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 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.

Admission Review

The Utilization Management Case Review Clinician 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 (877) 708-2110

Concurrent/Continued Stay Review

Concurrent/Continued Stay Review is a process coordinated by the Utilization Management Case Review Clinician and is initiated within 24 hrs of or next business day following notification of the admission 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 $500 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

- 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***

See Prior Authorization attached
IMPORTANT INFORMATION FOR MOLINA HEALTHCARE

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.

- 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.

(Need to determine what contact phone numbers UM wants LIHP providers to use.

Providers may utilize Molina Healthcare’s ePortal at: [www.molinahealthcare.com](http://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

Rev 1/18/2012 Molina Healthcare does not require prior authorization for the following services:

- Emergency services
- Urgent Care services
- Treatment of sexually transmitted diseases
- Confidential HIV testing and counseling
- Sensitive and confidential services (e.g. services related to sexual assault, drug and alcohol abuse for children aged 12 and over)
- 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.
LAB REFERRALS

UNILAB/QUEST

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 pickup.

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
- 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: Conducted by Registered Nurses and is initiated within 24 hrs of or on the next business day following notification of admission.
- 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.

(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 Customer Support Center at (877) 814-2221, who will assist the member in coordinating the second opinion request with the member’s PCP or specialist.
- Members assigned to a direct contracted PCP/FQHC/Community Clinic or 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.
- 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 Rev 1/18/2012 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 who has been providing care for:

Conditions For Continuation of Services:
• 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.

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.)

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, 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, 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 and the terminated Provider/Practitioner.

Continuity of care for outpatient services, outstanding and ongoing authorizations, for a terminated Provider/Practitioner shall be reviewed by Molina Healthcare’s Medical Director in consultation with the PCP and other Providers/Practitioners involved with the patient’s care.
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
- Catastrophic Medical Conditions (HIV, Neoplasms, Organ/Tissue Transplants, Multiple Trauma)
- Chronic Illness (Asthma, Diabetes, ESRD)
- HighTechnology 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
- Members receiving care in noncontracted 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.

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
- 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. Section 9 2 • 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 selfhelp.

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 18005268196, Ext. 127604 Fax (888) 2731735
Glossary Term Definitions

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 will have an initial health assessment scheduled within less than ninety (< 90) 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. Assessment is designed to be self-completed by members while waiting for their medical visit. If a member 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.

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 Healthcare'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.

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, 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.

VISION CARE SERVICES

Referral

Members may be referred for vision care services outside of the LIHP by their PCP. A referral for a diabetic retinal exam is not required if there is a diagnosis of diabetes.
Routine Eye Examination
The PCP plays a vital role in detecting ocular abnormalities that require referrals for a comprehensive eye examination outside of the LIHP.

SEXUALLY TRANSMITTED DISEASES (STD)
Molina Healthcare members may access care for STDs without prior authorization requirements. In accordance with Federal Law, LIHP enrollees 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.

Non-Participating Provider/Practitioners
Molina Healthcare requests that non-participating Providers/Practitioners contact the Customer Support Center at Molina Healthcare (1-877-814-2221) to confirm eligibility and benefits and to obtain billing instructions for Molina Healthcare members. 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 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. The billing address is located on the back of the member’s ID card.

**HUMAN IMMUNODEFICIENCY VIRUS (HIV) PRIMARY CARE, TESTING, AND COUNSELING**

The federal Department of Health and Human Services has determined that current Ryan White HIV/AIDS Program (Ryan White) clients eligible for LIHP services must be enrolled in county Low Income Health Programs. As such, the Sacramento County LIHP will include primary care providers with relevant expertise. Ryan White enrollees will be assigned to a primary care medical home who can meet these special service needs. Designated providers of specialized services will have these services identified in their Molina provider contract.

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 for services provided by HIV/AIDS primary care and specialist providers for the LIHP 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 lavage
- 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 outside of the LIHP 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

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.
- 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.

- 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.

<table>
<thead>
<tr>
<th>Class</th>
<th>Type</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>No TB exposure Not infected</td>
<td>No history of exposure Negative reaction to tuberculin skin test</td>
</tr>
<tr>
<td>I</td>
<td>TB exposure No evidence of infection</td>
<td>History of exposure Negative reaction to tuberculin skin test</td>
</tr>
<tr>
<td>II</td>
<td>TB infection No disease</td>
<td>Positive reaction to tuberculin skin test Negative bacteriologic studies (if done) No clinical or radiological evidence of TB</td>
</tr>
<tr>
<td>III</td>
<td>Current TB disease</td>
<td><em>M. Tuberculosis</em> cultured (if done) OR Positive reaction to the tuberculin skin tests AND Clinical or Radiological evidence of current disease</td>
</tr>
<tr>
<td>IV</td>
<td>Previous TB disease</td>
<td>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</td>
</tr>
<tr>
<td>V</td>
<td>TB suspected</td>
<td>Diagnosis pending</td>
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- 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

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 corticosteroid therapy
- Other immunosuppressive therapy
- Cancer of the head and neck
- Hematological and Reticuloendothelial disease
- End-stage renal disease
- Intestinal bypass or gastrectomy

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.
- Krames Communications, “Understanding Tuberculosis”. Telephone: (800) 333-3032.
- 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
- 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.

