Services Section of this Manual for details.
- Abnormal growth (underweight, overweight)
- Underweight is defined as being in the fifth (5th) percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics.
- Overweight is defined as being over the one hundred twentieth (120th) percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics.

Women who are pregnant, postpartum, and/or breast-feeding will be referred to WIC according to the Molina Healthcare perinatal protocols located in the Women's and Adult Health Services Including Preventive Care Section of this Manual.

Blood tests will be conducted not more than sixty (60) days prior to WIC certification and be pertinent to the category for enrollment. The following data will be collected:

- Data for persons certified as pregnant women will be collected during their pregnancy.
- Data for postpartum and breast-feeding women will be collected after the termination of pregnancy.

The biochemical values that are required at each certification include:

WOMEN - PERINATAL, POSTPARTUM, BREAST-FEEDING

- Hemoglobin or hematocrit values are required at each certification including:
  - Initial prenatal enrollment.
  - Postpartum certification - up to six (6) weeks after delivery.

- Certification of breast-feeding women - approximately six (6) months after delivery.

INFANTS AND CHILDREN UNDER THE AGE 5 YEARS

- Hemoglobin or hematocrit values are required at initial enrollment and with each subsequent certification approximately every six (6) months. Biochemical data is not required when:
  - An infant is six (6) months of age or under at the time of certification.
  - A child over one (1) year had blood values within normal limits at the previous certification. In this case, the hemoglobin and hematocrit (H&H) is required every twelve (12) months.

Assessments

All WIC eligible members will have a nutritional assessment completed at the time of the initial visit by the PCP. Children will be screened using the following tools to assess nutritional status:

- Nutritional assessment history form.
- Physical examination of height/weight.
- Laboratory screening of hemoglobin or hematocrit.
- Laboratory screening of blood lead levels.

Nutritional education will be done by the PCP and documented in the member's medical record. The Molina Healthcare Provider Services Department will inform Providers/Practitioners of the Federal WIC anthropometric and biochemical requirements for program eligibility, enrollment, and certification.

Providers/Practitioners will complete the WIC Medical Justification Form for members requiring non-contract special formula and state the diagnosis and expected duration of the request for the special formula. Provider/Practitioners will provide a copy of the member's health assessment, including nutritional risk assessment, to the local WIC office after the member's consent has been received to release this information.

Medical Documentation

It is essential that Providers/Practitioners document WIC referrals in the member's medical records. The documentation can be a copy of the referral form and/or notes in the member's file documenting the visit and subsequent referrals. WIC considers findings and recommendations of 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, the PCP should encourage members to inform him/her of the outcome of their WIC visit, thereby

allowing the PCP to provide appropriate and consistent follow-up, noting outcomes in the progress notes of the member's medical record.

Local Health Department Coordination

The WIC offices, through the Local Health Department, will function as a resource to Molina Healthcare and Providers/Practitioners regarding WIC policies and guidelines, program locations, and hours of operation.

BREAST-FEEDING PROMOTION, EDUCATION, AND COUNSELING SERVICES

Primary Care Providers/Practitioners, Pediatric Providers/Practitioners, and Ob-Gyn Providers/Practitioners must provide postnatal support to postpartum breast-feeding mothers through continued health education, counseling, and the provision of medically necessary interventions such as lactation durable medical equipment.

Postpartum women should receive the necessary breast-feeding counseling and support immediately after delivery. Assessment of breast-feeding support needs should be part of the first newborn visit after delivery.

Molina endorses the following statement by the American Academy of Pediatrics, that "breast-feeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant" (AAP Policy Statement, 2005). The vast benefits of breast-feeding for the infant, mother and the community have been well researched and documented. They include nutritional, developmental, immunological, psychosocial, economic and environmental benefits. It is recognized that there may be some barriers to breast-feeding due to physical or medical problems with the mother or infant, poor breast-feeding technique, or complementary feeding. All postpartum women should be offered breast-feeding resources to help them make informed choices about how to feed their babies and to get the information and support they need to breastfeed successfully. The distribution of promotional materials containing formula company logos is prohibited as per MMCD policy letter 98-10.

Pregnant members should be referred to Molina Healthcare's Motherhood Matters Pregnancy Program. Molina Healthcare Health Education Assistants conduct postpartum assessments and health education to members referred to the Motherhood Matters Pregnancy Program. Breast-feeding promotion and counseling are included in third trimester assessment and the postpartum health assessment conducted as part of the program. Members can also be referred to lactation counselors through local WIC offices. For breast-feeding education materials to support breast-feeding members, please contact the Health Education Department at (800) 526-8196 ext. 127532.

Durable Medical Equipment

Lactation management aids, classified as Durable Medical Equipment (DME), are covered benefits for Molina Healthcare members. Specialized equipment, such as electric breast pumps, will be provided to breast-feeding Molina Healthcare members when medically

necessary. Please refer to the Utilization Management Section, for further details regarding authorization requirements and processes.

Human Milk Bank

Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. The provision of human milk for newborns will be arranged in the following situations:

- Mother is unable to breastfeed due to medical reasons and the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas.

For information regarding human milk banks in your region, please contact your local WIC office.

ADULT PREVENTIVE CARE SERVICES GUIDELINES

Preventive maintenance represents an important part of the daily activities of Primary Care Practitioners (PCPs). These health promotional activities rely on an understanding of the member's health status and the detection of risk factors for disease before it develops. The initial health assessment is an opportunity to obtain this information. Important resources include USPSTF Preventive Care and Clinical Practice Guidelines.

These resources can be accessed on the Molina Healthcare website at www.molinahealthcare.com. You may also call (888) 665-4621 for a copy of the documents.

The recommended services noted in the Preventive Care and Clinical Practice Guidelines are based on clinical evidence; however, Providers/Practitioners and members should check with the Plan to determine if a particular service is a covered benefit.

MOLINA HEALTHCARE OF CALIFORNIA ADULT PREVENTIVE CARE SERVICES ADULT IMMUNIZATION RECOMMENDATIONS

Molina Healthcare Preventive Health Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. They are updated annually. These PHGs are available on the Molina Healthcare webpage at www.molinahealthcare.com or you can go to www.cdc.gov and access adult vaccines.

You may request a copy by contacting Provider Services at (888) 665-4621.

INITIAL HEALTH ASSESSMENTS (IHA)

Health maintenance represents an important part of the daily activities of a PCP. Various health promotional activities rely on an understanding of the member's health status and

detection of risk factors for disease before it develops. The initial health assessment is an opportunity to obtain this information.

IHA Overview

All members over 18 months of age will have an initial health assessment scheduled within less than ninety (< 90) days of the date of enrollment. All members under 18 months of age will have an initial assessment scheduled sixty (60) days of the date of enrollment. **This assessment should be done on the member's initial visit,** will be both gender and age specific, and include a history and physical examination. The initial health assessment for members under age 21, will be based on American Academy of Pediatrics guidelines and will include the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP), height, weight, vital signs, and appropriate laboratory testing. The initial health assessment for members over age 21 will meet the guidelines addressed in The Preventive Care and Clinical Practice Guidelines. These resources can be accessed on the Molina Healthcare website at www.molinahealthcare.com. You may also call (888) 665-4621.

The initial health assessment will be accompanied by an initial health education behavioral assessment, utilizing the DHCS produced "Staying Healthy" Assessment that consist of five (5) specific age categories (0 to 3 years, 4 to 8 years, 9 to 11 years, 12 to 17 years, and 18 and over). Assessment is designed to be selfcompleted by members age 12 and over and by parents for children age 11 and under, while waiting for their medical visit. If a member or parent requests help with completion, it must be provided. This assessment is designed to initiate dialogue between member and Provider/Practitioner, facilitating focused health education counseling addressing health behavior change. Multi-lingual forms are available on the Molina Healthcare website.

Members are to be encouraged to obtain a scheduled appointment for an initial health assessment upon enrollment. Molina Healthcare contacts members within thirty (30) days of enrollment to confirm that the member is scheduled for an IHA. If the member has not scheduled the appointment, the Molina Healthcare representative will schedule the appointment for the member with their PCP. Members are informed of the benefit in the Evidence of Coverage. The requirement is waived if the member's PCP determines the member's medical record contains complete and current information consistent with the Initial Health Assessment requirements (such as history and physical exam that is age and gender specific, evaluates risk factors, and the socioeconomic environment of a Plan member).

Primary Care Practitioner's Responsibilities

The PCP is required to administer to all members an initial health education behavioral assessment questionnaire ("Staying Healthy" Assessment). Providers/Practitioners must review the assessment, provide needed counseling or other intervention, document on the assessment, and file in the member's medical record with other continuity of care forms. The age-appropriate questionnaire must be reviewed with the member and/or parent at least annually.

The age-appropriate assessment must be re-administered when the member enters the next age category (0-3, 4 to 8, 9 to 11, 12 to 17, and 18+). Molina Healthcare recommends that adolescents complete the assessment annually as they change behaviors rapidly during this period. It is recommended that page two
(2) of the completed "Staying Healthy" Assessments for age 12-17 should be placed under the "sensitive tab" in the medical record, preventing photocopying should a parent/guardian request the record. This precaution protects the confidentiality of the minor's disclosures, according to the MMCD letter 99-07, Individual Health Behavioral Assessment.

Members must be informed that they may refuse to respond to any question or refuse to complete the entire assessment. Refusal must be documented in the member's medical record. This may be done by noting on the assessment itself, signing, dating, and filing it in the medical record.

Molina Healthcare will provide you with a supply of the forms (currently available in various languages), a training video for you and your office staff, and other resources to assist you with implementation. Contact your Provider Services Representative or Molina Healthcare's Health Education Department ((800) 526-8196, ext. 127532) with your request on "Staying Healthy" Assessment assistance.

There are copies, in English and Spanish, of the "Staying Healthy" assessment tools for all five age categories in the Exhibits of this section. You can also download the assessment tools in all languages (English, Spanish, Chinese, Hmong, Lao, Russian and Vietnamese) at Molina Heatlhcare's website (www.molinahealthcare.com.) Should you wish to order copies of the assessment tools as well as education and training materials to assist you in the implementation of the "Staying Healthy" assessments, all order forms can be accessed through the Molina Healthcare website at: www.Molinahealthcare.com or contact Health Education at (562) 901-1176, ext 127532.

The PCP will review existing medical records to determine if a health assessment is needed. Initial health assessments will include, but not be limited to, the following:

- Adult immunization recommendations
- Initial history guidelines
- Initial physical guidelines
- Recommendations of the U.S. Preventive Services Task Force

If the member refuses the initial health assessment, the PCP will document the refusal in the member's medical record. When a member refuses the initial health assessment, the PCP will inform the member of the benefits, risks, and suggest alternatives. The

Provider/Practitioner will document advice in the member's medical record.

Results of the initial health assessment will be documented in the Provider/Practitioner's progress notes in the member's medical record. The Provider/Practitioner may utilize an initial history and physical form that is specific to his/her practice. In the event that specific forms do not address all recommended areas, those findings are to be addressed in the Provider/Practitioner's progress notes in the member's medical record.

MOLINA HEALTHCARE INITIAL HEALTH ASSESSMENT FOR ADULTS INITIAL HISTORY GUIDELINES

Precise standards for Adult History Examinations are unavailable and recommendations are often in conflict. Sound recommendations are available for some items. Molina Healthcare history guidelines are based on Health Promotion and Disease Prevention in Clinical Practice, by Steven H. Woolf, 1996, and are as follows:

- Presenting complaint (if any) and history relevant to the complaint (i.e., onset, severity, duration, etc.).
- Member medical history to include questions regarding ear trouble, cancer, diabetes, serious infectious disease, or any surgery.
- Social history with questions regarding:
  - Sexual history including menstrual history, parity, contraceptive use
  - Use of alcohol, tobacco, or illicit substances
  - Safety - use of seat belts, sun exposure
- Occupation
- Geographic - has member traveled or resided outside the United States
- Family history of diabetes, heart disease, or cancer
- Dental Health - teeth brushing, visits to dentists
- Dietary History
- Screening question for behavioral risk assessment
  - Nervousness
  - Depression
  - Memory Loss
  - Moodiness - excessive
  - Phobias
  - Mental Illness

MOLINA HEALTHCARE INITIAL HEALTH ASSESSMENT FOR ADULTS INITIAL PHYSICAL GUIDELINES

Precise standards for Adult Physical Examinations are unavailable and recommendations are often in conflict. Sound recommendations are available for some items and Molina Healthcare suggested guidelines are as follows:

- Measurements of height, weight, and blood pressure
- Examination of eyes, ears, and oral cavity
- Examination of the thyroid and skin is at the discretion of the Clinician, as USPS Task Force has not taken a strong stand in support of this recommendation
- Examination of the thorax with auscultation of heart and lungs
- Examination of the abdomen
- Examination of female genitalia, as part of screening for cervical cancer
- Screening for colorectal cancer in members over age 50 by testing for fecal occult blood is advised; however, there is insufficient evidence to recommend for or against screening digital rectal examination to detect colon cancer or prostate cancer
- Musculoskeletal examination
- Screening neurologic examination

DENTAL SCREENINGS

Molina Healthcare members are entitled to an annual dental screening described in the periodic health exam schedules.

Dental services, other than dental screenings, are not covered.

A dental screening will be performed at the time of all health assessments by the Primary Care Practitioner (PCP). The screening will include, but not necessarily be limited to:

- A brief dental history
- Examination of the teeth
- Examination of the gum
- Dental education

Findings of the dental screen, including education provided to the member or family, will be documented in the member's medical record.

Referral Process

A dental referral does not require prior authorization. Each PCP office is encouraged to maintain a list of local fee-for-service Medi-Cal dentists to whom members may be referred. Members may obtain the DHCS 800 telephone number for dental referral assistance from Molina Healthcare's Member Services Department. The Denti-Cal Beneficiary line is **(800) 322-6384**.

Primary Care Practitioner's (PCP) Responsibility

The PCP should conduct a dental assessment to check for normal growth and development and for the absence of tooth and gum disease at the time of the initial health assessment and at each CHDP examination visit, according to the periodic health examination schedules. PCPs should perform a screening dental exam on adult members and encourage their adult patients to receive an annual dental exam.

The PCP should perform an initial dental exam referral to a Medi-Cal approved dentist when the member reaches age 3, or earlier if dental problems are identified, and continue to refer the member annually thereafter. All referrals, and the reason for the referral, should be documented in the member's medical record.

VISION CARE SERVICES

Molina Healthcare's members will receive access for covered vision care services.

Referral

Members may be referred for vision care services by their PCP or may access vision care services on a selfreferral basis. A referral for a diabetic retinal exam is not required if there is a diagnosis of diabetes. Members may obtain, as a covered benefit, one (1) pair of prescription glasses every two (2) years. No prior authorization is required for receipt of this benefit through a qualified participating Provider/Practitioner. Basic member benefits include an eye examination with refractive services and prescription eyewear every two (2) years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions.

Contracted Providers/Practitioners will order the fabrication of optical lenses from the Prison Authority Optical Laboratories for members enrolled in the health plan.

Molina Healthcare Providers/Practitioners are to refer members to March Vision Care for vision care services at (888) 493-4070

Routine Eye Examination

The PCP plays a vital role in detecting ocular abnormalities that require referrals for a comprehensive eye examination.

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at approximately three (3) years of age. Children between four (4) and six (6) years of age 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.

Children should have a comprehensive eye examination by an ophthalmologist if they have one (1) or more of the following indications:

- Abnormalities on the screening evaluation
- Recurrent or continuous signs or symptoms of eye problems
- Multiple health problems, systemic disease, or use of medications that are known to be associated with eye disease and vision abnormality
- A family history of conditions that cause, or are associated with, eye or vision problems
- Health and developmental problems that makes screening difficult or inaccurate

FAMILY-PLANNING SERVICES

Members are allowed freedom of choice in selecting and receiving family-planning services from qualified Providers/Practitioners. Members may access family-planning services from any qualified family-planning Provider/Practitioner without referral or prior authorization. Members may access family-planning services from any qualified Provider/Practitioner, including their PCP, contracted or non-contracted Provider/Practitioner, OB/GYN Providers/Practitioners, nurse midwives, nurse practitioners, nurse physician assistants, Federally Qualified Health Centers (FQHC), and local county family-planning Providers/Practitioners.

The right of members to choose a Provider/Practitioner for family-planning services will not be restricted. Members will be given sufficient information to allow them to make an informed choice, including an explanation of what family-planning services are available to them.

Family-Planning Services

Access to family-planning services will be convenient and easily comprehensible to members. Members will be educated regarding the positive impact of coordinated care on their health outcome, so members will be more likely to access services with Molina Healthcare. If the member decides to see an out-of-plan Provider/Practitioner, the member will be encouraged to agree to the exchange of medical information between Providers/Practitioners for better coordination of care. The following family-planning services will be available to all members of childbearing age to prevent or delay pregnancy temporarily or permanently:

- Health education and counseling necessary to understand and to make informed choices about contraceptive methods
- Limited history and physical examination
- Medically indicated laboratory tests (except Pap smear provided by a non-contracted Provider/ Practitioner where the plan has previously covered a Pap smear by a plan Provider/Practitioner within the last year)

- Diagnosis and treatment of sexually transmitted diseases
- Screening, testing, and counseling of at-risk individuals for HIV treatment
- Follow-up care for complications associated with contraceptive methods issued by the family-planning
  Provider/Practitioner
- Provision of contraceptive pills, devices, and supplies (including Norplant)
- Tubal Ligation
- Vasectomies
- Pregnancy testing and counseling

The following are NOT reimbursable as family-planning services:

- Routine infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only
- All abortions, including but not limited to, therapeutic abortions, spontaneous, missed, or septic abortions, and related services (Note: Pregnancy testing and counseling performed by an out-of-plan family-planning Provider/Practitioner are reimbursable regardless of the member's decision to abort) - Transportation, parking, and childcare

Provider/Practitioner Responsibilities

Providers/Practitioners may not restrict a member's access to family-planning services, nor should a Provider/Practitioner subject a member to any prior authorization process for family-planning services. Providers/Practitioners found to be non-compliant may be subject to administrative review and/or possible disciplinary action.

The family-planning Provider/Practitioner must obtain informed consent for all contraceptive methods, including sterilization.

Procedure

- Family-planning and Sexually Transmitted Disease (STD) services will be provided in a timely manner.
- Members who request an office visit for STD or family-planning services will be considered as an urgent care appointment request, requiring an appointment within twenty-four (24) hours.
- Family-planning services will be available through the PCP's office or through a referral from the PCP to a contracted specialist qualified to provide services, or to an out-of-network family-planning Provider/Practitioner.
- For services to be rendered by contracted Providers/Practitioners within the Molina Healthcare network, the PCP may initiate a referral on the same day as the member presents. This referral does not require prior authorization from Molina Healthcare Utilization Management.
- For family-planning services requiring an inpatient stay, the PCP is to notify Molina

Healthcare Utilization Management Department to coordinate care.

- Should a member request from the PCP a referral to a family-planning or STD Provider/Practitioner outside of Molina Healthcare's contracted network, the PCP will educate the member regarding the positive impact of coordinated care on his/her health outcomes, helping the member to recognize the advantages of seeking services within Molina Healthcare. If the member still wants to see an out-of-plan Provider/Practitioner, the member will be encouraged to agree to the exchange of medical information between Providers/Practitioners for coordination of care.
- The PCP should not refer members to non-contracted Providers/Practitioners for family-planning, STD, or HIV services; however, the member will be advised of his/her right of choice to family-planning Providers/Practitioners through the Evidence of Coverage.
- When a member presents, the PCP will evaluate the request for family-planning services and inform the member of his/her recommendations and options.

Patient Information

Members will receive information to allow them to make an informed choice including:

- Types of family-planning services available
- Right to access these services in a timely and confidential manner
- Freedom to choose a qualified family-planning Provider/Practitioner

Minors

Minors have the right to seek treatment in a confidential manner. (Refer to Molina Healthcare policies, Confidential Access to Services for Minors, Collection, Use, Confidentiality, and Release of Primary Health Care Information.)

Documentation

The PCP will document recommendations made and options available, the consultation and counseling provided, and the response of the member. The documentation will include any referral or recommendations.

Documentation by the Provider/Practitioner will be in compliance with Molina Healthcare Policy, Medical Records Content and Documentation.

Confidentiality

- The member must give his/her consent to any Family-planning Services assessment and treatment. A signed, informed consent will be obtained when indicated by surgical or invasive procedure.
- Records are to be maintained in a confidential manner according to Molina Healthcare policy, Collection, Use, Confidentiality, and Release of Primary Health Care Information.
- All information and the results of the Family-Planning Services of each member will be

confidential and will not be released without the informed consent of the member.

- Appropriate governmental agencies will have access to records without consent of the member; i.e. Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Department of Health and Human Services (DHHS), Department of Justice (DOJ).

Non-Compliance

Missed Family-Planning Service appointments within the Molina Healthcare network will be addressed by utilizing Molina Healthcare's policy for Failed or Missed Appointments.

Non-compliance by a member will be acted upon by the PCP through Molina Healthcare policy, Access to Health Care, which addresses follow-up and documentation of failed or missed appointments.

Coordination With Out-of-plan Providers/Practitioners

Reimbursement to out-of-plan Providers/Practitioners will be provided at the applicable Medi-Cal rate appropriate to the Provider/Practitioner type, as specified in Title 22, Section 51501. Records obtained from out-of-plan Providers/Practitioners will be shared with the PCP for the purposes of assuring continuity of care. Out-of-plan Providers/Practitioners will be reimbursed for family-planning services only if:

- The out-of-plan Provider/Practitioner is qualified to provide family-planning services based on the licensed scope of practices.
- The out-of-plan Provider/Practitioner must submit the claim to Molina Healthcare on a HCFA1500 form.
- The out-of-plan Provider/Practitioner must provide pertinent medical records sufficient to allow Molina Healthcare to meet case management responsibilities.
- Molina Healthcare will reimburse contracted Providers/Practitioners at contracted rates. Molina Healthcare will reimburse non-contract, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate.

Reimbursement for family-planning services will only be made if the Provider/Practitioner submits treatment records or documentation of the member's refusal to release medical records to Molina Healthcare along with billing information.

Policies and Procedures

PCPs or their staff may obtain detailed information on any Molina Healthcare policy/procedure by contacting the Provider Services Department at (888) 665-4621. Available policies include, but are not limited to:

- Confidential Access to Services to Minors
- Access to Health Care
- Collection, Use, Confidentiality, and Release of Primary Health Care Information
- Safeguarding and Protecting Medical Records

SEXUALLY TRANSMITTED DISEASES (STD)

Molina Healthcare members may access care for STDs without prior authorization requirements as stated in its contracts with the California Department of Health Care Services. In accordance with Federal Law, Medi-Cal members are allowed freedom of choice of Providers/Practitioners when seeking STD services, without prior authorization. STD services include education, prevention, screening, counseling, diagnosis, and treatment.

Participating Provider/Practitioner Responsibilities

Participating Primary Care Practitioners (PCPs) are responsible for the primary medical care of STDs. The PCP may perform services or refer members to Local Health Department clinics, participating specialists, or upon request of the member, to out-of-plan Providers/Practitioners. Each PCP is responsible to report certain information regarding the identification of STDs to the Local Health Department within seven (7) days of identification.

When reporting to the Local Health Department, the following information must be included:

- Patient demographics: name, age, address, home telephone number, date of birth, gender, ethnicity, and marital status.
- Locating information: employer, work address, and telephone number.
- Disease information: disease diagnosed, date of onset, symptoms, laboratory results, and medications prescribed.

The PCP will provide and document preventive care and health education, counseling, and services at the time of any routine exam for all members with high-risk behaviors for STDs. Access to confidential STD services by minors is a benefit of Molina Healthcare.

Minors

Members age 12 and over may access STD services without parental consent. Molina Healthcare Policy, Confidential Access to Services for Minors, may be obtained by contacting the Provider/Practitioner Quality Improvement Department.

Non-Participating Provider/Practitioners

Molina Healthcare requests that non-participating Providers/Practitioners contact the Member Services Department at Molina Healthcare to confirm eligibility and benefits and to obtain billing instructions for Molina Healthcare members. Non-participating Providers/Practitioners are requested to contact the affiliated health plan's Member Services Department to confirm eligibility and benefits and to obtain billing instructions. The non-participating Providers/Practitioners will also be given the name of the member's PCP to arrange for follow-up services. If the non-participating Provider/Practitioner contacts the PCP directly, the PCP is responsible for coordinating the member's care with the non-participating Provider/Practitioner.

If the non-participating Provider/Practitioner requests Case Management services, the call will be transferred to Molina Healthcare's Case Management Department. The Case Manager will then arrange for any necessary follow-up care and will coordinate with the member's PCP as necessary.

Member Education

Molina Healthcare provides member education on STDs which includes disease-specific material, right to out-of-plan treatment, cost, assessment for risk factors, and the methodology for accessing clinical preventive services. Members are advised of these services in the Evidence of Coverage which is mailed at the time of enrollment and annually thereafter. Molina Healthcare's Health Education Department will send STD health education information to Providers/Practitioners upon request. See the section in this manual entitled "Health Education" for instructions on ordering materials and order forms.

Provider/Practitioner Guidelines for STD Episodes

For the purposes of providing reimbursement to the Local Health Department for sexually transmitted diseases, an episode is defined based upon the specific sexually transmitted disease diagnosed as follows:

- Bacterial Vaginosis, Trichomonisis, Candidiasis Initiation of treatment of vaginal or urethral discharge for symptoms and signs consistent with any one or a combination of these diagnoses is considered an episode, and one (1) visit is reimbursable.
- Primary or Secondary Syphilis - Initial visit and up to five (5) additional visits for clinical and serological follow-up and re-treatment, if necessary, may be required for certain high-risk individuals. A maximum of six (6) visits per episode is reimbursable. Documentation should include serologic test results upon which treatment recommendations were made.

NOTE: Members who are found to have a reactive serology, but show no other evidence of disease, should be counseled about the importance of returning to the Provider/Practitioner for follow-up and treatment of possible latent syphilis. For female members of childbearing age who refuse to return to the Provider/Practitioner for their care, up to six (6) visits are reimbursable for treatment and follow-up.

- Chancroid - Initial visits and up to two (2) follow-up visits for confirmation of diagnosis and clinical improvement are reimbursable.
- Lymphogranuloma Venereum, Granuloma Inguinale - Based upon the time involved in confirming the diagnosis and the duration of necessary therapy, a maximum of three (3) visits is reimbursable.
- Herpes Simplex - Presumptive diagnosis and treatment (if offered) constitute an episode, and one (1) visit is reimbursable.
- Gonorrhea, Non-Gonococcal, Urethritis and Chlamydia - Can often be presumptively diagnosed and treated at the first visit, often with single-dose therapy. For individuals not presumptively treated at the time of the first visit, but found to have gonorrhea or chlamydia, a second visit for treatment will be reimbursed.
- Human Papilloma Virus - One (1) visit reimbursable for diagnosis and initiation of therapy with referral to PCP for follow-up and further treatment.
- Pelvic Inflammatory Disease - Initial visit and two (2) follow-up visits for diagnosis,

treatment, and urgent follow-up are reimbursable. Member should be referred to PCP for continued urgent follow-up after the initial three (3) visits have been provided by the LHD.

