PHYSICIAN RESPONSIBILITIES

Section Contents

Introduction
IPA Provider Services Contacts 2 - 3

Provider Responsibilities
General Responsibilities of Providers (PCPs and Specialists) 2 - 4
Primary Care Physicians (PCP) Responsibilities 2 - 5
Specialist Responsibilities 2 - 11

New Member Initial Health Assessment (IHA) 2 - 12

Hospital Panel Service and Duties of Hospital Panel 2 - 16

Communication of Provider Address and Data Changes
Change Process / Documentation 2 - 18

Termination of Contract/Business Associate Agreement 2 - 19

Access Standards
Access to Care Standards 2 - 20
Required Components 2 - 22
Sample After Hour Message 2 - 23

Reporting Violence, Abuse, and Neglect 2 - 24
Reporting Violence/Abuse 2 - 25
Reporting Child Abuse/Neglect 2 - 30
Reporting Elder and Dependent Abuse/Neglect 2 - 34

Cultural, Linguistic, and Physical Communication Needs and Services
Responsibility 2 - 43
Telephonic Language Interpretation 2 - 43
Language Assistance Program 2 - 44
Face to Face Interpretation 2 - 44
TDD/TTY Access for the Hearing Impaired 2 - 45
Auxiliary Aids 2 - 45
Blue Cross Medi-Cal and Healthy Families Requirements 2 - 45
Cultural and Linguistics Toolkit 2 - 46
Member Printed Materials (Blue Cross) 2 - 47
**PHYSICIAN RESPONSIBILITIES**

<table>
<thead>
<tr>
<th>Terminating a Member from your Practice</th>
<th>2 - 48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>2 - 49</td>
</tr>
</tbody>
</table>

**Miscellaneous**

<table>
<thead>
<tr>
<th>Pharmacy Utilization</th>
<th>2 - 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recredentialing</td>
<td>2 - 50</td>
</tr>
</tbody>
</table>

**Appendix**

- Introduction to the Comprehensive Perinatal Services Program (CPSP) form
- PMGSJ Quality Management Committee Recommendations for Increasing Satisfaction with After Hours Care
- Required Components - After Hours Message
- Cultural and Linguistics
  - Reference Numbers for Interpretative and Language Services
  - Blue Cross Translation Services (Quick Reference)
  - Request/Refusal Form for Interpretive Services
- Sample Terminating Member From Your Practice Letter
INTRODUCTION

This section defines and describes the general responsibilities of Primary Care and Specialist Physicians contracted with the IPA.

Several required Office Policies and Procedures are also included in this section. These procedures describe the responsibilities associated with the reporting of Violence and Abuse, Child Abuse/Neglect, and Elder/Dependent Adult Abuse. For electronic copies of these Procedures, go to http://www.pmgmd.com.


IPA Provider Services Contacts

If you have any questions about the information contained herein, or need additional assistance, please contact Provider Services.

Provider Services Coordinator (408) 937-3612
Provider Credentialing/Recredentialing (408) 937-3612
Provider Services Manager (408) 937-3604
PHYSICIAN RESPONSIBILITIES

PROVIDER RESPONSIBILITIES
General Responsibilities (for both PCPs and Specialists)

Physicians contracted with the IPA are responsible for:

- Supporting member rights and responsibilities
- Collecting appropriate co-payment at the time of service
- Checking eligibility of member/patient before services are rendered
- Providing, accommodating, and facilitating cultural and linguistic needs for patients (see additional information provided in this Section.)
- Reporting suspected domestic violence and abuse, child abuse/neglect, and elder/dependent adult abuse
- Providing/arranging for 24 hour coverage
- Notifying the IPA when on vacation and who is covering. (Fax letter to Provider Services Department at (408) 937-3639)
- Providing an updated and detailed phone answering system message with all the required elements
- Submitting all claims within 90 days
- Cashing checks within 14 calendar days of issue
- Complying with all terms of their Physician Agreement
- Notifying affected members if he/she leaves the group
- Referring X-Ray, laboratory, and ancillary services to IPA contracted facilities.

*Note:* A list of these contracted facilities (effective at the time of publication) is located in the Authorizations section. We issue updates as information changes throughout the year.

*Note:* Providers must never balance bill patients for covered services. Members may be billed for co-pay and non-covered services (e.g. cosmetic surgery). Call the HMO if you have questions about the member’s benefits.

For guidelines, discussion and exceptions see [http://www.pmgmd.com](http://www.pmgmd.com).

See also: Member Rights and Responsibilities in the Quality Management Section of this manual.
Primary Care Physician (PCP) Responsibilities

Scope of Services

The Primary Care Physician (PCP) in managed care is responsible to provide and coordinate all covered services required by the patient, except when a sudden emergency may preclude the primary physician’s role.

The primary care physician’s services are personalized for each member, and his/her responsibility is comprehensive, i.e. all required preventive services.

The PCP should provide services which can be provided appropriately within his/her skills, and obtain consultation when additional knowledge or skills are required from a Specialist. A Specialist consultation may consist of telephonic advice from a Specialist or may involve referring the member to be seen by that Specialist for services. The PCP must coordinate all services for members including services performed by them, as well as all services by all Specialists.
PCP Responsibilities and Services (continued)

Definition of Primary Care Physician Responsibilities and Services

Basic Capitated Services

Primary care services for commercial and state sponsored programs including Medi-Cal Managed Care and Healthy Kids. PCP care for patients under capitation arrangements include, but are not limited to the following items:

1. Preventive Medical Care and Health Education

   Provide education to member to assist them with:

   a) making appropriate use of health care services
   b) information about personal lifestyle behavior and healthy guidelines appropriate for their age group
   c) information to achieve and maintain physical and mental health

2. Primary care physician visits and examinations, including consultation time and treatment, telephone consultations, and home visit if necessary.

3. Supplies provided in primary care physician’s office. These services include routine office visits, evaluations, minor office surgical procedures (e.g. suture removal), injections, periodic physical examinations, and other usual and customary care.


5. Periodic health appraisal evaluations, including all periodic examinations recommended under the appropriate health maintenance standards adopted by member’s HMO, payor, or IPA.
6. Pediatric and adult immunizations in accordance with the recommendations of the American Academy of Pediatrics, the Federal Centers for Disease Control, HMO’s policies and other appropriate agencies and professional societies.

7. Vision and hearing screening for members when covered by the Health Plan (excluding refractions for vision-corrective prescriptions).

