
9. ACCESS STANDARDS

A. Access Standards

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. All applicable practitioners including PCPs, PCP/OBs, and Specialists must meet the access standards delineated below to participate in the IEHP network.
- B. IEHP monitors practitioner access to care through IEHP and IPA performed access studies, review of grievances and other methods.
- C. All IPAs and Behavioral Healthcare Providers are required to provide or ensure that 24-hour, seven days a week access to medical care for Members is available, including after business hours telephone access to a PCP or a triage system utilizing specific licensed personnel.
1. For medical triage, licensed and trained screening or triage personnel include Registered Nurses (RN), Nurse Practitioners (NP) or Physician Assistants (PA). Physician backup must be available.
- D. For behavioral health triage, licensed and trained screening or triage personnel include RNs or Master's level behavioral health practitioners. Supervision must be provided by a licensed behavioral health care practitioner with a minimum of a Master's degree and five years of post-master's clinical experience.
- E. IEHP ensures that the contracted Dental Network has adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services. This is monitored through grievances, Member satisfaction surveys and access studies provided by the delegated Dental Provider.

PROCEDURE:

- A. **Access Standards for Clinical Services** - The following information delineates the access standards for availability of services to Members including primary care, specialty care, after hours emergency services, waiting times for appointments, and proximity of specialists and Hospitals to primary care.

1. Appointment Standards:

Type of Visit

Timeframe

Emergency

Immediate disposition of Member to appropriate care setting

Urgent visit

Same day

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<u>Type of Visit</u>	<u>Timeframe</u>
Urgent prenatal visit	Same day
Initial prenatal visit	One week
Routine prenatal care	Two weeks or as directed by physician
Non-urgent, acute illness visit	Three business days, or as directed by physician
Non-urgent with a non-Physician Mental Health Care Provider	Within 10 business days of request
Non-urgent ancillary services (for diagnosis and treatment)	Within 15 business days of request
Routine non-urgent visit	Within 10 business days of request
Well Child Visit	Two weeks
Non-urgent appointments with specialist referral physician	Within 15 business days of request
Routine physical (complete)	30 Days
Initial health assessment (for State Program Members Only)	30 Days (within 120 days of enrollment)
Initial health assessment (for State Program Members under 18 months of age only)	30 Days (within 60 days of enrollment)
Routine pelvic, Pap and breast exam	30 Days
Follow-up exam	As directed by physician
Urgent appointments within the dental plan network shall be offered when consistent with the Member's individual needs and as required by professionally recognized standards of dental practice	Within 72 hours of the time of request for appointment
Non-urgent appointments shall be offered	Within 36 business days of the request for appointment
Preventive dental care appointments shall be offered	Within 40 business days of the request for appointment

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2. Preventive care services and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy and other conditions, lab and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.
3. Practitioner Office Waiting Time - For primary or specialist care, the waiting time for a scheduled appointment must be no longer than 60 minutes. Waiting times for Members that are advised to “walk-in” to be seen must be no longer than 4 hours.
4. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
5. Proximity of Specialists, Hospitals, and other Providers to Sources of Primary Care - IEHP network specialists, pharmacies, Hospitals, and other providers must be located within 15 miles or 30 minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. These proximity standards must be met whether using private car, public bus, hospital van, dial-a-ride, or Metrolink train transportation.
6. Proximity of PCPs to Members – IEHP network PCPs must be located within 10 miles or 30 minutes travel time from assigned Members’ residence, as applicable, based on geographic regions. This proximity standard must be met whether using private car, public bus, hospital, van, dial-a-ride, or Metrolink transportation.
7. Minimum Hours On-Site - The PCP must be on site and available for Member care a minimum of 20 hours per week, or meet the criteria identified in Policies 6C, “Residency Teaching Clinics” and 6D, “Rural Clinics.”
8. Telephone Answer Time - All telephone calls to a PCP or Specialist must be answered within 6 rings. Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person.
9. Telephone Hold Time - A Member must not be kept on hold for more than five minutes. If a Member is placed on hold, an employee should let the Member know the reason for the delay and offer the Member the choice to either wait or have his/her call returned within the timeframe specified in this policy.
10. Telephone Access Standards - When a Member leaves a message with the office of a PCP or specialist, requesting a return call, an employee of the office must

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attempt to return the Member's call within the following timeframes and log that attempt:

- a. Within 3 working days for a non-urgent matter (e.g. refills for medications that have not run out; requests for paperwork or medical records; requests for appointments for non-acute conditions).
 - b. No later than the same day for an urgent (non-emergency) matter (e.g. refills of critical medications which have run out; acute illness or acute complaint not already dealt with at the Provider's office).
 - c. A minimum of three attempts must be made to return the Member's call. It is understood that the same staff member or physician with whom the Member wishes to speak with, may or may not be the party available to return the Member's call. It is also understood that the staff member returning the call may or may not be able to definitively address the Member's issue during that call. However, it will be expected that the staff member returning the Member's call be prepared to do at least one of the following during that return phone call:
 - 1) determine the urgency of the Member's request, solicit more information from the Member if needed, and act accordingly;
 - 2) reassure the Member if appropriate;
 - 3) agree to pass a message to the Member's physician or to another relevant staff member if appropriate; and/or
 - 4) provide the Member with a timeline or expectation of when the request can be definitively addressed.
 - d. This time requirement and policy for attempting to return Member phone calls (3 business days for non-urgent; same day for urgent non-emergency, with a minimum of three attempts) is understood to be a minimal guideline; i.e. this policy is not meant to over-ride more rigorous internal office policy, if one is already in place.
 - e. Members who reach voice mail must receive detailed instructions on how to proceed.
11. All PCP offices must have an active and working fax machine 24 hours per day, 7 days per week.

- B. **Emergency Services** - IEHP has continuous availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and supportive paramedical personnel to provide covered services including the provision of all medical care necessary under emergency circumstances. IEHP network physicians and Hospitals must provide access to appropriate triage personnel and emergency services

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24-hours a day, seven days a week.