Reimbursement

Participating Providers/Practitioners must bill Molina Healthcare or the appropriate capitated IPA/Medical Group in accordance with their Provider/Practitioner agreement and all applicable procedures. If you are an individually contracted Provider/Practitioner rendering referred or authorized STD services, you are reimbursed at the lowest allowable Medi-Cal fee-for-service rate determined by DHCS if a specific rate has not been included in your Provider/Practitioner contract.

90% of claims will be paid/denied within thirty (30) calendar days of receipt. 100% of claims must be paid/denied within forty five (45) working days of receipt. Provider/Practitioner's will be notified in writing of any contested claim in suspense for more than forty five (45) working days. If the STD service is denied, for example, those patients not eligible under the Medi-Cal program, the claim will be sent to the Provider/Practitioner of service to protect the confidentiality of the member.

If the member received STD services from a non-participating Provider/Practitioner and was required to pay out-of-pocket for the services, the member must bill Molina Healthcare or the affiliated health plan or IPA/Medical Group, according to their affiliation. The billing address is located on the back of the member's ID card.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING AND COUNSELING

Molina Healthcare is responsible for promoting access to confidential HIV testing and counseling services available to its members. Molina Healthcare is to assist in the coordination of care and follow-up with the Local Health Department (LHD). Molina Healthcare ensures coordination of Medical Case Management and AIDS Waiver Case Management in developing a comprehensive approach to achieve healthy outcomes for Molina Healthcare members diagnosed with AIDS or symptomatic HIV disease.

Policy

Molina Healthcare is responsible for ensuring that its members have access to appropriate and confidential HIV testing and counseling services and that Providers/Practitioners are reimbursed properly for services rendered. Molina Healthcare must also ensure that the collection, management, documentation, and release of information regarding HIV tests are handled in compliance with state and federal laws and regulations. In addition, Molina Healthcare must ensure the safety and confidentiality of its members and staff. Molina Healthcare's network of PCPs will perform or order confidential HIV testing, counseling, and follow-up services, when indicated. Molina Healthcare members may also receive HIV testing and counseling from a LHD or from other non-participating family-planning Providers/Practitioners.

Local Health Department Coordination

Molina Healthcare will collaborate with the Local Health Department for the following:

- To develop a Memorandum of Understanding (MOU) or a cooperative agreement addressing HIV testing and counseling services
- To coordinate the development of applicable policies and procedures
- To identify strategic opportunities to share resources, that maximize health outcomes
- To routinely communicate and facilitate optimal data and information exchange
- To ensure appropriate case management collaboration
- To work to resolve conflict at the local level

Provider Training and Education

The Provider Services Department at Molina Healthcare, in collaboration with the LHD, provides ongoing program education and training on HIV/AIDS services. This training provides information regarding the eligibility criteria for the AIDS Waiver Program. The Molina Healthcare Provider Services Department maintains a list of all agencies providing AIDS Waiver Program services within the geographic region. The Molina Healthcare Provider Services Department, in collaboration with the LHD, educates providers on the conditions that make an individual eligible for AIDS Waiver Program Services and the referral process.

PCP Responsibilities

PCPs will routinely obtain a sexual history and perform a risk factor assessment for each of their members. When appropriate, the Provider/Practitioner will screen for HIV infection with pre and post-test counseling. The PCP's initial disclosure of HIV test results to the member can greatly affect the member's knowledge of, and attitude about his/her condition. Prior to disclosing results, the PCP will assess the degree to which the member, parent, or guardian is prepared to receive the results. The PCP will consider social, cultural, demographic, and psychological factors. Disclosure and counseling will always take place face-to-face. Immediate interventions may include assessing the member for potential violence to him/herself or others, informing the member of available services, making referrals as necessary, and addressing the prevention of HIV. PCPs will educate the member regarding the State's HIV reporting requirements.

Confidentiality

Counseling suggestions for the HIV positive members include:

- Providing information on available medical and mental health services as well as guidance for contacting sexual or needle-sharing partners. HIV-infected individuals should be counseled with regard to safe sex, including the use of latex condoms during sexual intercourse.
- Describing the symptoms of common diseases that occur along with HIV and AIDS and when medical attention should be sought.

Counseling suggestions for the HIV negative member may include:

- Not exchanging bodily fluids unless he/she are in a long-term mutually monogamous relationship with someone who has tested HIV antibody-negative and has not engaged in unsafe sex for at least six (6) months prior to or at any time since a negative test.
- Using only latex condoms along with a watersoluble lubricant.
- Reminding never to exchange needle or other drug paraphernalia.

Reporting of Test Results

The reporting of HIV test results is not mandatory at this time. However, Molina Healthcare requires Providers/Practitioners to report to the Department of Health Care Services and the County Health Officer whenever a patient is diagnosed with AIDS.

When reporting AIDS cases, the report is to include the name, date of birth, address, and social security number of the patient, the name of the Provider/Practitioner and clinic, and date of the patient's hospitalization as appropriate. An AIDS Adult Confidential Case Report Form is completed for members age 12 and over.

Screening and Testing

Molina Healthcare requires the written consent of the patient prior to testing of patient's blood for antibodies to the causative agents of AIDS (HIV test). The patient's written consent is obtained by the Provider/Practitioner/designee. If blood is drawn at the Provider/Practitioner's office, the consent will be filed in the member's medical records and the blood sample will be forwarded to the laboratory. Initial evaluation by the PCP will include a history and physical for all members suspected of HIV infection. The member's history is key to differential diagnosis, primary prevention, and partner notification.

The following information should be obtained and documented in the member's medical record:

- Member's sexual orientation
- Intravenous drug abuse history
- Transfusion history
- Incidents of sexual contact with a person(s) with AIDS or who subsequently developed AIDS
- History of homosexual or heterosexual promiscuity
- History of work related exposure

The physical exam of the HIV member will include all body systems and may prove to be entirely normal. Abnormal findings range from those completely non-specific to those highly specific for HIV infection. The member may also present with symptoms to a large number of diseases that are commonly seen in HIV infected members. A complete physical examination

will be documented in the member's medical record and will include:

- All body systems
- Visual acuity
- Oral cavity
- Gynecological exam

Common complaints may include:

- Systemic, i.e. fever, night sweats, weight loss, fatigue
- Gastrointestinal, i.e. nausea, vomiting, diarrhea, abdominal pain
- Respiratory, i.e. shortness of breath, cough, sinus pain
- Central nervous system, i.e. visual changes, headache, focal neurological deficits, seizures
- Peripheral nervous system, i.e. numbness, tingling, pain to the lower extremities
- Musculoskeletal, i.e. joint swelling and pain, muscle tenderness, proximal weakness

Initial laboratory evaluations may include, but are not limited to, any of the following *when indicated:*

- ELISA (Enzyme-Linked Immunosorbent Assay)
- Western Blot (after 2 positive ELISA tests)
- CBC and blood chemistry when transaminase
- Hepatitis B and C serology
- CD4 count - absolute and percent
- Baseline serology for cytomegalovirus (CMV) toxoplasmosis, and crytoantigen
- Septum culture
- Blood culture (if temperature is greater than 38.5 C)
- Wright-Giemsa stain
- Bronchoalveolar lovage
- Rapid Plasma Reagin (RPR) or Venereal Disease Research Laboratory (VDRL), i.e. rules out Syphilis, screen for other sexually transmitted diseases as indicated.

Confidentiality of Test Results

Results of blood tests to detect antibodies to the probable causative agent of AIDS (HIV test) are confidential and disclosure is limited. Results may be disclosed to any of the following persons without written authorization from the subject:

- To the subject of the test or the subject's legal representative, conservator, or to anyone authorized to consent to the test for the subject

Disclosure of Information

- Test results are placed in the medical record clearly marked "Confidential" for the use of the treatment team at Molina Healthcare.
- To a Provider/Practitioner of care who procures, processes, distributes, or uses human body parts donated pursuant to the Uniform Anatomical Gift Act.
- The Provider/Practitioner who ordered the antibody test may, but is not required to, disclose positive test results to a person reasonably believed to be a sexual partner or a person with whom the patient has shared the use of hypodermic needles (provided the Provider/Practitioner does not disclose identifying information about the test subject to the individual) or to the County Health Officer. He/she will not be civilly or criminally liable for doing so.
- Molina Healthcare Providers/Practitioners who disclose the results as outlined above are required to document such release, including first name and last initial of the person mentioned in the medical record of the patient, also giving the reason for the release, i.e. believed sexual partner, possible shared needles, etc.
- Prior to disclosing results to a third party, the Provider/Practitioner must first discuss the results with the patient, counsel the patient, and attempt to obtain the patient's voluntary, written consent and authorization to notify the patient's contacts.
- If the Provider/Practitioner discloses the information to a contact, the Provider/Practitioner must refer that person for appropriate care.

Release of HIV Test Results

In all cases, except as mentioned previously, written authorization for release of HIV test results is required.

- Such disclosure includes all releases, transmissions, dissemination, or communications whether they are made orally, in writing, or by electronic transmission.
- A valid authorization to release results of a blood test to detect antibodies of HIV is to be in writing and include to whom the disclosure must be made.
- Written authorization is required for each separate disclosure of test results.
- HIV test results will not be released pursuant to a subpoena for medical records unless accompanied by a court order directing the release.
- The current applicable Release Form will be used for all releases under this section.
- All requests for release of HIV test results will be verified for appropriateness.
- Providers/Practitioners and employees of Molina Healthcare are not permitted to remove the HIV test from the medical record or photocopy the HIV test results under

any circumstances except as heretofore described.

Please refer to Molina Healthcare Policy and Procedure, Collection/Use/Confidentiality, and Release of Medical Records and MMCD Policy letter 9708, HIV Counseling and Testing Policy. These policies and procedures, in their entirety, can be obtained by contacting the Provider Services Department.

Penalties for Improper Disclosure of Test Results

Health and Safety Code, Section 199.21, provides penalties for the negligent or willful disclosure of results of a blood test to detect antibodies to the probable causative agent of AIDS to any third party. The penalty applies if the disclosure is not authorized by the patient or by law.

- If an improper disclosure resulted from negligence there may be a fine up to $1,000 plus court costs.
- If an improper disclosure resulted from a willful act, there may be a fine up to $5,000.
- If an improper disclosure, whether negligent or willful, results in economic, bodily, and/or psychological harm to the subject of a test, the person who made the improper disclosure may be found guilty of a misdemeanor and fined up to $10,000 or be imprisoned in county jail for up to one (1) year, or both, and may also be liable to the subject of the test for all actual damage caused, including economic, bodily, and/or psychological harm.
- Any employee who releases information regarding HIV testing, whether results are positive or negative, in violation of this policy has also breached Molina Healthcare's confidentiality policy and is subject to such disciplinary action as is warranted, up to and including dismissal from employment or service.

Continuing Care

As the disease progresses, and depending on any accompanying diseases the member acquires, referrals to subspecialties will be initiated as needed. The PCP will consider management by an infectious disease specialist or HIV specialist when CD 4+ 200 cells u/L or the member develops clinical AIDS. During the terminal phase of care, issues such as advanced directives, durable power of attorney, and hospital care will be addressed by the PCP. The Medical Case Manager will monitor and coordinate care and services provided to HIV/AIDS members by PCPs as well as any out-of-plan providers.

Out-of-plan Providers/Practitioners

Members may access out-of-plan Providers/Practitioners for diagnosis of HIV/AIDS. Molina Healthcare will reimburse contracted Providers/Practitioners at contracted rates. Molina Healthcare will reimburse non-contracted, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate, unless otherwise negotiated. The diagnosis, counseling, and treatment of HIV/AIDS will be reimbursed if the Provider/Practitioner submits treatment records or documentation of the member's refusal to release records along with billing information. Medical records obtained from out-of-plan Providers/ Practitioners other than the member's PCP will be shared with the PCP for the purposes of assuring continuity of care.

If a member refuses to release the medical records required for billing, the out-of-plan Provider/ Practitioner must submit documentation of such refusal. Properly billed claims from out-of-plan Providers/Practitioners will be paid timely and in accordance with the Knox-Keene Act (amended).

TUBERCULOSIS (TB) SCREENING AND TREATMENT AND DIRECT OBSERVED THERAPY (DOT)

The estimated number of persons in the United States with latent tuberculosis (TB) infection is ten (10) to fifteen (15) million. Studies have shown the treatment of such patients with at least six (6) months of antibiotics can significantly reduce progression to active tuberculosis. Preventive treatment is ninety percent (90%) effective when the patient compliance is good. Tuberculosis is associated with considerable morbidity from pulmonary and extrapulmonary symptoms.

Direct Observed Therapy (DOT) Services are offered by Local Health Departments to monitor those patients with active tuberculosis who have been identified by their Provider/Practitioner as at-risk for non-compliance with treatment regimen. DOT is a measure both to ensure adherence to tuberculosis treatment for at-risk members who either cannot or likely will not follow the treatment regimen and to protect the public health.

Molina Healthcare and Providers/Practitioners coordinate and collaborate with Local Health Departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. Molina Healthcare's guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), and the Advisory Committee for Elimination of Tuberculosis (ACET). Molina Healthcare coordinates with LHDs for the provision of Direct Observation Therapy (DOT), contact tracing, and other TB services. Members meeting the mandatory criteria for DOT are identified and referred to LHDs.

Policy

- TB screening and treatment services for members are covered responsibilities under the Two-Plan Model Contract. Molina Healthcare collaborates with LHDs to control the spread of TB and to facilitate access to TB treatment. Molina Healthcare coordinates with LHDs to establish an effective coordination of care to achieve optimum clinical outcomes for members. Early diagnosis, immediate reporting to LHDs, and appropriate TB treatment are critical to interrupting continued transmission of TB. Molina Healthcare informs PCPs that they must report known or suspected cases of TB to the LHDs TB Control Program Office within one (1) day of identification, per Title 17, CCR, Section 2500.
- PCPs will coordinate and collaborate with LHDs for TB screening, diagnosis, treatment, compliance, and follow-up of Molina Healthcare members. Molina Healthcare medical policy guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society ATS, CDC, and the ACET.

- Molina Healthcare will coordinate with LHDs for the provision of (DOT), contact tracing, and other TB services. Molina Healthcare members meeting the mandatory criteria for DOT are identified and referred to LHDs.
- Molina Healthcare will direct diagnosed Class III and Class V TB cases to the applicable LHD for treatment.
- The PCP is responsible for coordination of care with the LHD and for meeting any additional healthcare needs of the member, unrelated to TB services.

Tuberculosis Control Strategy

Molina Healthcare's TB control strategy for members include the following: continued collaboration, communication, and contracting with the LHDs in the areas of public health coordination, community education/training, Provider/Practitioner and Provider/Practitioner staff education/ training, referral process, screening/ treatment, DOT, and case management processes. The control strategy includes the following:

- Communicating with the LHDs in order to facilitate an effective TB prevention, screening, and treatment process
- Identifying and reporting of TB cases to LHD
- Providing educational programs to the members residing in various counties
- Providing education and resources to Provider/Practitioners and Provider/Practitioner's staffs regarding the prevention, screening, identification, and treatment of TB
- Providing Molina Healthcare members diagnosed with TB with early and appropriate treatment
- Promoting compliance with treatment programs
- Preventing the spread of TB

Screening for Tuberculosis Infection

Screening for TB is done to identify infection in members at high-risk for TB who would benefit from therapy. Screening is also done to identify members with active TB disease who need treatment. An assessment of risk for developing TB must be performed as part of the initial health assessment required within ninety (90) days of enrollment with Molina Healthcare. Molina Healthcare collaborates with the LHD TB Control Programs to identify refugees who are possible candidates for local refugee health clinic services.

Tuberculosis Risk Assessment in Adults

For adult members, an assessment of risks for developing TB will be performed as part of the initial health assessment required to be conducted within ninety (90) days of enrollment. TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease. High-risk individuals include the following:

- Persons infected with HIV
- Persons having close contact with known or suspected TB carriers
- Persons with medical risk factors associated with TB
- Immigrants from countries with high TB prevalence
- Alcoholics
- Drug users
- Residents of long-term care facilities

Tuberculosis Risk Assessment in Children

For Molina Healthcare members under age 21, assessment for risk factors for developing TB and tuberculin skin testing must be conducted in compliance with current American Academy of Pediatric Requirements. The risk factors include the following:

- Those who have had contact with a person(s) with infectious TB
- Those who are from, or who have parents who are from, regions of the world with a high prevalence of TB
- Those with abnormalities on chest roentgenogram suggestive of TB
- Those with clinical evidence of TB
- Children who are HIV-sero positive
- Those with immunosuppressive conditions
- Those with other medical risk factors such as Hodgkin's Disease, lymphoma, diabetes mellitus, chronic renal failure, and/or malnutrition
- Incarcerated adolescents
- Children who are frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, residents of nursing homes, and migrant farm workers

TB Skin Testing Protocols

Mantoux tuberculin skin testing is the standard method of identifying persons infected with TB. The Mantoux test will be given and read by qualified staff. Steps of tuberculin skin testing are as follows:

- TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease.
- The screening test to be used is the Mantoux tuberculin test. The multi-puncture test must not be used.
- Trained personnel must read the skin test results and record the result in millimeters.

- Tuberculin testing will be done by injecting five (5) Tuberculin Units (TU) of PPD (0.1 ml) intradermally.
- Previous BCG Vaccination is never a contraindication to tuberculin testing.
- Members with a history of previous positive PPD (Mantoux) should not be retested.
- Interpretation of the test result: The test will be read forty eight (48) to seventy two (72) hours after the injection. In the general member population, a reaction of greater than or equal to 10mm of induration will be considered a positive test.
- Members with a positive skin test will have a chest x-ray to exclude pulmonary TB.
- Members with an asymptomatic infection (positive skin test, but no evidence of disease on chest x-ray) will be treated with INH alone. In infants and children, recommended duration of INH is nine (9) months. Note: INH is given daily, 10 mg pr kg, in a single dose, or 300 mg/day in adults.
- Children receiving INH do not need Pyridoxine supplements unless they have nutritional deficiencies. (Pyridoxine is recommended for children and adolescents on meat or milk deficient diets, or with other nutritional deficiencies, breast-feeding infants, and women during pregnancy.)
- Immunizations - Members who are receiving treatment for TB may be given measles vaccine or other live virus vaccines as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications.
- Adults treated with INH should have baseline liver function tests (LFT) done. LFTs should be repeated monthly. In children, the incidence of hepatitis during INH therapy is so low that routine determination of LFTs is not recommended.
- Adults under age 35, should be treated with INH for nine (9) months if they have a positive PPD and a negative chest x-ray. In members 35 years and over, the risk of hepatic toxicity from INH outweighs the risk of progression of TB and is not recommended.

The definition of a positive tuberculin skin test is as follows:

- Greater than or equal to five (5) mm for persons known or suspected to have HIV infections
- Contact with an infectious case of TB
- Person with an abnormal chest radiograph, but no evidence of active TB
- Greater than or equal to ten (10) mm, all persons except those listed above
- Greater than or equal to fifteen (15) mm. In California, this cut off is not recognized by Public Health Departments.

Tuberculin skin tests are not recommended for persons at low-risk for TB infection. Tuberculin skin test conversion is defined as an increase of at least 10mm of induration from below 10mm to greater than or equal to 10mm within twenty four (24) months of a documented negative to a positive tuberculin skin test.

If the test is positive, a chest x-ray must be done. Since a positive 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.

If the member does not return to have his/her skin test read, follow-up will be conducted by the PCP according to the missed appointment policy and process with documentation of steps taken in the member's medical record.

Classification of TB

Class	Type	Description
0	No TB exposure Not infected	No history of exposure Negative reaction to tuberculin skin test
I	TB exposure No evidence of infection	History of exposure Negative reaction to tuberculin skin test
II	TB infection No disease	Positive reaction to tuberculin skin test Negative bacterioligic studies (if done) No clinical or radiological evidence of TB
III	Current TB disease	*M. Tuberculosis* cultured (if done) OR Positive reaction to tuberculin skin test AND Clinical or Radiological evidence of current disease
IV	Previous TB disease	History of episode(s) of TB OR Abnormal but stable radiograph findings Positive reaction to the tuberculin skin tests Negative bacteriologic studies (if done) AND No clinical or radiographic evidence of current disease
V	TB suspected	Diagnosis pending

Preventive Therapy

The following classes of members may be eligible for preventive therapy if they have not received a prior course of anti-TB treatment. Before starting preventive therapy, active TB must first be excluded. It is essential to obtain a chest x-ray when evaluating a person for TB. Bacteriologic studies should be obtained for all members with an abnormal chest x-ray.

- TB Class II - TB infection, no disease: a member with a positive reaction to tuberculin skin test, no clinical and/or radiographic evidence of tuberculosis, and a negative bacteriologic study.
- TB Class IV - TB, no current disease: a member with a positive reaction to a tuberculin skin test, abnormal, but stable radiographic findings over a period of at least three (3) months, or the radiographic abnormalities of known duration, negative bacteriologic studies, and no other clinical or radiographic evidence of active tuberculosis.

Immunizations - Members who are receiving treatment for TB can be given measles vaccine or other live virus vaccinations as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications.

Persons with the following conditions that have been associated with an increased risk of TB should be started on preventive therapy, regardless of age:

- Drug abuse, especially with injecting drug use
- Diabetes mellitus, especially insulin dependence
- Prolonged corticosteriod therapy
- Other immunosupressive therapy
- Cancer of the head and neck
- Hematological and Reticuloendothelial disease
- End-stage renal disease
- Intestinal bypass or gastrectomy
- Chronic malabsorption. Low body weight. Malnutrition and clinical situations associated with rapid weight loss.

Clinical trials have shown that daily isoniazid (INH) for six (6) - twelve (12) months is highly effective in reducing the risk of TB. Every effort will be made by the PCP and the Local Health Department TB Control Program to ensure that members adhere to preventive therapy for at least six (6) months. Every effort will be made to ensure compliance for six (6) - twelve (12) months. For close contacts with infectious members who have INH-resistant TB, preventive therapies with Rifampin (RIF) should be considered. RIF should also be considered for INH-intolerant members.

For documented recent converters who were contacts to cases with monoresistance to INH, RIF should be given for six (6) months; longer duration recommended for immunocompromised individuals.

Standard Initial Regimes

All TB cases, TB Class III, or TB Class V individuals in California should be started on a four (4) drug regimen of INH, RIF, Pyrazinamid (PZA), and Ethambutol (EMB), unless contra--indicated. The treatment may be given in three (3) ways:

- Daily treatment regime: Drugs should be given together; dosages should not be split.
- Bi-weekly regime: Four (4) drug therapy, administered daily for two (2) weeks and then two (2) times a week for six (6) weeks. This sequence should then be followed by therapy with INH and RIF given two (2) times a week for sixteen (16) weeks.
- Thrice weekly treatment regime: Three (3) times weekly from the beginning; all four (4) drugs must be given for six (6) months.

For number one (1) above, EMB should be continued until drug susceptibility results are available and resistance to INF and RIF has been excluded. PZA is continued for the first two (2) months. RIF and INH are continued for a total of six (6) months. Intermittent therapy (see above) should only be given to directly observed therapy members. If cultures remain positive beyond two (2) months of treatment, therapy should be prolonged. Ideally, treatment should be continued at least six (6) months after the culture converts to negative.

Case Management

Management of members with suspected or diagnosed TB will be referred to the Case Management program of Molina Healthcare or its affiliated health plan. The Case Management staff will notify the Local Health Department TB Control Program of the designated Molina Healthcare Provider/Practitioner or staff responsible for coordination of TB care with the LHD TB Control Program. Molina Healthcare will promptly notify the LHD TB Control Program of any changes in the Provider/Practitioner assigned to a confirmed or suspected TB case within seven (7) days.

The PCP must respond to requests for information from the LHD TB Control Program in a timely manner and will consult with the LHD TB Control Program about treatment recommendations and protocols, as needed. The Case Management staff, PCP, and the LHD TB Control Program collaborate in identifying barriers to member compliance with self--administered treatment. Fixed-dose combination drug preparations will be available for members on self-administered therapy, and they are strongly encouraged for treatment of adults to promote compliance.

As agreed with the Local Health Department, the LHD TB Control Program will assign a TB Case Manager (TBCM) who will:

- Assess risk of transmission within two (2) working days of case notification
- Visit the member within seven (7) working days, depending on transmission risk factors
- Initiate contact investigations, when indicated
- Assess and address potential barriers to treatment adherence
- Verify initial information and collect additional information needed to complete the TB case report
- Visit the member as needed to assess and ensure treatment adherence
- Promptly notify Molina Healthcare of assignment or change of the TBCM
- Respond to information requests from the PCP in a timely manner

Reporting

PCPs will comply with all applicable state laws and regulations pertaining to the reporting of confirmed and suspected TB cases to the LHD. The PCP will report known or suspected cases of TB to the LHD TB Control Program within one (1) day of identification. Reporting will be done in accordance with Molina Healthcare's Confidential Morbidity Reporting policy.

PCPs will promptly submit treatment plans, including dosage changes, to the LHD with updates at regular intervals as requested by the LHD until treatment is completed.* PCPs will notify the LHD when there are reasonable grounds to believe that a member has ceased treatment. Such grounds include member's failures to keep appointments, relocation without transferring care, or discontinuation of care. The LHD Local Health Officer may require Molina Healthcare Providers/Practitioners at any time to report any clinical information deemed necessary including the prompt reporting of drug susceptibility by the Local Health Officer to

protect the member's health or the health of the public.

*NOTE: This is not applicable if the LHD is serving as the primary treatment center for the TB member.

Referrals

- The PCP will identify Class III and Class V TB cases and will route a copy of the referral form to the LHD TB Officer. A copy of the referral form will also be sent to the Molina Healthcare Utilization Management Department.
- The PCP may make a referral to Molina Healthcare or the subcontracted affiliated plan's Utilization Management Department for case management of services for members who are repeated no-shows for appointments. If the Case Manager determines that the member is considered lost to medical follow-up, the health plan's Case Manager will notify the LHD.
- Members diagnosed with TB must be referred by the PCP to the LHD and the health plan's Utilization Management Department.
- The following members may be appropriate for referral to the LHD and the health plan's Utilization Management Department:
  - Substance abusers
  - Persons with major mental health disease
  - Elderly Persons
  - Homeless Persons
  - Formerly incarcerated person
  - Persons with slow sputum conversion
  - Persons with slow/questionable clinical adherence
  - Persons with adverse reaction to TB medication
  - Persons with poor understanding of their disease process and management
  - Persons with language and/or cultural barriers

Contact Investigation and Treatment

PCPs will cooperate with the LHD TB Control Program in conducting contact and outbreak investigations involving Molina Healthcare members. The Case Management Department will be available to facilitate, and if necessary, direct the coordination efforts between LHD TB Control Program and the contracted Provider/Practitioners.

Contracted Provider/Practitioners must provide appropriate examination treatment to Molina Healthcare members identified by the LHD as contacts in a timely manner, usually within seven (7) days. Examination reports will be reported back to the LHD in a timely manner. PCPs and/or the Case Management Department will promptly notify the LHD when contacts of Molina Healthcare members are referred to the LHD TB Control Program for examination.