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:

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Diagnosis and treatment

- Medical therapy
- Highrisk infant followup
- 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 multidisciplinary and multispecialty 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 nonrelated CCS conditions.

Case Managers coordinate with the PCP to provide all nonCCS 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 ICD9CM categories and the presence of
certain qualifying conditions. The following listing by ICD9CM 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
- Need diagnostic services to confirm a CCS eligible condition; or
- Have MediCal 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

Rev 09-28-2012
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 MediCal approved benefits and may lose his or her CCS eligibility if he or she loses MediCal eligibility.

If the form is on file with CCS, CCS may provide services in addition to the MediCal benefits and the member may continue to receive services through CCS even if he/she loses MediCal 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 MediCal 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 MediCal 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 MediCal beneficiaries
- RESIDENTIAL: The patient resides in the applicable county (information for MediCal 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 timeframe 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, MediCal beneficiaries are offered the full range of CCS benefits including those unique CCS benefits that are beyond the scope of the MediCal 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 MediCal program for MediCal benefits or by the CCS Program for unique CCS benefits. All authorizations are timelimited 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 Xray 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 DentiCal Provider/Practitioner for services.
- Scoliosis: Xray 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 HighRisk Infant FollowUp (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

Section 11 28
Exhibits
## VACCINES FOR CHILDREN (VFC) PROGRAM

**PROVIDER ENROLLMENT FORM—PRIVATE SECTOR**

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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 Alaska 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 (VIS)) 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 fee 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 or 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 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 (visible and non-visible) VFC vaccine. I also will comply with the VFC Program's procedures for return of the vaccine.

**PROVIDER OF RECORD**

<table>
<thead>
<tr>
<th>PROVIDER OF RECORD</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Exhibit 11D-3

Rev 09-28-2012
VACCINES FOR CHILDREN (VFC) PROGRAM
PROVIDER PROFILE FORM - PRIVATE SECTOR

"I 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 VFC Program. The State also may use the information to compare the estimated needs of providers with actual vaccine orders submitted. This 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 (VFC 8455) 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 number of eligible children is changed; (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.

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

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

STATE USE ONLY

Please Print or Type.

EMPLOYEE IDENTIFICATION NUMBER

MEDICAL LICENSE NUMBER

IDEA PROVIDER:

MCCP PROVIDER:

CHIEF PROVIDER:

MEDICAL PROVIDER:

DATE:

TYPE OF FACILITY (Please Check The One Box That Represents the Type 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

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>VACCINE DELIVERY ADDRESS (Number, Street, Suite, No, P.O. Box, City):</td>
</tr>
<tr>
<td>CITY</td>
</tr>
<tr>
<td>ZIP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAILING ADDRESS:</td>
</tr>
<tr>
<td>CITY</td>
</tr>
<tr>
<td>ZIP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAX NUMBER</td>
</tr>
<tr>
<td>EMAIL ADDRESS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DAYS AND TIMES FOR DELIVERY (Specify all days and times during which you may receive vaccine deliveries):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Tues (Time:<strong><strong><strong><strong><strong><strong><strong><strong>) ☐ Wed (Time:</strong></strong></strong></strong></strong></strong></strong></strong>) ☐ Thurs (Time:<strong><strong><strong><strong><strong><strong><strong><strong>) ☐ Fri (Time:</strong></strong></strong></strong></strong></strong></strong></strong>)</td>
</tr>
</tbody>
</table>

Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category.*

<table>
<thead>
<tr>
<th>Ages</th>
<th>&lt;1</th>
<th>1-6</th>
<th>7-18</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CHDPA/Medi-Cal Eligible</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>Without Private Insurance</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3.</td>
<td>American Indian or Alaskan Native</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>SUBTOTAL (1+2+3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Not Eligible for VFC Program Vaccine (Include children with health insurance and Healthy Families Program subscribers)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>TOTAL (1+2+3+4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>TYPE OF DATA USED FOR ESTIMATES</th>
<th>Doses Administered Reports</th>
<th>CHDPA/Medi-Cal Claim Data</th>
<th>Other (Specify)</th>
</tr>
</thead>
</table>

Please send the white copy (original) to this address: 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

Exhibit 11D-2

Rev 09-28-2012
### VACCINES FOR CHILDREN (VFC) PROGRAM
#### VACCINE ORDER FORM

**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. If you should not take 30 days to deliver vaccines, 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. You may receive a duplicate order. If you have any questions, call (510) 704-3700.

**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

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**Notes:**
1. Toxoids and vaccines not available through the VFC Program: DT-Pediatric and Te-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 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 at least one person at high risk of complications from varicella (e.g., immunocompromised persons).