8. Family planning services as set forth in applicable certificates of coverage.

9. Coverage, including emergency/urgent medical services, must be available seven (7) days per week, twenty-four (24) hours per day.

10. Participation in educational classes conducted by or recommended and recognized by the IPA for the purpose of providing training and information about procedures to be performed by primary care providers.

11. Referral of enrollee to appropriate contracted Specialist physician or ancillary services as medically necessary and according to referral guidelines established by the IPA.

12. Office GYN services (PAP Smears, pelvic exams, breast examinations, screening for infertility) when appropriate.

13. Identification of chemical dependency and mental /behavioral health illnesses.

14. Allergy treatment (including maintenance injections).
Responsibilities

- Time for personal attendance with the member during a confinement in a hospital, skilled nursing facility, or other covered facility.
- Minor surgical procedures; Suture removal.
- Simple Incision and Drainage (I&D) procedures.
- Simple burn care.
- Minor injuries, including minor lacerations.
- Ear irrigation.
- Office visits outside of normal hours for urgent matters.
- Biopsy or removal of suspicious lesions, excluding face.
- Electrosurgical / cryosurgical destruction of lesions, excluding face.
- Physician services in a member’s home, as necessary.
- Annual routine well woman exam including PAP smear.
PCP (continued)

Professional Services - beyond capitated services

In general, PMGSJ reimburses for immunizations and injections. However, with legislation, some of the HMOs have begun to reimburse directly. **Billing Instructions:** Send encounters and claims to the IPA or appropriate payor.

PMGSJ will update their providers with any necessary changes through the monthly Physicians Newsletter distributed to all providers.

- **Immunizations/Injections**

  Includes recommended immunizations for all members. Payment per Health Plan or IPA Fee Schedule(s).

  In addition, Medi-Cal beneficiaries under 21 years old are covered by the CHDP program. (Send CHDP claims to member’s health plan.)

- **Inpatient Hospital Care**

  The IPA will reimburse for authorized and eligible adult and children inpatient hospital visits, except for those visits provided by the Inpatient Hospital Team.

- **Home visits as indicated by nature of the illness.**

  **Important:** All other services must be authorized before payment.
Additional PCP Responsibilities (Under Medi-Cal Managed Care)

The following additional services are required for Medi-Cal patients under capitation (a per member per month management fee, or “PMPM” payment), with no authorization required. Claims must be submitted to the IPA within 90 days of patient encounter. (See Section 4 of this Manual for claims submission information.)

- **Initial Health Assessment:** If member has not had a preventive exam within the past year, one should be scheduled within 120 days of the effective date with his or her Primary Care Physician;

- **Under Medi-Cal Managed Care Plans, Child Health and Disability Prevention Services (CHDP) well child care is to be performed by participating CHDP physicians and billed directly to the member’s plan—either Blue Cross or Santa Clara Family Health Plan.**

- **Office visit access**

  See the health plan’s Provider Manual for details of office visit access standards.

- **Referrals as needed to separately-funded State/County Public Health programs: California Children Services (CCS), WIC, Mental Health and Substance Abuse programs, etc. (Member remains assigned to the IPA’s PCP for primary care).**
Specialist Responsibilities

- Specialist Physicians must provide a written and/or oral report to Primary Care Physicians as the result of consultation or follow-up visits in a timely manner.

- Specialists must contact other Specialists to consult on a hospitalized patient.

- Provide consultation information to the PCP (e.g. screening results)

- A “covering” specialty physician in a group may only cover emergencies. He/she may not see patients for routine referral.

- Subsequent to obtaining an initial referral authorization by a Primary Care Physician, Specialists may request authorizations for follow-up visits, diagnostic tests and/or procedures directly from the Utilization Management Department without going through the Primary Care Physician.

- CPSP must be offered and provided to all Medi-Cal Healthy Families/Healthy Kids members.

  See Authorization Section for additional details.
NEW MEMBER INITIAL HEALTH ASSESSMENT (IHA)

The purpose of an Initial Health Assessment (IHA) is to initiate the patient-doctor relationship, and to assist the PCP in becoming familiar with the newly enrolled member’s health needs in a non-crisis situation. Initial health assessment is required to be performed on all new members under the Medi-Cal Managed Care Plan.

Preventive health examinations assist in maintaining and improving long-term health, early detection of disease, and to prevent increased risk of subsequent disease. Additionally, using a preventive orientation and early intervention approach for assessing patients’ current and future health care needs may also reduce unnecessary emergency room visits and after hours calls.

An IHA consists of a comprehensive history and physical examination conducted to assess the member’s health status, including acute, chronic, and preventive health care needs. All age-specific assessments and services, including necessary immunizations and age-specific individual health education behavioral assessments must be provided at the time of the IHA. Otherwise, their delivery must be scheduled with the proposed/future date of service entered into the medical record.

Documentation

The practitioner must document all findings in the medical record, and it must include:

- the diagnosis of and treatment for any disease or health condition detected;
- counseling, anticipatory guidance and risk factor interventions provided and proposed;
- other preventive, diagnostic or treatment follow-up services needed;
- referrals made for problems noted;
- the scheduled or proposed next revisit date;
- provisions for continuation or initiation of all services necessary to treat preexisting conditions, including initiation or continuation of specialty care.
PHYSICIAN RESPONSIBILITIES

The practitioner may also document that the member was up-to-date for their age at the time of the visit if the IHA services were provided during a prior examination or treatment visit. Such a statement will serve as evidence of an IHA, without the need to provide additional services, although all required documentation must be entered into the medical record.

The IHA requirement would NOT be met by the following types of services:

- A visit for evaluation and/or management of a specific problem;
- Prenatal visits, other than the initial complete assessment of a pregnant woman according to American College of Obstetricians and Gynecologists (ACOG) guidelines
- Urgent care and/or emergency type visits or services.

Specific Contents of IHA

1. **Individual Health Education Behavioral Assessment (IHEBA)**
   Please use the appropriate (age-specific) assessment form. Forms are available on [http://www.pmgmd.com](http://www.pmgmd.com). Call Provider Services to request copies if you do not have Internet access.

2. **For members under 21 years of age**
   Service requirements of current age-specific American Academy of Pediatrics (AAP) and Child Health Disability Prevention (CHDP) and Santa Clara Family Health Plan Pediatric Preventive Guidelines. (Pediatric Age-specific Periodicity Table and Well Visit Forms; also refer to Medical Record Standards for all requirements)

3. **For members 21 years and older**
   Adult Preventive Guidelines using the current Guide to Clinical Preventive Services – A Report of the U.S. Preventive Services Task Force (USPSTF) (Adult Preventive Health Guidelines and Age-Specific Adult Well Visit Forms; also refer to Medical Record Standards)
4. For pregnant members
Must include all age-specific requirements including the required pregnancy health risk assessment (such as the Comprehensive Perinatal Services Program). The Initial Comprehensive Assessment (ICA) consists of assessments for obstetric/medical, nutrition, psychosocial, and health education.

