19. FINANCE AND REIMBURSEMENT

A. Financial Viability
   1. IPA

APPLIES TO:

A. This policy applies to all IPAs participating in the Medicare product line contracted with IEHP.

POLICY:

A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of an IEHP contracted IPA.

B. IEHP monitors the financial viability of all contracted IPAs and has established funding requirements to ensure all contracted IPAs are financially sound and can handle the risks associated with capitation.

C. IEHP requires all contracted IPAs to meet IEHP’s and DMHC’s financial viability standards/requirements for Risk bearing Organizations (RBOs) under SB260 prior to assignment of Members to the IPA’s PCPs and on an ongoing basis.

PROCEDURES:

A. Prior to entering into a contractual agreement with IEHP and annually thereafter, IPAs must submit their most current audited financial statements, and their most recent monthly and year-to-date financial statements comprising Balance Sheets, Income Statements, Cash Flow Statements and supporting worksheets for IBNR or IBNR certification by an independent, certified actuary mutually acceptable to IEHP. Additionally, the IPA must submit their required periodic financial and organizational information disclosures as stated in section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act as an RBO within five (5) business days after the due date. The financial statements must demonstrate that the IPA is financially viable and is able to meet IEHP’s and DMHC’s SB260 financial viability standards/requirements. IEHP does not contract with IPAs that do not meet these standards.

B. On an ongoing basis, all contracted IPAs are required to submit to IEHP a copy of their financial statements comprising Balance Sheets, Income Statements, Cash Flow Statements and supporting worksheets for IBNR on a quarterly basis within forty-five (45) days of the end of each calendar quarter. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures as stated in section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act as an RBO within five (5) business days after the due date. When requested, IPAs shall also provide written explanation within two (2) weeks substantiating any of the following (but not limited to):
   1. Cash & Cash Equivalents including Restricted Assets
   2. All Receivables – Current and Long Term
19.  **FINANCE AND REIMBURSEMENT**

A.  **Financial Viability**  

1.  **IPA**

   3.  All Liabilities – Current and Long Term, including IBNR  
   4.  Any Due To/From Shareholders/Partnership  
   5.  Any Intercompany or Related Transaction  
   6.  Revenues  
   7.  Medical Expenditures  
   8.  General and Administrative Expenditures  

C.  On an annual basis, all contracted IPAs are required to submit annual audited financial statements, including IBNR certification to IEHP for compliance review no later than one fifty (150) days after the end of the IPA’s fiscal year. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures as stated in section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act as an RBO within five (5) business days after the due date.  

D.  Financial statements must clearly display the financial condition of the entity that holds the contract with IEHP. Submission of related party, affiliate, consolidated or parent company financials are not acceptable. Consolidating financial statements are only acceptable if the financial condition of the IEHP contracted entity is clearly documented and identified. Consolidating financial statements must clearly identify any intercompany transactions between related parties, affiliates or parent company.  

E.  IEHP will review the financial statements submitted by the IPAs to ensure the following IEHP financial viability standards/requirements are met at all times:  

   1.  Tangible Net Equity (TNE) is positive;  
   2.  The Current Ratio (the ratio of current assets to current liabilities) always exceeds 100%;  
   3.  Quick ratio is always greater than 1.0;  
   4.  Debt Coverage Multiple is always greater than 1.2;  
   5.  Cash to Claims Ratio is always 0.75 or greater;  
   6.  The plan must be notified if claims payable days outstanding is more than four (4) months;  
   7.  The plan must be notified if accounts receivable days outstanding is more than sixty (60) days;  
   8.  Total Assets, (Net of Intangibles and/or Due from Officers, Directors, and Affiliates) as reported on the financial statements, shall fully fund Incurred But Not Reported (IBNR) claims;
19. FINANCE AND REIMBURSEMENT

A. Financial Viability

1. IPA

9. IBNR calculation worksheets that support the amounts represented on the financial statements accompany all submissions. IPAs must also provide the following:
   a. The methodology used to calculate IBNR.
   b. The data and work papers to substantiate IBNR.
   c. Independent review and certification, if necessary, by:
      1) IEHP
      2) IPA’s Actuary

F. IEHP reserves the right to request additional detailed work papers supporting account balances represented on the IPA’s or MSO’s financial statements.

G. IEHP reserves the right to ask for more frequent financial reports and information upon written notice to the IPA, and making appropriate inquiries of the IPA’s key financial personnel during any review.

H. IEHP reserves the right to approve or deny use of a particular MSO by the IPA.

I. All contracted IPAs shall also have the ability to secure an Irrevocable Standby Letter of Credit (LOC) (See Attachment, “Irrevocable Letter of Credit” in Section 19), with IEHP as the beneficiary, prior to receiving Member enrollment, and quarterly thereafter. This requirement will be waived for IPAs having a Limited Knox-Keene license.

J. The LOC secured amounts generally are linked to the IPA’s combined ownership of IEHP enrollment as follows:

<table>
<thead>
<tr>
<th>IPA’s enrollment</th>
<th>Deposit Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to - 10,000</td>
<td>$100,000.00</td>
</tr>
<tr>
<td>10,001 - 20,000</td>
<td>$200,000.00</td>
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<tr>
<td>20,001 - 30,000</td>
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<td>80,001 - 90,000</td>
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<td>90,001 plus</td>
<td>$1,000,000.00</td>
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</tbody>
</table>
19. FINANCE AND REIMBURSEMENT

A. Financial Viability
   1. IPA

K. Enrollment levels will be reviewed at the end of the reporting quarter, and LOC deposit amounts adjusted, as applicable, within thirty (30) days after the end of the reporting quarter.

L. In addition to securing an Irrevocable Standby LOC with IEHP as the beneficiary, IPAs are also required to establish a restricted cash reserve in the amount of 25% of the average monthly capitation revenue for the reporting quarter. This requirement will be waived for IPAs having a Limited Knox-Keene license.

M. In order to satisfy the restricted cash reserve requirement, IPAs have the following options:
   1. Secure an Irrevocable Standby Letter of Credit (LOC) designating IEHP as the beneficiary.
   2. Elect to have the monthly IPA capitation revenue adjusted by IEHP.

N. IEHP reserves the right to increase the LOC amount for an IPA failing to meet TNE requirements by the amount the IPA is deficient, which may be in addition to the deposit required based on enrollment.

O. IEHP reserves the right to increase the LOC amount for an IPA based on either the enrollment level or IBNR, whichever one is higher.

P. Deposit amounts must remain in place for the entire contract year and for one hundred eighty (180) days after the contract expiration/termination.

Q. If the IPA fails to meet any of the above referenced standards, IEHP may take the following actions:
   1. Freeze the IPA to new membership;
   2. Place the IPA in a contractual cure for breach of contract;
   3. Seize any capitation and/or monies owed and place the IPA under Financial Supervision until breach is cured;
      a. Financial Supervision to include:
         1) Withholding of monthly capitation
         2) Managing and releasing withheld capitation to the IPA to fund:
            • Administrative Expenses
            • PCP Capitation Payments
            • Claims Payments - limited specifically to months/DOS withheld capitation was intended for payment
19. FINANCE AND REIMBURSEMENT

A. Financial Viability
   1. IPA

3) Reviewing financial statements, bank statements and/or other records to ensure payments are made

4. Immediately terminate the IEHP/IPA Agreement for cause.

R. In the event an IPA fails to perform a financial covenant of its IEHP contract, IEHP may exercise its ability to draw down on the deposit or line of credit for its full amount.

S. The above procedures, including LOC Requirements, may be adjusted by other factors that provide similar financial security as determined by the IEHP Chief Executive Officer or designee of the IEHP Chief Executive Officer.

T. Upon request by IPA(s), at its sole discretion, IEHP may change/waive any/or part of the IPA Financial Viability Requirements as it deems necessary either globally or specific to an IPA.

REFERENCE:

A. Section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act (SB260).
19. FINANCE AND REIMBURSEMENT

A. Financial Viability

2. Hospital

APPLIES TO:

A. This policy applies to all Hospitals contracted with IEHP under a Capitated Agreement.

POLICY:

A. IEHP complies with all regulatory requirements to protect its Members from the consequences of financial failure of an IEHP contracted Hospital.

B. IEHP has established financial viability standards to ensure all Capitated Hospitals are financially sound and can handle the risks associated with capitation.

C. IEHP requires all Capitated Hospitals to meet IEHP’s financial viability requirements.

D. All financial viability requirements must be met prior to any assignment of Members to the Hospital with ongoing conformance with the requirement.

PROCEDURES:

A. Prior to entering into a contractual agreement with IEHP and annually thereafter, Capitated Hospitals must submit their most current audited financial statements comprising Balance Sheets, Income Statements, Statements of Cash Flow and supporting worksheets for IBNR or IBNR certification by an independent, certified actuary mutually acceptable to IEHP. The financial statements must demonstrate that the hospital is financially viable and able to meet IEHP’s financial viability standards/requirements. IEHP does not enter into Capitated Agreements with Hospitals that do not meet these standards.

B. On an annual basis, Hospitals are required to submit a copy of their annual audited financial statements, including IBNR certification to IEHP for compliance review no later than one hundred fifty (150) days after the end of the Hospital’s fiscal year.

C. Financial statements must clearly display the financial condition of the entity contracted with IEHP. Subject to the following conditions, the submission of consolidated or parent company financial statements in good form are acceptable to IEHP. Consolidated financial statements are acceptable if the financial condition of the contracted entity is clearly stated. Typically, consolidating work papers supporting the consolidated statements are required. A parent company’s financial statements are acceptable in lieu of the contracted entity’s, if IEHP has accepted the parent company’s financial guarantee of the subsidiary.

D. IEHP reviews the financial statements submitted by the Hospital to ensure the following financial viability standards are met at all times:

1. Tangible Net Equity equals no less than $1 million at all times;
2. The Current Ratio (the ratio of current assets to current liabilities) always exceeds 100%; and
3. IBNR calculation worksheets that support the amounts on the financial statements accompany all submissions.

E. IEHP may request interim financial statements and supporting information upon written notice to the Hospital.

F. If the Hospital fails to meet any of the above referenced standards, IEHP may take the following actions:
   1. Freeze the Hospital to new membership;
   2. Place the Hospital in contractual cure for breach of contract;
   3. Seize any capitation and risk pool monies owed until breach is cured; or
   4. Immediately terminate the IEHP/Hospital Agreement for cause and convert to a Per Diem Agreement.

G. The above procedures may be adjusted by other factors that provide similar financial security as determined by the IEHP Chief Executive Officer or designee of the IEHP Chief Executive Officer.
19. FINANCE AND REIMBURSEMENT

B. Medicare Capitation
   1. IPA

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) IPAs.

POLICY:

A. IEHP delegates the responsibility of providing medical services for its Members to its IPAs who are contracted with IEHP under a capitated arrangement. In exchange for these services IEHP makes monthly capitation payments to the IPA for Members assigned to that organization.

B. The amount of capitation is paid per contract on a percent of premium basis and is paid in full to the IPA for a specified list of services provided to an assigned Member. The list of services covered by capitation is described in the IEHP Capitated Agreement with the IPA.

C. Capitation is paid monthly to each IPA for all of their assigned Members. The payments are transferred via Electronic Funds Transfer (EFT) by the 15th day of each month and by the first day of each month following the month of service. Retroactive enrollment and disenrollment activities of assigned Members are automatically calculated and included in the monthly capitation payments.