1. IEHP evaluates inappropriate use of Emergency Room services, issues regarding Member access to health care, and under- or over-utilization of services through assessment of encounter data, special studies, claims information, and medical records audits with oversight of the Quality Management (QM) Committee.
- C. **Emergency Medical Condition** – This is a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
 2. Serious impairment to bodily function; or
 3. Serious dysfunction of any bodily organ or part; or
 4. Emergency service and care also means a screening examination and evaluation by a physician to determine if a psychiatric emergency medical condition exists, as applicable.
- D. **Urgent Care Services** – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity that care is needed within the same day, but are not emergency medical conditions.
- E. **Non-urgent, Acute Illness Visit** – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity to be addressed within three days, however, they do not warrant an urgent care visit.
- F. **Routine Non-urgent Visit** – These are health care services needed to diagnose and/or treat medical conditions that do not need urgent care or non-emergent attention. These visits are used for routine check-ups and can be scheduled within ten (10) business days of request.
- G. **Well Child Visit** – These are periodic health care services needed to provide preventive health services for Members under the age of 21 years. These visits must be scheduled within two (2) weeks.
- H. **Physical Exam** – This is a routine preventive exam occurring every one to three years. These visits must be scheduled within 30 days.
- I. **Walk-In Clinic Visits** – If an IEHP Member is informed by the PCP or the PCP’s office staff that they may “walk-in” on a particular day for routine, non-urgent or non-urgent acute visits, the IEHP Member must be seen at that office on the same day in which the Member was advised to come in, and must not have a wait time in excess of 4 hours.
- J. **Urgent Prenatal** – These are health care services needed to diagnose and/or treat actual

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or perceived prenatal conditions that are of sufficient severity that care is needed the same day but are not emergency medical conditions.

- K. **Initial Prenatal** – These are health care services needed to determine potential risk factors and the care plan for a woman during the period of pregnancy. This exam must take place within one week of confirmation of pregnancy.
- L. **Routine Prenatal Care** – These are routine medical visits throughout the period of pregnancy. These visits consist of periodic exams and monitoring for the determination of the condition of both the fetus and the mother. These visits should be scheduled within two (2) weeks or as directed by the physician in order to detect any untoward changes in the condition of the fetus or mother so that necessary treatment may be initiated.
- M. **Non-urgent Specialist Appointment** – These are referrals to a health care professional who has advanced education and training in a specific area. The appointment to the specialist is to be scheduled within fifteen (15) days of request unless otherwise indicated by the referring physician.
- N. **Medical Triage Screening and Advice During Business Hours** – All PCP sites must have licensed staff available for telephone or on-site triage for Members during normal business hours. Triage and screening waiting time must not exceed 30 minutes. Waiting time may be extended if the trained, licensed staff has determined and documented that a longer waiting time will not have a detrimental impact on the health of the Member and has informed the Member when the triage and screening will be completed. Approved licensed triage personnel include RNs, NPs, or PAs. IEHP has not developed specific triage protocols; it is expected that all licensed triage personnel use appropriate medical judgment in determining the disposition of the patient (e.g., treat at office, refer to Urgent Care, Emergency Department, or call 911). There must be sufficient information on how to proceed for Members who reach voice mail.
- O. **After Hours PCP Access** – IEHP provides Members with 24 hour, seven days a week access to a licensed triage person through the IEHP Nurse Advice Line. IEHP also requires that PCPs and IPAs have arrangements in place for telephone access 24 hours a day, seven days per week. Availability of the IEHP Nurse Advice Line does not supplant the requirement for PCPs and IPAs to maintain 24/7 telephone access. Members can access the IEHP Nurse Advice Line by calling the toll free phone number listed on the Member's ID card. The IEHP Nurse Advice Line provides access to licensed triage personnel including RNs, NPs, and PAs. By calling the Nurse Advice Line, Members are able to receive assistance with access to urgent or emergency services from the assigned PCP, an on-call physician, or licensed triage personnel. Licensed triage personnel use appropriate protocols and sound medical judgment in determining the disposition of the Member (e.g., refer to Urgent Care, Emergency Department). When a Member accesses service through the IEHP Nurse Advice Line, the Member's PCP receives a faxed copy of the encounter including the Member's medical situation and the disposition of the call. In the event that a Member calls a physician's office after hours, there must be sufficient

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access to information on how to proceed, either through an answering service or phone message instructions.

- P. **Missed Appointments** – IEHP network practitioners must maintain procedures to identify and follow-up on missed appointments, including staff training, as outlined in Policy 9B, “Missed Appointments.” Missed and/or rescheduled appointments must be scheduled appropriate to the health care and continuity of care and needs of the Member.
- Q. **Follow-up of ED or Urgent Care Visits** – IPAs are responsible for informing PCPs of Members that receive an ED or Urgent Care visit, including information regarding needed follow-up, if any. PCPs are responsible for obtaining any necessary medical records from such a visit, and arranging any needed follow-up care.
- R. **Initial Health Assessment** – See Policy 10I, “Initial Health Assessment.”
- S. **Hospital Standards** – All contracted Hospitals must provide timely access for IEHP Members accessing Emergency Departments, being admitted for an inpatient stay, or utilizing hospital based diagnostic or treatment services. Hospital based clinics must meet all the primary care and specialty access standards delineated above.
- T. **Provider Shortage** - If timely appointments within the time or distance standards required are not available, then the IPA shall refer Member to or assist in locating available and accessible contracted Provider to obtain the necessary health care services in a timely manner appropriate for the Member’s needs.

Special Access Standards

- A. The following information outlines the standards for special access needs for Members including sensitive services and access for the disabled and hearing impaired, as well as dental, behavioral health, and special programs:
 - 1. Sensitive Services for Minors and Adults - Providers and practitioners must have procedures to ensure that minors and adults have access to sensitive and confidential services as outlined in Policy 9D, “Access to Sensitive Services.” Minors and adolescents have the right of access to treatment and/or referral for sensitive services without parental consent. Sensitive services include: access to family planning, STD, and HIV testing and counseling services from qualified family planning providers or the Local Health Department (LHD). Sensitive services for minors include sexual assault, drug or alcohol abuse, pregnancy, family planning, sexually transmitted diseases, and behavioral health care.
 - 2. Access for People with Disabilities - All IEHP facilities and practitioners are required to maintain access in accordance with the requirements of Title III of the Americans with Disabilities Act of 1990. Each PCP’s office is assessed to identify if barriers to Member care exist during the site reviews. Areas audited include but are not limited to: designated parking spaces, wheelchair access,

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restroom and drinking fountain access for wheelchair users, handrails near toilets, appropriately placed telephones, and appropriate handicapped signage. If a practitioner's office or building is not accessible to Members with disabilities, an alternative access to care must be provided per Policy 9C, "Access to Care for People with Disabilities."