Educational Material

Educational material may be obtained for members from various resources including, but not limited to:

- Molina Healthcare Health Education Department Telephone: (800) 526-8196, ext. 127532
- American Academy of Pediatrics, "Patient Medication Instructions: Isoniazid" Telephone: (800) 433-9016.
- American Lung Association, "Facts About Tuberculosis". Telephone: (800) 586-4872.
- Krames Communications, "Understanding Tuberculosis". Telephone: (800) 333-3032.
- American Thoracic Society, 61 Broadway, New York, 10006-2755. (212) 315-8600
- U.S. Centers for Disease Control and Prevention/ National Centers for Prevention Services
- Division of Tuberculosis Elimination, 1600 Clifton Rd. NE Mail Stop E, Atlanta, Georgia 30333. Telephone: (404) 639-8135.

The Molina Healthcare Health Education, Provider Services, and Case Management Departments will cooperate with the LHD TB Control Program to make health education resources available to Molina Healthcare members, Provider/Practitioners, and Provider/Practitioner's staff. This includes education to Providers/ Practitioners and Provider/Practitioner's staff on how to perform and interpret TB screening tests.

References

Included for your reference are the following:

- Classification System for TB

Direct Observation Therapy (DOT) for TB is not a covered service but is offered directly by the LHD. Any claims for DOT are to be submitted to the Medi-Cal field office, not to Molina Healthcare.

DOT Referrals to LHDs

When a PCP identifies a TB patient who is at-risk for compliance with his or her treatment regime, the PCP will fax a copy of the DOT referral form obtained from the LHD to the Control Officer. The LHD must be notified when the PCP has reasonable grounds to believe that a patient has ceased treatment, failed to keep an appointment, has adverse drug reactions, relocated without transferring care, and/or has discontinued care.

The following members with diagnosed TB must be referred for DOT services:

- Members having multiple drug resistance (defined as resistance to INH and RIF)

- Members whose treatment has failed
- Members who have relapsed after completing a prior regime
- Children
- Adolescents
- Noncompliant individuals

Members with the following conditions should be considered for referral for DOT:

- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence
- Persons with adverse reaction to TB medication
- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

Follow-up Care

PCPs are required to coordinate with the LHD TB Control Officer and to provide follow-up care to all members receiving DOT services. PCPs should inform the LHD TB Control Program of any changes in the member's response to the treatment or drug therapy. PCPs will receive a periodic report from the LHD TB Control Program, which advises them of each member's treatment status. The LHD TB Control Program will send a copy of the member's medical record and final status report upon completion of the DOT services to the PCP.

The PCP will arrange for the member to receive a follow-up appointment in order to develop a follow-up treatment plan. The PCP will follow-up if the patient is a no-show for the scheduled appointment, through telephone or letter, and will document such follow-up effort in the member's medical record. The PCP will notify the LHD TB Control Program if the member continues to miss follow-up appointments.

SECTION 11: PEDIATRIC AND CHILD HEALTH SERVICES

CHILDREN'S PREVENTIVE SERVICES INCLUDING CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) SERVICES

Children's Preventive Services

The Children's Preventive Services program is a preventive, well-child screening program for children under 21 years. It encompasses the requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the Child Health and Disability Prevention Program (CHDP), and the Prenatal Guidance Program. The purpose of these programs is to prevent childhood disability by screening children during critical times of growth and development and making referrals as necessary to improve their health.

Physician Certification (Suggested)

CHDP certification is provided at no cost by the county CHDP Program and usually involves an interview and office evaluation. Non-CHDP certified physicians may contact the State directly or the Molina Healthcare Provider Services Department at (888) 665-4621 for assistance to help facilitate this process.

Appointments and Referrals

Members requesting a Children's Preventive Services appointment with their PCP must be scheduled for an appointment within less than or equal to ≤ seven (7) working days of request.

Examinations

When conducting a Children's Preventive Services (including CHDP) exam, physicians are responsible for providing members with the following:

- A complete health and development history, including assessment of both physical and mental health development
- A "head-to-toe" unclothed physical examination, including assessment of physical growth
- A vision screen
- A hearing screen
- A dental screen, including inspection of mouth, teeth, and gums
- A nutritional assessment
- Laboratory tests appropriate to age/sex, (e.g. anemia, diabetes and urinary tract infections)
- Tuberculin test
- Sickle cell trait test, when appropriate
- Lead test per CHDP guidelines
- Immunization(s), if needed
- Additional tests or exam(s) as indicated
- Evaluation of results in terms of needed diagnosis and treatment
- A copy of the results and an explanation of their meaning
- Health education and anticipatory guidance appropriate to the member's age and health status

Please refer to the exhibits in Section 19, Medical Record Documentation, for sample Pediatric Initial Health Assessment and Aticipatory Guidance forms.

All members over 3 years of age must be referred for routine dental care. Molina Healthcare members with dental problems are to be referred directly to a dentist for care. The Dental referral number is (800) 322-6384.

Detailed descriptions and requirements for the following child services and examination components can be found in Section 10: Women's and Adult Health Services, Including Preventive Care:

- Initial Health Assessments (Section 10-26)
- Dental Screenings (Section 10-29)
- Vision Care Services (Section 10-29)
- Family-Planning Services (Section 10-30)
- Sexually Transmitted Diseases (STD) (Section 10-33)
- Human Immunodeficiency Virus (HIV) Testing and Counseling (Section 10-35)
- Tuberculosis (TB) Screening and Treatment (Section 10-39)

Coordination of Care

The PCP is responsible for the supervision of practitioner extenders, ongoing care, and the coordination of care for all services that the member/child receives. The PCP serves as the primary case manager for the member. The PCP will verify any suspected serious medical condition (e.g. heart murmur, scoliosis, and/or developmental problems). If needed services fall outside the PCP's scope of practice, appropriate referrals must be made with initiation of treatment within sixty (60) days from the health assessment appointment (or earlier if the condition warrants). Medical Case Managers are available to provide coordination if indicated by the member's condition and requested by the PCP.

If members in need of transportation assistance do not meet the criteria for non-emergent transportation, the PCP will refer the parent/guardian to the CHDP Program office for procurement of transportation.

Obtaining Consent

Physicians must obtain the voluntary written consent of the member (if over 18 years) or parent/guardian (if under 18 years) before performing a CHDP exam. Consent is also required for any release of information.

If the member or parent/guardian refuses to have the exam or any portion of the exam performed, this information must be documented in the member's medical record.

Certification for School Entry

California state law requires that children entering first grade must provide their schools with a certificate signed by the physician, documenting that they have had a CHDP exam or a waiver of the exam signed by the parent or guardian. The exam may be done within eighteen (18) months prior to or within ninety (90) days of entrance into the first grade. Physicians should give the parent/guardian of a child entering kindergarten or first grade a certificate that documents that the child has received the appropriate health exam.

A child may be certified without a CHDP exam if the child has received a physical exam and ongoing comprehensive medical care from that physician during the eighteen (18) month period prior to or within ninety (90) days of entrance into the first grade. An interim exam may be indicated to meet the school entry requirements. It is the policy of the CHDP Program and local schools to urge parents to get their child's health assessment upon entry into kindergarten. If the parent or guardian refuses a health assessment, the parent or guardian must submit a waiver to the school.

Follow-Up for Missed Appointments

For members who are a "no-show" at the time of their appointment(s), the member (parent/guardian) should be followed-up with a telephone call and, if necessary, a letter from the physician's office to schedule another appointment. Documentation of the telephone call or a copy of the letter must be maintained in the member's medical record.

All physicians who deliver care to potential CHDP-eligible members must complete a PM 160 INF (Information Only) Form. The PM 160 INF form is used for Medi-Cal members enrolled in a managed care plan and not used for billing purposes. The PM 160 INF form is used to monitor the quality of and compliance with CHDP screening requirements.

Where to Send Completed Forms

Copy 1 (white and brown)	Send to: Molina Healthcare of California Attn: CHDP Department P.O. Box 16027 Mail Stop "HFW" Long Beach, CA 90806
Copy 2 (yellow)	Send to: The local county CHDP office. PLEASE ensure that the physician (site of service) address and telephone number are completed in the lower left-hand corner of the form. Please include the applicable county code in the lower left-hand corner of the form as well.
Copy 3 (white)	Maintained in the member's medical record.
Copy 4 (pink)	Given to the member (parent/guardian) at the time of the visit.

The PM 160 Information Only Form (PM 160 INF) must be completed for each child who receives a CHDP health assessment. All PM 160 INF forms must be complete and accurate. Incomplete forms will be returned to the physician of services for completion. Molina Healthcare must submit the completed PM 160 INF forms to the Department of Health Care Services (DHCS) within thirty (30) days from the end of the month in which services were rendered

Ordering PM 160 INF Forms

To order PM 160 INF forms, please contact Provider Services at (888) 665-4621 or visit Molina Healthcare's website at http://www.molinahealthcare.com.

IMMUNIZATIONS

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for members under age 21. PCPs are responsible for the administration of immunizations to their patients. Immunization services may be accessed during any PCP visit. Molina Healthcare does not require rescheduling of visits for immunizations for immediate evaluation unless the child has a medical contraindication to receiving immunizations at the time of his/her visit to the PCP. Local Health Departments (LHDs) may also administer immunizations to Molina Healthcare Medi-Cal members. Go to www.cdc.gov to view the childhood immunization requirements. A sample Vaccine Administration Record for Children and Teens can also be found in Section 19, Exhibit 19M.

Additional information addressing protocols for care coordination and patient follow-up can be found in the Adult Preventive Care and Children's Preventive Services sections of this Manual.

Molina Healthcare Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. They are updated annually. Age specific PHGs for members are available on the Molina Healthcare webpage at www.molinahealthcare.com.

You may request a copy by contacting Provider Services at (888) 665-4621.

Participating Providers/Practitioners

PCPs are available to administer immunizations during routine office hours. The PCP also has the responsibility of updating the immunization card supplied by the Local County Health Department. Members are encouraged by Molina Healthcare to set up evaluations for immunizations during the first ninety (90) days of membership for adults and sixty (60) days of membership for children. Molina Healthcare sends members welcome and reminder letters advising them of this service. Members will receive written notice from the PCP to prompt members to come in for needed immunizations.

At each visit the PCP will inquire if the member has received immunizations from another Provider/Practitioner. The PCP will also educate members regarding their responsibility to inform their PCP if they receive immunizations elsewhere, i.e. non-plan Providers/Practitioners, LHD, etc. When a member experiences complications (e.g. infection or abscess), members should contact their PCP for follow-up care just as they would with any other medical condition or concern.

Upon request, the LHD will provide technical assistance, training, and material related to immunizations for Molina Healthcare Providers/Practitioners. LHDs will assist Molina Healthcare in their outreach efforts by conducting public education campaigns regarding immunizations. Provider/Practitioner bulletins will include updates of information on immunizations. Providers/Practitioners will be encouraged to participate in the Vaccines For Children (VFC) Program which is a federally funded program that provides free vaccines for eligible children and distributes immunization updates and related information to participating Providers/Practitioners. PCPs will maintain a current medical record on all members addressing applicable immunizations, notifications, and immunization services provided by an out-of-plan Provider/Practitioner. The PCP will cooperate with the out-of-plan Provider/Practitioner when requested to share member's immunization history. The PCP will document diligent effort in assessing the actual immunization status of the Molina Healthcare member prior to any immunization services.

Local Health Department (LHDs)

In accordance with Department of Health Service (DHCS) guidelines, Molina Healthcare will reimburse LHDs for certain immunizations and services without prior authorization. Molina Healthcare requires that the LHD contact the member's PCP or Medi-Cal Member Services Department to confirm eligibility and benefits before administering the immunization. The LHD should verify the member's immunization status, as they will not be reimbursed for immunizations provided when the member's immunization status is current. The LHD must provide a copy of the member's immunization record with their itemized claim form. Upon request, Molina Healthcare will help LHDs in obtaining the member's immunization history.

Molina Healthcare will forward copies of a member's immunization records to the member's PCP for inclusion in his/her medical record. If the member receives an immunization from the LHD and complications arise, the member must get in touch with their PCP for care just as they would with any other medical condition.

Member Identification

All members are encouraged to maintain a current immunization status. Members requiring immunizations are identified through the following sources:

- Initial health assessments
- Primary care practitioners (PCPs) and specialists
- Quality Improvement Department
- Member Services Department
- Utilization Management Department
- Emergency room/urgent care facilities
- Local Health Departments
- Claims and encounter data
- Provider Service Department through Provider/Practitioner inquiries
- Members
- Health Education Department
- Schools

PM 160 Documentation

All Provider/Practitioners providing services to children under 21 years are responsible for submitting well-child screening information on the PM 160 INF forms. These forms include information on immunizations. Additional information addressing completion of the PM 160 INF form can be found at the end of this section.

Member Outreach and Education

Molina Healthcare's member outreach and health education efforts for both pediatric and adult immunization concentrate on informing members about the necessity of immunizations. The Molina Healthcare Health Education Department distributes member education via a member newsletter, website and other educational materials that include information promoting immunizations. The PCP is responsible to ensure the member is up to date with immunizations.

Promoting Access to Care

Molina Healthcare promotes appropriate access to care as well as immunizations by offering Provider/Practitioner educational materials and Provider Online Directory on www.molinahealthcare.com. Members also have access to twenty four (24) hour Nurse Advice service, which includes answering questions on immunizations, and other health concerns.

Reporting of Vaccine Preventable Diseases

- Molina Healthcare will assist LHDs in educating Providers/Practitioners, including laboratories, about their responsibilities to report vaccine-preventable (and other infectious) diseases according to California Health and Safety Code regulations.
- The PCP and health plans will cooperate and assist LHDs in informing Providers/Practitioners of reported disease outbreaks and implementation of control procedures.

- Please refer to Molina Healthcare Policy and Procedure titled QM 41, Confidential Morbidity Reporting to Public Health, for details. This report can be obtained by contacting the Provider Services Department of Molina Healthcare. Information regarding Confidential Morbidity Reporting is located in the Tuberculosis section of this manual.

Public Health Coordination

Molina Healthcare has collaborated with Local Health Departments to:

- Negotiate the Memorandum of Understanding
- Develop and coordinate policies and procedures
- Provide in-service training to internal staff and contracted Providers/Practitioners

VACCINES FOR CHILDREN PROGRAM

Vaccine for Children (VFC)

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for Medi-Cal members under age 21. Medi-Cal Providers/Practitioners are encouraged to participate in the Vaccine for Children (VFC) Program. This federally and State funded program furnishes free vaccines in bulk to enrolled Providers/Practitioners. All Medi-Cal eligible children may receive these vaccines.

Participation

To participate in the VFC program, Providers/Practitioners must complete four (4) forms:

- Provider/Practitioner enrollment form
- Provider/Practitioner profile form
- Provider/Practitioner Profile Form Supplemental
- Suggestions for Developing Estimates

Samples of these forms are included for your reference. The original Provider/Practitioner enrollment form must be sent to VFC. Photocopies of the Provider/Practitioner profile form and the vaccine order form can be mailed to VFC. Please contact the VFC Program at toll-free telephone (877)-2GET-VFC (877-243-8832) for additional forms.

Mail all forms to the following address:

Vaccines for Children (VFC) Program, State of California
Department of Health Care Services
Immunization Branch
850 Marina Bay Parkway, Building P
Richmond, CA 94804

Annual Updates

You must update your Provider/Practitioner profile form on an annual basis, or more frequently if your estimate of eligible children changes. Vaccines will be delivered to the address specified on the Provider/Practitioner profile form. Providers/Practitioners must have adequate storage space in their offices for a two (2) month supply of vaccine. Additional information can be obtained by contacting the Provider Services Department of Molina Healthcare, or VFC Customer Service at toll-free telephone (877)-2GET-VFC (877-243-8832).

Attached for your reference are the following exhibits:

- Vaccines for Children (VFC) Program, Provider/Practitioner Enrollment Form
- Vaccines for Children (VFC) Program, Provider/Practitioner Profile Form
- Vaccines for Children (VFC) Program, Provider/Practitioner Profile Form Supplemental

- Suggestions for Developing Estimates

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SUPPLEMENTAL SERVICES

EPSDT Supplemental Services

EPSDT Supplemental Services are defined as medically necessary services, including EPSDT Case Management Services, that are not available to the Medi-Cal population over age 21 (e.g. not CHDP). EPSDT Case Management Services are those services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services.

Children and young adults under age 21 will be examined (screened) by health care Providers/Practitioners to determine their health needs for EPSDT Supplemental Services. Federal law requires that states provide medically necessary screening, vision, hearing, and dental services to Medi-Cal members under age 21. Any service that is medically necessary to correct or ameliorate a defect, physical and/or mental illness or a condition must be provided, even if the service is not otherwise included in the Medi-Cal plan.

Member Coordination

For Molina Healthcare members, Molina Healthcare will work with its delegated medical groups and IPAs to coordinate with PCPs to identify those who would benefit from these services. Molina Healthcare will determine the medical necessity of EPSDT Supplemental Services according to the criteria established in Title 22.

Referrals

In most cases, PCPs will identify members in need of EPSDT Supplemental Services as part of regular health screening visits. It is also possible that the need for services will be identified by the member, the member's parents or other family member, the local CHDP program, or another health professional. All referrals for EPSDT Supplemental Services will be directed to Molina Healthcare's Utilization Management Department. The Medical Case Manager and appropriate Medical Director will review the request and determine the medical necessity of EPSDT Supplemental Services using the criteria established in Title 22.

Requests for prior authorization for EPSDT Supplemental Services will be accompanied by the following information:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset and etiology if known
- Clinical significance or functional impairment caused by the illness or condition
- Specific types of services to be rendered by each discipline with Provider/Practitioner's prescription where applicable
- The therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
- Record of previously provided health care services and results demonstrated by prior care
- Any other documentation available that may assist the department in making its determination. EPSDT Supplemental Services must meet standards as determined by the Department of Health Care Services (DHCS)

Procedure

Molina Healthcare eligible Medi-Cal members will be identified for EPSDT Supplemental Services by the PCP. EPSDT Supplemental Services will be determined to be medically necessary if one (1) of the three (3) following conditions are met:

- The requested EPSDT Supplemental Service can meet existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population; or
- The requested EPSDT Supplemental Service can meet distinct EPSDT service specific requirements (please see "Service Specific Criteria" below); or
- If, regarding the criteria above, the first bullet below cannot be met and the second bullet below is not applicable to the service, then the requested EPSDT Supplemental Service must be evaluated under the expanded medical necessity criteria established in the EPSDT regulations in Title 22, CCR, Section 51340(e)(3), as summarized below:
  - The services are to correct or ameliorate defects or physical and mental illnesses or conditions discovered by the screening services.
  - The supplies, items, or equipment to be provided are medical in nature.
  - The services are not requested solely for the convenience of the member, family, Provider/Practitioner, or other Provider/Practitioner of services.
  - The services are safe and not experimental and are recognized as an accepted modality of medical practice.
  - Where alternative medically accepted modes of treatment are available, the EPSDT Supplemental Services are the most cost effective. Molina Healthcare may determine the most cost-effective setting for services on a case by case basis. Where the determination of cost-effectiveness involves an assessment of services not covered by Molina Healthcare (i.e. home and community based waiver services or long-term care in a nursing facility), Molina Healthcare will coordinate the determination of cost-effectiveness with DHCS.
  - The services to be provided are generally recognized as an accepted modality of medical practice or treatment, are within the authorized scope of practice of the Provider/Practitioner, and are an appropriate mode of treatment for the medical condition of the beneficiary.
  - There is scientific evidence, consisting of well-designed and conducted investigations published in peer-reviewed journals, demonstrating that the service can produce measurable physiological alterations beneficial to health outcomes, or in the case of psychological or psychiatric services, measurable psychological outcomes concerning the short and long-term effects of the proposed services. Opinions and evaluations published by national medical organizations, consensus panels, and other technology-evaluation bodies supporting provision of the benefit will also be considered when available.
  - The predicted beneficial outcome of the service outweighs potential harmful effects.
  - The services improve the overall health outcomes as much as, or more than, established alternatives.

Examples of EPSDT Supplemental Services are cochlear implants, EPSDT case management services, and EPSDT Supplemental nursing services.

Prior authorization criteria developed by Molina Healthcare will be the same or not be more restrictive than the criteria for approval set forth in the Medi-Cal fee-for-service (FFS) program.

Service Specific Criteria

There are two (2) kinds of services, orthodontic and hearing, which have service specific requirements. For orthodontic dental services to be provided as EPSDT Supplemental Services:

- The services must be medically necessary for the treatment of handicapping malocclusion pursuant to the criteria set forth in the Medi-Cal "Manual of Criteria of Medi-Cal Authorization".
- The services must be medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions which meet the medical necessity criteria for either EPSDT diagnostic and treatment services or EPSDT supplemental services (Title 22, CCR, Sections 51340(e)(1) and (3)).

- Hearing aids and other hearing services are subject to the criteria for medical necessity applicable to services that are available to the general Medi-Cal population or the medical necessity criteria for other EPSDT Supplemental Services. One (1) package of six (6) hearing aid batteries in size 675, 13, 312, or 10A may be furnished on a quarterly basis without prior authorization. Batteries in different sizes or more frequent intervals may be requested through prior authorization.
- EPSDT Supplemental Services require prior authorization. Requests for prior authorization will be submitted to the Utilization Management (UM) Department at Molina Healthcare and will be evaluated under the direction of the Medical Director.

  When the standards set forth are not applicable to the services being requested, all of the following criteria, where applicable, will be reviewed:

- The services are necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions discovered by the screening services as defined in this policy.
- The supplies, items, or equipment to be provided are medical in nature.
- The services are not requested solely for the convenience of the member, family, PCP, or another Provider/Practitioner of services.
- The services are safe for the individual EPSDT-eligible beneficiary and are not experimental.
- The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the member's appearance. The correction of severe or disabling disfigurement will not be considered to be primarily cosmetic nor primarily for the purpose of improving the member's appearance.
- Where alternative medically accepted modes of treatment are available, the requested services are the most cost-effective
- The services to be provided:
  - Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed. Such acceptance will be demonstrated by scientific evidence, consisting of well-designed and well-conducted investigations published in peer-review journals, and, when available, by opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence will demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.
    - Are within the authorized scope of practice of the Provider/Practitioner and are an appropriate mode of treatment of the health condition of the member.

California Children's Services (CCS) Program for EPSTD Supplemental Services

When a member qualifies for services through CCS, Molina Healthcare will defer to CCS for EPSDT Supplemental Services to the extent the services are provided by the CCS Program.

Utilization Management Coordination

The Medical Case Manager will ensure the appropriate utilization of local government agencies and organizations, including RCs, which provide EPSDT Supplemental Services. The Medical Case Manager will follow-up with the member's PCP to ensure that referrals are made to the proper agencies and programs. If EPSDT Supplemental Services are not available to a local government agency or organization, the Medical Case Manager will issue letters of authorization and negotiated claims payment instructions to EPSDT Supplemental Services Provider/Practitioners, while continuing to provide case management services and updating the case management plan as necessary.

Medical Case Managers will ensure that members under age 21 years, who qualify for EPSDT Supplemental Services, will be referred to a EPSDT Supplemental Provider/Practitioner or to an entity, such as RCs, that provide EPSDT Supplemental Services. If EPSDT Utilization Management Services are rendered by these referred Providers/Practitioners, the Medical Case Manager of Molina Healthcare, along with the appropriate

Medical Director, will determine the medical necessity of diagnostic and medical treatment services. The Medical Case Manager for the involved plan is responsible for comprehensive case management services. If EPSDT Utilization Management Services are not available from these referral Providers/Practitioners, the appropriate health plan will arrange and pay for all appropriate EPSDT Supplemental Services.

EPSDT Supplemental Services Providers/Practitioner

Any contracting Molina Healthcare Provider/Practitioner, including a clinic, home health agency, medical equipment supplier, psychologist, speech therapist, or audiologist may provide EPSDT Supplemental Services subject to prior authorization through the Utilization Management/Authorization process. PCPs are to refer to a Molina Healthcare contracted Provider/Practitioner when possible.

- Provider/Practitioner will be credentialed by Molina Healthcare according to the credentialing and recredentialing process.
- Provider/Practitioner will be licensed or certified under state laws governing the healing arts to provide services.
- If licensure or certification is not available under state laws, the Provider/Practitioner will be otherwise authorized under state laws governing the healing arts to provide the service.
- Out-of-plan Providers/Practitioners will receive temporary privileges upon verification of licensure or certification, DEA status, and malpractice insurance as applicable.

Documentation

The member's medical record will reflect the following regarding EPSDT Case Management Services:

- Patient and family education regarding EPSDT Supplemental Services
- Referral to EPSDT Case Management Services as appropriate
- Reason for referral
- Patient/family reply to referral
- Subsequent care plan

Problem Resolution

Issues regarding responsibility for necessary EPSDT Supplemental Services will be resolved by Molina Healthcare. The appropriate Medical Case Manager will continue to coordinate and authorize all immediate health care needs of the member in collaboration with the PCP until resolution is obtained.

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM

The California Children Services (CCS) Program provides medically necessary care and case management to children who meet CCS eligible conditions and who meet program eligibility requirements. The care is delivered by Providers/Practitioners in local communities and tertiary medical centers who meet CCS standards. The program performs other functions that include assessing the qualifications of and selecting appropriate Providers/Practitioners and sites for care, case management, determining appropriateness of care plans, and authorizing funding for services. The program is administered at the County level through a local CCS office. The four (4) components of the program are as follows:

- Diagnosis and treatment
- Medical therapy
- High-risk infant follow-up
- Human Immunodeficiency Virus (HIV) children's screening program

The program's working hypothesis is that children with complex, disabling conditions receive improved care and achieve better long-term outcomes when services are provided and coordinated through special care centers. These special care centers work with multi-disciplinary and multi-specialty teams that plan and carry out comprehensive, coordinated care for groups of illnesses, generally based on a particular organ system.

Benefits

CCS services are not covered under Molina Healthcare; however, Primary Care Practitioners (PCPs) along with Molina Healthcare's Case Management Department will identify children with CCS eligible conditions and arrange for their referral to the local CCS office. The PCP will continue to collaborate in case management until the child's CCS eligibility is established. The PCP will then continue to provide primary care services unrelated to the CCS condition. The Molina Healthcare CCS Coordinator, in conjunction with the Molina Healthcare Utilization Management Department will ensure coordination between its PCPs, CCS Specialty Providers, and the local CCS Program. Once the case is identified as a CCS eligible condition, the Molina Healthcare CCS Case Manager will ensure that appropriate timely referrals are made to the applicable local CCS liaison within twenty four (24) hours. Any Provider/Practitioner, family member, or other interested party may make a referral to CCS.

Primary Care Practitioner Responsibilities

Molina Healthcare is responsible for performing all preliminary testing and examination to determine a member's diagnosis or condition and for sufficiently documenting the information to support the diagnosis in the member's medical record. In accordance with CCS eligibility criteria, potentially eligible members are referred by the PCP or specialist physician to the CCS program for comprehensive case management.

Molina Healthcare members enrolled in the CCS Program remain members of Molina Healthcare. PCPs continue to be responsible for:

- Maintaining a comprehensive medical record on the CCS eligible member.
- Referring potentially eligible members to the appropriate CCS panel Provider/Practitioner or Molina Healthcare CCS/Medical Case Manager.
- Providing overall primary case management for the member.
- Providing primary care and preventive care needs for non-related CCS conditions.