D. Capitation is only paid for Members with active eligibility at the end of the prior month as noted on the file received from the Centers for Medicare & Medicaid Services (CMS).

E. It is the responsibility of the IPA to provide or arrange for services that are the financial responsibility of the IPA.

PROCEDURES:

A. IEHP calculates capitation payments per the contract for each IPA based on the current (new) month’s membership and any retroactive adjustments.

B. Capitation payments are transferred via EFT to the IPA no later than the 15th day of each month for the month of service. Retroactive enrollment and disenrollment activities of Members assigned to IPAs are automatically calculated and included in the monthly capitation payments.

C. Each month IEHP creates a capitation file containing all of the detail information from the capitation reports. These files are placed on the Secure File Transfer Portal (SFTP) server by the first of the month for the prior month’s capitation, and by the 16th of the month for the mid-month capitation (for file format information see Attachment “Capitation Data File Format” in Section 19, or refer to the IEHP Provider Electronic Data Interchange (EDI) Manual).
19. FINANCE AND REIMBURSEMENT

B. Medicare Capitation
   1. IPA

D. To reconcile the amount paid each month, IPAs should review the electronic cap files and capitation reports provided by IEHP.
19. **FINANCE AND REIMBURSEMENT**

B. **Medicare Capitation**

2. **IEHP Direct Providers**

**APPLIES TO:**

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) PCPs.

**POLICY:**

A. IEHP delegates the responsibility of providing medical services for its Members to its PCPs who are contracted with IEHP under a capitated arrangement. In exchange for these services IEHP makes monthly capitation payments to the PCPs for Members assigned to that organization.

B. The amount of capitation paid is based on the Medicare HCC score and is paid in full to the PCP for a specified list of services provided to an assigned Member. The list of services covered by capitation is described in the IEHP Capitated Agreement.

C. Capitation is paid monthly to each PCP/Medi-Cal Group for all of their assigned Members. The payments are sent or transferred via Electronic Funds Transfer (EFT) by the first day of each month following the month of service. Retroactive enrollment and disenrollment activities of assigned Members are automatically calculated and included in the monthly capitation payments.

D. Capitation is only paid for Members with active eligibility at the end of the prior month as noted on the file received from the Centers for Medicare & Medicaid Services (CMS).

E. It is the responsibility of the PCP to provide or arrange for services that are the financial responsibility of the PCP.

**PROCEDURES:**

A. IEHP calculates capitation payments for each PCP based on the current (new) month’s membership and any retroactive adjustments.

B. Capitation payments are sent or transferred via EFT to the PCP no later than the first of each month following the month of service for all assigned Members. Retroactive enrollment and disenrollment activities of Members assigned to IPAs are automatically calculated and included in the monthly capitation payments.

C. Each month IEHP creates capitation files containing all of the detail information. These files are accessible from Secure Provider Website by the first of the month for the prior month’s capitation.

D. To reconcile the amount paid each month, PCPs should review the capitation reports provided by IEHP.
19.  FINANCE AND REIMBURSEMENT

B.  Medicare Capitation
   2.  IEHP Direct Providers
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance (P4P)

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

A. The IEHP’s Pay for Performance Program (P4P), was designed to increase the provision of preventive health services to IEHP Members as well as improve HEDIS results in the following areas:

1. To ensure that all IEHP Members are fully immunized by the age of 2 years.
2. To ensure that all IEHP Members from birth up to their 7th birthday and age 11 years up to their 19th birthday receive well child visits in accordance to IEHP’s Well Child Services Schedule.
3. To ensure that female IEHP Members receive annual Pap Test that focus on the needs and risk factors of Members.
4. To ensure that all pregnant IEHP Members receive timely prenatal and post partum care assessments.
5. To ensure that all IEHP Members with persistent asthma receive appropriate long-term controller medication (LTC) assessments and treatment to improve their health status.
6. To ensure that all IEHP DualChoice Members receive timely annual visits with emphasis on chronic illness.
7. To ensure that all IEHP Members with diabetes receive appropriate assessments and treatment to improve their health status.

B. Under P4P, PCPs and Obstetrical (OB) Specialists are eligible to receive additional compensation directly from IEHP for specific services.

C. P4P includes the following eight (8) components:

1. Immunizations;
2. Well Child Visits;
3. PAP Tests;
4. Perinatal Services;
5. Postpartum Services;
6. Asthma;
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance (P4P)

7. IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Annual Visit; and
8. Diabetes.

D. PCPs and OB Specialists are automatically enrolled in P4P upon completion of IEHP’s credentialing process, designation of an effective date for participation in the IEHP network and initial Provider in-services completion. Request for Taxpayer Identification Number and Certification (Form W-9) information verified during the credentialing process will be used for remittance of P4P payment.

1. PCPs may participate in all of the components as applicable.
2. OB specialists may only participate in the PAP Test, Perinatal and Postpartum Services components.

E. The PCP can only receive reimbursement for an active Member who is assigned to them on the date services are provided, unless otherwise specifically noted. OB specialists receive reimbursement only if the Member is active with IEHP on the date of service.

F. Providers must submit online only www.iehp.org. IEHP will not accept or reimburse initial paper submissions made via mail or fax except corrective resubmission only.

G. PM 160 forms are used to report Immunizations and Well Child Visits, they are processed for reimbursement within thirty (30) working days. Completed PM 160 forms must be submitted for reimbursement online only at www.iehp.org. Failure to submit completed forms within two (2) months from the date of service will result in denial of reimbursement.

H. Pap Test component is submitted on CMS 1500 forms online only at www.iehp.org with the appropriate ICD code(s) and CPT code(s) and are processed for reimbursement within thirty (30) working days. Failure to submit completed forms online at www.iehp.org within two (2) months from the date of service will result in denial of reimbursement.

I. Perinatal and Postpartum Services components are submitted on the P4P Pregnancy Notification/Outcome Report Form only (See Attachment, “PNO Form” in Section 19) and are processed for reimbursement within thirty (30) working days, if properly submitted and other required forms are attached as appropriate. Failure to submit completed forms online at www.iehp.org within one (1) month from the date of service will result in denial of reimbursement.

J. Pap Test reimbursement may be submitted using the same PNO form with the appropriate ICD code(s) and CPT code(s) during the PNO submission online only at www.iehp.org

L. Complete the Asthma Form online only at www.iehp.org and indicate appropriate ICD code(s), asthma visit date, date of prescription and type of LTC prescription provided. The Asthma form must be submitted online to IEHP within two (2) months from the date
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance (P4P)

of service and meet IEHP’s submission standards to qualify for incentive. Record of asthma visit and prescriptions must be retained in Member’s chart.

M. IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Annual Visit must be submitted online only at www.iehp.org using appropriate form. All of the Member’s significant conditions/diagnoses must be assessed at the annual visit. Accurate clinical documentation and ICD coding reflecting the Member’s condition/diagnoses must be entered on the form, including appropriate assessments and plans. Completed annual visit forms must be submitted online to IEHP within two (2) months from the date of service and must meet IEHP’s submission standards to qualify for the incentive. Failure to submit completed forms within the required timeframes will result in denial of reimbursement.

N. Diabetes component is submitted online only at www.iehp.org with the appropriate ICD code(s), date of diagnosis, collection date for each Test Type ordered or given and the results for completed tests. The Diabetes form must be submitted two (2) months from the date of services and must meet IEHP’s submission standards to qualify for the incentive. Failure to submit completed forms online within the required timeframes will result in denial of reimbursement.

O. IEHP conducts on-going audits of P4P Providers for compliance with Pay for Performance program requirements, including submission accuracy, completeness of forms, and supporting documentation in the Member’s medical record for P4P submissions.

PROCEDURES:

A. The following outlines each component included in the P4P Program, including participation details and reimbursement requirements.

1. Immunization Component

a. All PCPs credentialed to see Members between the ages of 0 and 18 are eligible to participate in the Immunization component.

b. The goal of the Immunization component is to ensure that all IEHP Members are fully immunized by the age of 2 years.

c. Eligible immunizations are outlined in (See Attachment, “Recommended and Catch-Up Immunization Schedule” in Section 19) and must be provided to an eligible Member between the ages of 0 and 18 in accordance with the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule (See Attachment, “Recommended and Catch-Up Immunizations Schedule” in Section 19). Immunizations given must be documented in the Member’s chart in
C. Pay For Performance (P4P)

accordance with Policy 10C2, “Pediatric Preventive Services - Immunization Services”.

d. PCPs report immunizations by completing a PM 160 form and indicating either the immunization given along with the shot number in the series or a PPD skin test (See Attachments, "PM 160 Immunizations – Version 8" and "PM 160 Immunizations and Well Child Visit – Version 8" in Section 19). PCPs must use the most recent version of the PM 160 form (currently Version 8). In the event that a new version is released by the state, PCPs may use the previous version until the new version becomes readily available.

e. PM 160 forms must be submitted online at www.iehp.org within two (2) months from the date of service and must meet IEHP’s PM 160 submission standards as stated in Medi-Cal Policy 10C2, “Pediatric Preventive Services – PM 160 Information Only Reporting” in order to be eligible for reimbursement.

f. PCPs are reimbursed $9.00 directly by IEHP for each eligible immunization administered to an eligible Member (See Attachment, "P4P Reimbursable PM160 Immunization Codes" in Section 19).

g. PCPs are reimbursed $9.00 for TB tests and can be reimbursed up to a maximum of two (2) times per year with a minimum of thirty (30) days in between each TB test per eligible Member.

h. PCPs are reimbursed a $150 bonus incentive for immunization compliance by 2 years of age when appropriately performed and submitted within the required timeframes by the Provider.

1) Required shots must be administered by the Member’s 2nd birthday (on or before 24.0 months of age).

2) Required shots are:
   - Polio #1, #2, and #3
   - Hep B #1, #2, and #3
   - Hib #1, #2, #3 and/or #4
   - DTaP #1, #2, #3 and #4
   - MMR #1
   - Varicella #1
   - Pneumococcal Heptavalent (Prevnar) #1, #2, #3 and #4
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance (P4P)

3) Effective September 7, 2015 to comply with a new accreditation standard, IEHP is adding two (2) additional shots to the yellow card screen online. Although not required, IEHP recommends the following shots to be administered and submitted:
   - Rotavirus (3 shots)
   - Tdap/Td (1 shot)

4) Submit a completed PM 160 form with any final shot(s) and a copy of the Immunization Record and History Form (DHS 8608) or the yellow “Immunization Record” card with all of the required shots. Yellow Card can be submitted up to five (5) months after the last eligible vaccination is administered. Proof of compliance is verified when the shot record is submitted with the PM 160 form.

5) IEHP accepts yellow card submission online only. Complete all required immunizations online at www.iehp.org to receive compliance bonus.
   i. Reimbursements are made on a monthly basis.
   j. Providers are strongly encouraged to participate in the California Immunization Registry (CAIR), formerly known as Vax Track, administered by the Local Health Departments (LHDs) in Riverside and San Bernardino Counties. Participating Providers can enter and access all relevant immunization data for any child tracked by the system, including children receiving immunizations at different sites. Providers interested in participating and enrolling in the program should call the following number information: 1-800-578-7889. Further information and web access are also available online at www.cairweb.org.