3. Access and Interpretation Services for People with Hearing Impairments and/or Limited English Proficiency - All IEHP network Providers and practitioners, including network pharmacy and vision practitioners, must provide services to limited English proficient Members in the Member's primary language. For face-to-face interpretation services, including sign language, practitioners must provide interpreters, as needed, for Members appointments. IEHP is responsible for the cost of interpretation services as discussed in Policies 15C1, "Cultural and Linguistic Services – Foreign Language Capabilities" and 9C1, "Providing Interpreters for Members Who Are Deaf or Hard-of-Hearing."
4. Interpretation Services - All Providers must provide services to limited English proficient Members in the Member's primary language.
 - a. These linguistic capabilities must be available to Members 24 hours a day, seven days a week.
 - b. During the process of adding a physician to IEHP's network, all physicians are asked to indicate their foreign language abilities. Assignment of Members to PCPs able to communicate in the Member's preferred spoken language is done whenever possible.
 - c. Providers are encouraged to have bilingual practitioners and staff.
 - d. Providers may use face-to-face interpreters or telephonic interpretation services to meet the requirement of providing linguistic services to Members.
 - e. IEHP contracts with Pacific Interpreters to provide telephone interpretation services to Members. Providers access these services by contacting IEHP Member Services at (800) 440-4347. Pacific Interpreters offers interpretation services 24 hours a day, seven days a week.
 - f. Members or providers must contact IEHP Member Services at least 5 working days before the medical appointment to arrange for face-to-face interpreter service.

- B. **Access Standards for Behavioral Health Services** - The following information delineates the access standards for availability of services to Members for Behavioral Health care and after-hours emergency services.

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A. Access Standards

Riverside County Healthy Kids Members:

1. Administration of Behavioral Health benefits for Riverside Healthy Kids Members is retained by the State and/or counties and is not a contractual responsibility for IEHP. Behavioral health benefits are provided through county and state providers.
2. Network practitioners are responsible for assessing Riverside Healthy Kids Members for behavioral health or substance abuse issues and referring for assistance by a behavioral health specialty provider.
3. Providers and practitioners are responsible for directing Riverside Healthy Kids Members to the Riverside County Community Access, Referrals, Evaluation, and Support (CARES) Line by calling (800) 706-7500.

Healthy Families and San Bernardino Healthy Kids Members:

1. IEHP is responsible for administering Behavioral Health benefits for Healthy Families Members in both counties, and Healthy Kids Members who reside in San Bernardino.
2. Behavioral Health and substance abuse services are provided by IEHP Behavioral Health Program.
3. Behavioral Health Access Standards:

<u>Type of visit</u>	<u>Timeframe</u>
Life-threatening emergency	Immediate disposition of Member to appropriate care setting
Non-life-threatening emergency	Six hours
Urgent behavioral health needs	Within 48 hours
Routine behavioral health visit	Within 10 working days

4. Behavioral Health Telephone Screening and Triage:
 - a. Telephone callers must be able to reach a non-recorded voice within 30 seconds.
 - b. The telephone abandonment rate must not exceed five percent at any given time.
5. After Hours Access for Behavioral Health Care:
 - a. All Behavioral Health Providers are required to provide or ensure that 24-hours a day, seven days a week access to behavioral health care for Healthy Families and San Bernardino Healthy Kids Members is available,

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including after business hours telephone access to a triage system utilizing specific licensed personnel.

- 1) For behavioral health triage, this includes RNs or Master's level behavioral health practitioners. Supervision must be provided by a licensed behavioral health care practitioner with a minimum of a Master's degree and five years of post-Master's clinical experience.

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Chief Approval: <i>Signature on file</i>	Effective Date:	September 1, 1996
Chief Title: Chief Medical Officer	Revised Date:	January 1, 2012

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B. Missed Appointments

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. The responsibility of follow-up for missed appointments is delegated to physicians with oversight by contracted IPAs and IEHP.
- B. IEHP physicians must maintain procedures to identify and follow-up on missed appointments including staff training.

PROCEDURE:

- A. IEHP physicians must have a process in place to follow-up on missed appointments that includes at least the following:
1. Notation of the missed appointment in the Member's medical record.
 2. Review of the potential impact of the missed appointment on the Member's health status including review of the reason for the appointment by a licensed staff member of the physician's office (RN, PA, NP, or MD).
 3. Notation in the chart describing follow-up for the missed appointment including one of the following actions: no action if there is no effect on the Member due to the missed appointment, a letter or phone call to the Member as appropriate, given the type of appointment missed and the potential impact on the Member. The chart entry must be signed or co-signed by the Member's assigned PCP or covering physician.
 4. Three attempts, at least one by phone and one by mail, must be made in attempting to contact a Member if the Member's health status is potentially at significant risk due to missed appointments. Examples include Members with serious chronic illnesses, Members with test results that are significant (e.g., abnormal PAP smear) and Members judged by the treating physician to be at risk for other reasons. Documentation of the attempts must be entered in the Member's medical record and copies of letters retained.
 5. Office staff in IEHP physician offices must be trained in, and be familiar with, the missed appointment procedure specific to their site.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	September 1, 1996
Chief Title: Chief Medical Officer	Revised date:	February 1, 2006

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C. Access to Care for People with Disabilities

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. It is the goal of IEHP to ensure that all facilities and services are fully accessible to individuals with disabilities. In accordance with the requirements of Title III of the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act and other applicable Federal and State laws and regulations that prohibit discrimination on the basis of disability, all IEHP Providers and practitioners contracted to provide care to Members are required to provide and maintain access for people with disabilities, to include whenever feasible, service animals.
- B. Access must be provided, whenever feasible, to service animals, as required by the ADA and pursuant to regulations.
- C. IEHP performs a comprehensive access survey for people with disabilities during the initial facility review of Primary Care Physician (PCP) sites, prior to a practitioner being approved to receive membership, as well as the high volume specialists and high volume ancillary service providers. This survey is repeated every three (3) years thereafter. The Physical Accessibility Review Survey (PARS) assessment tool is attached (see Attachment 6-4 in Section 6, "Attachments").
- D. IEHP consults with representatives of the local community of people with disabilities to continuously evaluate and maintain accessibility of services for Members with disabilities.