5. Identification of special health care needs
The IHA must include screening questions designed to identify members with special health care needs, including physical, mental, behavioral, and/or developmental problems. The IHA needs to identify and document provision of services to the member by agencies outside of the Health Plan network, such as Regional Centers, early intervention programs, California Children Services (CCS), education and special education agencies, mental health agencies, alcohol and substance abuse programs, and other programs serving aged and/or disabled members, in order to facilitate case management and continuity and coordination of care.

The Utilization Management Department has nurses who are trained in Care and Disease Management who can answer questions and assist you and your staff with members who have special health care needs.
New Member Initial Health Assessment - IHA Timelines

1. For members under the age of 18 months upon enrollment:

   The IHA must be provided within 60 days following enrollment or within AAP Periodicity Guidelines. For children under one year of age, the IHA must be provided as soon as possible following enrollment.

2. For members 18 months of age and older upon enrollment:

   The IHA must be provided within 120 days (4 months) of enrollment unless a valid exemption exists.

3. For members who are pregnant upon enrollment:

   Prenatal Care must be initiated as soon as possible after enrollment or discovery that the member is pregnant.

4. Physicians who are PCPs receive a monthly report from the Health Plan listing the new or re-enrolled members 120-Day Initial Health Assessment (IHA) Requirement.

**Exemptions:** If a member, including emancipated minors, or a member’s parent(s) or guardian, refuses an IHA, the refusal must be documented in the member’s medical record by a statement signed by the member, or in the case of refusal to sign a statement, a note to that effect in the medical record. ALL exemptions from the IHA requirement must be appropriately documented in the medical record.

**Scheduling IHA’s and Follow-up for Missed Appointments**

If a practitioner is unable to contact a member to schedule an IHA after at least two attempts have been made, or a member has missed a scheduled appointment and an attempt to reschedule has been unsuccessful; or the member has missed a second scheduled appointment, there is no requirement to make further attempts to schedule an IHA. If unable to contact a member, all attempts must be documented in the member’s medical record.
HOSPITAL PANEL SERVICES

(Adult Panel)

The Hospital Panel will provide inpatient admission and continuing care coverage for IPA adult members (over the age of 16) requiring hospitalization at Regional Medical Center of San Jose or O’Connor Hospital, and pediatric members at O’Connor Hospital.

The purpose of the Hospital Panel is to ensure that medically necessary, inpatient care is provided in a timely manner, and at the most appropriate level of care. The Hospital Panel is made up of IPA contracted physicians who have accepted this arrangement.

*The specific duties of the Hospital Panel are described on the next page.*
Hospital Panel Duties

The duties of the Hospital Panel physicians are to:

1. Provide coverage for IPA members who need to be admitted into the hospital from the ER of designated hospitals.
2. Be available for consultation with the ER staff.
3. Admit IPA members to the hospital for those IPA-contracted Physicians who either prefer not to admit their patients themselves or who do not have admitting privileges.
4. Attend IPA members during their entire hospital stay unless arrangements have been made to transfer the care to another contracted physician.
5. Involve appropriate Specialists in a member’s care, when warranted, to provide medically necessary, quality care during the patient’s hospitalization.
6. Treat members at appropriate levels of care, as indicated by medical needs.
7. Refer members for large case management, as indicated by medical needs.
8. Initiate discharge planning on the first day of admission for all members.
9. Discharge members to home or to other levels of care as indicated by medical needs.
10. Accept transfers of members from outside or non-contracted facilities as needed.
11. Cooperate with EXCEL’s inpatient and large case manager, Medical Director, and hospital case manager, in discharge planning and moving the member through the continuum of inpatient care.
The following describes the process for requesting address and data changes.

- Providers shall notify the IPA in writing (preferably on office letterhead) along with any required supporting documentation (e.g. a TIN change requires copies of the W-9 forms.)
- Requests may be sent to the Provider Services Coordinator by mail or fax.

*Important: Delay in notifying us with address and data changes may affect your claims payments.*

The following table illustrates some common data changes and the corresponding document(s) we require before each change can be made. Call Provider Services at (408) 937-3612 if you have questions.

### Change Documentation

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Document Needed</th>
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<tbody>
<tr>
<td>Adding a new practice location, change of address, phone, fax, etc.</td>
<td>Letter, effective date</td>
</tr>
<tr>
<td>Change practice location, change of address, phone, fax, etc.</td>
<td>Letter, effective date</td>
</tr>
<tr>
<td>Billing address change</td>
<td>Letter, effective date</td>
</tr>
<tr>
<td>Closing of panel; eliminating services</td>
<td>Letter, effective date</td>
</tr>
<tr>
<td>TIN Change</td>
<td>Letter, copy of W-9s</td>
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</table>

OR submit changes by **mail** to: **Physicians Medical Group of San Jose**
Provider Services
75 East Santa Clara Street, Suite 950
San Jose, CA 95113

OR by **fax** to: Provider Services Coordinator  Fax: (408) 937-3639
TERMINATION OF CONTRACT/BUSINESS ASSOCIATE AGREEMENT

Advanced notice must be given in writing when electing to discontinue as an IPA provider. Refer to your IPA contract for specifics.

If you have any questions, please contact Provider Services at (408) 937-3612.
PHYSICIAN RESPONSIBILITIES

ACCESS STANDARDS

Access to Care Standards

It is expected that EXCEL’s IPA partners, physician providers and employees ensure that health services are available and accessible to members and that they are able to obtain services within a reasonable period of time. We have adopted access guidelines using both the California Managed Health Care Quality Coalition as well as the National Committee on Quality Assurance (NCQA). A copy of the access standards is located on the next page. EXCEL MSO, LLC official policy regarding this issue can be found in the Quality Management Policy and Procedure Manual, Policy #110. This policy is available for your review at our Corporate Office.

Compliance to these Guidelines will be monitored and coordinated with other activities throughout the organization. Ways this is monitored may include member surveys and complaints. The IPA will conduct Access Studies on a yearly basis focusing on appointment scheduling, waiting times and after hours care. Based on previous studies, recommendations have been made for increasing your patient’s satisfaction in this area.