#### Vaccines

<table>
<thead>
<tr>
<th>Number of Doses (VFC Only)</th>
<th>Number of Doses (All Orders)</th>
<th>Lot Number</th>
<th>Expiration Date</th>
<th>New Vaccine Order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REGULAR ORDER VFC VACCINES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTaP (Preferred MR.:</td>
<td>10 or 15 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (Pediatric)1</td>
<td>5 or 10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (Pediatric/Adolescent)</td>
<td>1 package (1 dose)</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B/Hib Combination</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib (Prefered MR.:)</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*V (inactivated Polio Vaccine)</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dIPV (Combined Measles, Mumps, and Rubella)</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>6 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)*</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SPECIAL ORDER VFC VACCINES (These vaccines are available only for special circumstances.)*

<table>
<thead>
<tr>
<th>Number of Doses (VFC Only)</th>
<th>Number of Doses (All Orders)</th>
<th>Lot Number</th>
<th>Expiration Date</th>
<th>New Vaccine Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (Adult)</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(only for adolescents 11-15 years of age)</td>
<td></td>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (September-October ONLY; only for ACIP high risk categories)</td>
<td>10 doses</td>
<td>doses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IMPORTANT**

- Send another manufacturer's vaccine.
- Send the manufacturer's vaccine I requested when it is available.

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**STATE USE ONLY**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSIGNED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>APPROVED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ASSIGNED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ENTERED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SHIPPED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Exhibit 11D-1**
<table>
<thead>
<tr>
<th>ELIGIBLE CONDITIONS</th>
<th>INELIGIBLE CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenal disorders</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
</tr>
<tr>
<td>Ambiguous genitalia</td>
<td>Amblyopia</td>
</tr>
<tr>
<td>Anemia – dietary deficiency, if causes life threatening complications</td>
<td>Anemia – dietary deficiency, simple</td>
</tr>
<tr>
<td>Anemia, aplastic</td>
<td></td>
</tr>
<tr>
<td>Anemia, hemolytic</td>
<td>Autism</td>
</tr>
<tr>
<td>Aneurysm</td>
<td></td>
</tr>
<tr>
<td>Arthrogryposis</td>
<td></td>
</tr>
<tr>
<td>Asthma, if CLD demonstrated by CXR or PFTs</td>
<td>Behavioral disorders</td>
</tr>
<tr>
<td>Biliary atresia</td>
<td></td>
</tr>
<tr>
<td>Blindness, congenital or acquired</td>
<td>Burns, minor</td>
</tr>
<tr>
<td>Burns, 2nd &amp; 3rd degree of face, ear, mouth, throat, genitals, perineum, major joints, hands, feet</td>
<td>Burns, minor</td>
</tr>
<tr>
<td>Burns, 3rd degree, &gt;5% BSA, any age</td>
<td>Burns, minor</td>
</tr>
<tr>
<td>Burns, electrical</td>
<td></td>
</tr>
<tr>
<td>Burns, other - specific criteria pg. 44</td>
<td>Burns, minor</td>
</tr>
<tr>
<td>Burns, w/inhalation injury, respiratory distress</td>
<td>Burns, minor</td>
</tr>
<tr>
<td>Cardiac dysrhythmias - requiring medical or surgical treatment</td>
<td>Cardiac dysrhythmias, no treatment required</td>
</tr>
<tr>
<td>Cataracts</td>
<td></td>
</tr>
<tr>
<td>Cerebral hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy - specific criteria pg. 24</td>
<td>Chalazion</td>
</tr>
<tr>
<td>Cholecystitis - if chronic &amp; stones present</td>
<td>Chalazion</td>
</tr>
<tr>
<td>Choleithiasis</td>
<td></td>
</tr>
<tr>
<td>Cholesteatoma</td>
<td></td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td></td>
</tr>
<tr>
<td>Chronic lung infections - abscess or bronchiectasis</td>
<td></td>
</tr>
<tr>
<td>Chronic respiratory failure - ventilatory assistance</td>
<td></td>
</tr>
<tr>
<td>Circulatory disorders, arterial, venous, lymphatic</td>
<td></td>
</tr>
<tr>
<td>Cirrhosis</td>
<td></td>
</tr>
<tr>
<td>Cleft lip &amp; palate</td>
<td></td>
</tr>
<tr>
<td>Club feet</td>
<td></td>
</tr>
<tr>
<td>Congenital defects -<strong>if amenable to cure, correction or amelioration</strong> &amp; disfigure or cause dysfunction</td>
<td></td>
</tr>
<tr>
<td>Congenital heart defects - if treatment required</td>
<td></td>
</tr>
<tr>
<td>Craniosynostosis</td>
<td></td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td></td>
</tr>
<tr>
<td>Cryptorchidism - if bilateral (undescended testicles)</td>
<td>Cryptorchidism - unilateral</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td></td>
</tr>
<tr>
<td>Dacrocystitis - chronic</td>
<td></td>
</tr>
</tbody>
</table>
ccsquickrefgde Exhibit 11 C-1
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>Developmental delay</td>
</tr>
<tr>
<td>Disseminated Intravascular Coagulation - DIC</td>
<td>Down’s syndrome</td>
</tr>
<tr>
<td>Diverticulitis</td>
<td></td>
</tr>
<tr>
<td>Epidermolysis bullosa</td>
<td></td>
</tr>
<tr>
<td>Eye infections that may lead to blindness</td>
<td></td>
</tr>
<tr>
<td>Femoral anteversion, if requires <strong>more than</strong> special shoes, splints, simple bracing</td>
<td>Femoral anteversion, if requires <strong>only</strong> special shoes, splints, simple bracing</td>
</tr>
<tr>
<td>Flat feet, if requires <strong>more than</strong> special shoes, splints, simple bracing</td>
<td>Flat feet, if requires <strong>only</strong> special shoes, splints, simple bracing</td>
</tr>
<tr>
<td>Foreign bodies - requiring surgery, could result in death or permanent dysfunction</td>
<td>Failure to thrive</td>
</tr>
<tr>
<td>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</td>
<td>Fracture, femur - <strong>no additional qualifiers</strong> Fracture, orbital blow-out Fracture, pelvis - <strong>no additional qualifiers</strong> Fracture, skull - if CNS complications, disfiguring Fracture, spine - <strong>no additional qualifiers</strong></td>
</tr>
<tr>
<td>Gastrochisis</td>
<td>Fracture, mandible - simple Fracture, nasal bones - simple Fracture, mid-shaft, casting only</td>
</tr>
<tr>
<td>GE reflux – if part of or complicates an eligible condition or is isolated w/complications like esophageal stricture or chronic aspiration pneumonia</td>
<td>GE reflux - simple, primary</td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
</tr>
<tr>
<td>Glomerulonephritis, acute – in presence of acute renal failure, malignant hypertension, or CHF</td>
<td></td>
</tr>
<tr>
<td>Glomerulonephritis, chronic</td>
<td></td>
</tr>
<tr>
<td>Growth Hormone Deficiency – growth chart must show a height of &gt;3 standard deviations below mean for age or a linear growth rate &lt;the 3rd percentile for age</td>
<td></td>
</tr>
<tr>
<td>Hearing Loss - specific criteria pg. 30</td>
<td></td>
</tr>
<tr>
<td>Hearing loss risk factors or symptoms. CCS may open for diagnostic services leading to confirmation of condition</td>
<td></td>
</tr>
<tr>
<td>Heart diseases, chronic</td>
<td></td>
</tr>
<tr>
<td>Hemophilia</td>
<td></td>
</tr>
<tr>
<td>Hernia, diaphragmatic</td>
<td>Hernia: umbilical, inguinal, Hydrocele</td>
</tr>
<tr>
<td>Hirschsprung’s Disease</td>
<td></td>
</tr>
<tr>
<td>HIV +</td>
<td></td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td></td>
</tr>
<tr>
<td>Hydronephrosis, chronic</td>
<td></td>
</tr>
<tr>
<td>Hydronephrosis, congenital</td>
<td></td>
</tr>
<tr>
<td>Hypertension - primary, requires treatment</td>
<td></td>
</tr>
</tbody>
</table>

**CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE**

ccsquickrefgde Exhibit 11 C-2

Rev 09-28-2012
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypospadius</td>
<td></td>
</tr>
<tr>
<td>Idiopathic Thrombocytopenic Purpura (ITP)</td>
<td></td>
</tr>
<tr>
<td>Immune deficiency disorders, congenital or acquired</td>
<td></td>
</tr>
<tr>
<td>Immunization reactions, severe - require extensive care</td>
<td></td>
</tr>
<tr>
<td>Imperforate anus</td>
<td></td>
</tr>
<tr>
<td>Inborn errors of metabolism</td>
<td></td>
</tr>
<tr>
<td>Ingestion of drugs, poisonous - accidental, life threatening</td>
<td>Ingestion of drugs, self-inflicted</td>
</tr>
<tr>
<td>Intervertebral disc herniation</td>
<td></td>
</tr>
<tr>
<td>Joint infections, acute or chronic</td>
<td></td>
</tr>
<tr>
<td>Juvenile Rheumatoid Arthritis</td>
<td></td>
</tr>
<tr>
<td>Kawasaki disease, if cardiac involvement</td>
<td></td>
</tr>
<tr>
<td>Knock knees, genu valgum, if requires <strong>more than</strong> special shoes, splints, simple bracing</td>
<td>Knock knees - genu valgum, if requires <strong>only</strong> special shoes, splints, simple bracing</td>
</tr>
<tr>
<td>Kyphosis</td>
<td></td>
</tr>
<tr>
<td>Lead poisoning - blood level 20 mcg or above</td>
<td>Learning disabilities</td>
</tr>
<tr>
<td>Leg length discrepancy</td>
<td></td>
</tr>
<tr>
<td>Legg-Calve-Perthes disease</td>
<td></td>
</tr>
<tr>
<td>Liver failure, acute or chronic</td>
<td></td>
</tr>
<tr>
<td>Lymphedema - chronic</td>
<td></td>
</tr>
<tr>
<td>Malabsorption syndromes</td>
<td>Meningitis - acute</td>
</tr>
<tr>
<td>Malocclusion, handicapping – subject to CCS screening</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>Mastoiditis</td>
<td></td>
</tr>
<tr>
<td>Microtia</td>
<td>Microcephaly</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Migraine headaches</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td></td>
</tr>
<tr>
<td>Myasthenia Gravis</td>
<td></td>
</tr>
<tr>
<td>Necrotizing enterocolitis (NEC)</td>
<td></td>
</tr>
<tr>
<td>Neoplasms - all malignant, including blood &amp; lymph systems</td>
<td></td>
</tr>
<tr>
<td>Neoplasms, benign – if causes significant disability, dysfunction or visible deformity</td>
<td></td>
</tr>
<tr>
<td>Nephritis, chronic</td>
<td></td>
</tr>
<tr>
<td>Nephrotic syndrome, chronic</td>
<td></td>
</tr>
<tr>
<td>Neurofibromatosis</td>
<td></td>
</tr>
<tr>
<td>Omphalocele</td>
<td>Obesity, Exogenous</td>
</tr>
<tr>
<td>Optic atrophy, hypoplasia or neuritis</td>
<td>Orthodontia, routine</td>
</tr>
<tr>
<td>Osteochondroma</td>
<td>Otitis media, acute</td>
</tr>
<tr>
<td>Osteochondrosis</td>
<td></td>
</tr>
<tr>
<td>Osteogenesis Imperfecta</td>
<td></td>
</tr>
<tr>
<td>Osteomyelitis</td>
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<tr>
<td>Otosclerosis</td>
<td></td>
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<tr>
<td>Ovarian dysfuction</td>
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<tr>
<td>CCS CONDITIONS MATRIX - QUICK REFERENCE GUIDE</td>
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<td>-----------------------------------------------</td>
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<tr>
<td>ccsequickrefgde Exhibit 11 C-4</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic disorders</td>
</tr>
<tr>
<td>Pancreatitis - if chronic</td>
</tr>
<tr>
<td>Paraplegia</td>
</tr>
<tr>
<td>Parathyroid disorders</td>
</tr>
<tr>
<td>Pemphigus erythematous, foliaceus, vegetans, vulgaris</td>
</tr>
<tr>
<td>Peptic ulcer</td>
</tr>
<tr>
<td>Perforated TM requiring tympanoplasty</td>
</tr>
<tr>
<td>Phenylketonuria - PKU</td>
</tr>
<tr>
<td>Pigeon toes - talipes varus, if requires <strong>more than</strong> special shoes, splints, simple bracing</td>
</tr>
<tr>
<td>Pigeon toes - talipes varus, requires <strong>only</strong> special shoes, splints, simple bracing</td>
</tr>
<tr>
<td>Pituitary disorders</td>
</tr>
<tr>
<td>Pneumonia, aspiration – secondary to CCS condition</td>
</tr>
<tr>
<td>Poliomyelitis</td>
</tr>
<tr>
<td>Poliomyelitis</td>
</tr>
<tr>
<td>Polycythemia</td>
</tr>
<tr>
<td>Polydactyly, complex</td>
</tr>
<tr>
<td>Precocious or delayed puberty</td>
</tr>
<tr>
<td>Ptosis of eye lid</td>
</tr>
<tr>
<td>Quadriplegia</td>
</tr>
<tr>
<td>Renal calculus</td>
</tr>
<tr>
<td>Respiratory infections- chronic, if causes significant disability &amp; respiratory obstruction or complicates the management of a CCS eligible condition</td>
</tr>
<tr>
<td>Retinal detachment</td>
</tr>
<tr>
<td>Retinopathy of prematurity</td>
</tr>
<tr>
<td>Scars – involving joint &amp; are disabling or disfiguring</td>
</tr>
<tr>
<td>Scleroderma</td>
</tr>
<tr>
<td>Scoliosis - 20 degree defect, X-ray only needed</td>
</tr>
<tr>
<td>Seizure Disorders - specific criteria, pg. 24</td>
</tr>
<tr>