DEFINITIONS:

- A. Service animals are (1) guide dogs, (2) signal dogs, or (3) other animals individually trained to provide assistance to a person with a disability.
- B. Medically qualified personnel include attending or consulting physicians, residents, and supervisory nurses.

PROCEDURE:

- A. Office Access Standards
 - 1. Each practitioner's office must demonstrate the following:
 - a. Accessible parking spaces marked with adequate signage and having appropriate curb cuts within a reasonable distance from the facility's main entrance;

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- b. Easy wheelchair access to the main entrance via a ramp or absence of stairs or steps;
 - c. Inaccessible entrances have signs indicating the location of the nearest accessible entrance;
 - d. Provide an alternate access to care if the practitioner's office or building is not accessible to Members with disabilities;
 - e. Restroom is wide enough to accommodate wheelchair-users or a mobile commode;
 - f. Adequately secured handrails near toilets are provided in at least one restroom within the facility;
 - g. Drinking fountains and/or water coolers are accessible to wheelchair-users, if available;
 - h. If public telephones are available within the facility, at least one is appropriately placed within access for people with disabilities and has TTY availability;
 - i. All features for the Members with disabilities are marked by adequate signage;
 - j. Facility features designed specifically for access by people with disabilities are regularly inspected and repaired or replaced when necessary; and
 - k. Grievances, complaints, and disenrollments mentioning inadequate access for people with disabilities are carefully analyzed and researched to determine areas where improvements can be made.
- B. Providers who are anticipating modification to their facilities must meet Americans with Disabilities Act Access Guidelines (ADAAG).
- 1. The ADA establishes design requirements for the construction and alteration of facilities.
 - 2. The ADA requires health care providers to follow specific accessibility standards in ADAAG and California's Title 24 accessibility codes when constructing new facilities and when making alterations that could affect access to or use of the facility by people with disabilities.
 - 3. For more information regarding the ADAAG, go to www.access-board.gov/adaag/html/adaag.htm. For additional assistance, call IEHP's Disability Program Manager at (909) 890- 5833.
 - 4. For more information on the ADA, go to IEHP's "ADA and Beyond" web page: <http://ww2.iehp.org/IEHP/Who+We+Are/Resource+Center/ADAandBeyond/>
- C. Service Animals:

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C. Access to Care for People with Disabilities

1. Service animals are animals that are individually trained to perform tasks for people with disabilities such as guiding people who are blind, alerting individuals who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other special tasks. Service animals are working animals, not pets.
 - a. The ADA prohibits public accommodations from requiring “certification” or proof of an animal’s training, or proof of a person’s disability, for the purposes of access. However, evidence of current vaccinations such as rabies, may be requested.
 - b. Providers must make reasonable modifications in their policies, practices and procedures when necessary to provide accommodations to Members with disabilities. Generally, this includes modifying any no-pets policy to permit use of a service animal by an individual with a disability.
2. A service animal must be permitted to accompany the Member to all areas of the facility where Members are normally permitted unless a medical justification showing that the presence or use of a service animal would pose a health risk in certain parts of the institution directly involved.
3. Providers may request that the Member be separated from their service animal for short periods of time, if it is necessary to provide a service (i.e. Aqua PT, Audiology testing, or other procedures where there is limited space). The separation should not be any longer than it takes to provide the service.
4. Care and supervision of a service animal are the responsibility of the Member and/or guardian.
 - a. Neither IEHP nor its Providers are required to supervise or care for the service animal. Therefore, Members need to make their own arrangements to have someone feed, water and walk the animal during necessary separation in a medical facility.
5. Restrictions on Service Animals
 - a. A person with a disability cannot be asked to remove his service animal from the premises unless:
 - 1) The nature of the goods and services provided or accommodations offered at the Provider’s medical facility would be significantly altered.
 - 2) The safe operation of the medical facility would be jeopardized, or the animal poses a direct threat to the health or safety of others, such as preventing what should be a sterile environment (such as a surgical suite) or present a threat to others’ safety (such as an animal being out of control and the owner does not take effective

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C. Access to Care for People with Disabilities

action). Such areas may include, but are not limited to, the following:

- Operating room suites and post-anesthesia rooms;
- Burn unit;
- Coronary care units;
- Intensive care units;
- Oncology units;
- Psychiatric units;
- Isolation areas;
- Medication storage areas; and
- Clean or sterile supply areas.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	September 1, 1996
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

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C. Access to Care for People with Disabilities

1. Providing Interpreters for Members who are Deaf or Hard-of-Hearing

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. IPAs will provide equal access to its medical care services in a non-discriminatory manner as required by Title III, C.F.R Part 36 of the Americans with Disabilities Act of 1990. All IEHP providers and practitioners contracted to provide care to Members are required to provide and maintain access for people with disabilities.
- B. Requests for the scheduling of interpreter services for a Member who is deaf or hard-of-hearing may originate from:
1. Member,
 2. Family Member,
 3. Member's PCP or Specialist, or
 4. Member's IPA.
- C. For interpretation services, including American Sign Language (ASL), oral, and signed English, all practitioners must provide interpreters as requested for Member appointments at no charge to the Member.
- D. IEHP and its providers and practitioners may not suggest or require that Members provide their own sign language or oral interpreters.
- E. Members have the right not to use family members or friends as interpreters. If a Member chooses to use a family or friend in place of a qualified sign language or oral interpreter, signed documentation that interpreting services were offered and declined must be kept in the Member's record.
- F. It is recommended that the Member or provider make arrangements for an interpreter at the same time that the medical appointment is being scheduled. Interpreter services can be scheduled by calling IEHP Member Services at 1-800-440-IEHP (4347)/TTY 1-800-718-4347.
- G. IEHP can better ensure the availability of interpreters for the medical appointment if given at least 5 working days notice.
- H. Medical appointments may be rescheduled by a Member's health care provider upon agreement of both parties if there is no qualified interpreter available for the Member at that time.