A summary sheet illustrating the access standards is provided on the following page.
Access Standards (continued)

The following describes standards for member Access to Appointments, After Hours Access to MDs, Office Waiting Time. All providers are surveyed against the applicable Standards:

<table>
<thead>
<tr>
<th>1. a Appointment Access Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency exam</td>
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<tr>
<td>Urgent exam</td>
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<tr>
<td>Non-urgent exam with assigned provider</td>
</tr>
<tr>
<td>Non-urgent specialist referral</td>
</tr>
<tr>
<td>Adult or Pediatric Health Assessment</td>
</tr>
<tr>
<td>Provider office phone pick-up time</td>
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</tbody>
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<table>
<thead>
<tr>
<th>1.b Maternity Patient Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent exam within 1st or 2nd trimester</td>
</tr>
<tr>
<td>When initial visit is in the third trimester</td>
</tr>
<tr>
<td>High-risk</td>
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<tr>
<td>Emergency (any trimester)</td>
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<table>
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<tr>
<th>1.c Behavioral Health Access</th>
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<tbody>
<tr>
<td>Life-threatening emergency</td>
</tr>
<tr>
<td>Non-life threatening emergency</td>
</tr>
<tr>
<td>Urgent Needs</td>
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<table>
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<tr>
<th>2. AFTER HOURS ACCESS</th>
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<tbody>
<tr>
<td>Components of the After Hours Message:</td>
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<tr>
<td>After Hours, an answering machine or answering service message should have the following components:</td>
</tr>
<tr>
<td>1. Provider is identified</td>
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<tr>
<td>2. Mention made of the way to reach the provider (or on-call MD) urgently</td>
</tr>
<tr>
<td>3. Hours of operation are given on the voice mail message or the answering service knows the hours of operation</td>
</tr>
<tr>
<td>4. Directions to go to the nearest Hospital Emergency room if patient has a medical emergency and</td>
</tr>
<tr>
<td>5. Hang up and call 911 if the patient feels it is a life-threatening emergency.</td>
</tr>
</tbody>
</table>

**Standard: Members have access to medical care twenty-four (24) hours per day, every day of the year.**

*Having only a message after hours telling members to go to the emergency room is not adequate after hours access: A timeframe must be specified on the after hours message for a call back to patient who wishes to leave a message concerning an urgent issue. PMGSJ recommends that a timeframe of 30 minutes be given for a return call.

If you have any questions, please call the Quality Improvement Coordinator at (408) 937-3628.
REQUIRED COMPONENTS - AFTER HOUR MESSAGE

The required components in your after hours message are:

1. Provider is identified
2. The office is now closed
3. Your office hours
4. For a life threatening emergency, instruct the caller to hang up and call 911, and/or go to the nearest Emergency Room
5. How to reach the MD (or on-call MD) for an urgent issue;
6. Patient will expect a return call within 30 minutes;

The message, whether live or recorded, needs to specify a call back within 30 minutes
SAMPLE AFTER HOURS MESSAGE FOR PROVIDERS

1. You have reached the office of Dr. (Name of Doctor). The office is currently closed. Our office hours are (hours and days of the week).

2. If this is a life threatening emergency, please hang up and dial ‘911’ and/or go to the nearest emergency room immediately.

3. If you have an urgent issue and wish to speak with Dr. (Name of Doctor),

   Choose one
   a. Please hold and you will be connected to Dr. (Name of Doctor)
   b. You may reach the Doctor directly by calling (Phone Number)
   [Pager] c. Please call (Pager Number), the doctor will be paged and you will expect a return call within 30 minutes.
   [Answer Machine] d. Please leave a message for Dr. (Name of Doctor) and you will receive a call back within 30 minutes.

   The message, whether live or recorded, needs to specify a call back within 30 minutes

4. If this is a non-urgent call, please call back during regular business hours or leave a message and we will return your phone call during the next business day.

REPORTING VIOLENCE, ABUSE, AND NEGLECT

The following pages include recommended procedures for reporting:

- Violence and Abuse
- Child Abuse/Neglect
- Elder and Dependent Adult Abuse
PHYSICIAN RESPONSIBILITIES

Sample copies of these policies and procedures are located on our website, http://www.pmgmd.com.
Reporting Violence and Abuse

Assault or abusive conduct is defined to include any number of prohibited criminal acts or attempted acts such as assault with a deadly weapon, murder, manslaughter, mayhem, rape, spousal rape, battery, sexual battery, etc. (Penal Code 11160(d)(1)-(d)(24). Domestic violence can occur between unmarried or married, cohabitating or not, heterosexual or homosexual.

When a healthcare practitioner (in his/her professional capacity) observes that a person has been injured or killed as a result of a violent act, where there is reason to suspect assault or abusive conduct by a domestic partner, that practitioner will report these observations by telephone and follow up with a written report to the local law enforcement agency.

Health professionals will:

1. Identify, assess, and document any possible symptoms of abuse.
2. Maintain well documented medical records.
3. Report suspected assault or abusive conduct.

Additional information regarding these recommended procedures are provided below. A written report shall be created and sent to the local law enforcement agency within two (2) working days.

Identify, Assessment and Document

The healthcare practitioner should identify any symptoms or signs of abuse and report this information to the proper authorities. The possibility of assault should be considered if a patient’s explanation of any injury does not seem plausible or when there has been a delay in seeking medical attention. There are certain types of injuries and/or behaviors which are commonly associated with abuse.
Reporting Violence and Abuse (continued)

The injuries listed below may be indicative of abuse; however, an overall assessment of the individual may need to be done to produce conclusive findings.