2. Well Child Visit Component
   a. All PCPs credentialed to see Members between the ages of 0 and 18 are eligible to participate in the Well Child Visit component.
   b. Well Child Visits must be provided to an eligible Member from birth up to their 7th birthday and age 12 up to their 19th birthday and must be in accordance with the IEHP Well Child Services schedule (See Attachments, “Recommended for Preventive Pediatric Health Care Schedule” and “CHDP Periodicity Schedule and Assessment Requirements by Age Group” in Section 19), regardless if the Member has had multiple PCPs.
   c. Well Child Visits must include all of the components required under Policies 10C1, “Pediatric Preventive Services - Well Child Visits.”
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance (P4P)

d. PCPs report Well Child Visits by completing a PM 160 form, including boxes 01 through 05 under the CHDP Assessment section, and all other applicable sections (See Attachments, "PM 160 Well Child Visit – Version 8" and "PM 160 Immunizations and Well Child Visit – Version 8" in Section 19). PCPs must use the most recent version of the PM 160 form (currently Version 8). In the event that a new version is released by the state, PCPs may use the previous version until the new version becomes readily available.

e. PM 160 forms must be submitted online at www.iehp.org within two (2) months from the date of service and must meet IEHP’s PM 160 submission standards.

f. PCPs are reimbursed directly by IEHP for each eligible Well Child visit administered to an eligible Member.

1) $40 for ages 0 up to their 7th birthday.

2) $50 for ages 11 up to their 19th birthday.

g. Eligible PCPs receive incentive for non-assigned Members seen for the two (2) weeks or one (1) month Well Child visit.

h. Reimbursements are made on a monthly basis.

3. PAP Test Component

a. All PCPs and OB specialists credentialed to see female Members over 18 years of age or who are sexually active, are eligible to participate in the PAP test component.

b. PAP tests must include all of the components required by Policy 10B, “Adult Preventive Services.” A copy of the lab report must be retained in the Member’s chart.

c. Providers report PAP tests by properly completing a CMS 1500 form online with the appropriate CPT and ICD code(s) (See Attachment. "PAP Test Codes" in Section 19).

d. Completed CMS 1500 forms must be submitted online at www.iehp.org within two (2) months from the date of service in order to be eligible for reimbursement.

e. Providers are reimbursed $50.00 directly by IEHP for each PAP test administered to an eligible Member.

f. Only one (1) exam per Member per year is eligible, regardless of the number of PCPs the Member has been enrolled with throughout the year.
C. Pay For Performance (P4P)

4. Perinatal Services Component

a. All OB/PCPs and OB specialists credentialed for obstetrical privileges are eligible to participate in the Perinatal Services component.

b. OB/PCPs and OB specialists are reimbursed directly by IEHP for the Perinatal Services component of the initial visit for each eligible Member based on the time of visit.

1) $225.00 if the date of service for the initial visit is in the 1st trimester.

2) $100.00 if the date of service for the initial visit is in the 2nd trimester.

3) $100.00 if the date of service for the initial visit is in the 3rd trimester.

c. To receive reimbursement for the initial visit, Providers must submit a completed Pregnancy Notification/Outcome Report (PNO) with the appropriate CPT and ICD codes for the specific prenatal visit (See Attachment, "Perinatal Services Codes" in Section 19). PNOs must be submitted online only at www.iehp.org within one (1) month from the date of service in order to be eligible for reimbursement.

d. To receive reimbursement for Pap Test using the PNO form, Providers must submit a completed PNO form with the appropriate ICD code(s) and CPT code(s) during the PNO submission only at www.iehp.org.

e. Reimbursements are made within thirty (30) working days of properly submitted PNO form as referenced. Failure to submit completed forms within the required timeframes will result in denial of reimbursement.

5. Postpartum Services

a. All credentialed PCPs, OB/PCPs and OB Specialists are eligible to participate in the Postpartum Services component.

b. PCPs, OB/PCPs and OB Specialists are reimbursed directly by IEHP for one Postpartum assessment performed to a postpartum Member within three to eight (8) weeks after delivery.

c. To receive reimbursement for the postpartum visit, PCPs, OB/PCPs and OB/Specialists must submit a completed Pregnancy Outcome Report Form (PNO) (See Attachment, "Pregnancy Notification Form" in Section 19) with the appropriate CPT and ICD code(s) (See Attachment, “Postpartum Services Codes” in Section 19) indicating a postpartum visit. PNO must be
19. **FINANCE AND REIMBURSEMENT**

C. **Pay For Performance (P4P)**

submitted online only at [www.iehp.org](http://www.iehp.org) within one (1) month from the date of service in order to be eligible for reimbursement.

d. PCPs and OB/Specialists are reimbursed $200 directly by IEHP for a postpartum visit administered to an eligible Member.

e. Reimbursements are made within thirty (30) working days of a properly submitted PNO form online.

6. **Asthma Component**

a. All credentialed PCPs that treat IEHP Asthma Members are eligible to participate in the Asthma component.

b. PCPs will be able to review online a roster of active IEHP Members identified as having asthma.

c. PCPs who do not receive a roster – but are treating Members with asthma can add these Members to the program by completing an Asthma Form online and confirming both date of diagnosis and ICD code(s).

d. PCPs are reimbursed $25 for performing an asthma risk assessment, prescribing appropriate LTC medication and ensuring the prescription is filled for an eligible IEHP Member within specified time frames. Physicians can earn up to $100 per Member per year for total compliance with the program.

e. PCPs are reimbursed $25 for each Asthma visit where either LTC medication was prescribed and Member consequently filled the prescription or Member is already compliant with LTC medication prescribed. The Member must fill the LTC prescription no later than fourteen (14) days after the Asthma Visit in order to qualify for the incentive. IEHP will look for an LTC medication fill within the past three (3) months of the date of asthma visit submitted. Up to four (4) quarterly visits per Member are eligible for payment per year.

f. Reimbursements are made within forty (45) working days of properly submitted Asthma forms online.

7. **IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Annual Visit**

a. Any credentialed IEHP PCP participating in IEHP DualChoice Program are eligible to participate in the IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Annual Visit component.

b. Only IEHP DualChoice Members are eligible for the IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Annual Visit.
19.  FINANCE AND REIMBURSEMENT

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c.  The goal of the IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Annual Visit component is to ensure that IEHP DualChoice Members receive timely annual visit with emphasis on chronic illness.

d.  Participating PCPs must record significant chronic diagnoses and document history and physical findings related to these diagnoses in the medical record.

e.  The new individual Member specific IEHP DualChoice form is available through the Member Eligibility Webpage. A copy of this form must be printed prior to the Member’s visit.

f.  Participating PCPs must review the Diagnosis Review sections of the IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Annual Visit form. The conditions need to be confirmed, identified with the appropriate ICD code(s) and noted with its respective assessment/plan.

g.  Participating IEHP Direct PCPs are paid $200 and non-IEHP Direct PCPs are paid $100 for each annual Visit they provide to an eligible IEHP DualChoice Member. The incentive is paid in addition to your FFS visit reimbursement or your capitated PCP agreement.

h.  Only one (1) exam per year qualifies for this incentive, regardless if the IEHP DualChoice Program Member has had several PCPs and multiple exams.

i.  Annual visit performed must be submitted online at www.iehp.org and indicate the appropriate ICD codes for the visit within two (2) months from date of service. Failure to submit within the required timeframe may result in non reimbursement.

j.  Reimbursements are made within thirty (30) working days of receipt of a complete IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Annual form submitted online.

8.  Diabetes Component

a.  All credentialed PCPs that treat IEHP diabetic Members are eligible to participate in the Diabetes component.

b.  Identified PCPs who are treating IEHP diabetic Members can access their roster identifying their diabetic Members. The roster of Diabetic Members can be found online at www.iehp.org.

c.  PCPs who are treating IEHP diabetic Members and who are not currently listed on the Diabetic roster can add these Members to the program by
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completing a Diabetic form online and confirming the date of diagnosis and ICD code(s) online. Data submitted triggers the addition of the Member to the Diabetic roster for the following month.

d. PCPs are reimbursed $25.00 directly by IEHP for each measure completed within the specified timeframes on rostered Members.
   1) HbA1c testing and result.
   2) Microalbumin testing and result
   3) Documentation that the Member received Diabetic Retinal Exam and the result.

e. HbA1c exams can be submitted up to four (4) times a year. Lab results must be submitted online for payment

f. Microalbumin and Diabetic Retinal exam can be submitted once a year. Lab results and Diabetic Retinopathy exam results from an Optometrist or Ophthalmologist must be submitted online for payment.

g. PCPs are reimbursed a Control bonus when the following results are reported and submitted within the required timeframes, by the same Provider.
   1) $50.00 Control bonus for HbA1c Control result of <8.0 up to 1 per Member per year

h. Diabetes measures performed must be submitted online only at [www.iehp.org](http://www.iehp.org) and indicate the appropriate ICD code(s), diagnosis date, collection date and result for the appropriate visit. Diabetes form must be submitted online within two (2) months from the date of service in order to be eligible for reimbursement. Failure to submit the completed forms within the required time frames may result in denial of reimbursement. Copies of the lab reports must be retained in the Member’s chart.

i. Reimbursements are made within thirty (30) working days of properly submitted IEHP Diabetes form online.

B. Corrective Resubmissions

1. Except for corrective resubmission, IEHP will not accepts or reimburse initial paper submissions made by fax or mail.

   a. The word “Correction” must be written under the Comment Section of your PM160s.
C. Pay For Performance (P4P)

b. Corrections to your PM160s, PNOs, Asthma and IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan) Annual Visits and Diabetes must be submitted to IEHP within sixty (60) days of your initial electronic submission to IEHP.

c. Any corrections received after sixty (60) days from the date of submission are not eligible for incentive.

d. Mail your corrections to:

IEHP – Quality Informatics
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

C. P4P Reports

1. Providers can print summary remittance advice reports with each payment distribution (See Attachments, “Remittance Advice – Asthma,” “Remittance Advice – Perinatal,” “Remittance Advice – Pap,” “Remittance Advice – Immunizations and Well Child Visit,” and “Remittance Advice – DualChoice Annual Visit” in Section 19). To access RAs online, log on to the secure site login at [www.iehp.org](http://www.iehp.org).

2. Detailed activity reports are also included with reimbursements made for the Well Child and Immunization components (See Attachment, "P4P Detail Activity Report – Medicare" in Section 19).

D. P4P Audit Process

1. IEHP conducts on-going audits of P4P Providers for compliance with P4P requirements, including submission accuracy, completeness of forms and supporting documentation in the Member’s medical record for submitted reimbursement.

2. Providers are notified in writing approximately two (2) weeks prior to the targeted audit date. IEHP follows up with a phone call to schedule the audit.

3. IEHP provides the names of the Members’ charts to pull two (2) days prior to the scheduled audit.

4. On-site, IEHP reviews the medical record to confirm the following:
   a. Submission dates, diagnosis and forms completion dates match the date of service as documented in the Member’s chart. IEHP uses progress notes, physical exam records (including CHDP Assessment Forms for Well Child Visits), immunization records, completed PM 160 forms, and lab reports, as applicable, to determine the date of service.
   b. PM 160 forms are completed and filed in the medical record.
19. FINANCE AND REIMBURSEMENT

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c. Lab result for Pap test must be in the chart for the date of service billed.
d. PAP tests or Well Child Visits are completed during a routine visit and/or include all of the components required by IEHP.