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C. Access to Care for People with Disabilities

1. Providing Interpreters for Members who are Deaf or Hard-of-Hearing

I. IEHP is responsible for the cost of the interpretation services.

PROCEDURE:

- A. Providers who are requesting interpreter services should call IEHP Member Services at 1-800-440 IEHP (4347) and provide the following information:
1. Member's name;
 2. Member's IEHP# or SS#;
 3. PCP or specialist's name;
 4. Date and location of appointment;
 5. Time and expected length of appointment;
 6. Type of interpretation needed e.g. American Sign Language (ASL), oral, or written;
 7. Preferred gender of the interpreter required; and
 8. Single or an on-going appointment.
- B. IEHP must authorize all interpretation service requests. IEHP will call the contract interpreting services agency to make the arrangements.
- C. IEHP will confirm with the agency the scheduled interpreter's name and expected arrival time.
- D. IEHP will provide notification of confirmation to Member's PCP or specialist via a telephone call. IEHP will provide notification of confirmation to the Member via the Member's preference, using one of the four following methods: TTY, Video Phone Relay, California Relay Services, or e-mail.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	February 1, 2004
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

9. ACCESS STANDARDS

D. Access to Sensitive Services

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. Members have access to sensitive services through their PCP, or other network physicians within the IPA.
- B. Sensitive services include the following:
1. Treatment for sexual assault;
 2. Drug or alcohol treatment services;
 3. Pregnancy related services;
 4. Family planning services;
 5. Sexually transmitted disease diagnosis and/or treatment;
 6. HIV testing;
 7. Behavioral health care; and
 8. Abortion services.
- C. Members are bound by the rules or procedures required for the specific services they are accessing.
- D. Members are informed of their rights to access sensitive services through the Member Handbook.
- E. There are additional regulations that deal specifically with services provided to minors. The following table represents a summary of minor consent laws, as they apply to Sensitive Services.

9. ACCESS STANDARDS

D. Access to Sensitive Services

California Minor Consent Laws		Definitions:
Services teens can get without permission from their parent/guardian	Can provider tell teen's parent/ guardian?	<p>Minor: a person 16 years old and not legally an adult.</p> <p>Confidentiality: your health care provider cannot share your information with others without your permission.</p> <p>Note: Exceptions to confidentiality include reporting child abuse and billing insurance companies for health services.</p> <p>Consent: giving your health care provider permission to share your information with others; or giving permission to receive a health service.</p> <p>Notification: when your health care provider tells someone (such as your parent/guardian) you received a special health service.</p> <p>Contagious and reportable diseases: illnesses and infections that can spread quickly to other people and must be reported to government agencies.</p> <p>Outpatient: services that do not require an overnight stay or hospitalization.</p> <p>Rape: sexual intercourse without your permission.</p> <p>Sexual Assault: for the purposes of minor consent alone, sexual assault includes but is not limited to acts of oral sex, sodomy, rape, and other violent crimes of a sexual nature that occur without your permission.</p>
Abortion	Minors of any age	No
Birth Control	Minors of any age Except sterilization	
Pregnancy (Prev, Dx, Tx)	Minors of any age Including inpatient care	
STD's, Contagious and Reportable Diseases (Dx & Tx)	Minors 12 yrs or older	
HIV Testing	Minors 12 yrs or older and assessed as competent to give informed consent	
Rape	Minors 12 yrs or older Including inpatient care	
Alcohol/Drug Counseling by Federally Assisted Treatment Program	Minors 12 yrs or older ^{1,2} Including inpatient care	
Alcohol/Drug Counseling by Non-Federally Assisted Treatment Program	Minors 12 yrs or older ³	Yes
Outpatient Mental Health Treatment		An attempt to notify must be made, except when provider believes it is inappropriate
Sexual Assault	Minors of any age	Yes
		An attempt to notify must be made except when provider believes parent/guardian is responsible for assault

¹ However, parent/guardian can consent over the minor's objection.

² Parent/guardian's consent is required for methadone treatment.

³ If (1) the minor is 12 years or older, is mature enough to consent AND (2) the minor is (A) the victim of incest or child abuse or (B) would present a threat of serious physical or mental harm to self or others without treatment.

Adolescent Health Working Group, Adapted from CALIFORNIA MINOR CONSENT LAWS: *Who can consent for what services & providers' obligations.* © National Center for Youth Law: www.youthlaw.org. Revised 8/2006

9. ACCESS STANDARDS

D. Access to Sensitive Services

PROCEDURE:

- A. Treatment of sensitive services for minors may be obtained without parental consent through a practitioner other than the PCP if so requested and consistent with other access policies and procedures.
- B. Members, regardless of age, may obtain information regarding access to care and assistance with appointment scheduling for sensitive services through IEHP Member Services at (800) 440-4347 or their PCP's office. Assistance is provided with complete confidentiality.
- C. Periodic monitoring of practitioner compliance is performed through chart review and assessment of encounter data.
- D. Specific authorization or access requirements include:
 - 1. **Sexual Assault** - No prior authorization is required.
 - 2. **Drug or Alcohol Treatment Services:**
 - a. Covered under Healthy Families when medically necessary; services can be accessed with prior authorization through the PCP and IEHP Behavioral Health Program.
 - b. Coverage for Healthy Kids Program Members is limited to hospitalization for medically necessary detoxification for alcoholism or drug abuse. Authorization must be obtained from IEHP Behavioral Health Program prior to admission.
 - 1) Outpatient crisis intervention and treatment services for Riverside Healthy Kids Members are available through the Riverside County Department of Mental Health Intake Unit.
 - 2) Outpatient crisis intervention and treatment services for San Bernardino Healthy Kids Program Members are available through IEHP Behavioral Health Program.
 - 3. **Pregnancy Related Services** - No prior authorization is required; services can be provided by any credentialed obstetrical practitioner (OB/GYN or Family Practice), within the IPA's network.
 - 4. **Family Planning:**

Healthy Families and Healthy Kids Program Members do not have open access to Family Planning. Family Planning benefits are provided by the PCP or by PCP referral and IPA authorization.
 - 5. **Sexually Transmitted Disease Diagnosis and Treatment:**

9. ACCESS STANDARDS

D. Access to Sensitive Services

Healthy Families and Healthy Kids Program Members can obtain services through the PCP or by referral and IPA authorization to an IEHP practitioner or the Local Health Department (LHD).