Case Managers coordinate with the PCP to provide all non-CCS related health care services. The secondary and tertiary care that is related to the member's CCS eligible condition is arranged and paid for by the CCS Program. Any care provided to a child enrolled in the CCS Program and related to the CCS condition must be prior authorized by the CCS Program, not Molina Healthcare.

Eligibility Criteria

Medical eligibility criteria for CCS is based on a combination of ICD9-CM categories and the presence of certain qualifying conditions. The following listing by ICD9-CM categories is a guide for participating Providers/Practitioners to identify potential CCS eligible conditions.

Who Qualifies for CCS?

The program is open to anyone who:

- Is under 21 years old;
- Has or is suspected of having a medical condition that is covered by CCS;
- Is a resident of California; and
- Has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form or whose out of pocket medical expenses for a child who qualifies are expected to be more than 20 percent of family income; or the child has Healthy Families coverage.

There are no financial eligibility requirements for children who:

- Need diagnostic services to confirm a CCS eligible condition ; or
- Are applying only for services through the Medical Therapy Program; or
- Have Medi-Cal full scope, no share of cost; or
- Have Healthy Families coverage; or
- Live on an Indian reservation.

What Medical Conditions Does CCS Cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. Listed below are categories of medical conditions that may be covered and some examples of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Diseases of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Diseases of the genitourinary system (serious chronic kidney problems)
- Diseases of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Diseases of the sense organs (hearing loss, glaucoma, cataracts)
- Diseases of the nervous system (cerebral palsy, uncontrolled seizures)
- Diseases of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions of poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care
- Diseases of the skin and subcutaneous tissue (severe hemangioma)

Special Programs

Several CCS programs are mandated for special segments of the county population and are described below. These are funded separately from the general CCS Program and have different policies and procedures to determine eligibility. The special therapy program usually operates within the public school context to provide long-term physical and occupational therapy.

Referrals to CCS

Referrals to CCS may be made by the PCP, other medical Providers/Practitioners, family members, or other community resources. Providers/Practitioners may refer the child directly to the CCS Program or to Molina Healthcare CCS/Medical Case Manager for referral to CCS. The Molina Healthcare CCS/Medical Case Manager will facilitate the CCS referral and assist the CCS liaison in gathering information as needed.

For those members that are directly referred to CCS, the CCS liaison is requested to notify Molina Healthcare CCS/Medical Case Manager within twenty four (24) hours in order to facilitate information gathering for the eligibility process.

If the member is currently an inpatient and not in the CCS Program, the health plan UM Nurse Reviewer will assess the case for eligibility. When a case meets criteria, the Molina Healthcare UM Nurse Reviewer will refer the case to the health plan CCS/Medical Case Manager for referral to the CCS Program. Referral for potential CCS eligible member may also be received directly to CCS through a non-Molina Healthcare facility staff member, such as the Social Worker, Case Manager, or Discharge Planner. When a CCS eligible member is received through a non-Molina Healthcare source, the CCS liaison will inform the health plan CCS/Medical Case Manager of the referral within twenty four (24) hours of the accepted referral.

The PCP may identify a CCS eligible condition during the initial health assessment. In this case, the PCP may directly refer the eligible member to the CCS Program, or may refer the case to the Molina Healthcare or affiliated health plans CCS/Medical Case Manager for referral to CCS.

A community agency with no contractual relationship with Molina Healthcare or its affiliated health plan may also identify a CCS eligible case and directly refer to CCS. In this case, the CCS liaison is required to notify Molina Healthcare's CCS/Medical Case Manager within twenty four (24) hours of the referral.

Molina Healthcare or affiliated health plan's CCS/Medical Case Manager will continue to review inpatient and outpatient cases for appropriateness of care and service; however, the CCS liaison will generate approvals from services directly related to CCS benefits. The Molina Healthcare CCS/Medical Case Manager will ensure communication between entities, including the PCP, Molina Healthcare, and CCS. Case Management services are not delegated to contracted groups or IPAs at this time.

Acceptance of any case for treatment is dependent upon factors relating to individual members, including:

- Prognosis
- Reasonable expectation of cure or restoration of useful function
- Availability of accepted forms of treatment
- Priority of need for medical care

Prior authorization for CCS services will be:

- Obtained directly by the PCP through the CCS Liaison, or
- Obtained by the Molina Healthcare CCS/Medical Case Manager at the request of the PCP.

CCS Application Form

Referrals to CCS must include medical documentation from the PCP or specialist. The referring Provider/Practitioner should also provide a CCS Application Form to the parent or guardian of a potentially eligible child and assist in the completion of the forms, if required. The Case Managers are also available to assist, as requested. It is strongly recommended that the CCS Application Form be completed to facilitate timely transition of care. Completion of the form is not required to receive services from CCS, but if the form is not filled out, the member may only receive Medi-Cal approved benefits and may lose his or her CCS eligibility if he or she loses Medi-Cal eligibility.

If the form is on file with CCS, CCS may provide services in addition to the Medi-Cal benefits and the member may continue to receive services through CCS even if he/she loses Medi-Cal eligibility. If the family does not agree to a CCS referral, the Case Manager, in conjunction with the Medical Director, will work with the PCP to develop a comprehensive case management plan to identify other available programs and services and to coordinate referrals. Documentation of the denial will be submitted to the CCS program.

CCS Application Processing

CCS eligible members will have case management services until their eligibility is established with the CCS Program. If the member is not accepted into the CCS Program, the case is referred back to the Plan's Medical Director for review. If the denial was appropriate, the referring Provider/Practitioner is notified, and the availability of other programs and services is explored. If the denial is deemed inappropriate, the Medical

Director attempts to resolve the conflict at the local level. If this is not possible, conflict resolution will take place involving the State CCS Regional Office.

Acceptance into CCS Program

If the member is accepted into the CCS Program, the referring Provider/Practitioner and the member's family receives a Notice of Action from the CCS Program. The Case Manager calls the CCS Program to confirm the member's acceptance into the program and make contact with the CCS Case Manager. The Molina Healthcare Case Manager will continue to receive regular status reports from the CCS Case Manager throughout the member's participation in the program. The member's PCP is also required to submit any additional requested medical records to assist in the development of the comprehensive case management plan.

OVERVIEW OF REFERRAL PROCESS

The CCS program is mandated to accept referrals for eligibility determination from any source. The following information must be provided on the standard referral form.

Date of Referral	Homes and Work Phone Numbers
Name of Patient	Diagnosis
Social Security Number (SSN)/Patient	Referring Practitioner/Agency
Date of Birth	Managed Care Plan (MCP)
Parent/Guardian Names	Medi-Cal Number
SSN of Parent/Guardian	Private Insurance Company or HMO
Home Address	Benefits or Services Requested

All relevant medical records must be submitted along with the referral. When this is not possible, the reports should be sent as soon as they are available.

NOTE: Managed Care Plans that directly refer patients to CCS should completely fill out the referral form and forward it along with **medical records that accurately and legibly document original findings by their Providers/Practitioners to their applicable county CCS office:**

Receipt of a referral by CCS will trigger the following steps:

Application

The family will be notified by CCS that a referral has been received and an application will be mailed to them for completion. This is not required unless the member will be participating in the Medical Therapy Unit Program. Financial eligibility is waived for Medi-Cal beneficiaries. Families who request assistance in completing their paperwork may schedule an appointment with the CCS office staff.

Program Eligibility

There are four (4) areas of eligibility that must be met in order to qualify for the CCS Program.

- **AGE:** The patient must be under 21 years of age
- **MEDICAL:** The patient must have a CCS eligible condition as documented in the medical reports
- **FINANCIAL:** Waived for Medi-Cal beneficiaries
- **RESIDENTIAL:** The patient resides in the applicable county (information for Medi-Cal beneficiaries will be based on the MEDS database)

The Medical Therapy Unit (MTU) is a **component of the CCS Program** that provides medically necessary physical and occupational therapy. The CCS therapy program works cooperatively with the State Department of Education. The family must complete the program application for this service.

The High-Risk Infant Follow-Up (HRIF) program is for "graduates" from a CCS approved neonatal intensive care unit that are at-risk of developing CCS eligible conditions.

If the medical documentation is insufficient, a letter will be sent to the Provider/Practitioner within five (5) days indicating the referral is in pending status. The fifteen (15) day time-frame begins again when the Provider/Practitioner responds to the CCS Status Report. **If the patient is not medically eligible, a Notice of Action** is sent to the Provider/Practitioner, the MCP, and the family when they have completed an application.

Enrollment/Program Agreement

If the patient is determined to be CCS eligible, a **Program Services Agreement must be signed by the patient, parent, or legal guardian** to indicate his/her enrollment in the CCS Program and agreement to abide by CCS policies and procedures. At this point, Medi-Cal beneficiaries are offered the full range of CCS benefits including those unique CCS benefits that are beyond the scope of the Medi-Cal program. This applies to Medical Therapy Unit (MTU) services only.

Authorizations

After CCS eligibility is confirmed, the patient may be directed to an appropriate CCS approved Special Care Center and/or CCS paneled Provider/Practitioner(s). **Authorizations** are sent by the CCS Program to Providers/Practitioners, with a copy to the MCP. This assures the Provider/Practitioner will be reimbursed on a fee-for-service basis for those specific services prior authorized by CCS. Reimbursement will be by either the Medi-Cal program for Medi-Cal benefits or by the CCS Program for unique CCS benefits. All authorizations are time-limited and are **for care related to the CCS eligible condition only.**

Emergency Referrals

Phone or FAX referrals for emergency hospital admissions must be sent to Molina Healthcare within twenty four (24) hours or if on a weekend or holiday by the next working day. A "face sheet" or admission/registration form is acceptable as long as the **admitting diagnosis and all secondary diagnoses are included.**

Guidelines for Making Referrals

The Managed Care Plan (MCP) is responsible for the provision of primary care services, including most diagnostic procedures. The CCS Program will require, at the time of referral, that sufficient medical documentation be submitted to provide the evidence or to support the opinion that a CCS eligible condition exists. For example, the following documentation should be submitted for patients considered having eligible conditions:

- **Asthma:** Chest X-ray report showing changes characteristic of chronic lung disease. Abnormal pulmonary function tests during symptom free interval and post bronchodilator treatment.
- **Cerebral Palsy:** Detailed medical reports documenting the findings from a complete physical and **neurological exam.**
- **Congenital Heart Disease:** If a heart murmur is detected on routine physical exam, the patient should be seen by a pediatrician to confirm the significance of the murmur. CCS will not cover the cost of the pediatrician's evaluation, but costs related to pediatric cardiology services **after a functional murmur has been ruled-out** are covered.
- **Growth Hormone Deficiency: Growth charts documenting height** of at least three (3) standard deviations below the mean for age or linear growth rate less than the 3rd percentile for age.
- **Hearing Loss:** Failure to pass at twenty five (25) decibels on **two (2) separate screening audiometric evaluations** performed two (2) to six (6) weeks apart. Alternatively, one (1), evaluation by a CCS paneled E.N.T. Provider/Practitioner or audiologist will suffice.
- **HIV Infection:** Infections that are symptomatic and/or being treated are eligible.
- **Lead Poisoning:** Single blood level of 20 ug/dl or greater if symptomatic. Otherwise, two (2) blood levels of 20 ug/dl or one, of 45 ug/dl or greater even if asymptomatic.

- **Malocclusion:** Patients without cleft palate or craniofacial anomalies who need orthodontic treatment should not be referred to CCS. Instead they should be referred to a Denti-Cal Provider/Practitioner for services.
- **Scoliosis:** X-ray reports showing a curvature of the spine **greater than twenty (20) degrees.**
- **Strabismus:** Determination by an ophthalmologist that **surgery is required** to correct the condition.

Outpatient Referrals

Outpatients should be referred to CCS with medical reports and/or lab results when the presence of a CCS eligible condition is documented. When the **diagnosis is unclear**, the MCP should authorize an initial evaluation by the appropriate specialist within its Provider/Practitioner network, indicating "rule out CCS condition" on the authorization. Ideally, the specialist should also be CCS paneled allowing for continuity of care if an eligible condition is identified. However, the diagnostic report does not have to be from a CCS Provider/Practitioner.

The Provider/Practitioner is responsible for referring patients to CCS **when a diagnosis is clearly eligible** per the previous example. A formal denial from the MCP is not needed before a Provider/Practitioner can refer the patient to CCS. If the primary care practitioner initiates the referral, a desired specialist may be indicated.

The Provider/Practitioner should indicate the specific CCS services being requested on the **Request for Prior Authorization of Services** form. In particular, he/she should note if the referral is only for the Medical Therapy Unit (MTU) or High-Risk Infant Follow-Up (HRIF).

MTU Referrals

Patients being referred for MTU services only (occupational or physical therapy) do not need to meet financial eligibility, but those with HMO coverage must obtain prescriptions from their private Providers/Practitioners. **A copy of the prescription** and relevant medical records relating to therapy should accompany the referral. It is recommended that these prescriptions and medical assessments be done by a CCS paneled orthopedist, psychiatrist, or neurologist.

Inpatient Referrals

Hospitals are responsible for making referrals on patients with CCS eligible conditions admitted to their institutions. In order to reduce inappropriate referrals, inquiries about CCS eligibility by Providers/Practitioners should be made as soon as possible after admission.

Hospitals should send or fax a copy of the admission History and Physical with referral and Discharge Summary as soon as available **even if the admission was prior authorized.** Authorizations for unexpected admissions will ordinarily be effective beginning the date that CCS receives notification. When the admission occurs on a weekend or holiday, CCS must be notified by the next working day. The same timeliness rules apply to requests for extending a previously authorized length of stay. Justification of continued hospitalization must accompany extension requests.

A list of CCS Approved Hospitals can be found on the DHCS website at:
http://www.dhcs.ca.gov/pcfh/cms/ccs/pdf/paneled/ahc.pdf

EARLY START PROGRAM

The California Early Intervention Services Act, known as Early Start, is designed for children with developmental delays and disabilities or those at high-risk for developmental disabilities who are under 3 years of age. The program mandates services for children under age 3, who:

- Have an established condition that will likely lead to developmental delay.
- Have symptoms of significant developmental delay.
- Have a health history with a combination of bio-medical risk factors that places them at risk for developmental disability.

The goal of the Early Start Program is to promote and facilitate early identification and access to service delivery for eligible infants and their families. Regional Centers (RCs) and Local Education Agencies (LEAs) are designated as the local agencies to receive referrals, evaluate eligibility, conduct assessments for special needs, prepare an Individualized Family Service Plan (IFSP), and manage coordination of delivery.

Identification of Condition

The PCP should identify infants and toddlers from birth to 36 months with a disability that continues, or can be expected to continue indefinitely, and that constitutes a substantial handicap. These conditions may include, but not be limited to:

- Mental Retardation
- Cerebral Palsy
- Epilepsy
- Autism

In addition, handicapping conditions found to be closely related to mental retardation may require treatment similar to that required for mentally retarded individuals but will not include other handicapping conditions that are solely physical in nature.

The RCs are responsible for all children with broad developmental delays and disabilities, while LEAs have complete responsibility for all children with solely visual, hearing, or severe orthopedic impairments or combinations thereof. LEA eligible beneficiaries are those people who are eligible for services under Title XIX of the Social Security Act and certified for Medi-Cal who is one of the following:

- Under age 22 and enrolled in a school within an LEA in California. Any person who becomes 22 years of age while participating in an Individualized Education Plan or Individualized Family Service Plan may continue his or her participation in the program for the remainder of that current school year; or
- A Medi-Cal eligible family member of a student meeting the requirements noted above.

Early Start Intervention Services, birth to 36 months, include all infants eligible under the California Early Intervention Services Act and include:

- Developmentally delayed in one (1) or more areas:
  - Communication
  - Physical and motor developmental, including vision and hearing
  - Cognitive development
  - Social and/or emotional development
  - Adaptive development
- Established risk conditions expected to result in developmental delay, including:
  - Chromosomal disorders

- Inborn errors of metabolism
- Neurological disorders
- Visual and hearing impairments
- At high-risk for developmental disability

This program offers services to children under age 3 who:

- Have an established condition leading to developmental disability
- Are suspected of having significant developmental delay
- Have health history with a combination of bio-medical risk factors that places them at risk for developmental disability

Referrals to Early Start Program

- The PCP is responsible for identifying infants and toddlers who are at risk or suspected of having a developmental disability or delay by providing appropriate screening and assessment measures.
- The PCP will provide and/or arrange for all medically necessary services including diagnosis, specialty or subspecialty consultation, and therapy services necessary to correct and/or ameliorate the identified conditions.
- The PCP will refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation within two (2) working days of determining the need for developmental services.
- Referrals will be directed to the intake screener of the RC. (NOTE: When referring to both CCS and RC, one (1) referral will not delay the other.) The Provider/Practitioner will route member information to the RC as soon as possible, as the RC may take up to forty five (45) days to respond. Information should include the following:
  - Reason for referral
  - Detailed medical information and a developmental health evaluation, documenting health status including vision and hearing
  - Medical history
  - Results of developmental or psychological screening/assessment if available
- Specialty referrals are conducted through the referral and authorization process of Molina Healthcare.
- Referrals to psychologists or psychiatrists for diagnosis and treatment of mental health disorders not within the scope of practice of the PCP, as defined by Molina Healthcare and Mental Health/Short Doyle.
- The PCP will provide for diagnostic tests and/or specialty consultation as necessary to determine the etiology of the developmental disability or delay.
- If the member is eligible for both CCS and RC, the first or primary referral will be to CCS if the diagnosis or treatment for the CCS eligible condition is the major concern.
- Molina Healthcare may notify CCS and the RC simultaneously if both medical and early intervention services are necessary.

The Primary Care Practitioner's (PCPs) Responsibilities

The PCP is responsible for:

- Identifying infants and toddlers who are at risk or suspected of having a developmental disability or delay and administering appropriate screening or assessment measures

- Providing all medically necessary services, including diagnosis, specialty or subspecialty referral, and indicated therapy
- Referring children identified as needing developmental intervention services to the local Early Start Program
- Participating or consulting with staff of the local RC or LEA in the development of the IFSP

The PCP will directly submit a written referral to the RC or referrals to the LEAs, which will be routed through the RC for approval. If requested by the PCP, the Case Management Department for either Molina Healthcare will assist with the referral process and coordination. The PCP will provide information as requested by the RC or LEA to assist in the referral process for example:

- Specific physical findings will include:
  - A comprehensive physical examination and assessment for congenital abnormalities and/or treatable medical conditions
  - A review of the mother's prenatal/perinatal course to identify bio-medical or environmental risk factors
  - Follow-up of newborn screening tests to assure normal values or initiate appropriate treatment
- Developmental screening:
  - Provide developmental and/or behavioral assessments
  - Detection of any sensory deficit
  - Detection of any early developmental problem of significant interest
- Primary preventive and pediatric care:
  - Periodic comprehensive physical examination
  - Anticipatory parental guidance - health education, injury prevention, etc.
  - Immunizations
  - Lead screening and hematocrit
  - Monitoring of nutrition status
- Diagnosis and, if possible, etiology:
  - Complete family history including prenatal course in genetics and genetic history
  - Comprehensive medical evaluation to determine underlying causes and any chromosome or metabolic tests performed
  - Referrals for special consultations

Referral Coordination with California Children Services

In situations where the member is eligible for both CCS and Early Start, the first or primary referral should be to CCS, if the diagnosis or treatment for the CCS eligible condition is the major concern. The PCP should notify CCS and the appropriate RC simultaneously when both medical and early intervention services are necessary.

Coordination of Care

Depending on plan affiliation, the Medical Case Manager and Medical Director are available to assist PCPs and families with the referral procedure to ensure their referral was completed successfully and services were activated. If a member was previously referred to or accepted into the Early Start Program, the Medical Case Manager assesses the case to determine if further case management services, including health education, are

needed. The Medical Case Manager also contacts the parent/guardian for approval to discuss the member's care with a RC. If the parent/guardian approves the involvement of the RC, the Case Manager coordinates an Individual Family Service Plan (IFSP) with the RC's Case Manager and the PCP. The IFSP must be completed within forty five (45) days. The RC's system is able to provide guidance and follow-up on referrals to specialists.

Once the referral has been made, the PCP and Medical Case Manager will:

- Provide/refer for medically necessary therapy and/or equipment.
- Continue with medical management.
- Consult with and provide appropriate reports to the Early Intervention Team.
- Assist the client and/or family in following the IFSP recommendation.

Transportation

Transportation may be provided by Molina Healthcare when an ambulance or special vehicle is needed.

Consent, Record Keeping, and Confidentiality

The member or parent/guardian of a minor will consent to any screening, assessment, or treatment. Results of any screening, assessment, or treatment will be recorded in the member's medical record.

- Documentation will be in compliance with Molina Healthcare Policy and Procedure, regarding Collection/Use/Confidentiality and Release of Primary Health Care Information.
- Findings, recommendations, and response to recommendations will be recorded by the Provider/Practitioner in the member's medical record.
- All information and results of the health assessment of each member will be confidential and will not be released without the informed consent of the member or parent/guardian.
- Appropriate governmental agencies will have access to records without consent of the member or responsible adult, i.e. DHCS, DMHC, DHHS, etc.

Problem Resolution

Unresolved questions and conflicts concerning Early Start program eligibility, diagnostic testing, treatment plan, and associated benefits should be directed to:

Molina Healthcare of California
Attn: Medical Case Manager
200 Oceangate, Suite 100
Long Beach, CA 90802
(888) 665-4621
Fax (562) 499-6149

Or
Manager, DDS Prevention and Children Services Branch
Department of Developmental Services
1600 Ninth Street, Room 360
Sacramento, CA 95814
(916) 654-2773

The Medical Case Manager and the Medical Director will coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is obtained. The Medical Case Manager will pursue resolution at both the county and state levels.

DEVELOPMENTAL DISABILITY SERVICE AND REGIONAL CENTER COORDINATION

The California Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with mental retardation, cerebral palsy, epilepsy, and autism. NOTE: The DDS Waiver Program is described in this manual in section 12, "Waiver Programs."

RCs are private, non-profit corporations under contract with the 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 incidents of developmental disabilities. Providers/Practitioners must provide eligible Medi-Cal members identified with, or suspected of having, developmental disabilities with all medically necessary and appropriate developmental screenings, primary preventive care, and diagnostic and treatment services. For members at risk of parenting a child with a developmental disability, Molina Healthcare provides genetic counseling and other prenatal genetic services.

Eligibility Determination

The PCP will complete an intake and assessment for members three (3) years and over with, or suspected to have, a developmental disability. Children and adults will receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This medical evaluation may include, but not be limited to:

- Prenatal/Perinatal
- Developmental
- Family history
- Metabolic and chromosomal studies
- Specialty consultation as indicated

The PCP will coordinate the developmental, psychological, and psychiatric assessment as appropriate. Referral to the appropriate fee-for-services Provider/Practitioner will be made through the County Mental Health, Short Doyle process when indicated.

Prior to receiving services from a RC, a member must be determined eligible under one (1) of the following categories:

- Developmental Disability

  "Developmental disability" means a disability that originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap. As defined by the Director of the DDS, in consultation with the Superintendent of Public Instruction, developmental disability includes mental retardation, cerebral palsy, epilepsy, and autism. This term also includes handicapping conditions found to be related closely to mental retardation or to required treatment similar to that required for mental retardation. It does not, however, include other handicapping conditions that are solely psychiatric disorders, solely learning disabilities, and/or, solely physical in nature.

- Persons at Risk

  Preventive services may be provided to any potential parent determined to be at high risk of parenting a child with a developmental disability and, at the request of the parent or guardian, to any infant at high risk of becoming developmentally disabled.

Referral Process

The PCP may refer members to the RC who are in need of non-medical, home, and community based services such as:

- Training in skills for daily living
- Acquisition of skills and behavior
- Family support
- Day habilitation
- Respite care
- Residential care or assisted living

Members having, or suspected of having, a developmental disability may be referred to the RC nearest the member's place of residence. Referrals from the PCP should be directed to the Intake Coordinator at the RC and will include the reason for referral, the complete medical history and physical examination report with appropriate developmental screens, the results of developmental assessment/psychological evaluation, and other diagnostic tests as indicated.

When Molina Healthcare and the Medical Director determine that a member is potentially eligible for a RC service, the Case Manager will contact the PCP or specialist to determine if the member and the family have been informed and have approved the referral or have been previously referred or accepted into a RC.

If a member was previously referred to or accepted into the RC, the Case Manager assesses each individual case to determine if further case management services are needed. If services are not required, Molina Healthcare contacts the parent/guardian for approval to discuss the member's case with the RC. At parent/guardian request, the Case Manager may coordinate the individual's Family Service Plan with the RC's Case Manager. If the member was not previously referred to or accepted into the RC, the Case Manager contacts the PCP and the family regarding assistance with the referral process. If requested, the Case Manager assists the family and Provider/Practitioner to complete the referral process.

Intake and Assessment

The RC must accept for evaluation an eligibility assessment of persons believed to have a developmental disability. The initial intake must be performed within fifteen (15) working days following a request for assistance. Assessments must be performed within one hundred twenty (120) working days, or within sixty (60) days if delay in initiating services were to seriously impact mental or physical development.

Determination of RC eligibility is the responsibility of the RC Interdisciplinary Team. As mandated by Title 17, chapter 3, subchapter 1, article 54001, the Interdisciplinary Team must include the Service Coordinator, a Provider/Practitioner, and a psychologist. The assessment process includes collection and review of available medical history, diagnostic data, the provision or procurement of necessary tests and evaluations, and a summary of developmental/intellectual and adaptive levels of functioning as well as service needs.

PCPs must assist the RCs in obtaining medical records, diagnostic tests, and specialty consultations, as needed, to aid in a complete diagnosis. If the member is not accepted into the RC, the Case Manager from Molina Healthcare or its affiliated health plan will confer with the referring Provider/Practitioner and the family and coordinate the referral for problem resolution.

Primary Care Practitioner's Responsibilities

PCPs will ensure the appropriate referral of children over thirty six (36) months and adults suspected of having disabilities to the appropriate local RC when requested by the individual and his/her parents, if a minor. The member's disability must manifest before he or she attains 18 years, show signs of continuing indefinitely, and constitute a substantial handicap. The PCP may request assistance from Molina Healthcare in making referrals. The PCP will be directed to the RC's Intake Coordinator and his/her referral will include the following information:

- Reason for referral.
- Complete medical history and physical examination report, including appropriate developmental screens.
- The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.

Referrals

Referral to the RC will be made by the PCP directly. At PCP's request, the Molina Healthcare Case Management Department will assist with the referral process. The referral will be made to the RC located nearest the member's place of residence. The RC service for various regions is included for your reference.