5. IEHP provides the Provider with written notice of the findings within thirty (30) days of the audit date. Providers have thirty (30) days to respond to the findings.

6. Providers not responding to CAP requests are subject to removal from participation in P4P.

7. Depending on the nature and severity of the findings and the Provider’s response, IEHP may take action against the Provider up to and including, but not limited to:
   a. Recoupment of all or a portion of the incentives paid under P4P for services deemed inappropriately performed and reimbursed.
   b. Removal from participation in P4P.
   c. Referral to the Peer Review Subcommittee and/or IEHP’s Fraud Prevention Committee.
   d. Removal from participation in the IEHP network.

8. Providers removed from P4P for non-response to CAP requests or because of the severity of the findings may appeal the removal decision by submitting a written appeal to IEHP as stated in Policy 16B2, “Appeal and Grievance Resolution Process for Providers - Health Plan.”

9. Providers removed from P4P may not re-apply for participation for six (6) months. Providers removed from P4P more than twice are prohibited from future participation.

E. P4P Appeals

1. Any appeals related to previously denied P4P reimbursements must be forwarded to the IEHP Director of Provider Relations for appropriate review and resolution within six (6) months of the date of denial.

2. P4P Providers of service must submit P4P Appeals or Inquiries online only at www.iehp.org. Providers should be able to click on the “A” for Appeal form next to any denied P4P component submission. The appeal form provides you reason for denial.

3. Required information must include the specific services the Provider is appealing or inquiring and the reason the appeal should be considered in the Comments Section of the Appeal form. Incomplete information may cause a delay in the resolution of your Appeals or Inquiry.

4. IEHP must identify and acknowledge the receipt of all P4P appeals within five (5) working days of receipt of a written appeal.
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C. Pay For Performance (P4P)

5. IEHP must resolve P4P appeals and issue a written determination and disposition within forty-five (45) working days of receipt of an appeal.

F. Future Changes to P4P Program

1. IEHP reserves the right to change any component of this Program at any time.
2. All decisions regarding the rules, requirements and compensation under the Program are at the sole discretion of IEHP.
19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

APPLIES TO:

A. This policy applies for all IPAs contracted with IEHP.

POLICY:

A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of an IEHP contracted IPA.

B. IEHP requires all contracted IPAs to meet IEHP’s and DMHC’s financial viability standards/requirements for Risk Bearing Organizations (RBOs) under section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act (SB260) prior to assignment of Members to the IPA’s PCPs and on an ongoing basis.

C. IEHP monitors the financial viability of all contracted IPAs and has established funding requirements to ensure all contracted IPAs are financially sound and can handle the risks associated with capitation.

D. IEHP shall place IPAs under the financial supervision program in the event an IPA is in breach of its contract with IEHP due to non-compliance with IEHP’s financial viability standards and/or with DMHC’s (SB260) requirements.

PROCEDURES:

A. For IPAs failing to meet IEHP’s financial viability standards and/or with section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act (SB260) requirements, shall be required to complete a Corrective Action Plan (CAP). The CAP shall include a timeline for when the IPA shall come into compliance with the financial viability requirements. IEHP shall place the IPA under Financial Supervision until breach is cured.

B. IPAs under Financial Supervision due to contractual breach may be subject to any or all of following actions at IEHP’s discretion:
   1. Freeze to new membership
   2. Withholding of monthly capitation revenue and other monies owed to the IPA
   3. Managing and releasing withheld capitation and other monies owed to the IPA to fund:
      a. Administrative Expenses funded monthly as specified in the IPA/MSO contract.
      b. PCP Capitation Payments for IEHP enrollees funded monthly for the current capitation period based on submission of a check run.
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c. Fee-For-Service (FFS) claims payments for professional services rendered to IEHP enrollees funded monthly or at other intervals to coincide with IPA check runs limited specifically to months/DOS withheld capitation was intended for payment.

d. Any other legitimate business expense subject to approval by IEHP.

4. Withdrawal of the funds available in the Standby Letter of Credit (LOC).

5. Immediate termination as stated in the IPA contract.

C. Any exceptions to the above including the limitation for FFS payments to fund existing claims run-out (IBNR) must be approved by IEHP.

D. Any remaining funds resulting from the implementation of the Financial Supervision may be netted against any claims expenses paid by IEHP for that IPA.

E. IEHP shall be review financial and other statements, including bank statements and/or other records to ensure payments are made and checks have been cleared.

REFERENCE:

A. Section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act (SB260).
## 19. FINANCE AND REIMBURSEMENT

### Attachments

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**TOTAL RECORD SIZE**: 246

All fields are left justified.
NOTES

Data Element

Element: 10
Note #10: SUBSCRIBER ID #
The Subscriber ID # is the IEHP assigned number for each Member. An example of a Subscriber ID # is 199609000001. Medi-Cal Members that became IEHP eligible in 9/96 have a Subscriber ID# that match their original Medi-Cal #

Element: 11
Note #11: CIN #
Client Index Number.
A state assigned number for non-Healthy Kids. The first eight characters are numeric and the last character is Alpha. Used if a SSN is not available for a Healthy Families Member.

Element: 12
Note #12: SOCIAL SECURITY NUMBER
A nine-digit number that is the primary and unique Member identifier.

For Medi-Cal Members, this field consists of one of two numbers:
SSN - Member SSN
PSEUDO- This number appears in this field if no SSN is available as provided by 834 File. First digit begins with the number "8 or 9" and ends with a letter.

For Healthy Families Members, this field consists of one of the following:
SSN – Member SSN, or
PSEUDO- This number appears in this field if no SSN is available as provided by FAME. First digit begins with the number "8 or 9" and ends with a letter, or
CIN – Member Client Index Number if no SSN is available.

Element: 16
Note #16: AID CODE

The following aid codes are covered aid codes by IEHP
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**Note # 17:** AID CODE CATEGORY

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<tr>
<td>RVC-ADULT</td>
<td>SBC-DISMM</td>
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<td></td>
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<tr>
<td>RVC-ADLTM</td>
<td>SBC-FAMMM</td>
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<td></td>
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<tr>
<td>RVC-AGDM</td>
<td>SBC-FAMIMM</td>
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<td>RVC-BCCTMM</td>
<td>SBC-TLICMM</td>
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<td>SBC-TLICMM</td>
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<td>SBC-CMMLTSS</td>
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<tr>
<td>RVC-FAMIMI</td>
<td>SBC-SPD</td>
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<td>RVC-FAMIMM</td>
<td>SBC-ADLTM</td>
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<tr>
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<tr>
<td>RVC-SPD</td>
<td>SBC-TLICMM</td>
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<tr>
<td>RVC-LTC</td>
<td>SBC-LTC</td>
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</tbody>
</table>

### Element: 20

**Note # 20:** Sign
Each Member that capitation is paid for is counted as an enrollment of one (1). If we have to take back capitation that we previously paid for a Member (decapitation) the enrollment count for that Member is –1. The field “Sign” stands for either a positive enrollment (1) or a negative enrollment count (-1) or enrollment of 0.

**Element: 27**

**Note # 27:** PayCode
PayCode consists of three possible values P1, P2 and Null. P1 is for payments made on the 15th for the paid Capitation month. P2 and Nulls are for payments made at the end of the Capitation month.

P1=Mid-Month
NULL, P2= End of Month
IRREVOCABLE STANDBY LETTER OF CREDIT FOR INCLUSION IN THE PROVIDER NETWORK OF THE INLAND EMPIRE HEALTH PLAN

BENEFICIARY: Inland Empire Health Plan

Governing Board
10801 Sixth Street, Suite 120
Rancho Cucamonga, CA 91730

APPLICANT: (IPA)

AMOUNT:________________________ (USD)

DATE AND PLACE OF EXPIRY: ______________________________

LETTER OF CREDIT NO.: ______________________________

[Identification]

Re: Irrevocable Standby Letter of Credit delivered as security for Inclusion of (IPA) in the Medical Provider Network of the Inland Empire Health Plan (“Agency”)

Members of the Board:

We hereby establish our Irrevocable Standby Letter of Credit in your favor available for payment by your draft(s) at sight drawn on (Name and Place of Financial Institution) ; and accompanied by documents as specified below:

1. This original Irrevocable Standby Letter of Credit and any amendments thereto.
2. A signed and dated certification worded as follows:
   “The Undersigned, the Chief Executive Officer, or Designee of the Chief Executive Officer, of the Inland Empire Health Plan, hereby certifies that there exists unpaid liabilities incurred by the IPA on behalf of an IEHP member, the terms of the capitation IPA agreement with IEHP are breached, and the time frame to cure said breach have been exhausted.”

Special Conditions:
1. Partial Drawing allowed.
2. Multiple presentations allowed.
3. It is a condition of this Irrevocable Standby Letter of Credit that it shall be deemed automatically extended without amendment for additional period of one (1) year periods from the present or any future expiration date, not to exceed four (4) additional years after the initial term, unless, at least ninety (90) days prior to any expiration date (Name of Financial Institution) shall notify the beneficiary, Inland Empire Health Plan, Governing Board in writing by overnight courier service at the above address, that we elect not to extend this letter of credit for any such additional period. Upon such
notice, you may draw, at any time prior to the expiration date, up to the full amount then available. The parties agree that upon the passage of a five (5) year term, a new Irrevocable Standby Letter of Credit shall be issued on behalf of the Inland Empire Health Plan on the same terms and subject to the same conditions herein.

We hereby guarantee you that all drafts drawn under and in compliance with the terms and conditions of this Irrevocable Standby Letter of Credit shall be duly honored if presented for payment at the office of ______ (Financial Institution) ______ on or before the expiration date of this Irrevocable Standby Letter of Credit.

Except so far as otherwise expressly stated, this Irrevocable Standby Letter of Credit is issued subject to the International Standby Practices 1998 (“ISP98”), ICC Publication no. 590. This Letter of Credit shall be deemed to be a contract made under the law of the State of California and shall, as to matters not governed by ISP98, be governed by and construed in accordance with the law of such State without regard to any conflicts of law provisions.