6. **HIV Testing:**

For Healthy Families and Healthy Kids Members, no prior authorization is required; services can be obtained through the PCP, LHD testing site, or any qualified family planning practitioner if part of a family planning visit.

7. **Behavioral Health Care:**

- a. Healthy Families Members are referred by their PCP or IPA to IEHP Behavioral Health Program for assistance with access to behavioral health services.

IEHP

Phone – (800) 440-4347

Online – www.iehp.org

- b. For Healthy Kids Members, the PCP is responsible for behavioral health care within his/her scope of practice, otherwise a referral is made as follows:

- 1) Riverside Healthy Kids Members are referred to the Riverside County Mental Health Department at (800) 706-7500.
- 2) San Bernardino Healthy Kids Members are referred to IEHP Behavioral Health Program for assistance with access to behavioral health services.

IEHP

Phone – (800) 440-4347

Online – www.iehp.org

8. **Abortion Services:**

- a. Covered under Healthy Families and Healthy Kids Programs with prior authorization.

- E. For more specific information regarding authorization requirements and other details, see specific policies related to the particular service or condition, as outlined in Section 10, “Medical Care Standards.”

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	September 1, 1996
Chief Title: Chief Medical Officer	Revised Date:	January 1, 2011

9. ACCESS STANDARDS

E. Open Access to OB/GYN Services

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. In accordance with state law, IEHP requires that all IPAs must allow women direct access without referral for obstetrical or gynecological (OB/GYN) practitioner services to a participating OB/GYN or Family Practitioner (FP) that meets IEHP credentialing standards to provide obstetrical and gynecological services.
- B. IEHP requires Members to obtain direct access only from those OB/GYNs or FPs within the IPA to which they are assigned, and to use their assigned Hospital for facility based services.
- C. IEHP requires OB/GYNs or FPs to obtain prior authorization for any specialized procedures or other treatments outside of a “well woman” exam or routine obstetrical or gynecologic care.
- D. IEHP requires OB/GYNs or FPs to communicate with the Member’s PCP regarding the Member’s condition, treatment, and follow-up care.
- E. IEHP contracts define OB/GYN services as an IPA responsibility. This responsibility includes payment of services accessed by Members under this policy. If it is determined that payment was denied for services under the Open Access policy, IEHP would reimburse the provider and decap the IPA for the cost.
- F. Persistent non-compliance related to this policy will result in action against the IPA.

PROCEDURE:

- A. IPAs must allow Members with obstetrical or gynecological problems to have direct access without referral to OB/GYNs or FPs that meet IEHP credentialing standards to provide obstetrical and gynecological services (see Attachment 9-2 in Section 9, “Attachments”). Hospital services must be provided through the Hospital to which the Member is assigned.
- B. FPs participating under this policy must be credentialed by IPAs in accordance with IEHP standards for obstetrical privileges.
- C. Typical conditions for which a woman can directly access an OB/GYN or eligible FP include, but are not limited to, the following:
 - 1. Abdominal/Pelvic Pain
 - a. Salpingo-oophoritis

9. ACCESS STANDARDS

E. Open Access to OB/GYN Services

- b. Endometriosis
 - c. PID
 - 2. Abortion
 - 3. Amenorrhea
 - 4. Breast Lump
 - 5. Bartholin gland enlargement/cyst
 - 6. Dysmenorrhea
 - 7. Ectopic Pregnancy
 - 8. Endometriosis
 - 9. Dysuria
 - 10. Estrogen Replacement
 - a. Therapy/hormonal changes
 - 11. Family Planning/Birth Control
 - 12. Mastitis
 - 13. Menopause
 - 14. Menorrhagia
 - 15. PMS
 - 16. Polymenorrhea
 - 17. Pregnancy
 - a. Prenatal Care
 - 18. STD – testing and or treatment GC, Chlamydia, PID, Condyloma, etc.
 - 19. Vaginal Bleeding
 - 20. Vaginal Discharge
 - 21. Vaginitis
 - 22. Well woman exam
 - a. Pap Smear
 - b. Breast exam
- D. The OB/GYN or FP providing care to non-assigned Members accessing them under this policy must obtain prior authorization from their IPA for procedures, surgery or other services beyond routine or follow-up office visits. Examples of services requiring prior

9. ACCESS STANDARDS

E. Open Access to OB/GYN Services

authorization include, but are not limited to, the following:

1. Diagnostic Procedures
 - a. Amniocentesis
 - b. Colposcopy
 - c. CT
 - d. Endometrial Biopsy
 - e. MRI
 - f. Other specialty diagnostic procedures
 - g. Ultrasound
 2. Services
 - a. Referrals to other specialists
 3. Surgical Intervention
 - a. D & C
 - b. Hysterectomy
 - c. Laparoscopy
 4. Treatments
 - a. Cone biopsy
 - b. Cryosurgery
- E. Any OB/GYN or FP providing care to Members under this policy is required to communicate to the Member's PCP, in writing, the Member's condition, treatment and any need for follow-up care. OB/GYNs or FPs can meet this requirement by providing this information to the Member's IPA, which then must forward the information to the PCP.
- F. OB/GYNs and FPs providing care to Members under this policy are encouraged to either contact their IPA when initiating treatment, or to provide appropriate clinical information when submitting claims to the IPA to ensure timely and appropriate processing of claims.
- G. IPAs are required to reimburse OB/GYNs and FPs providing care to Members under this policy according to the guidelines above utilizing appropriate claims review and processing standards. Approval types for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.
- H. OB/GYNs and FPs providing care to Members under this policy must first appeal denied or disputed claims to the IPA. If the appeal is denied, claims appeal should be directed to