<td>Sequelae of CNS infection if - e.g., motor or sensory deficit after meningitis</td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
</tr>
<tr>
<td>Skin diseases – persistent or progressive</td>
</tr>
<tr>
<td>Slipped Capital Femoral Epiphysis</td>
</tr>
<tr>
<td>Snake bite, poisonous - require complex care, life threatening</td>
</tr>
<tr>
<td>Spider bite, poisonous - require complex care, life threatening</td>
</tr>
<tr>
<td>Spina Bifida</td>
</tr>
<tr>
<td>Strabismus if surgery is required</td>
</tr>
<tr>
<td>Subarachnoid hemorrhage</td>
</tr>
<tr>
<td>Syndactyly, complex</td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Systemic Lupus Erythematosus</td>
</tr>
<tr>
<td>Testicular dysfunction</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
</tr>
<tr>
<td>Thromboembolism</td>
</tr>
<tr>
<td>Thymus disorders</td>
</tr>
<tr>
<td>Thyroid disorders</td>
</tr>
<tr>
<td>Tibial torsion, if requires more than special shoes, splints, simple bracing</td>
</tr>
<tr>
<td>Tracheoesophageal fistula</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
</tr>
<tr>
<td>Uropathies, obstructive - fistulas, strictures, adhesions, stones</td>
</tr>
<tr>
<td>Vesicoureteral reflux - grade II or greater</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>EARLY START</th>
<th>HEALTH DEPT. PROGRAM</th>
<th>EARLY START OR HEALTH DEPT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Biological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Prematurity (less than 32 weeks)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2. Birth weight (1500-1251 gms)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Birth weight (1250-1060 gms)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4. Birth weight (less than 1060 gms)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Small for gestational age (SGA), failure to thrive (FTT)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Prolonged hypoxemia</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Metabolic problem</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8. Hyperbilirubinemia (More than 20 mg/dl)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>9. Seizure Activity</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Serious bio-medical insult:</td>
<td></td>
<td></td>
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<tr>
<td>10a. CNS Bleeds - Grade III &amp; IV</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10b. CNS Bleeds - Grade I &amp; II</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>10c. Respiratory Distress Syndrome (RDS)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>10d. Sequelae of CMS, Syphilis, Rubella, Herpes</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>10e. Other confirmed infections</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>10f. PFS - Pulmon, hypertension</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11. Hx of maternal chemical exposure and/or substance abuse eg., alcohol, hydantoin, warfarin</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>12. Multiple congenital anomalies</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>13. Necrotizing Enterocolitis (NEC)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Exhibit 11B-1
<table>
<thead>
<tr>
<th>FACTOR</th>
<th>EARLY START</th>
<th>HEALTH DEPT. PROGRAM</th>
<th>EARLY START OR HEALTH DEPT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Psychosocial</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>1. Persistent feeding problems</td>
<td></td>
<td></td>
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<tr>
<td>2. Tenal problems</td>
<td></td>
<td>X</td>
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<tr>
<td>3. Continue evidence of delay in one or more developmental areas</td>
<td>X</td>
<td></td>
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<tr>
<td>4. Multiple birth</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>C. Environmental Factors</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. Poor parent/infant attachment</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Family hx of suspected child abuse or other domestic violence</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mother with medical or mental condition of a nature to require supervision &amp; support to fulfill parental responsibilities, excluding mental retardation</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>4. If in opinion of interdisciplinary team the infant is considered to be a high risk of becoming developmentally disabled</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5. Mother with mental retardation</td>
<td></td>
<td>X</td>
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</tbody>
</table>
# Vaccines for Children (VFC) Program Provider Profile Form—Supplemental