(Name of Financial Institution)

By: _______________________________

______________________________

By: _______________________________

______________________________
### Immunization/Well Visit Detail Activity Report For: Dr. Happy Doc

**Tuesday, May 12, 2009**

**Dr. Happy Doc**  
6186 Adobe Rd  
29 Vegas, CA 92277

#### Immunization/Well Visit Detail Activity Report For: Dr. Happy Doc

<table>
<thead>
<tr>
<th>Member Name</th>
<th>IEHP ID</th>
<th>DOB</th>
<th>On Type</th>
<th>DOS</th>
<th>Disposition</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy, Child</td>
<td>2006123456</td>
<td>01/01/2007</td>
<td>46 Varicella Imm</td>
<td>03/17/2009</td>
<td>1</td>
<td>$4.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>48 MMR Imm</td>
<td>03/17/2009</td>
<td>29</td>
<td>$0.00</td>
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<tr>
<td>Sunny, Sunshine</td>
<td>2008789100</td>
<td>12/01/2008</td>
<td>Well-Child Visit Age &lt;2</td>
<td>03/17/2009</td>
<td>1</td>
<td>$40.00</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>45 DTaP Imm</td>
<td>03/17/2009</td>
<td>1</td>
<td>$4.50</td>
</tr>
</tbody>
</table>

**Total Amount: $49.00**

**Disposition Code Description**

1. Pay Per Fee Schedule  
2. Member Not Eligible on Date of Service  
3. Member's Age Out of Qualifying Range  
4. Previously Paid  
5. Submission Received Too Late  
6. Incompleted Documentation Submitted  
7. Alternate Visit Already Paid  
8. Provider Not Eligible for P4P Program  
9. Submission Not Received Online  
10. Submission Limit Reached  
11. Missing Service Date  
12. Under 2 Next Visit Missing  
13. Ethnic Code Missing  
14. Assessment Incomplete  
15. No Height  
16. No Weight  
17. Over 3 Blood Pressure Missing  
18. Invalid Patient Visit  
19. Invalid Type of Screen  
20. Invalid Place of Service  
21. No Signature  
22. DOS before DOB  
23. Partial Screening/Procedure Recheck Missing  
24. A Component of This Combo Was Denied  
25. Component of a Valid Combo  
26. Component of an Invalid Combo  
27. Invalid Combo - Treated as Individual Antigens  
28. Immunization Info Incomplete  
29. Not a qualifying Immunization  
30. Duplicate Submission

**Tuesday, May 12, 2009**
## P4P Reimbursable PM160 Immunization Codes

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>PM160 Code</th>
<th>Age Range</th>
<th># Vaccinations</th>
<th>Reimbursement Rate</th>
</tr>
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<tbody>
<tr>
<td>MMR</td>
<td>33</td>
<td>1st birthday - 6th birthday 11th - 13th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Hib</td>
<td>38</td>
<td>0th birthday - 6th birthday</td>
<td>4</td>
<td>$9.00</td>
</tr>
<tr>
<td>Polio-Inactivated</td>
<td>39</td>
<td>0th birthday - 6th birthday</td>
<td>4</td>
<td>$9.00</td>
</tr>
<tr>
<td>Hepatitis B (5 mcg dose)</td>
<td>40</td>
<td>0th birthday - 6th birthday</td>
<td>4</td>
<td>$9.00</td>
</tr>
<tr>
<td>Hepatitis B (10 mcg dose)</td>
<td>42</td>
<td>11th - 13th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>DTaP</td>
<td>45</td>
<td>0th birthday - 6th birthday</td>
<td>5</td>
<td>$9.00</td>
</tr>
<tr>
<td>Varicella</td>
<td>46</td>
<td>1st - 13th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Influenza 2</td>
<td>53</td>
<td>6 months - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Pneumococcal Polysaccharide (23PS)</td>
<td>55</td>
<td>2nd - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
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<tr>
<td>Hep B/Hib Combination</td>
<td>56</td>
<td>0th birthday - 6th birthday</td>
<td>4</td>
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<tr>
<td>Td Adult – (DECAVAC)</td>
<td>58</td>
<td>7th - &lt; 19th birthday</td>
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<tr>
<td>DT Pediatric</td>
<td>59</td>
<td>0th - 6th birthday</td>
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<tr>
<td>Td Adult</td>
<td>60</td>
<td>7th - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Hep A</td>
<td>65</td>
<td>1st - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Pneumococcal Heptavalent (PCV7) – (PREVNAR7)</td>
<td>67</td>
<td>0th - 6th birthday</td>
<td>4</td>
<td>$9.00</td>
</tr>
<tr>
<td>DTaP/HepB/IPV (PIEDIARIX)</td>
<td>68</td>
<td>0th - 6th birthday</td>
<td>3</td>
<td>$9.00</td>
</tr>
<tr>
<td>MCV4 (Meningococcal Conjugate Vaccine)-MENACTRA &amp; MENVEO</td>
<td>69</td>
<td>2nd - &lt;19th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Influenza Virus Vaccine Live, Intranasal – (FLUMIST)</td>
<td>71</td>
<td>2nd - &lt;19th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
<tr>
<td>Tdap (Tetanus Diphtheria Acellular Pertussis) – (BOOSTRIX/ADACEL)</td>
<td>72</td>
<td>7th - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
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<tr>
<td>MMR/Varicella – (PROQUAD)</td>
<td>74</td>
<td>1st - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
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<tr>
<td>Rotavirus Vaccine (RV) – (ROTATEQ)</td>
<td>75</td>
<td>0th - &lt; 9 months</td>
<td>3</td>
<td>$9.00</td>
</tr>
<tr>
<td>Human Papillomavirus (Gardasil/Cervarix)</td>
<td>76</td>
<td>9th - &lt; 19th birthday</td>
<td>3</td>
<td>$9.00</td>
</tr>
<tr>
<td>Influenza Preservative Free 3</td>
<td>80</td>
<td>6 months - &lt; 4th Birthday</td>
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<tr>
<td>Rotavirus Vaccine – (ROTARIX)</td>
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<td>0th - &lt; 9 months</td>
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<td>$9.00</td>
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<tr>
<td>DTaP/Hib/IPV (PENTACEL)</td>
<td>82</td>
<td>6 weeks - &lt; 5th birthday</td>
<td>4</td>
<td>$9.00</td>
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<td>DTaP/IPV (KINRIX)</td>
<td>83</td>
<td>4th - &lt; 7th birthday</td>
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<td>Pneumococcal Conjugate Vaccine (PCV13) – (PREVNAR 13)</td>
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<td>0th - 18th birthday</td>
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<td>$9.00</td>
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<tr>
<td>Meningococcal B Recombinant Protein and Outer Membrane Vesicle Vaccine (Bexsero) 3</td>
<td>M1</td>
<td>10th - &lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
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<td>Meningococcal B Recombinant Lipoprotein Vaccine (Trumenba) 3</td>
<td>M4</td>
<td>10th - &lt; 19th birthday</td>
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<td>$9.00</td>
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<td>TB Mantoux</td>
<td>TB</td>
<td>&lt; 19th birthday</td>
<td>2</td>
<td>$9.00</td>
</tr>
</tbody>
</table>

1 INFLUENZA Vaccine – Children < 9 years should receive 2 doses, with a recommended interval of 21-28 days.
2 PM160 Code 53 (Influenza) is available twice per calendar year
3 Vaccine is payable effective for retroactive dates of service (DOS) October 1, 2015.

NOTE 1: Although the Mantoux TB test is not an immunization, it is paid out of the immunization fund and will be reimbursed at $9.00 each test up to 2 times/year with a minimum of 30 days in between each TB test.
The following is the CPT Code to be used when submitting CMS 1500s/UB92s for the Pap Test Component of the Pay for Performance Program

<table>
<thead>
<tr>
<th>P4P CPT CODE</th>
<th>P4P Description</th>
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<tbody>
<tr>
<td>88141P</td>
<td>Pap Test</td>
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The following are the CPT Codes to be used when submitting CMS 1500s/UB92s for the Perinatal Services Component of P4P

<table>
<thead>
<tr>
<th>P4P CPT CODES</th>
<th>P4P Description</th>
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</thead>
<tbody>
<tr>
<td>Z1032A</td>
<td>Initial Antepartum Visit 1&lt;sup&gt;st&lt;/sup&gt; Trimester</td>
</tr>
<tr>
<td>Z1032B</td>
<td>Initial Antepartum Visit 2&lt;sup&gt;nd&lt;/sup&gt; Trimester</td>
</tr>
<tr>
<td>Z1032C</td>
<td>Initial Antepartum Visit 3&lt;sup&gt;rd&lt;/sup&gt; Trimester</td>
</tr>
<tr>
<td>CHDP ASSESSMENT</td>
<td>NO PROBLEM SUSPECTED</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>HISTORY and PHYSICAL EXAM</td>
<td>✓</td>
</tr>
<tr>
<td>DENTAL ASSESSMENT/REFERRAL</td>
<td></td>
</tr>
<tr>
<td>NUTRITIONAL ASSESSMENT</td>
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<tr>
<td>ANTIQUITY GUIDANCE HEALTH EDUCATION</td>
<td></td>
</tr>
<tr>
<td>DEVELOPMENTAL ASSESSMENT</td>
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</tr>
<tr>
<td>SLENELL OR EQUIVALENT</td>
<td></td>
</tr>
<tr>
<td>AUDIMETRIC</td>
<td></td>
</tr>
<tr>
<td>HEMOGLOBIN OR HEMATOCRIT</td>
<td></td>
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<tr>
<td>URINE DIPSTICK</td>
<td></td>
</tr>
<tr>
<td>COMPLETE URINALYSIS</td>
<td></td>
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<tr>
<td>TB MANToux</td>
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<table>
<thead>
<tr>
<th>CODE</th>
<th>OTHER TESTS</th>
<th>PLEASE REFER TO THE CHDP LIST OF TEST CODES</th>
<th>CODE</th>
<th>OTHER TESTS</th>
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<tbody>
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<td>02</td>
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<td>12</td>
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<table>
<thead>
<tr>
<th>HEIGHT IN INCHES</th>
<th>WEIGHT</th>
<th>BODY MASS INDEX (BMI) PERCENTILE</th>
<th>BLOOD PRESSURE</th>
<th>INFORMATION ONLY REPORTING</th>
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</thead>
<tbody>
<tr>
<td>01</td>
<td>3</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>29</td>
<td>06</td>
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</table>

| HEMOGLOBIN HEMATOCRIT | O2S | .0% | Percent | 07 | 02 | |
|-----------------------|-----|----|---------|----|----|-
| 08                    | 5   | .0%|         |    |    | |

<table>
<thead>
<tr>
<th>DIAGNOSIS CODES</th>
<th>THE QUESTIONS BELOW MUST BE ANSWERED</th>
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</thead>
</table>
| 3               | 1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☑
| 3               | 2. Tobacco Used by Patient Yes ☐ No ☑
| 3               | 3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☑ No ☐

<table>
<thead>
<tr>
<th>PATIENT VISIT</th>
<th>TYPE OF SCREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ New Patient or Extended Visit</td>
<td>☑ Initial</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SERVICE LOCATION</th>
<th>HEALTH PLAN CODE / PROVIDER NUMBER</th>
<th>PLACE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy Doctor MD</td>
<td>301</td>
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</tr>
<tr>
<td>303 Doctor Rd SB</td>
<td>306</td>
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<table>
<thead>
<tr>
<th>CONFIDENTIAL SCREENING/BILLING REPORT</th>
</tr>
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<tbody>
<tr>
<td>COPY 1 - MAIL TO MEDI-CAL CHDP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal/CHDP P.O. Box 15300 Sacramento, CA 95861-1300</td>
</tr>
<tr>
<td>(PM 160 INFORMED CONSENT 1/2007)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMMUonisATIONS</th>
<th>PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES</th>
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</thead>
<tbody>
<tr>
<td>33 MMR #1</td>
<td>✓</td>
</tr>
<tr>
<td>46 VARICELLA #1</td>
<td>✓</td>
</tr>
<tr>
<td>40 Hep B #3</td>
<td>✓</td>
</tr>
<tr>
<td>45 DTaP #4</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT NAME: Dandy Jones, M.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRINT NAME: Manny Goodman, M.D.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONFIDENTIAL SCREENING/BILLING REPORT</th>
</tr>
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</tr>
<tr>
<td>(PM 160 INFORMED CONSENT 1/2007)</td>
</tr>
</tbody>
</table>
How to Complete the PM160

A PM160 must be complete for all well visits by IEHP members under the age of 21. Please fill out each PM106 completely, using the guidelines below.