- Minor lacerations, contusions, abrasions, fractures or sprains
- Injuries to the head, neck, chest, breasts, or abdomen
- Injuries during pregnancy, such as spontaneous abortions
- Multiple injury sites
- Chronic or repeated injuries
- Medical problems which indicate chronic or psychogenic pain
- Physical symptoms related to stress, anxiety disorders or depression
- Chronic diseases such as asthma, seizures, arthritis, etc.
- Multiple gynecological problems
- Frequent use of prescribed minor tranquilizers or pain medications
- Psychiatric symptoms such as panic attacks, substances abuse, inability to cope, feelings of isolation, suicidal tendencies
- Behavioral problems such as an appearance of fright, shame or embarrassment
Reporting Violence and Abuse (continued)

Documentation of Abuse

Well-documented medical records must be maintained by healthcare practitioners and should include the following information:

- Name and location of the injured person
- Extent and character of the person’s injuries
- Identify of the person the injured person alleges inflicted the wound(s), other injury(s), or assault or abuse upon the injured person
- Description of the abusive event or description of the major complaints in the injured person’s own words, whenever possible
- Medical and relevant social history of the injured person
- Map of the location of the injuries on the victim’s body documented at the time of the health care service
- A copy of the law enforcement reporting form
Reporting Violence and Abuse (continued)

Reporting

The healthcare practitioner should keep in mind that the abused or battered woman/man is often at greatest risk immediately after the police are first called, and after the police leave the scene. Prior to reporting instances of spousal abuse, the practitioner may wish to encourage the patient to locate a protected environment for herself/himself and children (if applicable), rather than run the risk of being in the same hostile environment he/she was in when the police were first called. Practitioners should obtain information on battered women’s/men’s shelters in the local area, as well as information on counseling programs for both victim and batterer to utilize in these instances.

- The telephone report must be made immediately or as soon as practically possible, and must be followed up with a written report to the local law enforcement agency within two (2) working days of receiving the information regarding the injured person. The written report must be on a standardized form and include the name of the injured person, location of injury, extent of injury, description of how the person was injured, and identity of the person inflicting the injury, if known. To be reportable, the injury must be current and the patient still suffering from it. If two or more persons are required to report the same incident, they may agree among themselves as to one reporter. No person who is obligated to report may be inhibited or impeded in his or her reporting duties by any supervisor or administrator.

- There are no Penal Code statutes prohibiting verbal or mental abuse per se or the psychological injuries arising out these acts, so healthcare practitioners are not legally obligated to report such cases.
Immunity

The law provides immunity for healthcare practitioners from civil and criminal liability for reports of known or suspected instances of abuse. Healthcare practitioners (or their agents) are also immune from liability for taking (or causing to be taken) photographs of the suspected victim of domestic violence and for forwarding the photographs with the mandated report. Further, a healthcare practitioner who, pursuant to a request from an adult protective services agency or a local law enforcement agency, provides the requesting agency with access to the victim of a known or suspected instance of abuse, shall not incur civil or criminal liability as a result of providing that access. In addition, in the event that a person required to report is required to defend a legal action based on the making of the report and prevails, the state will reimburse the individual’s reasonable attorney’s fees (not to exceed an hourly rate greater than the rate charged by the attorney general at the time the award is made, up to a maximum of $50,000).

Penalties

Failure to report domestic violence abuse is a misdemeanor punishable by up to six (6) months in jail and/or up to a $1,000 fine.

Practitioner Domestic Violence Training

Legislature now requires that physician applicants for licensure who have matriculated at medical school on or after September 1, 1994 must show that they have training or coursework in spousal abuse detection and treatment. (Business and Professions Code 2089)
Reporting Child Abuse/Neglect

To ensure child abuse cases are recognized, diagnosed, and reported as soon as practical. The provider is required to call the appropriate agency to follow-up the call with a written report.

Signs and symptoms of abuse and neglect should be identified by the healthcare practitioner according to the following indicators

Definitions

**Physical Abuse** (physical injury inflicted on a child by another person by other than accidental means) including:

- Bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.
- Burns that appear to be from a cigar or cigarette especially on the soles of the feet, palms, back or buttocks; patterned burns and immersion burns.
- Abrasions such as rope burns or lacerations especially on the wrist, ankles, torso, palate, mouth, gums, lips, eyes, ears, external genitalia.
- Fractures, many times at different stages of healing to the skull, ribs, or long bones.
- Injuries to the abdomen, kidney, bladder or pancreas; intestinal perforation; ruptured liver, spleen or blood vessels; or intramural hematoma of the duodenum or proximal jejunum.
- Symptoms of suffocation or chemical abuse or indicators pointing to Munchausen syndrome by proxy.
Physician Responsibilities

Reporting Child Abuse/Neglect

**Sexual Abuse** (includes both sexual assault and sexual exploitation)

- Bruises or abrasions to the inner thighs or external genitalia
- Attenuation or distortion of the hymen
- An alteration of anorectal tone
- Evidence of sexually transmissible disease
- Pregnancy (although pregnancy alone is not sufficient to constitute the basis of a reasonable suspicion of sexual abuse)

**Willful Cruelty or Unjustifiable Punishment of a Child**

**Unlawful Corporal Punishment or Injury**

**Neglect** (negligent treatment or maltreatment of a child by a person responsible for the child’s welfare where harm to the child’s health or welfare is indicated or threatened)

- History of lack of appropriate well-child care
- Failure of a child to thrive
- Malnutrition, untreated medical conditions, poor hygiene, rampant dental cavities
- Behavioral indicators such as anxiety, depression, sleep disturbances, enuresis, excessive masturbation, aggressive behavior, excessive household responsibilities for age including child care, poor school performance, discipline problems and impaired personal problems

**Abuse in Out of Home Care** (all cases of abuse as defined above in a child care, school, or other agency or institutional setting)
Reporting Child Abuse/Neglect – Diagnosis

Diagnosis

A thorough health assessment must be conducted by the physician, which includes a history, physical examination, and developmental assessment on a child who may be a victim of abuse. The Office of Criminal Justice Planning (OCJP) determines the protocols for performing physician examinations on a victim of sexual assault, including child molestation. X rays, CT scans, bone scans, or other laboratory studies are of use in determining and defining the current trauma, previous traumas and excluding other medical conditions. In cases of suspect child abuse, a physician, surgeon, or dentist (or their agents) may take x-rays without parental consent. The following diagnostic process should be performed:

- An assessment of the child’s immediate medical needs
- Compilation of the past medical and social history of the child and family members
- Assessment of the plausibility of the history being provided in light of pre-existing medical conditions
- Determination of how great a risk it would be if the child returns home

Reporting

A report must be made immediately or as soon as possible by telephone to a police or sheriffs department, a county probation department or a county welfare department. The report must include the name of the person making the report, the name of the child, the present location of the child, the nature and extent of the injury, and any other information, including information that let the person to suspect child abuse, requested by the child protective agency.