9. ACCESS STANDARDS

E. Open Access to OB/GYN Services

IEHP at:

Inland Empire Health Plan
P.O. Box 10129
San Bernardino, CA. 92423
Attention: Claims

- I. If IEHP determines that an IPA has denied payment for a claim submitted by an OB/GYN for a visit under Open Access policies, IEHP will reimburse the Provider and decap the IPA.
- J. IPAs should have a structure in place to monitor compliance with OB/GYN Open Access services. Process should include, but not limited to, review of denied services for OB/GYN services, review of Member and Provider grievances, review of Provider appeals and denial of OB/GYN Provider claims.
- K. IEHP will perform ongoing monitoring to assure compliance with these requirements. Persistent failure to comply with these requirements will result in negative action against the IPA, up to termination of the IEHP-IPA contract.
- L. Information regarding this policy or questions related to it can be obtained by calling the IEHP Provider Relations Team at (909) 890-2054.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 1999
Chief Title: Chief Medical Officer	Revised date:	August 1, 2007

9. ACCESS STANDARDS

F. Cancer Screening and Treatment Services

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

- A. IEHP requires that all IPAs approve screening tests for cancer by the Member's PCP or other treating physician if the request is based on generally medically accepted practice such as, but not limited to, those approved by the Food and Drug Administration (FDA), scientific evidence or IEHP policies and procedures and requested by the Member's physician and surgeon, nurse practitioner or certified nurse mid-wife, providing care to the Member and operating within the scope of practice otherwise permitted for the licensee.
- B. IEHP requires Members to obtain all care and services for cancer screening or diagnostic testing only from credentialed IEHP participating practitioners (including physicians, surgeons, nurse practitioners, certified nurse midwives, or other providers of service) within the IPA to which they are assigned, as applicable.
- C. IEHP requires Members obtaining care and services for cancer to receive services from the Member's assigned Hospital, as applicable.
- D. If the Member's treating physician, who is providing covered health care services recommends Member participation in a phase I thru IV clinical trial for cancer, coverage must be provided for all routine Member care costs related to the clinical trial. The clinical trial's endpoints must not be defined exclusively to test toxicity but must have a therapeutic intent.
- E. For services related to the treatment of cancer, IPAs can subject requests from treating physicians to prior authorization procedures.
- F. IEHP also requires that all IPAs approve diagnostic testing, screening, and treatment for breast cancer upon referral by the Member's participating physician if the request is based on generally medically accepted practice and scientific evidence.
- G. For reconstructive surgery or prosthetic devices necessary to restore symmetry for a Member after mastectomy, the IPA can subject the request to prior authorization.
- H. IEHP contracts define physician and other services as an IPA responsibility. This responsibility includes payment of services accessed by Members under this policy.
- I. For Healthy Families and Healthy Kids Members, all services including screening, diagnosing, surgery and prosthetic devices may be subject to coinsurance conditions applicable to other benefits.

9. ACCESS STANDARDS

F. Cancer Screening and Treatment Services

PROCEDURE:

- A. For cancer screening, IEHP requires IPAs to authorize the following services upon referral from, or if provided by, a Member's treating physician (either the Member's PCP, or OB/GYN, that the Member is directly accessing per Policy 9E, "Open Access to OB/GYN Services," or an authorized treating specialist), is in accordance with generally medically accepted practice and IEHP's policies and procedures:
1. Mammography screening
 2. PAP Smear testing
 3. Human Papillomavirus screening test
 4. Colorectal Screening and Fecal Occult Blood test
 5. Prostate Cancer Screening
 6. Other cancer screening tests as appropriate and approved by the FDA
- B. In addition, for breast cancer screening and diagnostic testing, IPAs must authorize the following services upon referral from a Member's treating physician (either the Member's PCP, an OB/GYN that the Member is directly accessing per Policy 9E, "Open Access to OB/GYN Services," or an authorized treating specialist):
1. Screening Mammography or Ultrasound – all requests for women over age 40 at least annually or more frequently if high risk; below the age of 40 if high risk
 2. Diagnostic mammography
 3. Diagnostic biopsy – as ordered by an appropriate specialist
- C. IPAs may require prior authorization for the following referral requests related to breast cancer services, but the services must be provided if medically necessary:
1. Surgical treatments – mastectomy, lumpectomy, etc.
 2. Chemotherapy
 3. Radiation therapy
 4. Treatments for complications related to breast cancer treatments
- D. IPAs may subject the following requests to prior authorization to determine the appropriate practitioner, but the services must be provided:
1. Prosthetic devices or reconstructive surgery necessary to restore symmetry for the patient after mastectomy.
- E. For a Member diagnosed with cancer and accepted into a phase I thru IV clinical trial for cancer, coverage must be provide for all routine Member care costs related to the clinical trials if the Member's treating physician, who is providing covered health care services

9. ACCESS STANDARDS

F. Cancer Screening and Treatment Services

recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member.

1. “Routine Member care costs” means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered if not in connection with an approved clinical trial program. This includes:
 - a. Services typically provided in the absence of a clinical trial.
 - b. Services required solely for the provision of the investigational drug item, device, or service.
 - c. Services required for the clinically appropriate monitoring of the investigational item or service.
 - d. Services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service.
 - e. Services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.
 - f. Co-payments may apply for routine care as described in the Member handbook.
2. “Routine Member care costs” does not include the following:
 - a. Drugs or devices that have not been approved by the FDA and that are associated with the clinical trial.
 - b. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Member may require as a result of the treatment being provided for purposes of the clinical trial.
 - c. Items or services provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member.
 - d. Services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Member’s health plan.
 - e. Services customarily provided by the research sponsors free of charge for any Member in the clinical trial.
3. Treatment shall be provided in a clinical trial that:
 - a. Involves a drug that is exempt under federal regulations from a new drug application.