<table>
<thead>
<tr>
<th>LAST NAME, FIRST, MI</th>
<th>MEDICAID PROVIDER NUMBER (i.e., CHIP or Medi-Cal number)</th>
<th>MEDICAL LICENSE NUMBER</th>
<th>TITLE (e.g., MD, DO, NP, PA)</th>
<th>SPECIALTY (e.g., Peds, Family Med, GI, Other [Specify])</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Instructions:** You must use this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided 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.

---

*Exhibit 11D-4*
EXCLUDED DRUGS: BILL MEDICAL FEEFORSERVICE DIRECTLY

The Department of Health Care Services through the MediCal FeeForService (FFS) program has assumed financial responsibility of select antipsychotics and HIV/AIDS medications. The following drugs should be billed to FeeForService MediCal, 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 MediCal Fee–For-

<table>
<thead>
<tr>
<th>PSYCHIATRIC DRUGS (Listed by generic name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acamprosate Calcium</td>
</tr>
<tr>
<td>Haloperidol Decanoate</td>
</tr>
<tr>
<td>Haloperidol Lactate</td>
</tr>
<tr>
<td>Promazine HCL</td>
</tr>
<tr>
<td>Isoxiprazole</td>
</tr>
<tr>
<td>Isocarboxazid</td>
</tr>
<tr>
<td>Benztropine Mesylate</td>
</tr>
<tr>
<td>Lithium Carbonate</td>
</tr>
<tr>
<td>Risperidone</td>
</tr>
<tr>
<td>Biperiden HCL</td>
</tr>
<tr>
<td>Lithium Citrate</td>
</tr>
<tr>
<td>Selegiline</td>
</tr>
<tr>
<td>Biperiden Lactate</td>
</tr>
<tr>
<td>Loxapine HCL</td>
</tr>
<tr>
<td>Thioridazine HCL</td>
</tr>
<tr>
<td>Buprenorphine HCl</td>
</tr>
<tr>
<td>Loxapine Succinate</td>
</tr>
<tr>
<td>Thiothixene HCL</td>
</tr>
<tr>
<td>Buprenorphine/Naloxone HCl</td>
</tr>
<tr>
<td>Mesoridazine Mesylate</td>
</tr>
<tr>
<td>Thiothixene HCL</td>
</tr>
<tr>
<td>Chlorpromazine HCL</td>
</tr>
<tr>
<td>Molindone HCL</td>
</tr>
<tr>
<td>Tranylcypromine Sulfate</td>
</tr>
<tr>
<td>Chlorprothixene</td>
</tr>
<tr>
<td>Naltrexone (oral and injectable)</td>
</tr>
<tr>
<td>Trifluoperazine HCL</td>
</tr>
<tr>
<td>Clozapine</td>
</tr>
<tr>
<td>Olanzapine/</td>
</tr>
<tr>
<td>Olanzapinefluoxetine</td>
</tr>
<tr>
<td>Triflupromazine HCL</td>
</tr>
<tr>
<td>Fluphenazine Decanoate</td>
</tr>
<tr>
<td>Paliperidone</td>
</tr>
<tr>
<td>Trihexyphenidyl HCL</td>
</tr>
<tr>
<td>Fluphenazine Enanthate</td>
</tr>
<tr>
<td>Perphenazine</td>
</tr>
<tr>
<td>Ziprasidone</td>
</tr>
<tr>
<td>Fluphenazine HCL</td>
</tr>
<tr>
<td>Phenelzine Sulfate</td>
</tr>
<tr>
<td>Haloperidol</td>
</tr>
<tr>
<td>Pimozide</td>
</tr>
</tbody>
</table>