The written report must be on a standardized form which should be available from child protective services agencies and must be sent within 36 hours of notice of the abuse. Special forms must be used by physicians who conduct an examination for sexual assault in an acute care hospital.
Three forms that are recommended for reporting child abuse cases are as follows:

- **Suspected Child Abuse Report Form SS 8572** which may be obtained from the local child protective service agency
- **Medical report – Suspected Child Abuse Form DOJ 900** which may be obtained from the local child protective agency
- **Medical Report – Suspected Child Sexual Abuse Form OCJP 925**

**Immunity**

The law provides immunity for healthcare practitioners, from civil and criminal liability, for reports of known or suspected instances of abuse. Healthcare practitioners (or their agents) are also immune from liability for taking or causing to be taken photographs of the suspected victim of child abuse without parental consent, and for forwarding the photographs with the mandated report. In addition, in the event that a person required to report is required to defend a legal action based on the making of the report and prevails, the state will reimburse the individual’s reasonable attorney’s fees (not to exceed an hourly rate greater than the rate charged by the attorney general at the time the award is made, up to a maximum of $50,000).

**Penalties**

Failure to report child abuse is a misdemeanor punishable by up to six months in jail and/or up to a $1,000 fine. A healthcare practitioner may also be liable in civil court for damages, which occur if the child is further victimized because of a failure to report the abuse.

**Employee Statements**

Physicians and other employers who hire licensed healthcare practitioners or other mandated reports must obtain a signed statement from those employees hired on or after January 1, 1985, attesting to the employees’ understanding of their child abuse reporting obligations per Penal Code 11166.5). Employers must retain these signed statements at the employer’s expense.
Reporting Elder and Dependent Adult Abuse

It is required that healthcare practitioners report physical injury or conditions appearing to be the result of physical abuse, abuse of financial affairs, neglect or abandonment of an elder or dependent adult, in accordance with state laws, to the local law enforcement agency and Department of Health. (Welfare and Institutions Code Section 15600-15659)

Physical abuse means a situation where any person who has the care or custody of or who stands in a position of trust with an elder or dependent adult, willfully inflicts upon that elder a cruel or inhumane corporal punishment or injury.

Abuse

Physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services which is necessary to avoid physical harm or mental suffering. All health care professionals and care givers, health educators, designated employees of adult protective services agencies and designated employees of local law enforcement agencies are required by law to report incidents of suspected abuse (i.e., physical abuse, sexual abuse, fiduciary abuse, neglect, abandonment, and isolation) of any elder or dependent adult. An immediate phone report is required to a 24 hour crisis line at the Department of Aging at (800) 231-4024. A written report (Department of Social Services form SOC341) must be sent within 48 hours to either the long term care ombudsman coordinator or to a local law enforcement agency when the abuse is alleged to have occurred in a long term care facility; or to either the county adult protective services agency or to a local law enforcement agency when the abuse is alleged to have occurred anywhere else.

Physical Abuse

Assault, battery, assault with a deadly weapon or force likely to produce great bodily injury, unreasonable physical constraint or prolonged or continual deprivation of food or water, use of a physical or chemical restraint or psychotropic medication (for punishment, for a period beyond that for which
the medication was ordered pursuant to the instruction of a licensed physician and surgeon, for any purpose not authorized by the physician and surgeon), and sexual assault.

**Sexual Assault**

Assault and battery, rape, rape in concert, incest, sodomy, oral copulation, penetration of the genital or anal opening by a foreign object.

**Physical Abuse Indicators**

- Multiple injury sites, bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.

- Burns that appear to be from a cigar or cigarette,

- Injuries to the head, neck, check, breasts or abdomen, contusions, abrasions such as rope burns or lacerations especially on the wrist, ankle, torso or extremities,

- Fractures, many times at different stages of healing, to the skull, ribs, or long bones, Injuries to abdomen, kidney, bladder or pancreas, intestinal perforation, ruptured liver, spleen or blood vessels, spontaneous abortions resulting from injury to the abdomen. Intramural hematoma of the duodenum or proximal jejunum.

- Chronic diseases such as asthma, seizures, arthritis, etc.,

- Medical problems indicating chronic or psychogenic pain,

- Symptoms of suffocation and chemical abuse,

- Improbably explanation of injuries or major inconsistencies between elder or dependent adult and caregiver’s injury etiology description,

- Changes in the elder or dependent adult’s behavior when the caregiver enters or leaves the room,
PHYSICIAN RESPONSIBILITIES

- Appearance of fright, shame or embarrassment, depression, agitation, stress, inability to cope, panic attacks, feelings of isolation, withdrawal, homicidal or suicidal tendencies,

- Frequent use of prescribed tranquilizers or pain medications,

- Risk factors such as caregiver substance abuse or historical family violence.

**Sexual Abuse**

- Bruises or abrasions on the inner thighs or external genitalia,

- Alteration in anorectic tone,

- Evidence of a sexually transmitted disease,

- Multiple gynecological problems

**Fiduciary Abuse**

A person who stands in a position of trust, with respect to an elder or dependent adult, and willfully steals the money or property of that elder or secrets or appropriates the money or property of that elder to any use or purpose not in the due and lawful execution of his or her trust (inclusive of misappropriation of Social Security funds) is committing abuse.
Physician Responsibilities

Neglect

Failing to care for an elder or dependent adult to the degree of care which a reasonable person in a like position would exercise constitutes neglect. Indicators may include:

- Historical or current lack or delay of appropriate care,
- Failure to protect from health and safety hazards,
- Malnutrition, untreated medical conditions, weight loss,
- Failure to provide physical aids (i.e. eyeglasses, hearing aids, dentures and/or ambulatory assistive devices),
- Signs that the caregiver has been unwilling or unable to provide assistance with daily living skills (i.e., poor hygiene, lack of appropriate clothing, lack of proper diet, urine stains on clothing, etc).

Abandonment

The desertion or willful forsaking of an elder or dependent adult by any person having the care or custody of that elder or dependent adult under circumstances in which a reasonable person would continue to provide care or custody.

Isolation

- Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his/her mail or telephone calls
- False imprisonment
- Physical restraining of an elder or dependent adult for the purpose of preventing them from meeting with visitors
PHYSICIAN RESPONSIBILITIES

- Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he/she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

Dependent Adult

A person between the ages of 18 and 64, who has physical or mental limitations, which restrict him or her from carrying out normal activities of protecting his or her rights, (including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age) may be a dependent adult. A dependent adult can also include any person between the ages of 18 and 64 who is admitted as an inpatient to a 24 hour health facility as defined in Section 1250, 1250.2 and 1250.3 of the Health and Safety Code.