The PCP will complete an Intake and Assessment for members three (3) years or over having, or suspected of having, a developmental disability:

- Children and adults will receive a complete medical evaluation to confirm the diagnosis and to determine the genetic and/or non-genetic etiology. This evaluation should include, but need not be limited to:
  - Prenatal/perinatal
  - Developmental
  - Family history
  - Metabolic and Chromosomal Studies
  - Specialty Consultation as indicated
- The PCP will coordinate the developmental, psychological, and psychiatric assessment as appropriate. Referral to the appropriate fee-for-service Provider/Practitioner will be made through County Mental Health, Short Doyle process.
- The PCP will refer members to the RC who are in need of non-medical, home and community based services such as:
  - Training in skills for daily living
  - Acquisition of skills and behavior
  - Family support
  - Day habilitation
  - Respite Care
  - Residential care or assisted living
- The PCP will ensure the appropriate referral of children over thirty six (36) months and adults suspected of having disabilities to the appropriate local RC when requested by the individual, or his/her parents if a minor.
- The member's disability must manifest before he/she attains 18 years, show signs of continuing indefinitely, and constitute a substantial handicap.
- The referral will be made by the PCP to the RC located nearest the member's place of residence.
- RCs will review referrals to determine RC eligibility and consider the need for development programs or family support services which are not available from other generic or private information.
- The PCP will be directed to the RC's Intake Coordinator and his/her referral will include the following information:
  - Reason for referral.
  - Complete medical history and physical examination report, including appropriate developmental screens.
  - The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.

The RC will see the referral within fifteen (15) working days of receipt and the evaluation will be completed within one hundred twenty (120) calendar days thereafter. The RC is to notify the Molina Healthcare PCP within one hundred twenty (120) days after the referral of member's eligibility.

On-going services for persons with developmental disabilities include developmental screening with vision and hearing assessments and review of dental status at intervals specified in the CHDP for children under age 21.

Referral Coordination with California Children Services

In situations where the child is eligible for both California Children Services (CCS) and RC services, the first referral should be to CCS if diagnosis or treatment for CCS eligible conditions is the major concern. The Provider/Practitioner may wish to notify CCS and the appropriate RC simultaneously if both medical and early intervention services are necessary.

Regional Center Responsibilities

The RC will see the referral within fifteen (15) working days of receipt and the evaluation will be completed within one hundred twenty (120) calendar days thereafter. The RC is to notify the PCP within one hundred twenty (120) days after the referral of the member's eligibility.

RCs do not have the responsibility for the provision of direct medical or health care services, but do provide overall case management for their clients, assuring access to health, developmental, social, and educational services from birth throughout the life of individuals who have a developmental disability. This benefit includes diagnostic services, counseling, client and family support, including family respite, and access to intervention and rehabilitation programs. RC staff will, as part of service coordination, undertake the following activities:

- Assist the client and/or family in following the recommendations of the health plan.
- Provide the necessary non-medical work or supportive services required in the client's individual program plans that are not available under the Medi-Cal Scope of Benefits.
- Provide consultation and share staff expertise regarding treatment and care of persons with developmental disabilities.

Case Management

- Molina Healthcare will provide case management, i.e. coordinating services with primary care practitioners, specialists, and allied health professionals (including speech, occupation and physical therapists), procuring of durable and non-durable medical equipment (such as - but not limited to - suction, ventilators, nebulizers, wheelchairs, lifts, ostomy care, incontinent supplies), and securing in-home nursing services and EPSDT supplemental services, unless CCS assumes responsibility for the case.
- When needed medical sub-specialty services are not available within the network, the service will be provided out-of-network, with the continuity of care maintained.
- With the written consent of the member or parent/guardian of a minor, medical records will be routed to the RC when appropriate.
- Case Management will provide follow-up and coordination of the treatment plan between the Molina Healthcare PCP, any specialists, and the RC.

Case Management includes the following:

- For members 36 months to adults, providing or arranging for medically necessary diagnostic and treatment services necessary to correct and/or ameliorate conditions discovered in the screening process, in accordance with MMCD Policy Letter 97-03.
- Providing available medical documentation and reports, as requested, to the RC Case Manager.
- Providing or arranging for medically necessary therapies and durable medical equipment.

Transportation

Molina Healthcare will provide transportation when ambulance or special vehicle is needed to accommodate equipment. Assistance with arrangement for transportation will be available through the health plan Member Services Department.

Transportation will be provided when the care needed is of such nature that its continuity must be assured. The type of transportation will be determined by the need of the member.

Community Resources

The PCP will be responsible for referring children and adults having, or suspected of having, developmental disabilities to the RC. Community resources include, but are not be limited to:

- Training in skills for daily living (ADL)
- Acquisition of skills and behavior
- Family support
- Day habilitation
- Respite care
- Residential care or assisted living

Unresolved Questions and Conflicts

RC staff determines eligibility and provides case management services to their clients. Issues that arise between the RC and Molina Healthcare, or the PCP will be resolved by Molina Healthcare's Medical Director or the Medical Director of the affiliated health plan. During any problematic periods, a Case Manager and the PCP or specialty practitioner will continue to manage the medical case of the member. Medical Case Managers will maintain routine interaction with the RC and will share data regarding health care encounters and program enrollment figures.

Unresolved questions and conflicts between Molina Healthcare and the RC concerning program eligibility, diagnostic testing, treatment plan, and associated member benefits, should be referred to Molina Healthcare's Case Manager and to:

Manager, DDS Prevention and Children Services Branch
Department of Developmental Services
1600 Ninth Street, Room 310
Sacramento, CA 95814
Telephone: (916) 654-2773
or

Molina Healthcare of California
Attn: Medical Case Manager
200 Oceangate, Suite 100
Long Beach, CA 90802
Telephone: (888) 665-4621
Fax: (562) 499-6149

The Molina Healthcare Case Manager and Medical Director will coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is obtained. Included for your reference is the RCs Information Sheet and Roster.

CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES

Regional Centers

The Department of Developmental Services (DDS) is responsible for coordinating a wide array of services for California residents with developmental disabilities, infants at high-risk for developmental disabilities, and individuals at high risk for parenting a child with a disability. These services are, provided through a statewide system of twenty (20) locally based RCs.

The DDS contracts with the RCs to offer services in all fifty eight (58) California counties. Located throughout the state, the local RCs serve as the point of entry into the developmental mental disabilities service system including admissions to the developmental centers. The RCs provide intake and assessment services to determine client eligibility and service needs. RCs then work with other agencies and utilize "generic services" whenever possible to arrange purchase and provide services including the full range of early intervention services. Early intervention services that cannot be provided by other publicly funded agencies are generally purchased through contracts with service Providers/Practitioners that are "vendored" by a RC. Services vary among the RCs based on local needs and resources.

With the implementation of Part H and California's Early Start Program, MMCD letter 97-02, the RCs share primary responsibility with the Special Education Local Plan Areas (SELPAs) for the coordination and provision of early intervention services at the local level RCs and SELPAs are responsible for coordination with other agencies and organizations, as needed, in the evaluation/assessment process and in the development of Individualized Family Services Plans (IFSPs) for those children eligible for early intervention services. The local RC can provide specific information on the services available in your community.

The local RC can provide specific information on the services available in your community.

LOCAL REGIONAL CENTERS LIST

REGIONAL CENTERS	DIRECTORS	PHONE
Alta California 2135 Butano Drive Sacramento, CA 95825	Gary Blumenthal, Director	(916) 978-6400
Central Valley 4615 North Marty Avenue Fresno, CA 93722-4186	David Riester, Director	(559) 276-4300
East Bay 7677 Oakport Street, #300 Oakland, CA 94621	James M. Burton, Director	(510) 383-1200
Eastern Los Angeles 1000 South Fremont Alhambra, CA 91802-7916	Gloria Wong, Director	(626) 299-4700
Far Northern 1900 Churn Creek Road, #319 Redding, CA 96002	Laura Larson, Director	(530) 222-4791
Frank D. Lanterman 3303 Wilshire Blvd., #700 Los Angeles, CA 90010	Diane Campbell Anand, Director	(213) 383-1300
Golden Gate 120 Howard Street, Third Floor San Francisco, CA 94105	James Shorter, Director	(415) 546-9222
Harbor 21231 Hawthorne Blvd. Torrance, CA 90503	Patricia Del Monico, Director	(310) 540-1711
Inland 674 Brier Drive San Bernardino, CA 92408	Mary Lynn Clark, Director	(909) 890-3000
Kern 3200 North Sillect Avenue Bakersfield, CA 93308	Michal C. Clark, Ph.D., Director	(661) 327-8531
North Bay 10 Executive Court Napa, CA 94558	Nancy Gardner, Director	(707) 256-1100
North Los Angeles County 15400 Sherman Way, # 170 Van Nuys, CA 91406-4211	George Stevens, Director	(818) 778-1900
Orange County 801 Civic Center Drive West, #300 Santa Ana, CA 92701	William J. Bowman, Director	(714) 796-5100

REGIONAL CENTERS	DIRECTORS	PHONE
Redwood Coast 525 Second Street, #300 Eureka, CA 95501	Phil Bonnet, Director	(707) 445-0893
San Andreas 300 Orchard City Drive, #170 Campbell, CA 95008	Santi J. Rogers, Director	(408) 374-9960
San Diego 4355 Ruffin Road, #205 San Diego, CA 92123-1648	Raymond M. Peterson, M.D., Director	(858) 576-2932
South Central Los Angeles 650 West Adams Blvd., #200 Los Angeles, CA 90007-2545	Dexter Henderson, Director	(213) 744-7000
Tri-Counties 520 East Montecito Street Santa Barbara, CA 93103	Omar Noorzad, Director	(805) 962-7881
Valley Mountain 7109 Danny Drive Stockton, CA 95210	Richard W. Jacobs, Director	(209) 473-0951

Exhibits

VACCINES FOR CHILDREN (VFC) PROGRAM
PROVIDER ENROLLMENT FORM–PRIVATE SECTOR

PIN (6 digit)	
COUNTY	

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC		DATE	
ADDRESS (Number and Street)		CITY	ZIP CODE
CONTACT PERSON	MEDI-CAL/CHDP PROVIDER NUMBER	TELEPHONE ( )	FAX ( )
EMPLOYER IDENTIFICATION NUMBER	MEDICAL LICENSE NUMBER	E-MAIL ADDRESS	

To participate in the Vaccines for Children (VFC) Program and receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

1. I will screen patients and administer VFC Program-purchased vaccine only to a child who is 18 years of age or younger who qualifies under one or more of the following categories:
   a. Is an American Indian or Alaskan Native;
   b. Is eligible for California's Child Health and Disability Prevention (CHDP) Program or Medi-Cal Program; or
   c. Has no health insurance.

   Note: Children with private health insurance and Healthy Family subscribers are not eligible for VFC vaccines.
2. I will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in VFC resolutions.

   Note: The ACIP schedule is compatible with the AAP recommendations.
3. I will maintain a record of each VFC-enrolled child's required information on VFC eligibility screening for a period of three (3) years. Release of such records will be bound by the privacy protection of the federal Medicaid law.
4. If requested, I will make such records available to the State or the Department of Health and Human Services (DHHS).
5. I will permit visits to my facility by authorized representatives of the State or DHHS to review my compliance with VFC Program requirements including vaccine storage and record-keeping.
6. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the ACIP, unless:
   a. In my medical judgement, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or
   b. The particular requirement contradicts the law in my State pertaining to religious and other exemptions.

   Note:The ACIP schedule is compatible with the AAP recommendations.
7. I will distribute written vaccine information (e.g. Vaccine Information Statements [VISs]) and maintain records in accordance with the National Childhood Vaccine Injury Act.
8. I will not impose a charge for the cost of the vaccine.
9. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State. (The current maximum for the State of California is $17.55 per dose administered.)
10. I will not deny administration of a federally procured vaccine to a child because the child's parent or guardian or individual of record is unable to pay the administration fee.
11. I will comply with the State's requirements for ordering vaccine as outlined on VFC order forms, etc. (e.g., reporting via the order forms my previous VFC vaccine usage and my current inventory of VFC vaccine, ordering vaccine no more than once every two months-no more than six times per year, etc.)
12. I will be financially responsible for the replacement cost of any VFC-provided vaccines that I receive for which I cannot account or that spoil or expire because of negligence.
13. I understand the State may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.

    Note: I understand that if this agreement is terminated, I must return to the VFC Program all unused (viable and non-viable) VFC vaccine. I also will comply with the VFC Program's procedures for return of the vaccine.

PROVIDER OF RECORD	DATE

To be enrolled in and receive vaccines through the VFC Program (or to receive other federally procured vaccines), you must submit the white copy (original) of this form with an ORIGINAL signature to the following address. (Please retain the yellow copy for your records.) **FAXED COPIES OF THIS FORM WILL NOT BE ACCEPTED.**

Mail original copy to: VFC Program, State of California, Department of Health Services, Immunization Branch
2151 Berkeley Way, Rm. 712, Berkeley, CA 94704

State of California—Health and Human Services Agency | Department of Health Services

VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER PROFILE FORM – PRIVATE SECTOR

PIN (6 digit)

COUNTY

'S IS NOT A VACCINE ORDER FORM. However, this form will help the State determine the amount of vaccine it will supply to participants in the C Program. The State also may use the information to compare the estimated needs of providers for vaccine with actual vaccine orders submitted.

It is a federal requirement that each enrolled site to which VFC Program vaccines will be delivered must complete and submit this form with a VFC Program Profile-Supplemental Form (DHS 8499S) to the address below at least once a year to receive VFC-supplied vaccine. Each enrolled site also must submit a Provider Profile Form and Profile-Supplemental Form whenever (1) the estimated of eligible children to be served changes; (2) the status of the facility changes (e.g., a private provider becomes an agent of a federally qualified health center, etc.), or the persons with prescription-writing privileges changes. This form may be completed by one provider or the entire practice.

Please Print or Type. **Date:**

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.

IF THIS OFFICE, CLINIC, ETC., IS PART OF A LARGER CORPORATE ENTITY OR DEPARTMENT, THE NAME OF THAT ENTITY IS.

STATE USE ONLY
Parent PIN:

EMPLOYER IDENTIFICATION NUMBER | MEDICAL LICENSE NUMBER | CHDP PROVIDER: ☐ No ☐ Yes _____ Provider # | MEDI-CAL PROVIDER: ☐ No ☐ Yes _____ Provider # if different from CHDP

TYPE OF FACILITY (Please Check The One Box That Represents the Bulk of Your Practice)

☐ Private Practice ☐ Private Hospital ☐ Other Private Sector (Specify) _____

PLEASE INDICATE IF ANY OF THE FOLLOWING INFORMATION HAS CHANGED.

☐ Vaccine Delivery Information ☐ Mailing Information ☐ Telephone Number ☐ Fax Number ☐ Email Address ☐ Times and Days for Delivery

Vaccine Delivery Information	Mailing Information (If different from shipping information)
CONTACT PERSON:	CONTACT PERSON:
VACCINE DELIVERY ADDRESS (Number/Street–No P.O. Boxes):	MAILING ADDRESS:
CITY: ZIP:	CITY: ZIP:
TELEPHONE NUMBER: ( )	FAX NUMBER: ( )
	EMAIL ADRESS:

DAYS AND TIMES FOR DELIVERY (Specify ALL days and times during which you may receive vaccine deliveries)

☐ Tues (Times: _____) ☐ Wed (Times: _____) ☐ Thurs (Times: _____) ☐ Fri (Times: _____)

Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category.*	Ages (Note: Do not count a child in more than one category.) <1	1–6	7–18	TOTAL
1. CHDP/Medi-Cal Eligible				
2. Without Private Insurance				
3. American Indian or Alaskan Native				
SUBTOTAL (1+2+3)				
4. Not Eligible for VFC Program Vaccine (Include children with health insurance and Healthy Families Program subscribers)				
TOTAL (1+2+3+4)				

**Choose only one category for each child. If the child meets two or more of the eligibility qualifications, choose the first one that applies.*

TYPE OF DATA USED FOR ESTIMATES

☐ Doses Administered Reports ☐ CHDP/Medi-Cal Claim Data ☐ Other (Specify) _____

Please send the white copy (original) to this address: nd retain the yellow copy for your records.

Vaccines for Children (VFC) Program
State of California
Department of Health Services
Immunization Branch
2151 Berkeley Way, Room 712
Berkeley, CA 94704
(510) 704-3750

DHS 8499PR (12/06) IMM-376B

Exhibit 11D-2

State of California—Health and Human Services Agency

Department of Health Services

VACCINES FOR CHILDREN (VFC) PROGRAM VACCINE ORDER FORM

PIN (6 digit)

COUNTY

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.

DATE

CHDP MEDI-CAL PROVIDER ☐ Yes ☐ No

DELIVERY ADDRESS (Number and Street—No P.O. Boxes)

☐ CHECK HERE IF THIS IS A NEW ADDRESS.

CITY

ZIP CODE

DELIVERY: Please specify all days and times you may receive vaccine.

DAY AND TIME ☐ Tue. _____

DAY AND TIME ☐ Wed. _____

DAY AND TIME ☐ Thu. _____

DAY AND TIME ☐ Fri. _____

CONTACT PERSON

TELEPHONE

FAX

Vaccines[1] Write in the name of the manufacturer you prefer (if any) for DTaP, hepatitis A, hepatitis B, and Hib vaccines in the indicated spaces below.	YOU MUST COMPLETE ALL THE BOXES IN THE FOUR COLUMNS BELOW FOR VFC TO PROCESS YOUR ORDER. (EVEN IF YOU ARE ONLY ORDERING ONE VACCINE)					
	Number of Doses (VFC Only) Used Since Last Order Enter "0" if None	VACCINE INVENTORY			Vaccine Shipped in Vials of the Following Sizes	New Vaccine Order
		Number of Doses (VFC Only) On-Hand	Lot Number	Expiration Date		
REGULAR ORDER VFC VACCINES						
DTaP (Preferred Mfr.: _____)					10 or 15 doses	doses
Hepatitis A (Pediatric)[2] (Preferred Mfr.: _____)					5 or 10 doses	doses
Hepatitis B (Pediatric/Adolescent) (Preferred Mfr.: _____)					1 package (1 dose)	doses
Hepatitis B/Hib Combination					10 doses	doses
Hib (Preferred Mfr.: _____)					10 doses	doses
IPV (Inactivated Polio Vaccine)					10 doses	doses
MMR (Combined Measles, Mumps, and Rubella)					10 doses	doses
Pneumococcal Conjugate					5 doses	doses
Varicella (Chickenpox)[3]					10 doses	doses
SPECIAL ORDER VFC VACCINES (These vaccines are available only for special circumstances.)						
Hepatitis B (Adult) (only for adolescents 11–15 years of age)					10 doses	doses
Influenza (September–October ONLY; only for ACIP high risk categories)					10 doses	doses

IMPORTANT IF THE SPECIFIC VACCINE MANUFACTURERS I HAVE INDICATED ABOVE ARE NOT AVAILABLE:
☐ Send another manufacturer's vaccine. ☐ Send the manufacturer's vaccine I requested when it is available.

Notes:

1. Toxoids and vaccines not available through the VFC Program: DT-Pediatric and Td-Adult toxoids, DTP-Hib, DTaP-Hib, OPV, tetanus, pneumococcal polysaccharide, measles, MR (measles-rubella), mumps, and rubella vaccines, HBIG, and PPD.
2. Only for children between 2-18 years of age.
3. For all susceptible children born on or after January 1, 1983 who are at least 12 months of age and susceptible children 18 years of age or younger who live in a household with a person at high risk of serious complications from varicella (e.g., immunocompromised persons).

Instructions:

1. Please Print or Type.
2. You should order no more than once every two months (i.e., no more than six times per year) and place your order with sufficient stock on hand to allow at least 30 days for delivery. (It should not take 30 days to deliver vaccine, but this will prevent you from running out of vaccine if there is a delay in filling your order.)
3. You may mail or fax your order to the VFC Program. Please do not mail orders you FAX, or vice versa; otherwise you may receive a duplicate order. If you have any questions, call (510) 704-3750.

FAX orders to: (510) 843-0242
Mail orders to: VFC Program
State of California, Department of Health Services, Immunization Branch
2151 Berkeley Way, Room 712 • Berkeley, CA 94704

STATE USE ONLY		
ASSIGNED		
APPROVED		
ASSIGNED		
ENTERED		
SHIPPED		

DHS 8561 (7/00)

IMM-376C

Exhibit 11D-1

CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE

ELIGIBLE CONDITIONS	INELIGIBLE CONDITIONS
Adrenal disorders	
AIDS	
Ambiguous genitalia	Amblyopia
Anemia – dietary deficiency, if causes **life threatening complications**	Anemia – dietary deficiency, simple
Anemia, aplastic	
Anemia, hemolytic	Autism
Aneurysm	
Arthrogryposis	
Asthma, if **CLD** demonstrated by CXR or PFTs	
Biliary atresia	Behavioral disorders
Blindness, congenital or acquired	
Burns, 2nd & 3rd degree of face, ear, mouth, throat, genitals, perineum, major joints, hands, feet	Burns, minor
Burns, 3rd degree, >5% BSA, any age	
Burns, electrical	
Burns, other - specific criteria pg. 44	
Burns, w/inhalation injury, respiratory distress	
Cardiac dysrhythmias - requiring medical or surgical treatment	Cardiac dysrhythmias, no treatment required
Cataracts	
Cerebral hemorrhage	
Cerebral Palsy - specific criteria pg. 24	
Cholecystitis - if chronic & stones present	Chalazion
Cholelithiasis	
Cholesteatoma	
Chronic lung disease	
Chronic lung infections - abscess or bronchiectasis	
Chronic respiratory failure - ventilatory assistance	
Circulatory disorders, arterial, venous, lymphatic	
Cirrhosis	
Cleft lip & palate	
Club feet	
Congenital defects - **if amenable to cure, correction or amelioration** & disfigure or cause dysfunction	
Congenital heart defects - if treatment required	
Craniosynostosis	
Crohn's disease	
Cryptorchidism - if bilateral (undescended testicles)	Cryptorchidism - unilateral
Cystic Fibrosis	
Dacrocystitis - chronic	

CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE

Diabetes Mellitus	Developmental delay
Disseminated Intravascular Coagulation - DIC	Down's syndrome
Diverticulitis	
Epidermolysis bullosa	
Eye infections that may lead to blindness	
Femoral anteversion, if requires **more than** special shoes, splints, simple bracing	Femoral anteversion, if requires **only** special shoes, splints , simple bracing
Flat feet, if requires **more than** special shoes, splints, simple bracing	Flat feet, if requires **only** special shoes, splints , simple bracing
Foreign bodies - requiring surgery, could result in death or permanent dysfunction	Failure to thrive
Fracture, all bones (***except mandible and nose)***, if ORIF needed, joints or growth plates involved **or** requires CR w/percutaneous pinning through a growth plate or joint	
Fracture, femur **- no additional qualifiers**	Fracture, mandible - simple
Fracture, orbital blow-out	Fracture, nasal bones - simple
Fracture, pelvis - **no additional qualifiers**	Fracture, mid-shaft, casting only
Fracture, skull - if CNS complications, disfiguring	
Fracture, spine - **no additional qualifiers**	
Gastroschisis	
GE reflux – if part of or complicates an eligible condition or is isolated w/complications like esophageal stricture or chronic aspiration pneumonia	GE reflux - simple, primary
Glaucoma	
Glomerulonephritis, acute – in presence of acute renal failure, malignant hypertension, or CHF	
Glomerulonephritis, chronic	
Growth Hormone Deficiency – growth chart must show a height of >3 standard deviations below mean for age **or** a linear growth rate <the 3rd percentile for age	
Hearing Loss - specific criteria pg. 30	
Hearing loss risk factors or symptoms. CCS may open for diagnostic services leading to confirmation of condition	
Heart diseases, chronic	
Hemophilia	
Hernia, diaphragmatic	Hernia: umbilical, inguinal, Hydrocele
Hirschsprung's Disease	
HIV +	
Hydrocephalus	
Hydronephrosis, chronic	
Hydronephrosis, congenital	
Hypertension - primary, requires treatment	

CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE

Hypospadius	
Idiopathic Thrombocytopenic Purpura (ITP)	
Immune deficiency disorders, congenital or acquired	
Immunization reactions, severe - require extensive care	
Imperforate anus	
Inborn errors of metabolism	
Ingestion of drugs, poisons - accidental, life threatening	Ingestion of drugs, self-inflicted
Intervetebral disc herniation	
Joint infections, acute or chronic	
Juvenile Rheumatoid Arthritis	
Kawasaki disease, if cardiac involvement	
Knock knees, genu valgum, , if requires **more than** special shoes, splints, simple bracing	Knock knees - genu valgum, if requires **only** special shoes, splints , simple bracing
Kyphosis	
Lead poisoning - blood level 20 mcg or above	Learning disabilities
Leg length discrepancy	
Legg-Calve-Perthes disease	
Liver failure, acute or chronic	
Lymphedema - chronic	
Malabsorption syndromes	Meningitis - acute
Malocclusion, handicapping – subject to CCS screening	Mental retardation
Mastoiditis	
Microtia	Microcephaly
Multiple Sclerosis	Migraine headaches
Muscular Dystrophy	
Myasthenia Gravis	
Necrotizing enterocolitis (NEC)	
Neoplasms - all malignant, including blood & lymph systems	
Neoplasms, benign – if causes significant disability, dysfunction or visible deformity	
Nephritis, chronic	
Nephrotic syndrome, chronic	
Neurofibromatosis	
Omphalocele	Obesity, Exogenous
Optic atrophy, hypoplasia or neuritis	Orthodontia, routine
Osteochondroma	Otitis media, acute
Osteochondrosis	
Osteogenesis Imperfecta	
Osteomyelitis	
Otosclerosis	
Ovarian dysfuction	

CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE

Pancreatic disorders	
Pancreatitis - if chronic	
Paraplegia	
Parathryroid disorders	
Pemphigus erythematous, foliaceus, vegetans, vulgaris	
Peptic ulcer	
Perforated TM requiring tympanoplasty	
Phenylketonuria - PKU	
Pigeon toes - talipes varus, if requires **more than** special shoes, splints, simple bracing	Pigeon toes - talipes varus, requires **only** special shoes, splints , simple bracing
Pituitary disorders	
Pneumonia, aspiration – secondary to CCS condition	Pneumonia, acute
Poliomyelitis	Psychiatric illness
Poliomyelitis	Pyloric stenosis
Polycythemia	
Polydactyly, complex	
Precocious or delayed puberty	
Ptosis of eye lid	
Quadriplegia	
Renal calculus	
Respiratory infections- chronic, if causes significant disability & respiratory obstruction or complicates the management of a CCS eligible condition	Respiratory infections, acute, upper
Retinal detachment	
Retinopathy of prematurity	
Scars – involving joint & are disabling or disfiguring	
Scleroderma	
Scoliosis - 20 degree defect, X-ray only needed	Scoliosis - less than 20 degree
Seizure Disorders - specific criteria, pg. 24	Self-inflicted injuries, trauma
Sequelae of CNS infection if - e.g., motor or sensory deficit after meningitis	
Sickle Cell Anemia	
Skin diseases – persistent or progressive	
Slipped Capital Femoral Epiphysis	
Snake bite, poisonous - require complex care, life threatening	
Spider bite, poisonous - require complex care, life threatening	
Spina Bifida	
Strabismus if surgery is required	
Subarachnoid hemorrhage	
Syndactyly, complex	

CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE

Systemic Lupus Erythematosus	
Testicular dysfunction	
Thrombocytopenia	
Thromboembolism	
Thymus disorders	
Thyroid disorders	
Tibial torsion, , if requires **more than** special shoes, splints, simple bracing	Tibial torsion, , if requires **only** special shoes, splints, simple bracing
Tracheoesophageal fistula	
Ulcerative colitis	
Uropathies, obstructive - fistulas, strictures, adhesions, stones	
Vesiculoureteral reflux - grade II or greater	Visual deficits requiring glasses only

REGIONAL CENTER ELIGIBILITY CRITERIA

A high risk infant may be accepted for prevention services following a regional center assessment by clinicians who are experienced in the biomedical and social causes of developmental disabilities and appropriate early intervention services for high risk infants. Consultation is requested from other clinicians and agencies serving the high risk infant in order to assure comprehensive assessment.