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.

Senior and Adult InHome Supportive Services
4875 Broadway
Sacramento, CA 95820
(916) 874-9471 and Fax (916) 874-9682

Rev 09-28-2012
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) 5268196 Fax: (562) 4996173

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.

SKILLED NURSING FACILITY 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 skilled nursing facility (SNF) is initiated by an inpatient 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 SNF should be made when the Provider/Practitioner has determined that the member meets, or may meet, the criteria for any of the following longterm care facilities:

- Transitional care
- Skilled nursing facility (SNF)
- Short term care
Potentially appropriate members for SNF 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.

SNF 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 SNF will be reviewed at a minimum of twice a week with the Utilization Management Medical Director.

If the member does not meet the criteria for an admission to a SNF, 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 Customer Support Center (1-877-814-2221), which will submit a request to Sacramento County for mandatory disenrollment of LIHP members requiring long term care. The Customer Support Center is responsible for the disenrollment process of the member. The PCP will provide all medically necessary covered services to the member until the disenrollment is effective.

---

**MENTAL HEALTH BENEFIT AND COORDINATION**

**Overview of General Structure**

Sacramento County LIHP enrollees are eligible for certain mental health benefits as noted below. Specialty mental health services must continue to be authorized and provided by the Sacramento County Mental Health Plan.

**Primary Care Medical Home General Requirements**

*Primary Care medical homes must:*

- Ensure licensed professionals provide services within their scope of practice.
- Either provide or ensure that LIHP enrollees receive the mental health core benefits when clinically indicated.
- Provide services within the scope of the MH core benefit to assigned LIHP members.
- Prior authorization is not required. Chart review may be used to monitor service quality and claims substantiation.

**Mental Health Core Benefit**

- LIHP enrollees are eligible for 12 outpatient encounters per calendar year.
- Acceptable encounters include assessment, individual therapy, medication support and assessment.
- Mental Health Services provided on the same day as another billed service visit are not claimable.
Documentation

- Within appropriate scope of practice document a mental health diagnosis as specified within the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.
- Document that the enrollee has at least one of the following impairments as a result of the diagnosed mental disorder:
  - A significant impairment in an important area of life functioning
  - A probability of significant deterioration in an important area of life functioning.
- Document an intervention, within their scope of practice, reasonably calculated to:
  - Significantly diminish that impairment; or
  - Prevent significant deterioration in an important area of life functioning.

Tracking

- Primary Care Medical Home designee will receive a monthly utilization report from County LIHP.
- Claims for outpatient visits beyond the maximum allowable will be denied.

Care Coordination

- Primary Care Medical Homes are expected to provide care coordination for LIHP enrollees served within the Mental Health Plan.

Outpatient Encounter Codes

<table>
<thead>
<tr>
<th>Encounter type</th>
<th>Visit Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment 45-60 min</td>
<td>90801</td>
</tr>
<tr>
<td>Therapy with LCSW 20-30 min</td>
<td>90804</td>
</tr>
<tr>
<td>Therapy with LCSW 45-50 min</td>
<td>90806</td>
</tr>
<tr>
<td>Therapy with LCSW 75-80 min</td>
<td>90808</td>
</tr>
<tr>
<td>Medication Management with no more than minimal psychotherapy / Psychiatrist</td>
<td>90862</td>
</tr>
</tbody>
</table>

Outpatient Service Definitions

Assessment

An assessment note documents the clinical evaluation of the client’s current status and history of the individual’s mental, emotional, or behavioral health including co-occurring substance abuse or significant medical conditions. Relevant cultural issues and history should be included where appropriate. Assessment charting may include self report, collateral reports, diagnostic impressions and/or information gathering from a variety of screening tools. The use of psychological testing, within staff scope of practice, when appropriate or authorized, is considered an assessment activity. Medical necessity must be documented.
**Individual Therapy**

Individual Therapy uses psychotherapeutic interventions to improve symptoms and functioning skills. Progress notes should include topic of discussion, therapeutic approach or intervention, assignments, client’s response and progress or lack thereof toward achieving treatment goals.