- **Elder** means any person 65 years of age or older.
To insure that the incident is properly documented, we highly recommend that the following be noted:

1. A thorough assessment must be conducted by the physician, which includes a history and physical examination of the elder or dependent adult suspected of being a victim of abuse. For known or suspected sexual assaults, examination protocol per Penal Code 13823.5, 13823.7, 13823.9 and 13823.11 must be followed. X-rays, CT scans, bone scans or other laboratory studies are of use in determining and defining the current trauma, previous traumas and excluding other medical conditions. The following diagnostic process should be performed:

   - An assessment of the elder or dependent adult’s immediate medical needs,
   - Compilation of the past medical and social history of the elder or dependent adult and family members (if applicable),
   - Assessment of the plausibility of the history being provided in light of pre-existing medical conditions.
   - Determination of how great a risk it would be if the elder or dependent adult were to return to their living situation or residence.

2. Medical Record documentation, maintained by the health care practitioner, should include but not be limited to the following:

   - Name of abuse victim,
   - Date/time abuse became known,
   - Physical assessment/evaluation, location, extent and character of injuries,
   - Map of the location of the injuries on the abuse victim’s body, documented at the time of the health care service,
   - Name/identify of alleged abuser
   - Description of the abusive event or abuse victim complaints (in their own words),
   - Medical and relevant social history of the abuse victim,
   - Health practitioner follow-up (i.e., reporting, etc.).
Reporting

Reporting is required of physicians, nurses, pharmacists and all other medical practitioners licensed under Division 2 of the Business and Professions Code. It is also required of certain non-medical practitioners, such as coroners, social workers, psychologists, family counselors, nursing home ombudsmen, care custodians, law officers and probation and welfare personnel. The law does not extend to members of a physician’s office support staff who are not licensed healthcare practitioners. One individual may make the required report for an entire group, and facilities may develop reporting protocols, so long as they are consistent with the statutory requirements. Reporting is required for physical abuse as defined above. Those required to report, may but are not required to report, known or reasonably suspected instances of other types of abuse, including cases of mental abuse, fiduciary abuse, neglect, abandonment, isolation or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

The telephone report must be made immediately or ASAP when reporter has knowledge or reasonable suspects that abuse has occurred, to:

- The long-term care ombudsman coordinator (when the abuse is alleged to have occurred in a long-term care facility),
- State Department of Mental Health, State Department of Developmental Services, or to a local law enforcement agency (when the abuse is alleged to have occurred in a state mental hospital or state developmental center),
- County Adult Protective Services Agency or County Welfare Department (when the abuse is alleged to have occurred anywhere else).

The report should include the name of the person making the report, the name, address and age of the elder or dependent adult, the nature and extent of the dependent adult or elderly person’s condition, present location of the elder or dependent adult, the names and addresses of family members or any other person responsible for the elder or dependent adult, (if known), the alleged incident of elder or dependent adult abuse and any other information
including what led the person to suspect elder or dependent adult abuse. The 24-hour toll-free number for the Department of Aging Crisis Hotline is (800) 231-4024.

- A written report must be completed within 48 hours of the telephone report, on a California Department of Social Services form SOC341 entitled “Report of Suspected Elder or Dependent Adult Physical Abuse,” and mailed to the address indicated by the agency that took the phone reports, and the county department of adult protective services. This form is obtainable from the County Adult Protective Services Agency or the local long-term care ombudsman program.

- The law provides that care custodians, health practitioners, or employees of adult protective services agencies or local law enforcement agencies will not incur either civil or criminal liability for any report they are required or permitted to make under this law. However, any person who knowingly fails to report, when required, an instance of elder abuse is statutorily guilty of a misdemeanor punishable by a fine not to exceed $1,000, or imprisonment in the county jail exceeding six (6) months or both. A healthcare practitioner may also be liable in civil court for damages that occur if the elder or dependent adult is further victimized because of failure to report the abuse.

**Endangered Adults Laws** — Physicians should ascertain whether the Protective Placement and Custody Laws have been adopted in their county by calling their local county medical society, law enforcement agency, adult protective services department of local county governing body. These laws provide that if a physician treating an adult determines that the person is an endangered adult (defined as in a situation posing an immediate risk of serious injury or death, when no other means are available to mitigate the risk to the individual), whether or not medical treatment is required, the physician may (but is not required to) delay the release of the endangered adult until the following:

- A local law enforcement agency takes custody of the endangered adult,
- It is determined by the responding agency the adult is not endangered,
PHYSICIAN RESPONSIBILITIES

- The responding agency takes other appropriate action to ensure the safety of the endangered adult.

In these instances, the physician must immediately notify local law enforcement of the delayed release decision, and request immediate assistance in the matter. Note – there are no explicit immunities for the physician in the event the presumed endangered adult or his or her family or guardian sues the physician for damages arising from the delayed release.

- Employee Acknowledgement Form – Physicians or other employers who hire licensed health care practitioners or other mandated reports on or after January 1, 1995, are required to obtain a signed statement to the effect that the employee has knowledge of the mandated reporter statute and will comply with its provisions. Employers must retain the signed statements at the employer’s expense. In addition, employers must inform licensed healthcare practitioners and other mandated reports in their employee who were hired prior to January 1, 1995 of their reporting responsibility. Effective with physician licenses issued on or after January 1, 1995, the Medical Board must obtain an acknowledgement that the physician understands and agrees to comply with the dependent and elder abuse reporting statutes.
Responsibility

It is expected that the IPA partners, physicians, providers, and employees facilitate member participation in their medical decisions, treatment, and self-care regardless of their language of origin, cultural orientation, and/or physical limitations. This expectation will allow increased awareness, communication, and cultural variances for physicians treating members whose primary language and ethnicity is different from their own; or for members who possess physical or sensory limitations related to communication. The IPA’s official policy and procedure for this issue can be found in the EXCEL MSO, LLC’s Quality Management Policy and Procedure Manual, Policy # 201. This policy is available for your review upon request at our corporate office.

In order to assist our providers, various processes and phone numbers are available. These are listed below and some additional references are in the Appendix section of this manual. Please be aware that the member will not be charged for these services. Some of the numbers that are listed may be specific for an individual health plan, so we recommend that you confirm the member’s health plan before calling.

Telephonic Language Interpretation

- For all plans other than Blue-Cross Medi-Cal, you may call the IPA’s Member Services Department or the member’s health plan Member’s Service Department to request cultural or linguistic translation services. *
- PMGSJ staff may also be able to provide telephonic interpretative services to a provider office where a request has been made for Vietnamese or Spanish translators. For other needs, AT&T language services may be contacted.
- For Blue Cross Medi-Cal members, a Blue Cross representative will coordinate the interpreter service.