The presence of a single risk factor, in and of itself, may not establish a child's eligibility. The regional center assessment team will determine eligibility with consideration of the combination and severity of the following clinical factors:

FACTOR	EARLY START	HEALTH DEPT. - PROGRAM	EARLY START OR HEALTH DEPT.
A. Biological			
1. Prematurity (less than 32 weeks)			X
2. Birth weight (1500-1251 gms)		X	
3. Birth weight (1250-1000 gms)			X
4. Birth weight (less than 1000 gms)	X		
5. Small for gestational age (SGA), failure to thrive (FTT)		X	
6. Prolonged hypoxemia	X		
7. Metabolic problem		X	
8. Hyperbili (More than 20 mg/dl)		X	
9. Seizure Activity	X		
10. Serious bio-medical insult: 10a. CNS Bleeds - Grade III & IV	X		
10b. CNS Bleeds - Grade I & II		X	
10c. Respiratory Distress Syndrome (RDS)			X
10d. Sequelae of CMS, Syphilis, Rubella, Herpes			X
10e. Other confirmed infections			X
10f. PFS - Pulmon. hypertension			X
11. Hx of maternal chemical exposure and/or substance abuse eg., alcohol, hydantoin, warfarin		X	
12. Mutiple congenital anomalies			X
13. Necrotizing Enterocolitis (NEC)		X	

FACTOR	EARLY START	HEALTH DEPT. PROGRAM	EARLY START OR HEALTH DEPT.
B. Psychosocial			
1. Persistent feeding problems			X
2. Tonal problems	X		
3. Continue evidence of delay in one or more developmental areas	X		
4. Multiple birth		X	
C. Environmental Factors			
1. Poor parent/infant attachment		X	
2. Family hx of suspected child abuse or other domestic violence		X	
3. Mother with medical or mental condition of a nature to require supervision & support to fulfill parental responsibilities, excluding mental retardation		X	
4. If in opinion of interdiciplinary team the infant is considered to be a high risk of becoming developmentally disabled			X
5. Mother with mental retardation	X		

MOLINA

PEDIATRIC HISTORY FORM

AGE: BIRTH TO 5 YEARS

— PRENATAL CARE (To be filled out by mother) —

1. Did you have regular visits with a doctor during the pregnancy?
   ☐ Yes ☐ No

2. Check any problems you had during the pregnancy:
   ☐ No Problems ☐ High Blood Presure ☐ Diabetes ☐ Infection Treated in the Hospital

— DELIVERY —

3. The Delivery was:
   ☐ Full Term (2 weeks before or after due date)
   ☐ Premature

4. Labor:
   ☐ Started by Itself
   ☐ Had to be Induced

5. The Delivery was:
   ☐ Vaginal ☐ By Cesarean Section
   ☐ Needed Help with Vacuum or Forceps

— AFTER BIRTH —

6. Did the baby go home with you?
   ☐ Yes ☐ No

7. Complications the baby had in the hospital: (Check all that apply)
   ☐ Sepsis (Serious infection)
   ☐ Respiratory Distress (Trouble breathing causing extra days in the hospital)
   ☐ Jaundice (Yellow skin causing extra days in the hospital)
   ☐ Other - Specify _____

8. Medicines your child takes regularly?
   ☐ None ☐ Yes (List below)
   _____
   _____
   _____
   _____

9. Medicines your child takes occasionally?
   ☐ None ☐ Yes (List below)
   _____
   _____
   _____
   _____

10. Medicines your child cannot take?
    ☐ None ☐ Yes (List below which ones and the reason)
    _____ Why? _____
    _____ Why? _____
    _____ Why? _____
    _____ Why? _____

11. Has your child ever had the following? (Please check all that apply)
    ☐ Chicken Pox
    ☐ Measles
    ☐ Mumps
    ☐ Seizures
    ☐ Burns
    ☐ Broken Bones
    ☐ More Than 3 Ear Infections in 1 Year
    ☐ Asthma
    ☐ Heart murmur
    ☐ No, my child has had none of the above.

12. Has your child been hospitalized for the following? (Please check all that apply)
    ☐ Surgery . . . If so, what kind? ☐ Tubes in ears ☐ Hernia
    ☐ Other _____
    ☐ Blood Transfusion
    ☐ Kidney Infection/Bladder Infection
    ☐ Cancer . . . . If so, what kind? _____

— FAMILY HISTORY —

13. Does anybody in your child's family have, or ever had any of the following?
    ☐ Asthma . . . . . If so, who? _____
    ☐ Crib Death (SIDS) . . . If so, who? _____
    ☐ Deafness at Birth . . . . If so, who? _____
    ☐ Diabetes . . . . . If so, who? _____
    ☐ Heart Problems . . . . . If so, who? _____
    ☐ TB . . . . . If so, who? _____
    ☐ Cancer . . . . . If so, who? _____
    What kind? _____

— COMMENTS —

14. Please tell us anything else that you want us to know about your child:
    _____
    _____
    _____
    _____

PROVIDER'S COMMENTS:

REVIEWED BY:

DATE:

MOLINA MEDICAL CENTERS
Form 1304 (PedHist 0-5: Rev. 10-95)

Exhibit 11 A

VACCINES FOR CHILDREN (VFC) PROGRAM
PROVIDER PROFILE FORM—SUPPLEMENTAL

PIN (6-digit)

COUNTY

OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.

DATE

ADDRESS (Number and Street)

CITY

ZIP CODE

CONTACT PERSON

EMAIL ADDRESS

TELEPHONE ( )

FAX ( )

LAST NAME, FIRST, MI	MEDICAID PROVIDER NUMBER (i.e., CHDP or Medi-Cal number)	MEDICAL LICENSE NUMBER	TITLE (e.g., MD, DO, NP, PA. Provider must have prescription writing privileges)	SPECIALITY (e.g., Peds, Family Med, GP, Other [Specify])
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

uctions: You must use this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-pro-ved vaccines. (You may use additional copies of this form to list additional providers.) Submit this form with the VFC Provider Profile Form.

Note: It is not necessary to include the names of all staff who may administer VFC vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.

SECTION 12: WAIVER PROGRAMS

DEVELOPMENTAL DISABILITIES SERVICES WAIVER

The Developmental Disabilities Services (DDS) administered Home and Community Based Services (HCBS) waiver program was established to meet the medical needs of developmentally disabled Medi-Cal recipients age 36 months to adults. DDS includes members with a disability that originates before the member attains 18 years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. DDS and Molina Healthcare coordinate the medical management of chronically ill, developmentally disabled Medi-Cal members, including those with catastrophic illnesses, technologically dependent and/or risk of life threatening incidences, who, but for the provision of such services, would reside in an intermediate care facility for the developmentally disabled.

DDS HCBS Waiver Program

Regional Centers (RCs) oversee the DDS administered HCBS waiver program. There are four (4) types of care settings in the HCBS waiver program:

- Member's home where specialized services may be delivered
- Local intermediate care facility licensed as an ICS/DD
- Local habilitative developmental-disability care facility licensed as a DDH
- Local nursing developmental-care facility licensed as a DDN

The RC Inter-Disciplinary Team is responsible for determining the HCBS waiver setting most appropriate for the eligible member. Although the RCs provide overall case management, they are not responsible for the direct medical services. During the member's participation in the DDS administered waiver program, Molina Healthcare will continue to provide all primary care and other medically necessary services.

Eligibility

Molina Healthcare Case Management staff will monitor and review all inpatient stays to determine appropriate utilization and to identify members who may potentially benefit from a DDS HCBS waiver. Case Managers will also work to ensure that potentially eligible members are referred in a timely manner. Included for your reference is the DHCS assigned waiver criteria.

Referrals to HCBS

When a Case Manager is notified of a member with a potential need for supportive care, the Case Manager will initiate a request for the medical record from the member's Primary Care Practitioner (PCP). Upon receipt of the member's medical records, the Case Manager and the Medical Director will review the records to determine if there is a need for supportive care. If supportive care is not needed, no referral is made and the member or family is notified.

If supportive care is deemed necessary, a case conference will be conducted with the member and/or family, PCP, specialist, ancillary Providers/Practitioners, and Molina Healthcare Case Manager. The Molina Healthcare Case Manager is responsible for coordinating with the RC Case Manager and the PCP.

Referral and Coordination of Services

Once a member is deemed eligible for the DDS administered HCBS program, a RC Case Manager is assigned to coordinate waiver services. The receiving of DDS administered HCBS services does not warrant or require a member's disenrollment from the Plan.

PCP's Responsibilities

The PCP's primary responsibility is to refer members, transmit medical records, and develop a plan of treatment. The PCP, along with the Case Manager as necessary, is still required to provide and coordinate care.

The Case Manager is responsible for coordinating with the RC Case Manager and the PCP in the development of the member's individual services plan/individual education plan.

If the member is receiving services through DDS, the Case Manager assists in coordinating care with the PCP and RC. If the member is not receiving services through DDS, the Case Manager conducts an analysis of the cost-effectiveness of in-home services versus institutional services:

- If the member's condition meet criteria for the waiver program, the Case Manager makes an appropriate referral to DDS at:

  Department of Developmental Services
  Department of Health Care Services
  1600 9th Street
  P.O. Box 944202
  Sacramento, CA 94244-2020
  (916) 654-1690

- If the member does not meet the criteria for the waiver program, or if placement is not available, Molina Healthcare will continue to case manage and provide all medically necessary services to the member

Problem Resolution

RC's staff determines eligibility and is responsible for the overall case management of the member. In the event that Molina Healthcare is in disagreement with the RC's decision and/or recommendation concerning the provision of waiver services, the Case Manager will be responsible for problem resolution. The Case Manager will continue to coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is reached.

WAIVER PROGRAMS - DEVELOPMENTAL DISABILITIES

DDS HCBS Waiver Participants

Administered by the Department of Developmental Services

- A recipient may only receive waiver services from the DDS HCBS
- A recipient may receive Medi-Cal benefits if "medically necessary"
- A recipient may receive Supplemental EPSDT benefits
- A recipient of waiver services must meet the criteria for participation in the waiver program AND meet the criteria for medical necessity
- The determinations of eligibility for participation in the DDS HCBS waiver are made by the RC
- The determinations of necessity of services are made by the RC Interdisciplinary Team using their person-centered planning process
- If the member has a qualifying condition or diagnosis under the Developmental Disabilities Program for the Waiver Programs and the member is over age 21, the Molina Healthcare Case Management Department will evaluate eligibility for other programs
- Children with diagnosis of developmental delay are not eligible for the DDS HCBS waiver
- Children at risk of developing a developmental disability are not eligible for the DDS HCBS waiver
- The member must be a consumer of the RC and the RC will be contacted to provide oversight
- The member must meet the admission requirements for an ICF/DD, ICF/DD-H, or ICF/DD-N facility and require some medical care and active treatment
- The member must be a Medi-Cal beneficiary

Institutional DDS HCBS Waiver Participants

- The member must meet all criteria for DDS HCBS waiver program
- The member must have been determined eligible for DDS HCBS waiver services
- The member must receive a referral from the RC to the County for Medi-Cal fiscal eligibility determination using institutional rules
- The member must receive at least one (1) DDS HCBS waiver service at all times in order to maintain Medi-Cal eligibility

AIDS WAIVER PROGRAM

The AIDS Waiver Program is designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

Eligibility

To qualify for enrollment in the AIDS Waiver Program, members with Acquired Immune Deficiency Syndrome (AIDS) or symptomatic Human Immunodeficiency Virus (HIV) disease must meet the following criteria:

- Be Medi-Cal eligible
- Require nursing facility (NF) level of care or above
- Score sixty (60) or less on the Kamofsky Scale
- Have exhausted other coverage for health care benefits similar to those available under the AIDS waiver prior to utilization of AIDS waiver services
- Have a safe home setting

For children, waiver agencies must choose the Centers for Disease Control and Prevention "Classification System for Human Immunodeficiency Virus Infection in Children Under 13 Years of Age." Children must be classified as "P2" under the CVC classification to be eligible for the waiver program.

The PCP, with assistance from the Case Management staff, as requested, will inform eligible members about the availability of the AIDS Waiver Program. At the request of a member, the PCP will provide the Waiver Agency with appropriate medical documentation including:

- History and physical
- Relevant lab results
- Therapeutic regime

Information and documentation will be submitted for acceptance to:

Office of AIDS, California Department of Public Health (CDPH)
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426
(916) 449-5900
(916) 449-5909

Case Management and Coordination Process

Once Molina Healthcare Case Management Staff is notified of a member with a potential need for supportive care, staff requests medical records from the member's PCP. Case Management Staff, with the PCP, meets with the member and caregivers to discuss AIDS Waiver Program availability:

- If the member is eligible for and requests program referral, the type of supportive care needed is identified and a referral is initiated by the Case Manager

- If the member is determined to be ineligible or declines program referral, the Case Manager initiates case management as necessary

The Case Manager coordinates the transfer of the case management plan and/or any pertinent information to the AIDS Waiver Program representative. Financial limitations of the program are provided on a yearly basis per patient per calendar year. The carve-out of AIDS medications is included for your reference.

Problem Resolution

Resolution of problems or conflicts between the HIV/AIDS provider/practitioner and Office of AIDS can be addressed to:

Molina Healthcare of California
Medical Director
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196

or

Office of AIDS, California Department of Public Health
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426
(916) 449-5900
(916) 449-5909 - fax

EXCLUDED DRUGS: BILL MEDI-CAL FEE-FOR-SERVICE DIRECTLY

The Department of Health Care Services through the Medi-Cal Fee-For-Service (FFS) program has assumed financial responsibility of select anti-psychotics and HIV/AIDS medications. The following drugs should be billed to Fee-For-Service Medi-Cal, using standard Electronic Data Systems (EDS) prior authorization and billing procedures. **Molina Healthcare pharmacies will not be able to bill Molina Healthcare directly for any of these drugs. Should they attempt to do so, the pharmacy computer systems have been programmed to reject the claim and display the message "Bill Medi-Cal Fee–For-Service."** Pharmacies should already be aware of this procedure. Should they have any further questions, they can always call the Molina Healthcare Pharmacy Desk at (800) 526-8196, ext. 127854.

PSYCHIATRIC DRUGS (Listed by generic name)		
Acamprosate Calcium	Haloperidol Decanoate	Procyclidine HCL
Amantadine HCL	Haloperidol Lactate	Promazine HCL
Aripiprazole	Isocarboxazid	Quetiapine
Benztropine Mesylate	Lithium Carbonate	Risperidone
Biperiden HCL	Lithium Citrate	Selegiline
Biperiden Lactate	Loxapine HCL	Thioridazine HCL
Buprenorphine HCI	Loxapine Succinate	Thiothixene
Buprenorphine/Naloxone HCI	Mesoridazine Mesylate	Thiothixene HCL
Chlorpromazine HCL	Molindone HCL	Tranylcypromine Sulfate
Chlorprothixene	Naltrexone (oral and injectable)	Trifluroperazine HCL
Clozapine	Olanzapine/ Olanzapinefluoxetine	Triflupromazine HCL
Fluphenazine Decanoate	Paliperidone	Trihexyphenidyl HCL
Fluphenazine Enanthate	Perphenazine	Ziprasidone
Fluphenazine HCL	Phenelzine Sulfate	
Haloperidol	Pimozide	

HIV DRUGS (Listed by generic name)		
Abacavir/Lamivudine	Enfuvirtide (Fuzion)	Raltegravir Potassium
Abacavir Sulfate (Ziagen)	Etravirine	Ritonavir (Norvir)
Amprenavir (Agenerase)	Fosamprenavir Calcium (Lexiva)	Saquinavir (Invirase, Fortovase)
Atazanavir (Reyataz)	Indinavir Sulfate (Crixivan)	Stavudine (Zerit)
Darunavir Ethanolate	Lamivudine (Epivir)	Tenofovir Disoproxil Fumarate (Viread)
Delavirdine Mesylate (Rescriptor)	Lopinavir/Ritonavir (Kaletra)	Tenofovir Disoproxil-Emtricitabine
Efavirenz (Sustiva)	Maraviroc	Tenofovir Disoproxil
Efavirenz/Emtricitabine/Tenofovir	Nelfinavir Mesylate (Viracept)	Zidovudine/Lamivudine
Emtricitabine (Emtriva)	Nevirapine (Viramune)	Zidovudine/Lamivudine/ Abacabir Sulfate

Detoxification/Dependency Treatments (Listed by generic name)	
Acamprosate Calcium	Buprenorphine HCI
Buprenorphine/Nalaxone HCI	Naltrexone (oral and injectable)

HOME AND COMMUNITY-BASED SERVICES WAIVER (HCBS)

The Home and Community Based Services (HCBS) are designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

The medical management of chronically ill members, including members with catastrophic illnesses, technologically dependant and/or risk of life threatening incidences; require close coordination between Molina Healthcare, its subcontracted Providers/Practitioners, and the In-Home Operations (IHO) administered HCBS waiver program. The primary goal is to ensure that the medical needs of members who are physically, and possibly mentally, disabled are met appropriately and safely in a home environment.

- In-Home Medical Care (IHMC) Waiver - The IHMC Waiver is designed for Medi-Cal recipients who, in the absence of the waiver, would be expected to require at least ninety (90) days of acute hospital care before beginning IHMC Waiver services
- Skilled Nursing Facility (SNF) - The SNF Waiver is designed for persons who are physically disabled or aged at the NF Level B SNF level of care and who are inpatients of an NF Level B, or whose admission to an NF Level B is imminent

Referral and Coordination Process

Molina Healthcare's Utilization Management Staff will monitor and review all in-patient stays to determine appropriate utilization and to identify members who may potentially benefit from an HCBS waiver. The Utilization Management Staff will review the potentially eligible member's medical needs and prognosis for ongoing care with the PCP and Inpatient Facility Discharge Planner/Case Manager.

The PCP will inform the member, guardian, or authorized representative about the availability of in-home care alternatives. Such education will be documented in the member's medical record. On consent of the member, guardian, or authorized representative, the Utilization Management Staff will coordinate with the Inpatient Facility Discharge Planner/Case Manager to refer the member to a licensed and Medi-Cal certified Home Health Agency for evaluation.

The Home Health Agency Multi-Disciplinary Team will evaluate the member's health care needs and the appropriateness of the member's home and health environment. In coordination with the hospital staff, Molina Healthcare's Case Manager will request a team conference. Attendees will include the member and/or family caregivers, PCP and/or attending Provider/Practitioner, Inpatient Facility Discharge Planner, Case Manager, and the Home Health Agency Case Manager. The purpose of this conference is to assess the feasibility of in-home care, to recommend the appropriate services necessary to meet the health care needs of the member and to predict a potential start date for in-home care.

Authorization

The Home Health Agency will prepare all necessary Letters of Agreement and the Treatment Authorization Request (TAR). Home Health Agencies are encouraged to identify the waiver recipient by highlighting "waiver recipient" in the Provider/Practitioner address section of the TAR. The Home Health Agency will submit the appropriate information to the following:

For programs administered by In-Home Operations, including Nursing Facilities Waiver and In-Home Medi-Cal Waiver, appropriate information should be submitted to:

Senior and Adult
In-Home Supportive Services
4875 Broadway
Sacramento, CA 95820
(916) 874-9471
(916) 874-9682 - fax

If the agency administering the waiver program concurs with Molina Healthcare's assessment of the member and there is available placement in the waiver program, the member will receive waiver services while still being enrolled with Molina Healthcare. Molina Healthcare shall continue to provide all medically necessary covered services to the member.

Problem Resolution

In the event of a disagreement with the Authorizing Unit decision and/or recommendations concerning the provision of waiver services, the Case Manager will be responsible for initiating the problem resolution process.

The Authorizing Unit Staff determines eligibility and the Home Health Agency Case Manager is responsible for the overall case management of the member. If prior to disenrollment from Molina Healthcare, a participating Provider/Practitioner disagrees with an Authorizing Unit's decision regarding eligibility or the Home Health Agency's Case Manager's service provisions, all medical records and correspondences will be forwarded to the Molina Healthcare Medical Director at:

Molina Healthcare of California
Attn: Medical Director
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196
Fax: (562) 499-6173

The Molina Healthcare Case Management/Utilization Review Department will continue to coordinate with the Molina Healthcare Medical Director to authorize all immediate health care needs for the member in collaboration with the PCP until resolution is obtained. The Authorizing Unit Staff will forward issues to Molina Healthcare's Medical Director for resolution at the County and State level.

NURSING FACILITY WAIVER PROGRAM

Criteria for Nursing Facility (NF) Waiver Program

Administered by In-Home Operations

- The beneficiary for whom in-home medical care waiver services are requested would otherwise require care in an inpatient acute care hospital for at least ninety (90) consecutive days
- The total cost incurred by the Medi-Cal program in providing in-home medical care waiver services and other medically necessary Medi-Cal services to the beneficiary is less than the total cost incurred by the Medi-Cal program in providing all medically necessary services to the beneficiary in an inpatient acute care hospital
- Case Management services that are provided by a licensed Registered Nurse (RN) consist of ongoing inpatient assessment, evaluation, routine case recording, and preparation of reports to PCP and Medi-Cal regional offices
- Nursing care is provided by a certified individual supervised by an RN or Licensed Vocational Nurse (LVN)

- Those physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual or to enable the recipient to function with greater independence in the home and without which the recipient would require institutionalization. The service is a one (1) time event as required by the recipient's plan of care
- Care consists of duties identified by the Board of Registered Nursing to be performed by RNs only, as defined in Title 22, C.C.R., Section 51067
- Care provided by a licensed individual as defined under Title 22, C.C.R., Section 51069
- A Personal Emergency Response System (PERS) is an electronic device which enables individuals at high-risk of institutionalization to secure help in the event of an emergency
- Family training is provided by a licensed RN for the families of individuals served under this waiver. Training includes instruction about treatment regimens and use of equipment specified in the plan of care and will include updates as necessary to safely maintain the individual at home
- Physical Therapy services will include evaluation, treatment planning, treatment, instruction, consultation services, and treatment of any bodily condition by the use of physical, chemical, and other properties of heat, light, water, electricity or sound, and by massage and active, resistive, or passive exercise. Single procedure to one (1) resistive, or passive exercise. Single procedure to one (1) area - initial thirty (30) minutes
- Occupational Therapy - services prescribed by a Provider/Practitioner to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness, or advanced age. Occupational Therapy services will include evaluation, treatment planning, instruction, and consultation services. Treatment - initial thirty (30) minutes with additional treatment of fifteen (15) minutes each
- Speech Therapy services - speech language therapy per one-half (1/2) hour
- Audiology services are services for the purpose of identification, measurement, appraisal, and counseling related to hearing and disorders of hearing, the modification of communicative disorders resulting from hearing loss affecting speech, language and audiological behavior, and the recommendation and evaluation of hearing aids. Hearing Therapy per one-half (1/2) hour
- Family Therapy is a service in which appropriate assessments are made by a qualified counselor to the recipient, as well as group and family counseling with the recipient, with regard to the psychological adjustment to home and community-based care. One (1) and one-half (1/2) hours maximum
- Utility services directly attributable to the operation of life-sustaining medical equipment in the recipient's place of residence to prevent re-institutionalization of waiver recipients who are dependent upon medical technology for survival in or out of an institution. Utility coverage must be included in the plan of care
- Shared nursing services provided to two (2) or more recipients by a licensed RN, in accordance with the plan of care
- Shared nursing services to two (2) or more recipients by a licensed LVN under the direction of an RN, in accordance with the plan of care
- Shared nursing services provided to two (2) or more recipients by a licensed Home Health Aide under the direction of an RN in accordance with the plan of care
- Unspecified waiver services to be used for unlisted NF waiver services
- Members do not need to disenroll from Molina Healthcare while they are enrolled in the Nursing Facility/Acute Hospital Waiver (NF/AH Waiver) Program.

Criteria for Pediatric Sub-Acute

- Tracheostomy care with continuous mechanical ventilation for a minimum of six (6) hours each day
- Tracheostomy care with suctioning and room air or oxygen as needed and one (1) of the six (6) treatment procedures listed below
- Administration of any three (3) of the six (6) treatment procedures listed below

Treatment Procedures

- Total parenteral nutrition
- Inpatient physical, occupational, and/or speech therapy, at least two (2) hours per day, five (5) days per week
- Tube feeding (nasogastric or gastrostomy)
- Inhalation therapy treatments every shift at a minimum of four (4) times per twenty four (24) hour period
- IV therapy involving:
  - The continuous administration of a therapeutic agent
  - The need for hydration
  - Frequent intermittent IV drug administration via a peripheral and/or central line
- Dependence on peritoneal dialysis treatments requiring at least four (4) exchanges every twenty four (24) hours

ADULT SUB-ACUTE

Criteria is based on: Milliman and Robertson: Alternative Setting Criteria.

IN-HOME MEDICAL WAIVER

Criteria for In-Home Medical Waiver

Administered by the In-Home Operations

- The attending Provider/Practitioner and Medical Director or designee has determined that the patient requires the acute level of care
- The attending Provider/Practitioner takes total responsibility for the care of the patient
- The patient's condition is chronic and requires long-term care. The patient is relatively stabilized so as to make in-home care safe and feasible
- The home setting is medically appropriate as determined by the Medical Director or designee
- A supportive home and/or community environment makes home placement possible
- The cost of home and community-based care is less than the cost of acute care for the individual and is the least costly care available and is appropriate for the individual

MULTI-DISCIPLINARY SENIOR SERVICES PROGRAM WAIVER

The Multi-disciplinary Senior Services Program (MSSP) assists frail, elderly members, sixty five (65) years and over and at-risk of nursing home placement, to remain safely in their homes.

Referral and Coordination Process

Molina Healthcare Utilization Management staff monitors and reviews members to determine appropriate utilization of services and to identify members who may potentially benefit from the MSSP waiver program. It is the responsibility of the health plan to ensure that potentially eligible members are referred to the MSSP waiver program in a timely manner.

The health plan's Utilization Management staff and PCP shall work with the MSSP Waiver Case Management Team to coordinate appropriate services.

Once the Case Manager is notified of a member with a potential need for support or care, he/she initiates the request for medical records from the member's PCP. If MSSP care is not indicated, no referral is made and the member and/or family member is notified by the Case Manager and the PCP continues to case manage. If MSSP care is indicated, a case conference shall be conducted with the member and/or family, PCP, specialist, ancillary Provider/Practitioners, and Case Manager. The case conference is coordinated by the MSSP Case Management Team.

Case Management Process

If the member is determined to be eligible for program referral to the MSSP, the Molina Healthcare or affiliated subcontracted plan Case Manager shall actively participate in the MSSP Case Management Team to develop a comprehensive case management plan.

The Case Manager will assist the MSSP team to ensure timely, effective, and efficiently coordinated services to meet the member's care plan goals.