Section 1 - Demographic Data
• Please fill in all information on the member and their responsible person.
• Record the member’s age in months up to the age of 2 years (24mos).
• PM160s that do not record the data of service will be returned.

Section 2 - Assessment Information
• Fill out the information relating to the Assessment completely, making sure to insert the proper follow-up codes in columns C and D. Checks in these columns will not be accepted.
• Record member’s height in feet and inches, weight in pounds and ounces. Metric measurements are not acceptable.
• Blood pressure must be recorded at every visit after the age of 3 years.
• Urinalysis or urine dipstick is needed, not both.
• Hemoglobin or Hematocrit is needed, both are not necessary.
• The Mantoux TB test is to be used; multipuncture is not acceptable.
• Birthweight should be record up to age 2 years.

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This section must be filled out completely and correctly in order to receive reimbursement.
• A column (A, B, C, or D) should be filled in for each Immunization.
• If an Immunization is given, the number of the series should be recorded in column A or B as appropriate. Failure to print the appropriate series number will result in no reimbursement.
• Checks should be recorded in columns C or D if an Immunization is not given.
• Write in Immunizations that are not listed, using codes supplied. A complete list of codes is available at www.IEHP.org.
• Record the series number of the Immunization on all PM160s, not 0-2 year olds only.

Section 4 - Referral Information
List diagnoses to correspond with assessment findings from section 2. Use follow-up codes as listed.
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• Enter the patient’s Dental Plan provider name and phone number in the “Referred To:” and “Telephone Number” boxes.
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• The PM160 must be signed by the provider of the services. Any other signatures will not be accepted.
• List member’s Media-Cal ID number, including county and aid codes.

Contact your IPA for PM160s when needed
**DANDY, JAMES S**

**BIRTHDATE**: 5/2/06

**SEX**: M

**PATIENT’S COUNTY OF RESIDENCE**: RIVERSIDE

**PHONE NUMBER**: 909-688-1111

**NEXT CHD VISIT**: 11/22/08

**CHDP ASSESSMENT**

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
<th>Other Tests</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 HISTORY and PHYSICAL EXAM</td>
<td>3</td>
<td>1</td>
<td>☑</td>
</tr>
<tr>
<td>02 DENTAL ASSESSMENT/REFERRAL</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03 NUTRITIONAL ASSESSMENT</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04 ANTENOPARTAL GUIDANCE</td>
<td>☑</td>
<td></td>
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<tr>
<td>05 DEVELOPMENTAL ASSESSMENT</td>
<td>☑</td>
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<td></td>
</tr>
<tr>
<td>06 SNELLEN OR EQUIVALENT</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07 AUDIOMETRIC</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08 HEMOGLOBIN OR HEMATOCRIT</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09 URINE DIPSICK</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 COMPLETE URINALYSIS</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 TB MANToux</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS**

- MMR #1
- VARICELLA #1
- Hep B
- IVP #3
- DtaP #4

**DIAGNOSIS CODES**

- 1

**THE QUESTIONS BELOW MUST BE ANSWERED**

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke: Yes ☐ No ☑
2. Tobacco Used by Patient: Yes ☐ No ☑
3. Counseled About/Deferred For Tobacco Use Prevention/ Cessation: Yes ☐ No ☑

**IMMUNIZATION**

- MMR #1
- VARICELLA #1
- Hep B
- IVP #3
- DtaP #4

**TOTAL FEES**

- Enrolled in WIC: ☑
- Referred to WIC: ☑
How to Complete the PM160

A PM160 must be complete for all well visits by IEHP members under the age of 21. Please fill out each PM106 completely, using the guidelines below.

Section 1 - Demographic Data
• Please fill in all information on the member and their responsible person.
• Record the member’s age in months up to the age of 2 years (24mos).
• PM160s that do not record the data of service will be returned.

Section 2 - Assessment Information
• Fill out the information relating to the Assessment completely, making sure to insert the proper follow-up codes in columns C and D. Checks in these columns will not be accepted.
• Record member's height in feet and inches, weight in pounds and ounces. Metric measurements are not acceptable.
• Blood pressure must be recorded at every visit after the age of 3 years.
• Urinalysis or urine dipstick is needed, not both.
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• The PM160 must be signed by the provider of the services. Any other signatures will not be accepted.
• List member’s Media-Cal ID number, including county and aid codes.

Contact your IPA for PM160s when needed
### Patient Information

**Name:** Mary Jones  
**Address:** 456 Brockton, 4B Riverside 92501

<table>
<thead>
<tr>
<th>CHDP ASSESSMENT</th>
<th>Indicate outcome for each screening procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 HISTORY and PHYSICAL EXAM</td>
<td>yes</td>
</tr>
<tr>
<td>02 DENTAL ASSESSMENT/REFERRAL</td>
<td>yes</td>
</tr>
<tr>
<td>03 NUTRITIONAL ASSESSMENT</td>
<td>yes</td>
</tr>
<tr>
<td>04 ANTIBIOTIC SUSCEPTIBILITY</td>
<td>yes</td>
</tr>
<tr>
<td>05 DEVELOPMENTAL ASSESSMENT</td>
<td>yes</td>
</tr>
<tr>
<td>06 SNELLEN OR EQUIVALENT</td>
<td>yes</td>
</tr>
<tr>
<td>07 AUOMETRIC</td>
<td>yes</td>
</tr>
<tr>
<td>08 HEMOGLOBIN OR HEMATOCRIT</td>
<td>yes</td>
</tr>
<tr>
<td>09 URINE DIPSTICK</td>
<td>yes</td>
</tr>
<tr>
<td>10 COMPLETE URINALYSIS</td>
<td>yes</td>
</tr>
<tr>
<td>11 TB MANTOUX</td>
<td>yes</td>
</tr>
</tbody>
</table>

**Follow Up Codes:**

1. NO DX/RX INDICATED OR NOW UNDER CARE  
2. QUESTIONABLE RESULT, RECHECK SCHEDULED  
3. DX MADE AND RX STARTED  
4. DX PENDING/RETURN VISIT SCHEDULED  
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX  
6. REFERRAL REFUSED.

**Fees:**
- New: 3  
- Known: 1  
- C: 0  
- D: 0

**Laboratory Results:**

**Height in Inches:** 01 3 5 3  
**Weight in Lbs:** 02 9 0 6  
**Body Mass Index (BMI, Percentile):** 0 8 5  
**Blood Pressure:** 0 1 7 0 2

**Immunizations:**

**Given Today:**
- 01 3 8 2 0 0  
- 02 7 8 5 2 0

**Not Given Today:**

**Routine Referral (50):**

**Patient is a Foster Child (0):**

**ICD 9 Codes:**
- 1
- 2

**Questions Below Must Be Answered:**

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke.  
   - Yes ☐  
   - No ☑

2. Tobacco Used by Patient.  
   - Yes ☐  
   - No ☑

3. Counselled About/Referred For Tobacco Use Prevention/Cessation.  
   - Yes ☑  
   - No ☐

**Date:** 11/22/07

**Signature:** Mary Goodman, M.D.

**Rendering Provider:** Manny Goodman, M.D.

**PCP Number:** C223457

**Service Location:** Happy Doctor MD  
**Address:** 303 Doctor Row  
**City:** SR  
**State:** CA  
**ZIP Code:** 1408

**Health Plan Code/Provider Number:** 3 1 6

**Place of Service:** 06

**Eligibility:** 3 3 3 0

**Identification Number:** 9 9 9 9 9 9 9 9 9 9

**State of California Child Health and Disability Prevention Program:**

**Signature of Provider:** Mary Goodman, M.D.

**Confidential Screening/Billing Report:**

**Copy 1 - Mail to Medi-Cal CHDP**

**P.O. Box 15300:** Sacramento, CA 95851-1300

**Med-Cal/CHDP:**

**Phone Number:** (999) 688-1111  
**Next CHDP Exam:** 11/22/08

**Telephone Number:**
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Contact your IPA for PM160s when needed
The following is the CPT Code to be used when submitting CMS 1500 for the Postpartum Services Component of P4P

<table>
<thead>
<tr>
<th>P4P CPT CODES</th>
<th>P4P Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z1038P</td>
<td>Postpartum Follow Up Visit</td>
</tr>
</tbody>
</table>
**Pregnancy Notification Form**  
**PERINATAL PROGRAM**

**DIRECTIONS FOR COMPLETION:**

A. **Pregnancy Notification Report:** complete and mail with HCFA 1500 Form within 14 days of the initial prenatal visit. This visit should include, but not be limited to, medical history, physical, pap smear, chlamydia cultures and other appropriate prenatal labs.

B. **Pregnancy Outcome Report:** complete and mail with HCFA 1500 Form within 14 days of post-partum visit.

Please send report(s) to:
Inland Empire Health Plan  
CLAIMS  
PO Box 4349  
Rancho Cucamonga, CA 91729-4349

**MEMBER/PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Member Name</th>
<th>OB Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>IEHP#/SSN</td>
<td>Address</td>
</tr>
<tr>
<td>Address</td>
<td>Phone</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
</tbody>
</table>

**A. PREGNANCY NOTIFICATION REPORT (to be completed at initial prenatal visit)**

<table>
<thead>
<tr>
<th>Date of prenatal visit</th>
<th>EDC</th>
<th>G</th>
<th>P</th>
<th>Pap</th>
<th>Chlamydia</th>
<th>Initial Risk Assessment</th>
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</thead>
</table>

**HIGH RISK CONDITIONS**

<table>
<thead>
<tr>
<th>Maternal age &lt;17 or &gt;34</th>
<th>Diabetes</th>
<th>Type</th>
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<tbody>
<tr>
<td>Multiple Pregnancy</td>
<td>HTN</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>Cardiac Disease</td>
<td>Drug Abuse</td>
<td>ETOH Abuse</td>
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**PREVIOUS PREGNANCY HISTORY**

<table>
<thead>
<tr>
<th>History of Pre-term labor</th>
<th>History of low birth weight</th>
<th>Other</th>
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<tbody>
<tr>
<td>History of fetal demise, stillborn or neonatal death</td>
<td>History of pre-eclampsia/toxemia</td>
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</tr>
</tbody>
</table>

**B. PREGNANCY OUTCOME REPORT (to be completed after delivery)**

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<tr>
<th>Delivery date</th>
<th>Delivery physician</th>
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<tbody>
<tr>
<td>Gestational age at delivery</td>
<td>Number of OB appointments</td>
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<td>Birth Weight</td>
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**TYPE OF DELIVERY**

<table>
<thead>
<tr>
<th>Vaginal</th>
<th>C-Section</th>
<th>VBAC</th>
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<tr>
<td>Repeat</td>
<td>C-Section for failed</td>
<td>VBAC</td>
</tr>
<tr>
<td>Maternal death</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fetal death</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Revised: 9/06/2013
Dr. Happy Doc  
6186 Adobe Rd.  
Vegas, CA 90000

NON NEGOTIABLE

Please reference other documents for remittance details.