* Exception: Call Santa Clara Family Health Plans’ Member Services at 800-260-2055 Monday - Friday from 8:30 a.m. - 5:00 p.m. to arrange translation services.
Language Assistance Program

Effective January 1, 2009 CA law (Senate Bill 853) and its accompanying regulations require that health plans establish and support a Language Assistance Program for enrollees who are limited English proficient. If a patient has limited English and requires language assistance, contact the appropriate health plan at the number listed below.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>LAP Phone †</th>
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<tbody>
<tr>
<td>Aetna</td>
<td>800-525-3148</td>
</tr>
<tr>
<td>Anthem Blue Cross (Commercial)</td>
<td>800-677-6669</td>
</tr>
<tr>
<td>Anthem Blue Cross (Medi-Cal)</td>
<td>800-407-4627</td>
</tr>
<tr>
<td>Blue Shield</td>
<td>800-541-6652</td>
</tr>
<tr>
<td>Care1st</td>
<td>800-544-0088 (8am-5pm)</td>
</tr>
<tr>
<td></td>
<td>877-904-8195 (after hours)</td>
</tr>
<tr>
<td>Cigna</td>
<td>800-806-2059</td>
</tr>
<tr>
<td>Health Net</td>
<td>800-522-0088</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>800-730-7270 (Spanish)</td>
</tr>
<tr>
<td></td>
<td>800-938-2300 (Chinese)</td>
</tr>
<tr>
<td></td>
<td>800-624-8822 (Other)</td>
</tr>
<tr>
<td>SCFHP</td>
<td>888-898-1364 (access code 8033)</td>
</tr>
</tbody>
</table>

†Lap Phone # may change – Call phone # on back of members ID card.
*Traditional Chinese

If a patient was offered an interpreter and refused the services, it is important to note the refusal in the medical record for that visit and include details on why it was refused.

It is especially important to document if the interpreter used is a minor.

For all limited English proficient patients, it is a best practice to document the patient’s preferred language in paper and/or electronic medical record.
Face to Face Interpretation

- For Blue Cross Medi-Cal and Healthy Family members have access to face-to-face translators if arrangements are made through Blue Cross of California.
- For all plans friends and family are only used as an interpreter when specifically requested by a member. NO minors are allowed to translate per California law.

TDD/TTY Access for the Hearing Impaired

- California State TDD line is 1 (800) 735 - 2922 and is available to all California residents.
- Blue Cross members are to call Blue Cross TDD at (888) 757 - 6034.

Auxiliary Aids

- Aids may be available through the member’s specific health plan. Your office can call the member’s health plan’s Member Service Department for assistance in obtaining these materials or PMGSJ’s Member Service Department who can assist you in obtaining these services.
- Sign language may also be available through the member’s health plan. There are several local agencies that are available in this area. These are located in the appendix of this section.
- It is highly recommended that if you need these services to call the appropriate Health Plan in advance so materials are available prior to the member’s appointment.
Physician Responsibilities

Blue Cross Medi-Cal and Healthy Families Requirements

The following is a summary based on Blue Cross Medi-Cal and Healthy Families Requirements:

Summary

- If an interpreter is used, the name of the person translating for the member will be entered into the member’s chart, as well as the language used.
- Member may request face-to-face (for signing or different language) or telephone interpreter services to discuss complex medical information and treatment options.
- Friends and family are only used as an interpreter when specifically requested by the member. NO minors are allowed to translate per CA law.
- Member’s refusal of interpreter services must be documented on chart.
Cultural and Linguistics Toolkit

Blue Cross of California has a Cultural and Linguistics Toolkit designed to help in removing communication barriers and to simplify the delivery of quality care to BCC Medi-Cal and Healthy Families members.

Each IPA contracted Physician shall be aware of and have a laminated interpreter card (contained in the Toolkit) explaining how to access free translation services for these members.

To request a copy of the Toolkit please contact Provider Services at (408) 937-3612.

The toolkit includes:

- Cultural and Linguistics Information Guide for Health Professionals
- Interpreter Services Display sign
- Instruction card for using BCC Interpreter Services
- Request/Refusal Form for Interpreter Services (Examples of these forms in different languages are located in the appendix of this section.
- Cultural and Linguistics Program Survey
Due to our wide population base, the IPA has member materials printed in the major languages that we serve. For example, we have materials available in English, Vietnamese, and Spanish.

Addition, each Health Plan has member materials available in various languages. You may request these materials directly from the Health plan.

- Section 8 of this manual provides a listing of some of the documents that can be ordered directly from Health Net by completing their standard request form.
Terminating Member from Your Practice

The IPA recognizes there may be situations where a Physician may wish to discontinue care of a patient. A Physician may transfer a patient out of their care when the member has:

- Failed to follow the Physicians’ medical advice
- Exhibited disruptive behavior/dangerous behavior in the course of seeking/receiving care
- Failed to pay required co-payments
- Missed three or more appointments within 6 consecutive months without 24 hour prior notice

There may be no obligations or discriminatory reasons for the termination.

See also Enrollment & Eligibility section 3 of this manual for Member Transfers.

*For process steps, go to the next page.*
Terminating a Member from your Practice

Process

1. Notify the member by certified letter (see guidelines below)
2. Follow the guidelines below when a patient is terminated.
3. Send a copy of the letter sent to the member to EXCEL MSO Provider Services.

The physician must follow certain procedures in order to avoid a possible charge of abandonment.

- Acute medical conditions must be resolved prior to termination of the relationship
- Check the provisions of any contract you have signed with the patient’s health plan (The Health Plan may have specific guidelines. Contact the health plan or EXCEL MSO for assistance.)
- Give the patient a 30 day notice (in writing) and sufficient time to find another physician (30 day notice)
- Continue to treat the patient during the period of notice
- Provide a copy or summary of records to the new treating physician upon the patient’s written request
- If the reason for termination relates to failure to follow medical advice, this may be specified
- Send a certified letter to the patient’s home, return receipt requested. A copy of the letter and the return receipt should be placed in the patient’s chart.
MISCELLANEOUS

Pharmacy Utilization

- All IPA physicians are expected to comply with the drug formulary requirements of the member’s health plan.

Please contact each appropriate Health Plan for the current formulary.

Recredentialing

All IPA physicians are expected to comply with requirements and requests from Provider Services for purposes of Recredentialing purposes. Documentation includes copies of current State medical license, Drug DEA, Board Certification (if applicable), Curriculum Vitae, completed Recredentialing Application, proof of current Malpractice and Premise Liability insurance, Documentation of PCP - related CME for Specialists requesting PCP status.