The MSSP staff shall prepare all necessary Letters of Agreement and the TAR and shall submit appropriate information to:

Department of Aging
Department of Health Care Services
1600 K Street
Sacramento, CA 95814
(916) 419-7500

Department of Health Care Services
In-Home Operations Section
Sacramento: (916) 552-9105
Los Angeles: (213) 897-6774

Department of Health Care Services
In-Home Operations Intake Unit
(916) 552-9105
(916) 552-9151 - fax

Problems and Resolutions

In the event that there is a disagreement with the MSSP decision and/or recommendations concerning the provision of waiver services, Molina Healthcare Case Management staff will be responsible for problem resolution. Problem resolution will be coordinated through the Department of Aging, the DHCS, as listed above, and in collaboration with the Molina Healthcare Medical Director.

SECTION 13: ADDITIONAL SERVICES OR CARVE-OUT SERVICES

ADULT DAY HEALTH CARE CENTERS (ADHCC)

Licensed Adult Day Health Care Centers (ADHCC) provide health and social services as an alternative to institutionalization and a safe and therapeutic environment for adult Molina Healthcare members with eligible conditions.

ADHCC is an excluded contract service; however, the member remains enrolled in Molina Healthcare and the Primary Care Practitioner (PCP) continues to be responsible for providing medically necessary care. ADHCC include nursing and therapeutic care for the member who may have a physical or mental impairment that handicaps daily activities but who does not require institutionalization.

Eligibility

Members that have physical or mental impairments, occurring after age 18, that adversely affect the performance of daily activities, may be eligible for ADHCC. Sample diagnoses which may be eligible for ADHCC include, but are not limited to:

- Disorders which cause dementia such as Alzheimer's or multi-infarct disease, cerebral vascular conditions such as strokes or aneurysms, degenerative diseases that cause both physical and cognitive impairment, brain injury due to trauma or infection, brain tumors, Human Immunodeficiency Virus (HIV) related dementia, diabetes, hypertension, ulcers, cardiovascular disease or cerebral vascular disease

Referral

Referrals to ADHCCs may be made as a self-referral or by the PCP. Coordination may be done by a multi-disciplinary team approach by the ADHCC with the PCP and the appropriate health plan Utilization/Case Management Department prior to acceptance to the center. Referral process includes the following:

- Member is referred to the Adult Day Health Care Center
- The ADHCC obtains medical history, current status, and recommendations for service from the PCP.
- The ADHCC multi-disciplinary team, including the Registered Nurse, social worker, and therapist conduct the initial assessment.
- Using the initial assessment and physical information, the multi-disciplinary team prepares the individual plan of care.
- After discussion with and approval of the Molina Healthcare member, the individual plan of care is submitted to the Medi-Cal Field Office for approval.

Once accepted to an ADHCC, the ADHCC multi-disciplinary team will develop a treatment plan for the member approved by the PCP.

Although the ADHCCs are not a covered benefit, the member will remain enrolled in Molina Healthcare and the PCP will continue to be responsible for providing medically necessary care for those members.

Caregiver Resource Centers

- Serving as a state wide resource consultant

  Family Caregiver Alliance
  (800) 445-8106

PCP's Responsibility

The PCP is responsible for:

- Identifying the members specific care needs
- Informing the members of their eligibility for these services
- Referring appropriately
- Requesting appropriate case management for services when indicated
- Rendering appropriate medical care and/or referral follow-up for medical problems identified by Providers/Practitioners
- Participating in the multi-disciplinary team coordinated by the ADHCC

The PCP is responsible for conferring with the appropriate California Caregiver Resource Center and assisting the family and caregivers in accessing the appropriate service Providers/Practitioners. When a referral is made to an ADHCC, the PCP will include an approved plan of medical treatment and other pertinent medical information. This is completed when requested by the ADHCC.

Training and Education

- The Molina Healthcare Provider Services Department will provide education to Providers/ Practitioners regarding ADHCC. Please contact the Provider Services Department at (888) 665-4621 if you require additional information regarding Adult Day Health Care Services.
- Providers/Practitioners may also access the Molina Healthcare Health Education Department at (800) 526-8196, ext. 127532 to receive additional information.
- Providers/Practitioners may contact Molina Healthcare's Utilization/Case Management Department for clarification of excluded benefits.
- Members are informed of their rights to access these services through the Evidence of Coverage (EOC) which is distributed to all members at the time of enrollment and annually thereafter.

Plan Responsibility

Molina Healthcare is responsible for:

- Education of Molina Healthcare Providers/Practitioners and Providers/Practitioner's staff of member eligibility for excluded services.
- Case Management services as identified for coordination of services.
- Oversight for appropriateness through the Quality Improvement Audit process.

ADHCC's Responsibilities

- The referred ADHCC is responsible for submitting a treatment authorization request and the individual plan of care to the State's Medi-Cal Field Office for approval.
- ADHCC will follow requirements as defined in Title 22, CCR, Section 54001 and 78000, et al.
- Each ADHCC will be licensed to provide Adult Day Health Care services.
- Each ADHCC will have an appropriate licensed allied health professional to provide services in accordance with Title 22.
- The ADHCC will be responsible for providing a multi-disciplinary team to meet the needs of the members.

Problem Resolution

If a problem should arise between Molina Healthcare and the ADHCC regarding mutual responsibilities, the health plan Medical Case Manager will be notified of the problem. All medical records and correspondence will be forwarded to the Molina Healthcare Medical Case Management Department at:

Molina Healthcare of California
Medical Case Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
(888) 665-4621
Fax: (888) 273-1735

The Medical Case Manager will:

- Issue related written correspondence to the appropriate ADHCC and the Medi-Cal Field Office
- Investigate the issue of conflict
- Refer to the appropriate Medical Director for review
- Report review determinations to the ADHCC and the Medi-Cal Field Office
- Communicate issues and determinations to the PCP and other involved parties

ALCOHOL AND DRUG TREATMENT SERVICES

Drug Medi-Cal (D/MC), also referred to as Short-Doyle Medi-Cal (SD/MC), alcohol and drug treatment services are excluded from Molina Healthcare's Medi-Cal Drug and Alcohol coverage responsibility under the Two-Plan Model Contract. Services are available under the SD/MC programs and through Heroin Detoxification Treatment Services. These services are provided through county operated SD/MC programs, or through direct contracting between the State Department of Alcohol and Drug Programs and community-based Providers/Practitioners.

Molina Healthcare and subcontracted Providers/Practitioners coordinate referrals for members requiring specialty and inpatient clinical dependency/substance abuse treatment and services. Members receiving services under the SD/MC Program remain enrolled in Molina Healthcare. Contracted PCPs are responsible for maintaining continuity of care for the member.

Alcohol and Drug Treatment Services

The alcohol and drug treatment services covered by the SD/MC programs include, but are not limited to:

- Outpatient methadone maintenance services
- Outpatient drug-free treatment services
- Daycare habilitative services
- Perinatal residential substance abuse services
- Naltrexone treatment services for opiate addiction

Members receiving alcohol and drug treatment services through the SD/MC program remain enrolled in Molina Healthcare.

Referral Documentation

PCPs are responsible for performing all preliminary testing and procedures necessary to determine an appropriate diagnosis. Referrals to SD/MC and/or Fee-For-Service Medi-Cal (FFS/MC) Program should include the appropriate medical records supporting the diagnosis and the required demographic information. After eligibility is approved by the County FFS/MC and/or SD/MC Program, the member's PCP will submit the requested medical record to assist in the development of a comprehensive treatment plan.

A final decision on the acceptance of a member for FFS/MC and/or SD/MC services rests solely with the County Alcohol and Drug Program.

Criteria for Referral for Alcohol and/or Drug Treatment Services

The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective 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. Various screening tools are included in this Manual to assist the PCP in the detection of substance abuse.

Referral Process

- The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health, and request for such services from either the member or the member's family
- Once the determination has been made to refer the member for alcohol and drug treatment services to a Short-Doyle (SD) Provider/Practitioner or a Fee-For-Service (FFS) Provider/Practitioner, the PCP may make the referral directly or may refer the member to Molina Healthcare or its affiliated health plan Medical Case Manager for the coordination of services and follow-up
- According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will conduct an authorization and review process to determine the appropriate level of care for the member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care and frequency of service
- When appropriate, the health plan Medical Case Manager coordinates with the Molina Healthcare Member Services Department &/or Health Education Department to meet a member's cultural and linguistic needs.
- Providers/Practitioners seeking guidance in the provision of services to members with specific cultural needs are referred to the Health Education Department and the department will offer assistance
- Daycare Habilitative Services are reimbursable only if they are provided for pregnant or postpartum members and for Early and Periodic Screening, Diagnosis and Treatment-eligible Medi-Cal members
- SD/MC services within the five (5) treatment modalities referenced may be provided to a member and billed to the SD/MC program. No other additional treatment services may be authorized and paid within the SD/MC payment system

PCP's Responsibilities

- PCPs are responsible to act as the primary care practitioner for the member and to make referrals to medical specialists, as necessary
- The PCP is responsible for performing all preliminary testing and procedures necessary to determine diagnosis. Should the member require specialty service, the PCP will refer the member to the appropriate SD/MC alcohol and drug Provider/Practitioner
- The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition prompting the referral
- The PCP will assure that appropriate documentation is in the member's medical record.
- The PCP will screen and thoroughly assess the member for additional conditions that may directly or indirectly impact the treatment or care of the member
- PCPs are responsible for coordinating care and services for non SD/MC related conditions, which may include problems and unmet health care needs directly and indirectly related to or affected by the member's addiction and lifestyle. This assessment may include medical conditions such as Acquired

Immune Deficiency Syndrome (AIDS)/HIV, cirrhosis, tuberculosis, abscesses, sexually transmitted diseases, infections, lack of necessary immunizations, and/or poor nutrition. This assessment may also include psychiatric disorders such as depression, bipolar disorder, and other anti-social personality disorders that contribute to repeating the cycle of addiction and substance abuse

Criteria for Inpatient Detoxification

A member will be considered a candidate for referral for acute inpatient detoxification if signs and symptoms are present that suggest the failure to use this level of treatment would be life threatening or cause permanent impairment once substance abuse is stopped. A member must have all of the following criteria for inpatient detoxification:

- Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions.
- Twenty-four (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.

The member must exhibit at least two (2) or more of the following symptoms for substance withdrawal:

- Tachycardia
- Hypertension
- Diaphoresis
- Significant increase or decrease in psychomotor activity
- Tremors
- Significantly disturbed sleep patterns
- Nausea/vomiting
- Clouding of consciousness with reduced capacity to shift, focus, and sustain attention

Additionally, criteria for inpatient alcohol detoxification is based on the anticipated severity of the withdrawal as deemed by application of the Revised Clinical Institute Withdrawal Assessment for Alcohol Scale. These tools should be applied as follows:

POINTS ON SCALE	SEVERITY OF WITHDRAWAL	TREATMENT
0 - 5	No withdrawal	Outpatient
6 - 9	Mild withdrawal	Outpatient
10 - 14	Mild-to-moderate withdrawal	Outpatient treatment possible for stable, compliant patients with no medical or psychiatric complications and no concurrent abuse of other classes drugs. One (1) day of CHB could be authorized for observation with subsequent assignment either to DCI or outpatient treatment based on reapplication of CIWA-Ar.
15 - 19	Moderate-to-severe withdrawal	Hospitalize for detox. Review CIWA-Ar after three (3) days for re-determination.
15 with threatened delirium tremens or score of 20+	Severe withdrawal	Hospitalize for detox. Review CIWA-Ar after three (3) days for re-determination.

Once the determination and authorization has been made to refer the member for alcohol and drug treatment services to a SD Provider/Practitioner or a FFS Provider/Practitioner, the PCP may make the referral directly, or may refer the member to the Molina Healthcare Case Manager for the coordination of services and follow-up. According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will review the case to determine the appropriate level of care for the member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care, and frequency of service.

Criteria for Admission to a Residential Facility for Treatment of Substance Abuse

A member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence that meets the current Diagnostic and Statistical Manual (DSM) criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities.
- The member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met.
- There is clearly documented evidence of the failure of appropriate partial hospitalization or structured outpatient treatment for substance abuse or dependence meeting the current DSM criteria.
- The member's environment or living situation is severely dysfunctional as a result of inadequate or unstable support systems, including the work environment, which may jeopardize successful treatment on an outpatient basis.
- 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 code-morbid disorder.

Criteria for Admission to a Partial Hospital Program for Treatment of Substance Abuse

A member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence, that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities.
- The member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met.
- The member requires up to eight (8) hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group or family therapy, education, and/or medical supervision.
- The member's environment or 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 and treatment in this care setting.
- The member has demonstrated, or there is reason to believe, that the member can avoid the abuse 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 Admission to a Structured Outpatient Program for Treatment of Substance Abuse

A Member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence, that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities.

- The member requires up to four (4) hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group, or family therapy, education, and/or medical supervision.
- The member's environment or 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 the member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment and pattern use.

Criteria for Inpatient Chemical Dependency Rehabilitation

A member will be considered a candidate for referral when a combination of the following conditions have been met:

- There is evidence of a substance dependence disorder as described in the DSMIV
- There is evidence of an inability to maintain abstinence outside of a controlled environment
- There is evidence of impairment in social, family, medical, and/or occupational functioning that necessitates skilled observation and care
- There is evidence of need for isolation from the substance of choice and from destructive home influences
- The member has sufficient mental capacities to comprehend and respond to the content of the treatment program

Continuity of Care

Providers/Practitioners should provide services in a manner that ensures coordinated and continuous care to all members requiring alcohol and/or drug treatment services including:

- Appropriate and timely referral
- Documenting referral services in the member's medical record
- Monitoring members with ongoing substance abuse
- Documenting emergent and urgent encounters, with appropriate follow-up, coordinated discharge planning, and post-discharge care in the member's medical record

Upon request, Molina Healthcare Case Management staff will assist in the identification of cases that require coordination of social and health care services.

In the event that the local SD/MC treatment slots are unavailable, the PCP and Molina Healthcare's Case Management's staff will pursue placement in out-of-network services until the time in-network services become available.

To assure continuity of care when a member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the member's medical record to the substance abuse Provider/Practitioner or program and, if appropriate, to the organization where future care will be rendered. Any transfer of member medical records and/or other pertinent information will be done in a manner consistent with confidentiality standards, including a release of medical records signed by the member.

Clinical needs and availability of follow-up care will be documented in the member's medical record. It is recommended that the member should be in contact with the follow-up therapist or agency prior to discharge from an inpatient facility or outpatient program.

It is expected that members discharged from a substance abuse inpatient unit will have their follow-up care arranged by the facility's discharge coordinator. Molina Healthcare recommends that the initial outpatient follow-up appointment occur no later than thirty (30) days after discharge. In addition, the facility discharge coordinator is responsible for notifying the PCP of the member's impending discharge.

Confidentiality

- Confidential member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Confidential member information may be learned by a staff member, in either a casual or formal setting, including conversation, computer screen data, faxes, or any written form, all of which will be treated with strict confidence.
- Molina Healthcare and affiliated health plan employees and contracting Providers/Practitioners and their staffs are expected to respect each member's right of confidentially and to treat the member information in a respectful, professional, and confidential manner consistent with all applicable federal and state requirements. Discussion of member information will be limited to that which is necessary to perform the duties of the job.
- Applicable Molina Healthcare policies and procedures include Collection/Confidentiality and Release of Primary Health Care Information and Safeguarding and Protecting Departmental Records.

Problem Resolution

If a disagreement occurs between Molina Healthcare and the County Office of Alcohol and Drug Programs regarding responsibilities, the Utilization Management Department is notified of the problem. All medical records and correspondence should be forwarded to Molina Healthcare at:

Molina Healthcare of California
Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196
Fax: (562) 901-9330

The Utilization Management Department will:

- Review medical records for issue of discrepancy and discuss with the MHC's Medical Director
- Discuss with the State or County Mental Health Department Office of Alcohol and Drug Programs the discrepancy of authorization and the MHC Clinical Review
- Report Molina Healthcare's review determination to the County Mental Health Department Office of Alcohol and Drug Programs
- Communicate State or County determinations to the PCP, Molina Healthcare Medical Director, and other involved parties

References/Exhibits

Included for your reference are the following:

- Red Flags for alcohol/drug abuse
- Questions to ask patients
- Drug use questionnaire (DAST-20)
- TACE
- "TWEAK" test

- Audit, The Alcohol Use Disorders Identification test
- Withdrawal assessment tool for alcohol

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 drug use

QUESTIONS TO ASK PATIENTS

1. Have you ever felt you should ***Cut Down*** on drinking or drug use? **C**
2. Have people ***Annoyed*** you by criticizing or complaining about your drinking or drug use? **A**
3. Have you ever felt bad or ***Guilty*** about your drinking or drug use? **G**
4. Have you ever had a drink or drug in the morning ***(Eye Opener)*** to steady your nerves or to get rid of a hangover? **E**
5. Do you use any drugs other than those prescribed by a practitioner?
6. Has a practitioner ever told you to cut down or quit use of 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)?

DRUG USE QUESTIONNAIRE (DAST - 20)

These questions refer to the past 12 months

		Circle Your Response	
1.	Have you ever used drugs other than 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 drug use?	Yes	No
11.	Have you neglected your family because of your drug use?	Yes	No
12.	Have you been in trouble at work because of drug use?	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 experienced withdrawal symptoms (felt sick) when you stop taking drugs?	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

T - ACE

(T = tolerance A = annoyed C = cut down E = eye-opener)

The T-Ace questions take approximately one (1) 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 two (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)**?

"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 question, check box at the 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 about things you said or did while you were drinking 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.

AUDIT - THE ALCOHOL USE DISORDERS IDENTIFICATION TEST

This audit was developed by the World Health Organization to identify persons whose alcohol consumption has become hazardous or harmful to their health. Persons at high-risk include medical patients, accident victims, suicidal persons, drunk driving offenders and armed forces personnel. Screening with AUDIT can be conducted in a variety of health settings.

AUDIT is a brief structured interview that can be incorporated into a medical history. It contains questions about recent alcohol consumption, dependence symptoms and alcohol related problems.

The optional Clinical Screening Procedure consists of two (2) interview items, a brief physical examination and a laboratory test. It is designed to complement the AUDIT under conditions where additional clinical information is required.

REMEMBER

- Read questions as written
- Record answers carefully
- Use the 10 AUDIT questions first
- Refer to the AUDIT Guidelines for detailed instructions
- Begin AUDIT by saying "NOW I AM GOING TO ASK YOU SOME QUESTIONS ABOUT YOUR USE OF ALCOHOLIC BEVERAGES **DURING THE PAST YEAR**". Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks".

AUDIT CORE

(Place correct answer in numbered box)

HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?
(0) Never (1) Monthly or less (2) 2 - 4 times a month (3) 2-3 times a week (4) 4 or more times a week

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 or 8 (4) 10 or more

HOW OFTEN DO Y0U HAVE SIX OR MORE DRINKS ON ONE OCCASION?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

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

HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT WAS NORMALLY EXPECTED BECAUSE OF DRINKING?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

HOW OFTEN DURING THE LAST YEAR HAVE YOU NEEDED A FIRST DRINK IN THE MORNING TO GET YOURSELF GOING AFTER A HEAVY DRINKING SESSION?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

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

HOW OFTEN DURING THE LAST YEAR HAVE YOU BEEN UNABLE TO REMEMBER WHAT HAPPENED THE NIGHT BEFORE YOU HAD BEEN DRINKING?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

HAVE YOU OR SOMEONE ELSE BEEN INJURED AS A RESULT OF YOUR DRINKING?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

HAS A RELATIVE OR FRIEND OR A DOCTOR OR OTHER HEALTH WORKER BEEN CONCERNED ABOUT YOUR DRINKING OR SUGGESTED YOU CUT DOWN?
(0) Never (1) Yes, but not in the last year (2) Yes, during the last year

Record the total of specific items here: _____. If total is 11 or greater, consult the User Manual.

WITHDRAWAL ASSESSMENT FOR ALCOHOL

Patient:	Date:	Time: (24 hr. clock)
Member #:	Group #:	CM:
Pulse/Heart Rate: (Taken for 1 minute)		Blood Pressure:

NAUSEA AND VOMITING (Does the patient have GI problems?)

Observations:

0 No nausea or vomiting
1 Mild Nausea, no vomiting
2
3
4 Intermittent nausea with dry heaves
5
6
7 Constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCE (Does the patient have any itching, pins and needles sensations, any burning, any numbness, or feel bugs crawling on or under their skin?)

Observations:

0 None
1 Very mild itching, pins and needles, burning and numbness
2 Mild Itching, pins and needles, burning and numbness
3 Moderate, pins and needles, burning and numbness
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Confused

TREMORS (Arms extended and fingers spread apart observe for tremors)

0 No tremors
1 No visible tremors but tremors can be felt fingertip to fingertip
2
3
4 Moderate, with patient's arms extended
5
6
7 Severe, even with arms not extended

AUDITORY DISTURBANCE (Does the patient have increased awareness/sensitivity to sounds? Are sounds perceived as harsh or frightening? Is the patient hallucinating or hearing disturbed by sounds?)

0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability to frighten
3 Moderate harshness or ability to frighten
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

PAROXYSMAL SWEATS

0 No sweat visible
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious
5
6
7 Drenching sweat

VISUAL DISTURBANCE (Does the patient have increased sensitivity to light? Is light perceived to be too bright or are colors distorted? Does light hurt the patient's eyes? Are their visual hallucinations or disturbing visual stimuli?)

0 Not present
1 Very mild sensitivity
2 Mild sensitivity
3 Moderate sensitivity
4 Moderately severe sensitivity
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

ANXIETY (Does the patient feel nervous? Assess verbally and by general observation)

0 No anxiety, at ease
1 Mildly anxious
2
3
4 Moderately anxious or guarded so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reaction

HEADACHE - FULLNESS IN HEAD (Does the patient's head feel different? Is there a sensation of a band around patient's head. Do not rate for dizziness or lightheadedness. Otherwise rate severity.)

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

AGITATION (Observation)

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5.
6.
7 Paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM (Is the patient oriented to time, place and person?)

0 Oriented and can do serial addition
1 Cannot do serial addition and uncertain as to date
2 Disoriented by date by no more than 2 calendar days
3 Disoriented by date by more than 2 calendar days
4 Disoriented for place and/or person
5
6
7

LONG-TERM CARE

Molina Healthcare will ensure that eligible members, other than members requesting hospice, in need of nursing facility services are placed in facilities providing the appropriate level of care commensurate with the member's medical needs.

Eligibility and Referral

When a referral to a long-term care facility is initiated by an in-patient attending physician, the Molina Healthcare Medical Director will be notified by the hospital Utilization Review Coordinator or Molina Healthcare's Utilization Management Department. The hospital Discharge Planner will notify the Molina Healthcare PCP of such referral.

Referral to the appropriate long-term care facility should be made when the Provider/Practitioner has determined that the member meets, or may meet, the criteria for any of the following long-term care facilities:

- Transitional care
- Intermediate care facility
- Sub-acute care facility
- Rehabilitative care facility
- Pediatrics sub-acute care facility
- Skilled nursing facility (SNF)
  - Short-term care
  - Long-term care
  - Custodial care

Potentially appropriate members for long-term care referral are identified by Molina Healthcare's or affiliated health plan's Utilization Management Nurse Reviewers during the admission and concurrent review process. Other sources of identification include, but are not limited to, case managers, specialty care Providers/Practitioners, social workers, discharge planners, and any other health care Providers/ Practitioners involved in the member's care.

Long-term care guidelines for determining the appropriate level of care are based on the MC/FFS guidelines.

Authorization

The PCP will perform an assessment of the member's needs to determine appropriate level of service prior to the request for an admission to a long-term care facility. The PCP will obtain an authorization for admission to a long-term care facility from Molina Healthcare's Utilization Management Department. The Utilization Management Department will direct the admission to a contracted long-term care facility. If a contracted facility is unavailable to meet the member's needs, the member will be placed at an appropriate facility on a case-by-case basis. All members receiving care in a long-term care facility will be reviewed on a weekly basis with the Utilization Management Medical Director.

If the member does not meet the criteria for an admission to a long-term care facility, the Utilization Management Department will continue to provide case management services until the treatment is completed.

Case Management

Molina Healthcare's Utilization Management Department will coordinate with the Member Services Department, which will submit a request to the Department of Health Care Services (DHCS) for mandatory disenrollment of members accepted to the above long-term care facility. The disenrollment will become effective thirty (30) days after the end of the month. The Member Services Department is responsible for the

disenrollment process of the member requiring long-term care. The PCP will provide all medically necessary covered services to the member until the disenrollment is effective. An approved disenrollment request will become effective the first day of the second month following the month of the member's admission to the long-term care facility, provided that Molina Healthcare's Member Services Department has submitted the disenrollment request at least thirty (30) days prior to that date. During the first month of the member's confinement in a long-term care facility, the Molina Healthcare Utilization Department will follow the case for thirty (30) days in order to track time spent in a long term care facility.

Hospice Care

Hospice services are a covered benefit regardless of the expected or actual length of stay in a nursing home. Hospice members in a long-term care facility are not subject to mandatory disenrollment. Members with terminal illnesses (a life expectancy of less than six (6) months) are candidates for hospice services. The determination of medical appropriateness for hospice is performed by the PCP or the Provider/Practitioner in charge of the member's care.

Once the determination for hospice is deemed appropriate, the PCP will obtain an authorization from the Case Management Department. The Utilization Management Nurse Reviewer will monitor the case and ensure coordination of all necessary services.

MAJOR ORGAN TRANSPLANTS

Organ transplants are a covered benefit of the Medi-Cal program. Under the GMC, Molina Healthcare Case Management is responsible for identifying and referring patients to Medi-Cal approved facilities for evaluation. Members undergoing transplants are to be disenrolled except for kidney or cornea transplants for which Molina Healthcare retains full responsibility.

The Medi-Cal program has established specific patient and facility selection criteria for each of the following Medi-Cal major organ transplants:

- Bone marrow transplants
- Heart transplants
- Liver transplants
- Lung transplants
- Heart/lung transplants
- Combined liver and kidney transplants
- Combined liver and small bowel transplants
- Small bowel transplants

Eligibility

Final authorization of major organ transplants is the responsibility of the Medi-Cal Field Office and, for children under 21 years of age, the California Children's Services (CCS) Central Office.

The PCP is responsible for identifying members who are potential candidates for a major organ transplant, for initiating a referral to appropriate specialists and/or transplant centers, and for coordinating care. The PCP may contact the Medical Director or Case Manager of Molina Healthcare to assist in the referral process.