INLAND EMPIRE HEALTH PLAN

Payee Claim Account  
P.O. Box 3923  
Riverside, CA 92502-3923  
909-393-2000

NON NEGOTIABLE

PAY
Five Hundred Fifty Dollars and 00/100

TO THE ORDER OF  
Dr. Happy Doc  
6186 Adobe Rd.  
Vegas, CA 90000

$550.00  

6/24/2009

VOID SIX MONTHS AFTER CHECK DATE
### Inland Empire Health Plan
**Remittance Advice**

**Dr. Happy Doc**  
11888 ABC Ave  
Adelanto CA 92301  
987654321

**Check Date:** 09/18/2013  
**Check Amt:** $**********25  
**Check No:** 123456  
**Page No:** 1

#### Member# | Line Of Business | DOB | Patient Name | Provider Name |
<table>
<thead>
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<th></th>
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<tbody>
<tr>
<td>123456789101-01</td>
<td>MEDI-CAL</td>
<td>06/06/2001</td>
<td>MORAN VELASCO, MIGUEL A</td>
<td>Dr. Happy Doc</td>
</tr>
<tr>
<td>00000E1321555750</td>
<td>001</td>
<td>09/12/13</td>
<td>09/03/13</td>
<td>99213</td>
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<td>00000E1321555750</td>
<td>002</td>
<td>09/12/13</td>
<td>08/03/13</td>
<td>86580</td>
</tr>
</tbody>
</table>

**Patient Account# 12053754**  
Claim Totals: 155.00  
Member Totals: 155.00  

**200412345678-01**  
MEDI-CAL  
05/17/2005  
SNELL JR, BRIAN K  
Dr. Happy Doc

| 00000E1321548400 | 001 | 09/12/13 | 08/22/13 | 08/22/13 | 2016F P | 1.0 | 25.00 | 25.00 | 0.00 | 0.00 | 0.00 | 0.00 | 25.00 | P4P |

**Patient Account# 200811006443**  
Claim Totals: 25.00  
Member Totals: 25.00  

**Provider Totals**  
Total: 180.00  
25.00  
59.26  
34.26  
0.00  
25.00  

**Vendor Account Totals**  
Total: 180.00  
25.00  
59.26  
34.26  
0.00  
25.00

---

**Summary Page**

- **Total Number Of Claims:** 2
- **Total Number Of Claim Lines:** 3
- **Total Payment Amount:** $25.00

---

**Explanations Code Legend**

- **MISD** this claim is being forwarded to correct payor.
- **P4P** pay for performance program
Please Note:

Medi-Cal, Healthy Families, Healthy Kids and Commercial

- Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California and Title 22 of the California Code of Regulations, the patient to whom services were provided is not liable for any portion of the bill, except non-benefit items or non-covered services.

- Acknowledgement of claim receipt – Contracted Providers can confirm receipt of submitted claim(s) by logging into the provider portal at www.iehp.org. To obtain website instructions or a secure password, please call IEHP at (909) 890-2054.

- In Compliance with AB1455, if you disagree with your payment, you may contact the IEHP Provider Team at (909)890-2054 or (866) 223-4347 Monday – Friday 8:00am to 5:00pm PST. You may also file a Provider Dispute within 365-days from the claim determination date. Disputes should be submitted to IEHP Claims Appeals Resolution Unit P.O. Box 4319, Rancho Cucamonga, CA 91729. Please visit www.iehp.org to obtain a Provider Dispute Resolution form online.

- In accordance with our agreement, negative balances will be offset against future claims to be paid to you.

Withhold Amount

- By statute enacted in February 2008 (in response to the California budget crisis), effective July 1, 2008, Medi-Cal has reduced payments to specific provider types by 10% with a corresponding reduction to Medi-Cal Managed Care Plans. Due to this legislative mandate, IEHP has reduced payments to all providers referenced in the statute by 10% for dates of service 07/01/08 – 02/28/09. Services rendered from 03/01/09, to current are reduced by 1%.

IEHP Medicare DualChoice (HMO SNP)

Withhold Amount – all providers

- In accordance with Medicare mandated guidelines, your payment for dates of services on or after 04/01/13, may reflect a 2% sequestration reduction.

Contracted Providers

- Acknowledgement of claim receipt – Contracted Providers can confirm receipt of submitted claim(s) by logging into the provider portal at www.iehp.org. To obtain website instructions or a secure password, please call IEHP at (909) 890-2054.

- In accordance with our agreement, negative balances will be offset against future claims to be paid to you.

- Appeals and Payment Dispute Requests – can be submitted within the timeframe indicated in your contract to: IEHP DualChoice (HMO SNP) Claims Appeals and Resolution Unit P.O. Box 4319, Rancho Cucamonga, CA 91729. Please visit www.iehp.org to obtain a Provider Dispute Resolution form online. For more information, please contact IEHP Provider Team at (909)890-2054 or (866) 223-4347.

Non Contracted Providers

- Both Appeals and Payment Dispute Resolutions can be submitted to: IEHP DualChoice (HMO SNP) Claims Appeals and Resolution Unit P.O. Box 4319, Rancho Cucamonga, CA 91729

- Appeals - If you disagree with the outcome of a claim, you may submit an appeal attached with a Waiver of Liability and any supporting documentation within 60-days from the payment or denial date. The waiver of liability form can be found on the CMS website – www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals reference Appendix 7.

- Payment Dispute Resolutions – If you disagree with the payment of a claim, you can submit your PDR with any supporting documentation within 120-days from the initial determination date. As a Non Contracted Provider you also have the option of sending your dispute to C2C Solutions Inc. For further information check their website regarding this process at PDRC@c2cinc.com.

Legal Notice

- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and will be subject to civil and criminal penalties with State and Federal Class Claims Acts.

- Please assist IEHP in preventing possible benefit abuse. Request another form of identification from the Member in addition to the IEHP card.
## INLAND EMPIRE HEALTH PLAN

### DUAL CHOICE PAY FOR PERFORMANCE PROGRAM

#### REMITTANCE ADVICE

<table>
<thead>
<tr>
<th>Submission Number:</th>
<th>1004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check Date:</td>
<td>11/30/2010</td>
</tr>
<tr>
<td>IPA/Provider Name:</td>
<td>Dr. Happy Doc</td>
</tr>
</tbody>
</table>
| Send Payment To:   | 6156 Adobe Rd.  
|                    | Victor, CA 92012 |

<table>
<thead>
<tr>
<th>Member's Name</th>
<th>IEHP ID</th>
<th>DOB</th>
<th>Detail Number</th>
<th>Provider</th>
<th>Type of Service</th>
<th>Date of Service</th>
<th>Amount</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td>2009123456789-01</td>
<td>01/01/37</td>
<td>1234</td>
<td>Happy Doc</td>
<td>DualChoice Annual Visit $300</td>
<td>09/29/2010</td>
<td>$300.00</td>
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</table>

**TOTAL: $300.00**

<table>
<thead>
<tr>
<th>Reason Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pay Per Fee Schedule</td>
</tr>
<tr>
<td>2. Member Not Eligible on Date of Service</td>
</tr>
<tr>
<td>3. Visit Previously Paid</td>
</tr>
<tr>
<td>4. Submission Received Too Late</td>
</tr>
<tr>
<td>5. Payment Adjustment</td>
</tr>
<tr>
<td>6. Alternate Visit Already Paid for Benefit Year</td>
</tr>
<tr>
<td>7. Provider Not Eligible for P4P Program</td>
</tr>
<tr>
<td>8. Date of Service Not Eligible for P4P Program</td>
</tr>
<tr>
<td>9. Member Not Dual Choice Member on Date of Service</td>
</tr>
</tbody>
</table>
## Inland Empire Health Plan

**Well-Child & Immunization Pay for Performance Program**

### Remittance Advice

**Submission Number:** 123  
**Submission Date:** 6/19/2009  
**IPA/Provider Name:** Dr. Happy Doc  
**Send Payment to:** 8166 Adobe Rd, Vegas, CA 90000

<table>
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<tr>
<th>Member's Name</th>
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<th>DOB</th>
<th>Detail Number</th>
<th>Submitting Provider</th>
<th>Type of Service</th>
<th>Date of Service</th>
<th>Amount</th>
<th>Reason Codes</th>
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**Reason Code Description**

1. Pay Per Pay Schedule  
2. Missing or Late  
3. Member Age Out of Qualifying Range  
4. Incomplete/Inaccurate  
5. Submission Too Late  
6. Incomplete Documentation Submitted  
7. Missing Signature  
8. Pay for Eligible for P4P Program  
9. Submission Not Received Online  
10. Submission Limit Reached  
11. Submission Limit Reached  
12. Date of Service Date  
13. Date of Service Date  
14. Date of Service Date  
15. Date of Service Date  
16. Date of Service Date  
17. Date of Service Date  
18. Date of Service Date  
19. Date of Service Date  
20. Date of Service Date  
21. Date of Service Date  
22. Date of Service Date  
23. Date of Service Date  
24. Date of Service Date  
25. Date of Service Date  
26. Date of Service Date  
27. Date of Service Date  
28. Date of Service Date  
29. Date of Service Date  
30. Date of Service Date

**Total:** $77.50
Dr. Happy Doc  
6166 Adobe Rd.  
Vegas, CA 90000  

NON NEGOTIABLE

Please reference other pages for further remittance details.

INLAND EMPIRE HEALTH PLAN  
Provider Claim Account  
P O Box 19025  
San Bernardino, CA 92423-9025  
909-850-2000

NON NEGOTIABLE

PAY
Five Hundred Fifty Dollars and 00/100

TO THE
Dr. Happy Doc

ORDER
6166 Adobe Rd.

OF
Vegas, CA 90000

5555 $550.00
# Attachment 19 - Remittance Advice - Pap

## Inland Empire Health Plan
**Remittance Advice**

### Member Information
- **Name**: Mr. Martin
- **DOB**: 06/01/1905
- **Address**: 123456789

### Claim Details
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<th>Amount Billed</th>
<th>Amount Allowed</th>
<th>Deduct Amount</th>
<th>Net Amount</th>
<th>Copay Amount</th>
<th>Other Adjustments</th>
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</table>

**Dr. Happy Doc**

### Adjustments

- **Patient Account 123**: Net Adjusted Total: 50.00
- **Member Total**: Net Adjusted Total: 50.00

### Other Claims

**NON NEGOTIABLE**

- **Claim # 120**: Claim Total: 50.00
  - **Member Total**: 50.00

**NON NEGOTIABLE**

- **Claim # 123**: Claim Total: 25.00
  - **Member Total**: 25.00
Attachment 19 - Remittance Advise - Pap

Inland Empire Health Plan
Remittance Advice

Dr. Happy Doc
6185 Ariloe Rd.
Vegas, CA 90690
123456780

Check Date: 5/24/2009
Check Amt: $566.00
Check No: 123456
Page No: 3

** Summary Page **

NON NEGOTIABLE
Number Of Claims: 9
Total Number Of Claims Lines: 18
Total Payment Amount: $550.00

Explanations Code Legends:

SCOPE NOT WITHIN SCOPE OF PROGRAM
PAP PAY FOR PERFORMANCE PROGRAM

ST Code Legends: I=Informational, P=Payable, D=Denied, A=Adjustment, R=Claim Received & In Process

Please Note:

Medi-Cal, Healthy Families, Healthy Kids, Commercial members

* Under the Knox-Koerner Act, Health and Safety Code §1278 of the State of California and Title 22 of the California Code of Regulations, the patient to whom services were provided is not liable for any portion of the bill, except non-benefit items or non-covered services.