9. ACCESS STANDARDS

F. Cancer Screening and Treatment Services

- b. Is approved by one of the following:
- 1) One of the National Institutes of Health;
 - 2) The FDA, in the form of an investigational new drug application;
 - 3) The United States Department of Defense;
 - 4) The United States Veterans' Administration.
4. The Member's right to the Independent Medical Review process is not limited.
- F. IPAs can direct all services noted above to practitioners within their network within those practitioners' scope of practice. If an appropriately qualified practitioner is not available within the IPA network, arrangements must be made for the Member to receive care from an appropriately qualified practitioner outside the IPA network.
- G. Practitioners rendering breast cancer services to Members are encouraged to either contact their IPA when initiating treatment or to provide appropriate clinical information when submitting claims to the IPA to ensure timely and appropriate processing of claims.
- H. IPAs are required to reimburse practitioners rendering care to Members under this policy according to the guidelines above, including appropriate claims review and processing standards. Approvals for visit codes and other CPT codes must follow appropriate claims review processes and not be arbitrarily pre-determined.
- I. Practitioners rendering care to Members must first appeal denied or disputed claims to the IPA. If the appeal is denied, the claims appeal should be directed to IEHP at:

Inland Empire Health Plan
P.O. Box 10129
San Bernardino, CA. 92423
Attention: Claims

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2000
Chief Title: Chief Medical Officer	Revised date:	January 1, 2009

9. ACCESS STANDARDS

Attachments

<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
9-1	Medical Transportation Services, Health and Safety Code, §51323	
9-2	OB/GYN Self-Referral, Health and Safety Code §1367.695	9E

22 CCR § 51323

Cal. Admin. Code tit. 22, § 51323

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 22. SOCIAL SECURITY
DIVISION 3. HEALTH CARE SERVICES
SUBDIVISION 1. CALIFORNIA MEDICAL ASSISTANCE PROGRAM
CHAPTER 3. HEALTH CARE SERVICES
ARTICLE 4. SCOPE AND DURATION OF BENEFITS

This database is current through 6/26/09, Register 2009, No. 26

§ 51323. Medical Transportation Services.

(a) Ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.

(1) Ambulance services are covered when the patient's medical condition contraindicates the use of other forms of medical transportation.

(2) Litter van services are covered when the patient's medical and physical condition:

(A) Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport.

(B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.

(3) Wheelchair van services are covered when the patient's medical and physical condition:

(A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

(B) Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation.

(C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(D) Does not require the specialized services, equipment and personnel provided in an ambulance, because the patient is in stable condition and does not need constant observation.

(b) Authorization shall be granted or Medi-Cal reimbursement shall be approved only for the lowest cost type of medical transportation that is adequate for the patient's medical needs, and is available at the time transportation is required.

(1) Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the patient. Each claim for program reimbursement of emergency medical transportation shall be accompanied by a written statement which will support a finding that an emergency existed. Notwithstanding Section 51056 (b), the statement may be made by the provider of the emergency transportation, describing the circumstances necessitating the emergency service. The statement shall include the name of the person or agency requesting the service, the nature and time of the emergency, the facility to which the patient was transported, relevant clinical information about the patient's condition, why the emergency services rendered were considered to be immediately necessary and the name of the physician accepting

responsibility for the patient at the facility.

(2) All nonemergency medical transportation, necessary to obtain program covered services, requires a physician's, dentist's or podiatrist's prescription and prior authorization except as provided in (C).

(A) When the service needed is of such an urgent nature that written authorization could not have reasonably been submitted beforehand, the medical transportation provider may request prior authorization by telephone. Such telephone authorization shall be valid only if confirmed by a written request for authorization.

(B) Transportation shall be authorized only to the nearest facility capable of meeting the patient's medical needs.

(C) Nonemergency transportation services are exempt from prior authorization when provided to a patient being transferred from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility licensed pursuant to [Section 1250 of the Health and Safety Code](#).

(c) Medical transportation by air is covered under the following conditions:

(1) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply:

(A) The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1).

(B) The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1).

(2) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

<[General Materials \(GM\)](#) - References, Annotations, or Tables>

Note: Authority cited: [Section 14124.5, Welfare and Institutions Code](#). Reference: [Sections 14132](#) and [14136.3, Welfare and Institutions Code](#).

HISTORY

1. New subsection (d) filed 7-6-82 as an emergency; effective upon filing (Register 82, No. 28). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 11-3-82. For prior history, see Register 82, No. 18.
2. Certificate of Compliance as to 7-6-82 order transmitted to OAL 11-3-82 and filed 12-3-82 (Register 82, No. 49).
3. Amendment of subsection (b) filed 4-11-84; effective thirtieth day thereafter (Register 84, No. 15).
4. Repealer of subsection (d) filed 8-9-85; effective thirtieth day thereafter (Register 85, No. 32).
5. Amendment of subsection (b)(2)(C), designation of portion of subsection (b)(2)(C) as new subsection (b)(2)(C)1. and amendment thereof, new subsections (b)(2)(C)2.-3., and amendment of Note filed 4-1-96 as an emergency; operative 4-1-96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 9-30-96 pursuant to [Welfare and Institutions Codesection 14132.22](#) or emergency language will be repealed by operation of law on the following day.

6. Editorial correction of History 5 (Register 96, No. 35).

7. Amendment of subsection (b)(2)(C), designation of portion of subsection (b)(2)(C) as new subsection (b)(2)(C)1. and amendment thereof, new subsections (b)(2)(C)2.-3., and amendment of Note refiled 8-28-96 as an emergency; operative 9-30-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-28-97 or emergency language will be repealed by operation of law on the following day.

8. Editorial correction of subsection (b)(2)(C)3. (Register 97, No. 11).

9. Certificate of Compliance as to 8-28-96 order transmitted to OAL 1-23-97 and filed 3-10-97 (Register 97, No. 11).

10. Change without regulatory effect amending subsection (b)(2)(C), repealing subsections (b)(2)(C)1.-3. and amending Note filed 6-12-2006 pursuant to [section 100, title 1, California Code of Regulations](#) (Register 2006, No. 24).

22 CCR § 51323, 22 CA ADC § 51323
1CAC

22 CA ADC § 51323

END OF DOCUMENT

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1367.695. (a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not be construed to diminish the provisions of Section **1367.69**.

(e) The Department of Managed Health Care shall report to the Legislature, on or before January 1, 2000, on the implementation of this section.