Referrals

- The PCP will identify members who may be potential candidates for major organ transplant. Following the identification, the PCP will initiate a referral to a specialist and/or Medi-Cal approved transplant center and will continue to provide and coordinate care until the member is disenrolled from the Plan

- If the transplant center deems the member to be a potential candidate, the transplant Provider/Practitioner will submit a request for authorization to the Medi-Cal Field Office or CCS Central Office
- Upon receipt of approval or denial of the transplant authorization request, the transplant center will immediately inform the plan so appropriate action may be taken
- If the request is denied because the member's medical condition does not meet DHCS criteria, the Plan remains responsible for the provision of all medically necessary services to the member
- If the request is approved, the health plan Case Management Staff will initiate disenrollment of the member in accordance with Molina Healthcare Policy and Procedure MS-02, Mandatory Disenrollments (including excluded services). To ensure continuity of care to the member, the member will be disenrolled only after the following steps have occurred:
  - The health plan Case Management Staff has approved a referral of the member to a Medi-Cal designated transplant center for evaluation
  - The transplant center Provider/Practitioner(s) has performed a pre-transplant evaluation on the Plan member and the center's Patient Selection Committee has determined the member to be a suitable candidate for transplant
  - The transplant center Provider/Practitioner(s) has submitted a prior authorization request to the appropriate state office and the transplant procedure has been approved and documentation sent to the health plan Case Management Staff by the transplant center
- The disenrollment request, accompanied by the approved authorization request, has been submitted by Molina Healthcare to the Health Care Options (HCO) contractor, which will then notify Molina Healthcare of receipt of the request and initiate the disenrollment process
- In the event of the necessity for an emergency organ transplant, Molina Healthcare's Case Management Staff will assure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization request is submitted to the appropriate State office. When an approval for the transplant, which may be retroactive, is received, the disenrollment request, accompanied by the approved authorization request, will be submitted by the health plan Case Management Staff to the HCO contractor, which will notify the health plan Case Management Staff of receipt of the request and initiate the disenrollment process
- The effective date of disenrollment will be retroactive to the beginning of the month in which authorization is given. Molina Healthcare will retain responsibility for providing all medically necessary covered services during the month in which the transplant is authorized, and will request the HCO contractor to initiate a routine, non-retroactive disenrollment
- Molina Healthcare is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollmet. Services performed after the effective date of disenrollment should be billed on a FFS basis
- When the transplant has been approved and the disenrollment process has been initiated, Molina Healthcare will notify the member and coordinate the transfer of the member's care to the transplant Provider/Practitioner
- PCPs are responsible for continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner
- For members under 21 years of age, the health plan CCS Staff will notify the local CCS program when the disenrollment process has been initiated, in order to maintain continuity of care
- Coordination of care is managed by the PCP, who is assisted by a health plan Case Manager (refer to Molina Healthcare Policy and Procedure CM-02, Case Management) until the member is disenrolled from Molina Healthcare

The PCP has primary responsibility for the coordination of care:

- Identification of potential Major Organ Transplants candidates
- Provision of primary medical care
- Referral to appropriate specialty care Provider/Practitioner
- Review of all medical records and reports received from transplant center
- Providing education to member regarding his/her condition
- Reinforcing the transplant team's treatment plan
- Referring member to additional psychosocial support resources as needed
- Provide all required documentation to the transplant center

The health plan Case Manager is responsible for the following:

- Referral to a contracted major organ transplant center and ensuring the appointment is scheduled appropriately
- Ensuring transfer of pertinent medical records to transplant center
- Communicating written or verbally as necessary
- Ensuring the transplant center evaluation appointment is kept by the member
- Contacting Member Services to process a member disenrollment from Molina Healthcare once transplant treatment has been authorized by the Medi-Cal Field Office (if transplants are carved out of Molina Healthcare's benefit coverage by contract) or the CCS Central Office
- Tracking each phase of the referral process to the transplant center(s)
- The health plan's Medical Director, Case Manager, and member's PCP (and Specialist if applicable) will continue to manage and coordinate member's health care needs with a contracted transplant center, if Molina Healthcare's benefit coverage includes transplants by contract
- The effective date of the disenrollment is retroactive to the beginning of the month in which the transplant was approved
- If the request for a transplant is denied by the Medi-Cal Field Office or CCS, the health plan's PCP will continue to provide and coordinate the member's care
- The health plan Case Manager will continue to provide case management services until such time that the denial decision is reversed by DHCS upon appeal by the member or the member is no longer eligible

Disenrollment

If the request is approved, Molina Healthcare Case Management will initiate disenrollment of the member. To ensure no disruption of care to the member, the member will be disenrolled only after the following:

- Molina Healthcare Case Management Staff has approved a referral of the member to a Medi-Cal designated transplant center for evaluation.

Major Organ Transplant

- The transplant center Provider/Practitioner has performed a pre-transplant evaluation on the member and the center's Patient Selection Committee has determined the member to be a suitable candidate for transplant.
- The transplant center Provider/Practitioner has submitted a prior authorization request and the transplant procedure has been approved.

- The disenrollment request, accompanied by the approved authorization request, has been submitted by Molina Healthcare to the Health Care Options (HCO) contractor, which will then notify Molina Healthcare of receipt of the request and initiate the disenrollment process.
- Should an emergency organ transplant be necessary, Molina Healthcare Case Management Staff will ensure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization request is submitted to the appropriate state office.

The effective date of disenrollment will be retroactive to the beginning of the month in which the authorization was given. Molina Healthcare will retain responsibility for providing a member's medically necessary covered service during the month in which the transplant authorization is given. Molina Healthcare is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollment. Services performed after the effective date of disenrollment should be billed on a FFS basis.

PCP's Responsibility

PCPs are responsible for ensuring continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner in a timely manner.

It is the responsibility of the PCP to refer any member who is a potential transplant candidate to the Case Management Department. Please contact the appropriate Case Management Department as follows:

Molina Healthcare 1-(800) 526-8196 ext. 127604
Fax: (888) 273-1735

Renal Transplants

Renal transplants for members 21 years and over are a covered benefit. The PCP and Case Management Staff will refer the identified member to a DHCS licensed and certified hospital with a renal transplant unit. The PCP is responsible for the coordination of all necessary primary care services and for the provision of all services related to renal transplantation, including the evaluation of potential donors and nephrectomy from living or cadaver donors.

Members under age 21 years in need of evaluation as potential renal transplant candidates will be referred to the appropriate CCS program office for a referral to an approved CCS renal dialysis and transplant center. Requests for renal transplants from CCS approved renal dialysis and treatment centers will be sent to the local CCS Program Office for authorization. The PCP and health plan's CCS Staff will coordinate the referral to the CCS Program Office.

Molina Healthcare remains responsible for the provision of primary care services and for coordination of care with CCS regarding renal transplant services.

MENTAL HEALTH COORDINATION SHORT-DOYLE FEE-FOR-SERVICE MENTAL HEALTH SERVICES

Services available under the SD/MC programs are excluded from Molina Healthcare's coverage responsibility. PCPs provide outpatient mental health services, within the scope of their practice, and coordinate referrals for members requiring specialty and inpatient mental health services. Members needing these services will be referred to treatment under the SD/MC program. The California Department of Mental Health oversees the SD/MC system. Each county is required by law to provide access to SD/MC services for Medi-Cal members, consistent with access provided to other Medi-Cal beneficiaries.

SD/MC Services

Medi-Cal beneficiaries receiving services under the SD/MC mental health program remain enrolled in Molina Healthcare's benefit plan. The PCP remains responsible for primary case management of the member. This includes the coordination of ongoing care with co-existing medical/mental health needs and the provision of medically necessary drugs.

Psychiatric Scope of Services for the PCP

These services are limited. Examples of the services that are generally considered psychiatric primary care services are listed below. However, the PCP must have received appropriate training and provide only those services that are consistent with state and federal regulations and statutes.

- Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, 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-Practitioner therapist
- Diagnose and manage child/elder/dependent-adult abuse and victims of domestic violence

PCP Responsibilities – Primary Caregiver and Referrals

PCPs will provide outpatient mental health services within their scope of practice. Should the member's mental health needs require specialty mental health services, the PCP should refer the member to the County Mental Health Department for assessment and referral to an appropriate mental health Provider/Practitioner, or the PCP may directly refer the member to a FFS/MC or SD/MC mental health Provider/Practitioner. The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition resulting in a referral.

The PCP will assure appropriate documentation in the member's medical record. The PCP will coordinate non-SD/MC conditions and services with specialists as necessary.

Psychiatric Referral Guidelines for Specialty Consultation

Examples of psychiatric conditions that a PCP generally refers for specialty consultation include:

- The diagnosis treatment and recommendations for medication regimens in difficult/complex cases, e.g. depressions that do not respond to a sixty (60) day trial of medications
- Members who report feeling suicidal or homicidal
- Severe anxiety
- Clear somatoform disorders
- Schizophrenic disorders
- Bipolar disorder

Psychologist Referral Guidelines for Specialty Consultation

Examples of psychological services available to referred members are:

- Diagnosis, treatment, and consultation regarding management of severe emotional issues for which the patient or PCP feels the need for consultation
- Psychological testing for clarification of diagnosis to establish a treatment plan

Referral Process

- The need for referral to SD/MC or FFS/MC services is determined by the PCP on the basis of objective and subjective 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 decision has been made to refer the member for mental health services to a SD Provider/Practitioner, the PCP may make a referral directly or refer the member to the County's Department of Mental Health for assessment and referral and to SD/MC and FFS/MC
- Molina Healthcare's Utilization Management Department will coordinate with the health plan Member Services Department when appropriate to meet a member's cultural and linguistics needs
- Providers/Practitioners seeking guidance in the provision of services to members with specific cultural needs are referred to the health plan's Health Education Department for a cultural and linguistics services consultation. Upon completion of the consultation, the Health Education Department will make recommendations to the Provider/Practitioner to resolve any related issue(s)

Molina Healthcare Responsibilities

Molina Healthcare will perform the following:

- Assure appropriate referral of its members by PCPs via periodic audit.
- Provide all covered psychotherapeutic drugs prescribed by a contracted PCP. Note: Molina Healthcare is not responsible for psychotherapeutic drugs prescribed by Psychiatrists or other specialists or medications which are billed to the Medi-Cal FFS system.
- Assure availability of comprehensive case management services when indicated and requested by the PCP or the mental health Provider/Practitioner.

Continuity of Care

PCPs will provide services and referrals in a manner that ensures coordinated and continuous care to all members needing SD/MC mental health services, including appropriate and timely referral, documentation of referral services, monitoring of members with ongoing medical conditions, documentation of emergency and urgent encounters with appropriate follow-up, coordinated discharge planning, and post-discharge care.

To assure continuity of care when a member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the member's records to that health care Provider/Practitioner and, if appropriate, to the organization where future care will be rendered. Any transfer of member medical records and/or other pertinent information should be done in a manner consistent with confidentiality standards including a release of the medical records signed by the member.

Confidentiality

- Confidential member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment
- It is the policy of Molina Healthcare that all of its employees and contracting Provider/Practitioners respect each member's right of confidentiality and treat the member information in a respectful, professional, and confidential manner consistent with all applicable federal and state requirements. Discussion of member information should be limited to that which is necessary to perform the duties of the job.
- Reports from specialty services and consultations are placed in the patient's chart at the PCP's office. Mental health services are considered confidential and sensitive. Any follow-up consultation that the PCP receives from the specialist or therapist is placed in the confidential envelope section of the member's medical record. Please refer to Molina Healthcare Policy and Procedure MR-26, Collection/Use/Confidentiality, and Release of Primary Health Information and MS-07, Safeguarding and Protecting Medical Records

Problem Resolution

If a disagreement occurs between Molina Healthcare and the California Department of Mental Health regarding responsibilities, the Utilization Management Department is notified. All medical records and correspondence should be forwarded to:

Molina Healthcare of California
Attn: Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196 ext. 127604
Fax: (888) 273-1735

The Utilization Management Department shall:

- Review medical records for issue of discrepancy and discuss with the Molina Healthcare Medical Director.
- Discuss with the California Department of Mental Health the discrepancy of authorization responsibility and the Molina Healthcare clinical review determinations.
- Molina Healthcare will authorize all services that are medically necessary that are not excluded from the contract agreement for Medi-Cal managed care.
- If a dispute cannot be resolved to the satisfaction of the California Department of Mental Health or Molina Healthcare, a request by either party may be submitted to the Department of Health Care Services within fifteen (15) calendar days of the completion of the dispute resolution process outlined in the applicable Memorandum of Understanding (MOU). The request for resolution shall contain the items identified in Title 9. CCR Section 1850.505.
- Molina Healthcare will communicate issues and determinations to the PCP and other involved parties.

SECTION 14: BREAST AND PROSTATE CANCER TREATMENT INFORMATION REQUIREMENTS

SPECIAL REQUIREMENTS FOR INFORMATION AND/OR CONSENT FOR BREAST AND PROSTATE CANCER TREATMENT

Breast Cancer Consent Requirements

A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to patients. A brochure has been prepared to accomplish this task and is available at the following address:

Medical Board of California
Breast Cancer Treatment Options
1426 Howe Street, Suite 54
Sacramento, CA 95825

Order requests can be faxed to (916) 263-2479. There is no charge for the brochure and it is available in bundles of 25, up to a maximum of 2 cases – 250 copies per case. It is available in the following languages: English, Spanish, Korean, Chinese, Russian, and Thai.

The brochure should be given to the patient before a biopsy is taken, whether or not treatment for breast cancer is planned or given. The brochure may not supplant the physician's duty to obtain the patient's informed consent. In addition to the distribution of the brochure, physicians should discuss the material risks, benefits, and possible alternatives of the planned procedure(s) with the patient and document such discussion in the medical record of the patient. Failure to provide the required information constitutes unprofessional conduct.

Every physician who screens or performs biopsies for breast cancer must post a sign with prescribed wording relating to the above brochure. The sign or notice shall read as follows:

"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 109275 of the California Health and **Safety Code**."

"The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures."

The sign must be posted close to the area where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8 1/2" X 11" and conspicuously displayed so as to be readable. The words "BE INFORMED" shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese.

Prostate Cancer Screening and Treatment Information to Patients

Providers/Practitioners are required to tell patients receiving a digital rectal exam that a prostate-specific antigen (P.S.A.) test is available for prostate cancer detection.

The National Institute of Health currently provides a prostate cancer brochure entitled: **"What You Need to Know About Prostate Cancer"**

It is available by calling (800) 4CANCER. Brochures can also be ordered by going online to www.cancer.gov or faxing an order to (301) 330-7968. The first 20 brochures are free and there is a $.15/brochure fee for orders over 20, with a minimum order of $8.00.

Every physician who screens for or treats prostate cancer must post a sign with prescribed wording referencing this information. The sign or notice shall read as follows:

"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 109280 of the California Health and **Safety Code**."

"The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of advantages, disadvantages, risks, and descriptions of procedures."

The sign must be posted close to the area where the prostate cancer screening or treatment is performed or at the patient registration area. The sign must be at least 8 1/2" X 11" and conspicuously displayed so as to be readable. The words "BE INFORMED" shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese. The sign shall include the internet web site address of the State Department of Health Care Services and the Medical Board of California and a notice regarding the availability of updated prostate cancer summaries on these web sites.

Information for Patients

The California Department of Public Health (CDPH) has information about breast and prostate cancer on their website at: http://www.cdph.ca.gov/HealthInfo/Pages/BreastCancerInformation.aspx

Information can be viewed or printed from this website.

SECTION 17: HUMAN REPRODUCTIVE STERILIZATION PROCEDURE AND CONSENT

Members must be appropriately and adequately informed about human reproductive sterilization procedures. Informed consent must be obtained prior to performing a procedure that renders a person incapable of producing children. Sterilization performed because pregnancy would be life threatening to the mother is included in this requirement. When sterilization is the unavoidable secondary result of a medical procedure and the procedure is not being done in order to achieve that secondary result, the procedure is not included in this policy.

Conditions for Sterilization

A sterilization may be performed only under the following conditions:

- The member is at least 21 years old at the time the consent is obtained.
- The member is not mentally incompetent, as defined by Title 22, i.e., an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared incompetent for purposes which include the ability to consent to sterilization.
- The member is able to understand the content and nature of the informed consent process.
- The member is not institutionalized, as defined by Title 22, i.e., someone who is involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- The member has voluntarily given informed consent in accordance with all of the prescribed requirements.
- At least thirty (30) days, but not more than one hundred eighty (180) days, have passed between the date of written informed consent and the date of the sterilization. Exceptions are addressed below.

Conditions When Informed Consent May Not Be Obtained

Informed consent may not be obtained while the member to be sterilized is:

- In labor or within twenty four (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 state of awareness.

Informed Consent Process Requirements

The following criteria, including the verbal and written member information requirements, must be met for compliance with the informed consent process:

- The informed consent process may be conducted either by Provider/Practitioner or appropriate designee.
- Suitable arrangements must be made to ensure that the information specified above is effectively communicated to any individual who is deaf, blind, or otherwise handicapped.
- An interpreter must be 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 must be permitted to have a witness present of that member's choice when consent is obtained.
- The sterilization procedure must be requested without fraud, duress, or undue influence.

Required Member Information

The member requesting to be sterilized must be provided with the appropriate booklet on sterilization published by the Department of Health Care Services (DHCS) BEFORE THE CONSENT IS OBTAINED. These are the only information booklets approved by DHCS for distribution to individuals who are considering sterilization:

- "Understanding Sterilization for a Woman"
- "Entendiendo La Esterilizacion Para La Mujer"
- "Understanding Vasectomy"
- "Entendiendo La Vasectomia"

Providers/Practitioners may obtain copies of the information booklets provided to members in English or Spanish by submitting a request on letterhead to:

California Department of Health Care Services
Warehouse - Forms Processing
1037 North Market Blvd., Suite 9
Sacramento, CA 95834
Fax: 916-928-1326

When the Providers/Practitioners or appropriate designee obtains consent for the sterilization procedure, he/she must offer to answer any questions the member to be sterilized may have concerning the procedure. In addition, all of the following must be provided verbally to the member who is seeking sterilization:

- Advice that the member is free to withhold or withdraw consent to the procedure at anytime before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits he/she is entitled to.
- A full description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the procedure, including explanation of the type and possible side effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected from sterilization.
- Approximate length of hospital stay.
- Approximate length of time for recovery.
- Financial cost to the member. Information that the procedure is established or new.
- Advice that the sterilization will not be performed for at least thirty (30) days, except in the case of emergency abdominal surgery or premature birth - when specific criteria are met.
- The name of the Provider/Practitioner performing the procedure. If another Provider/Practitioner is to be substituted, the member will be notified, prior to administering pre-anesthetic medication, of the Provider/Practitioner's name and the reason for the change in Provider/Practitioner.

The required consent form PM 330 must be fully and correctly completed after the above conversation has occurred. A copy of this consent form, in English and Spanish, are provided as an exhibit for your reference at the end of this section.

Certification of Informed Consent for Human Reproductive Sterilization

Consent form PM 330, provided by DHCS in English and Spanish, is the ONLY form approved by DHCS. A copy of this form and instructions on filling out the form are provided in this section.

The PM 330 must be signed and dated by:

- The member to be sterilized.
- The interpreter, if utilized in the consent process.
- The person who obtained the consent.
- The Provider/Practitioner performing the sterilization procedure.

By signing consent form PM 330, the person securing the consent certifies that he/she has personally:

- Advised the member to be sterilized, before that member has signed the consent form, that no federal benefits may be withdrawn because of a decision not to be sterilized.
- Explained verbally the requirements for informed consent to the member to be sterilized as set forth on the consent form PM 330.
- Determined to the best of his/her knowledge and belief, that the member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The Provider/Practitioner performing the sterilization certifies, by signing the consent form PM 330, that:

- The Provider/Practitioner, within seventy two (72) hours prior to the time the member receives any preoperative medication, advised the member to be sterilized that federal benefits would not be withheld or withdrawn because of a decision not to be sterilized.
- The Provider/Practitioner explained verbally the requirements for informed consent as set forth on the consent form PM 330.
- To the best of the Provider/Practitioner's knowledge and belief, the member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.
- At least thirty (30) days have passed between the date of the member's signature on the consent form PM 330 and the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is met.

The interpreter, if one is utilized in the consent process, will sign the consent form PM 330 to certify that:

- The interpreter transmitted the information and advice presented verbally to the member.
- The interpreter read the consent form PM 330 and explained its content to the member.
- The interpreter determined, to the best of the interpreter's knowledge and belief, that the member to be sterilized understood the translated information/instructions.

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. It will be documented that the booklet and copy of the consent form were given to the member. The original signed consent form must be filed in the member's medical record. A copy of the signed consent form must be given to the member and a copy is placed in the member's hospital medical record at the facility where the procedure is performed.

If the procedure is a hysterectomy, a copy of the informed consent form for hysterectomy should be placed in the member's medical record. This form is supplied by the facility performing the procedure.

Office Documentation

All participating Providers/Practitioners are responsible for maintaining a log of all human reproductive sterilization procedures performed. A sample of sterilization log is provided for your reference. This log must indicate the member's name, date of sterilization procedure, the member's medical record number, and the type of procedure performed.

Exceptions to Time Limitations

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the following requirements are met:

- A minimum of seventy two (72) hours have passed after written informed consent to be sterilized, and
- A written informed consent for sterilization was given at least thirty (30) days before the member originally intended to be sterilized, or
- A written informed consent was given at least thirty (30) days before the expected date of delivery

Special Considerations, Hysterectomy

A hysterectomy will not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a hysterectomy consent form must be completed in addition to other required forms.

Noncompliance

The Quality Improvement Department monitors compliance for the consent process of human reproductive sterilization. Identified deficiencies will be remedied through a course of corrective action(s) as determined appropriate by the Quality Improvement Committee with following reviews conducted to assess improvement or continued. The DHCS also performs audits for compliance with Title 22. Both Molina Healthcare and DHCS are required to report non-complaint Providers/Practitioners to the Medical Board of California.

Ordering of Consent Forms

Sterilization consent forms PM 330, with English printed on one (1) side and Spanish on the other side, can be ordered directly from DHCS by sending a request to:

Medi-Cal Benefits Branch
California Department of Health Care Services
714 P Street, Room 1640
Sacramento, CA 95814

Attachments/Exhibits

- The PM 330 Form (English and Spanish versions)
- Sample Reproductive Sterilization Procedures Log
- Hysterectomy Informed Consent Form

For more information on this topic, Providers/Practitioners may call (888) 665-4621 and request a copy of Policy QM-43, Human Reproduction and Sterilization Consent, which contains more detail and includes regulatory references.

INSTRUCTIONS FOR COMPLETING PM 330 FORM

Doctor or clinic - This line may be pre-stamped. If the Provider/Practitioner is a Practitioner group, all names may appear, e.g. Drs. Miller and Smith; the professional group name may be listed, e.g. "Westside Medical Group"; or the phrase "and/or his or her associates" may be used.

Name of procedure - Enter the name of the procedure. If the name of the procedure is lengthy, an abbreviation may be used with an asterisk. The full name of the procedure should be written out at the bottom of the form. If the consent document is being completed in Spanish, the name of the procedure may be written in Spanish.

Month, day, year - Enter the patient's birth date.

Patient name - The name used must be identical to the patient name appearing on the claim form. Use the boxes provided to enter the patient's name.

Doctor's name - May be pre-stamped. If a group, all names may be listed, or the phrase "and/or his or her associates" may be used.

Name of procedure - Enter the name of the procedure. If the name of the procedure is lengthy, an abbreviation may be used with an asterisk. The full name of the procedure should be written out at the bottom of the form. If the consent document is being completed in Spanish, the name of the procedure may be written in Spanish.

Signature of individual to be sterilized - The patient must sign here. If the patient is illiterate, the form of signature permitted is an "X", which must be countersigned by a witness.

Month, day, year - The patient's signature must be dated. The waiting period is calculated from this date.

Interpreter's statement - Indicate the language in which the patient was counseled if other than English or Spanish.

Interpreter's signature - Must be signed if an interpreter was used.

Month, day, year - The interpreter's signature must be dated.

Statement of person obtaining consent - Enter the patient's name here.

Name of procedure - If the name of the procedure is lengthy, an abbreviation may be used with an asterisk. The full name of the procedure should be written out at the bottom of the form. If the consent document is being completed in Spanish, the name of the procedure may be written in Spanish.

Signature of person obtaining consent - The person providing sterilization counseling may be the Provider/Practitioner or the Provider/Practitioner's designee, e.g. an office nurse. Once this section is completed, the patient should be given a copy of the form.

Month, day, year - The signature of the person obtaining the consent must be dated.

Name of Facility where patient was counseled - May be pre-stamped.

Address of Facility where patient was counseled - May be pre-stamped.

Physician's Statement: Name of patient - Enter the name of the patient here.

Date of procedure - Enter the date of the procedure.

Name of procedure - If the name of the procedure is lengthy, an abbreviation may be used with an asterisk. The full name of the procedure should be written out at the bottom of the form. If the consent document is being completed in Spanish, the name of the procedure may be written in Spanish. Consent is not invalidated if the procedures actually performed differs from the method of sterilization originally planned.

Final paragraphs - Cross out the paragraph not used. The minimum waiting period is thirty (30) days from the date consent was given, except in cases of premature delivery or emergency abdominal surgery.

Premature delivery date, individual's expected date of delivery or emergency abdominal surgery - Check applicable boxes and fill in information as requested.

Practitioner signature - Must be completed after the sterilization procedure by the Provider/Practitioner who has verified consent and who actually performs the procedure. The purpose of obtaining consent "shortly before" the procedure is to reaffirm consent. In this context, "shortly before" means up to seventy two (72) hours prior to the procedure.

Month, day, year - The Provider/Practitioner's signature must be dated.

Exhibits

SAMPLE

HYSTERECTOMY-INFORMED CONSENT

This is to certify that I, _____, have been
(name of patient)

Advised by my Physician or his or her designee,_____
(name of physician/designee)

that the 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.

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 _____ (Escribir o dictar). 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 médicos 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 ser 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 pérdida 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 antes de operar a _____ (Nombre de la persona a ser esterilizada) en ___/___/___ (Mes Día Año) (Fecha de esterilización), le explique la naturaleza del metodo de esterilizacion conocido como _____ (Nombre del procedimiento). también le expliqué que este método es final e irreversible y le informé de los malestares, riesgos 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 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.

(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 después 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: ___/___/___ (Mes Día Año) Fecha anticipada del parto: ___/___/___ (Mes Día Año) (Debe ser 30 días a partir de la firma de la persona).

B Cirugía del abdomen de emergencia; describa las circunstancias: _____

_____ Fecha: ___/___/___

Firma del Doctor a cargo de la cirugía — Mes Día Año

Exhibit 17-B

State of California – Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

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 will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

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 be sterilized by an operation known as a _____ (Name of procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ___/___/___ (Mo Day Yr).

I, _____ (Last) _____ (First) _____ (M.I.)

hereby consent of my own free will to be sterilized by _____ (Doctor's name) by a method called _____ (Name of procedure);

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

_____ Date: ___/___/___
Signature of individual to be sterilized Mo Day Yr

■ 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.

_____ Date: ___/___/___
Signature of Interpreter Mo Day Yr

PM 330 (1/90)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of individual to be sterilized) signed the consent form, I explained to him/her the nature of the sterilization operation _____ (Name of procedure), 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 anytime 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 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ Date: ___/___/___
Signature of person obtaining consent Mo Day Yr

Name of Facility where patient was counseled

Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on ___/___/___ (Date of Sterilization), I explained to him/her the nature of the sterilization operation _____ (Name of procedure), the fact that it is intended to be 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 21 years old 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 when 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 below which is not used.**

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) 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 below and fill in information requested.)**

A Premature delivery date: ___/___/___ Individual's expected date of delivery: ___/___/___ (Must be 30 days from date of patient's signature).
Mo Day Yr

B Emergency abdominal surgery; describe circumstances: _____

_____ Date: ___/___/___
Signature of Physician performing surgery Mo Day Yr

REPRODUCTIVE 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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16											
17											
18											
19											

SAMPLE