<table>
<thead>
<tr>
<th>LIHP CONTRACTED PRIMARY CARE MEDICAL HOME</th>
<th>COUNTY MENTAL HEALTH PLAN (MHP) Services not included in this contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>For treatment within the contracted PCP network, diagnosis by provider must include criteria including documented impairments as noted above</td>
<td>MHP diagnosis to include criteria as noted above including documented impairments as noted above</td>
</tr>
<tr>
<td>Services will be rendered within the patient’s primary care medical home within the provider’s scope of practice. NO AUTHORIZATION IS REQUIRED</td>
<td>County MHP will provide services authorization for LIHP enrollees who meet target population / medical necessity criteria. These include services such as: psychiatric hospitalization intensive outpatient or rehabilitation services field based services Other services not defined in the LIHP benefit</td>
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<td>This may occur in the following manner:</td>
<td>For those LIHP enrollees receiving appropriate MHP specialty services, for the MHP provider will be responsible ongoing diagnosis and treatment, as well as coordination of care with PCP.</td>
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<td>▪ Primary Care Provider provides services within their scope of practice. A typical service rendered may be treatment for depression or anxiety. These services are considered primary care services and do not count against the 12 visit benefit.</td>
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<td>▪ <strong>Enhanced Primary Care Provider:</strong> <em>(FQHC medical home with an approved scope of services that include Mental Health services)</em>. Physician services as above and Psychiatrist or LCSW services. A typical service rendered by licensed MH staff may be medication management, or individual therapeutic treatment as noted above in covered services. These services are considered mental health visits and count against the 12 visit benefit. CONTRACTOR will report these visits to COUNTY for tracking. When a level of care beyond any primary care setting is required, the patient will be referred to the MHP. Referral forms will be provided by COUNTY</td>
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**CARE COORDINATION**

- Care Coordination is a required activity between the primary care medical home and MHP specialty services (if applicable).
- If the primary care medical home (either PCP or MH staff working within the PCP clinic) determine MHP specialty services are required, a referral must be made to the MHP Adult Access Team utilizing their referral form.
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, overeating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)
- Diagnose physical disorders with behavioral manifestations
- Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a nonPractitioner 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 Plan for assessment and referral to an appropriate 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.

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 County Mental Health Plan 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

- Molina Healthcare’s Utilization Management Department will coordinate with the health plan Customer Support Center 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.
- 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 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 followup, coordinated discharge planning, and postdischarge 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 followup 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 MR26, Collection/Use/Confidentiality, and Release of Primary Health Information and MS07, Safeguarding and Protecting Medical Records
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”
“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 onehalf 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 prostatespecific 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) 3307968. The first 20 brochures are free and there is a $.15/brochure fee for orders over 20, with a minimum order of $8.00.

“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 onefifth 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.
CONSENT FORM - PM 330
Department of Health Services

CONSENTIMIENTO PARA ESTERILIZACIÓN

Declara que ha solicitado y obtenido información sobre esterilización de los programas y proyectos subsidizados con fondos federales. Le ha explicado que en caso de que desee reconsentirse, este documento debe ser devuelto, firmado y devuelto en el plazo de 30 días desde la fecha de recepción de este documento. En caso de que pase de ser esterilizado, el consentimiento perdió su validez a partir del momento en que se realizó la intervención quirúrgica.

DECLARACIÓN DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO

Declara que ambas de sus personas, no amamantó a su hijo/a en el momento de la intervención. En caso de que desee reconsentirse, este documento debe ser devuelto, firmado y devuelto en el plazo de 30 días desde la fecha de recepción de este documento. En caso de que pase de ser esterilizado, el consentimiento perdió su validez a partir del momento en que se realizó la intervención quirúrgica.

DECLARACIÓN DEL MÉDICO

Declaro que el médico de la persona que está a ser esterilizada, ha explicado la naturaleza del método de esterilización al paciente.

DECLARACIÓN DEL INTERPRETE

El lenguaje que se utiliza para describir los servicios de salud y servicios de salud incluidos en este formulario se debe a que la persona que está a ser esterilizada no habla español. En caso de que desee reconsentirse, este documento debe ser devuelto, firmado y devuelto en el plazo de 30 días desde la fecha de recepción de este documento. En caso de que pase de ser esterilizado, el consentimiento perdió su validez a partir del momento en que se realizó la intervención quirúrgica.
CONSENT FORM
PM 330

STATEMENT OF PERSON OBTAINING CONSENT

Before signing this form, I explained to the patient the nature of the sterilization operation.

[Signature of person obtaining consent]
[Date]

Name of facility where patient was admitted

Address of facility where patient was hospitalized

PHYSICIAN’S STATEMENT

I hereby certify that I performed a sterilization operation upon

[Signature of physician performing surgery]
[Date]
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Exhibit 17 D
SAMPLE