* In compliance with AB1455, if you disagree with your payment you may contact IEHP Claims Customer Service at (888) 222-6693. You may also file a Provider Dispute within 30 days of the claim determination date. Disputes should be submitted to IEHP Provider Dispute P.O. Box 10276, San Bernardino, CA 92423. Please visit www.iehp.org to obtain a Provider Dispute Resolution form online.

* In accordance with our agreement, negative balances will be offset against future claims to be paid to you.

Withdrawal Amount

* By statute enacted in February 2000 (in response to the California budget crisis) effective July 1, 2000, Medi-Cal has reduced payments to specific provider types by 10%, with a corresponding reduction to Medi-Cal Managed Care Plans. Due to this legislative mandate, IEHP has reduced payments to all provider referenced in the statute by 10%.

IEHP Medicare Dual Choice members

* If you disagree with the outcome of a claim, you may submit an appeal within 90 days of the payment or denial date. Upon receipt, IEHP will review the appeal and issue a written determination within 60 days of receipt. Payment appeals should be mailed to: IEHP Medicare Dual Choice Claim Appeals, P.O. Box 10276, San Bernardino, CA 92423. For more information, please contact IEHP Claims Services at (888) 222-6693.

Legal Notice

* Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties. NON NEGOTIABLE

* Please assist IEHP in preventing possible benefit abuse. Request another form of identification from the Member in addition to the IEHP card.
## INLAND EMPIRE HEALTH PLAN
### PERINATAL PAY FOR PERFORMANCE PROGRAM
#### REMITTANCE ADVICE

**Submission Number:** 2087  
**Submission Date:** 6/1/2009  
**IPA/Provider Name:** Dr. John Doe  
**Send Payment to:** 100 Provider Place  
Anytown, CA 90005  
**Tax ID:** 1230000000  
**Contact:**  
**Phone:** (909) 000-0000

<table>
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<tr>
<th>Member's Name</th>
<th>IEHP ID</th>
<th>DOD</th>
<th>Detail Number</th>
<th>Submitting Provider</th>
<th>Type of Service</th>
<th>Date of Service</th>
<th>Amount</th>
<th>Reason Codes</th>
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**Total:** $875.00

**Reason Code Description:**
- 1. Pay Not Paid on Schedule  
- 2. Member Not Eligible or Date of Service  
- 3. Does Not Submitted  
- 4. Previously Paid  
- 5. Paid to Claim Department  
- 6. Submission Received in Error  
- 7. Does Not Eligible for PAP  
- 8. Visit not Within Admit Date  
- 9. Reimbursement not Within 30 Days  
- 10. Payment Adjustment  
- 11. EDO Not Submitted  
- 12. Denial - Date Not Submitted  
- 13. Denial - Document Not Submitted  
- 14. Incomplete Documentation Submitted  
- 15. Previous 2nd Trimester Visit already Paid  
- 16. Previous 3rd Trimester Visit already Paid  
- 17. Payment PPA  
- 18. Submitted EDO is too far past Date of Service  
- 19. Not Eligible for PAP  
- 20. Original Payment Rejected for Later Payment  
- 21. Previous 1st Trimester Visit already Paid  
- 22. Submission Not Accredited Online

11-200300
Table 21.1  **CHDP PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS**

<table>
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<tr>
<th>Screening Requirement</th>
<th>Age of Person Being Screened</th>
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<tr>
<td></td>
<td>&lt; 1 mo</td>
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<tr>
<td>Interval Until Next CHDP Exam</td>
<td>1 mo</td>
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</table>

**History and Physical Examination**
- Dental Assessment
- Nutritional Assessment
- Psychological/Behavioral Assessment
- Developmental Screening
- Developmental Surveillance
- Tobacco Assessment
- Pelvic Exam

**Measures**
- Head Circumference
- Height/Length and Weight
- BMI Percentile
- Blood Pressure

**Sensory Screening**
- Vision - Visual Acuity Test
- Vision - Clinical Observation
- Hearing - Audiometric
- Hearing - Clinical Assessment

**Procedures/Tests**
- Hematocrit or Hemoglobin
- Blood Lead Risk Assessment/ Anticipatory Guidance
- Blood Lead Test
- TB Risk Assessment
- Anticipatory Guidance

**Other Laboratory Tests**
- When health history and/or physical examination warrants:
  - Urine Dipstick or Urinalysis
  - Sickle Cell
  - Ova and Parasites
  - FBG and Total Cholesterol
  - Papanicolaou (Pap) Smear
  - VDRL or RPR

**Immunizations**

**Key:**
- Required by CHDP one time within the interval given
- Recommended by AAP, Bright Futures and CHDP
- Perform when indicated by risk assessment.
- Perform if no documented lead level at 24 months

Note: The number of health assessments may be increased using MNIHA, as appropriate.¹

Note: Health assessments should be performed as close as possible to the age listed on the periodicity table, and must be in accordance with CA Administrative Code, Section 6847

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

---

1. CHDP intervals are greater than recommended by Bright Futures. Providers may use MNIHA for necessary assessments that fall outside of periodicity such as school, sports or camp physical, foster care or out-of-home placement, or follow-up indicated by findings on a prior health assessment that need monitoring including additional anticipatory guidance, perinatal problems or significant developmental delay.

2. Age-appropriate physical examination, including oral examination, is essential with child unclothed, and draped for older child or adolescent.

3. See Dental HAG.

4. Schedule indicates recommended ages for developmental screening and psychosocial/behavioral assessment. For reimbursement information, see CHDP PIN 09-14.

5. Pelvic exam recommended within 3 years of first sexual intercourse. Subsequent pelvic exams may be performed as part of MNIHA when clinically indicated by symptoms such as pelvic pain, dysuria, dysmenorrhea. See STI HAG.

6. Blood pressure before 3 years for all risk patients, then at each subsequent health assessment. See Blood Pressure HAG.

7. See Vision Screening HAG.

8. See Hearing Assessment HAG.

9. Hb/Hct starting at 9-12 months of age. See Iron Deficiency Anemia (IDA) HAG.

10. Test between the ages of 2 and 6 years if no documented lead level at or after 24 months. Test at any age when indicated by risk assessment or if lead risk changes. See Lead HAG.

11. Urine Dipstick or Urinalysis only when clinically indicated. See Urinalysis HAG.

12. Tuberculosis risk factor screen at each visit. TST when indicated. See TB HAG.

13. STI testing when risk identified by history/physical. See STI HAG.

14. Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).
## Recommendations for Preventive Pediatric Health Care

### Bright Futures/American Academy of Pediatrics

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in a comprehensive, evidence-based model that avoids fragmentation of care.

### Infancy

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<th>Age</th>
<th>Physical Assessment</th>
<th>Developmental Assessment</th>
<th>Behavioral/Psychosocial Assessment</th>
<th>Immunization</th>
<th>Nutrition and Feeding</th>
<th>Skin Care</th>
<th>Hearing</th>
<th>Screening</th>
<th>Vision</th>
<th>Gastrointestinal Assessment</th>
<th>Oral Health</th>
<th>Depression Screening</th>
<th>Developmental Surveillance</th>
<th>Injury Prevention</th>
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### Early Childhood

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<th>Nutrition and Feeding</th>
<th>Skin Care</th>
<th>Hearing</th>
<th>Screening</th>
<th>Vision</th>
<th>Gastrointestinal Assessment</th>
<th>Oral Health</th>
<th>Depression Screening</th>
<th>Developmental Surveillance</th>
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### Middle Childhood

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<th>Developmental Assessment</th>
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<th>Immunization</th>
<th>Nutrition and Feeding</th>
<th>Skin Care</th>
<th>Hearing</th>
<th>Screening</th>
<th>Vision</th>
<th>Gastrointestinal Assessment</th>
<th>Oral Health</th>
<th>Depression Screening</th>
<th>Developmental Surveillance</th>
<th>Injury Prevention</th>
<th>Routine Dental Care</th>
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### Adolescence

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<th>Developmental Assessment</th>
<th>Behavioral/Psychosocial Assessment</th>
<th>Immunization</th>
<th>Nutrition and Feeding</th>
<th>Skin Care</th>
<th>Hearing</th>
<th>Screening</th>
<th>Vision</th>
<th>Gastrointestinal Assessment</th>
<th>Oral Health</th>
<th>Depression Screening</th>
<th>Developmental Surveillance</th>
<th>Injury Prevention</th>
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### Key

- **A**: At least one positive finding in a specific area
- **B**: At least one finding in a specific area
- **C**: No findings in a specific area
- **D**: At least one major finding in a specific area
- **E**: At least one major finding in a specific area
- **F**: At least one major finding in a specific area
- **G**: At least one major finding in a specific area
- **H**: At least one major finding in a specific area
- **I**: At least one major finding in a specific area
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- **N**: At least one major finding in a specific area
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- **P**: At least one major finding in a specific area
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- **R**: At least one major finding in a specific area
- **S**: At least one major finding in a specific area
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- **U**: At least one major finding in a specific area
- **V**: At least one major finding in a specific area
- **W**: At least one major finding in a specific area
- **X**: At least one major finding in a specific area
- **Y**: At least one major finding in a specific area
- **Z**: At least one major finding in a specific area

### References

2. Recommended screening using the Kaiser Permanente/California Department of Health Care Services/California Association of School Nurses (CASN) tool is available in the GLAD PC toolkit and at [http://pediatrics.aappublications.org/content/134/3/e476.full](http://pediatrics.aappublications.org/content/134/3/e476.full).
3. For Health care–aged children and adolescents with obesity, see the 2006 AAP statement “Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening” (http://pediatrics.aappublications.org/content/117/1/e195.full).
4. Newborn infants discharged less than 48 hours after delivery must be examined within 24 hours after discharge from the hospital. Newborn infants discharged within 48 to 72 hours after discharge from the hospital should be examined before discharge from the hospital. 
5. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include assessment of the parents’ readiness for childrearing and risk factors for infant health problems. 
6. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening of Newborns.” 
8. The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. 
9. The 2016 AAP statement on “Screening for Critical Congenital Heart Disease Using Pulse Oximetry” is available at [http://pediatrics.aappublications.org/content/134/3/e476.full](http://pediatrics.aappublications.org/content/134/3/e476.full). 
10. Recommendations for Preventive Pediatric Health Care (Bright Futures). The AAP continues to emphasize the great importance of continuity of care in a comprehensive, evidence-based model that avoids fragmentation of care. 

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Summary of changes made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This Schedule reflects changes approved in October 2015 and published in January 2016. For updates, visit www.aap.org/periodicityschedule.

Changes made October 2015

- **Vision Screening**: The routine screening at age 18 has been changed to a risk assessment.
- Footnote 7 has been updated to read, "A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/51) and “Procedures for Evaluation of the Visual System by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/52).

Changes made May 2015

- **Oral Health**: A subheading has been added for fluoride varnish, with a recommendation from 6 months through 5 years.
- Footnote 25 wording has been edited and also includes reference to the 2014 clinical report, “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/626) and 2014 policy statement, “Maintaining and Improving the Oral Health of Young Children” (http://pediatrics.aappublications.org/content/134/6/1224.full).
- Footnote 26 has been added to the new fluoride varnish subheading: See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/626).

Changes made March 2014

- **Changes to Developmental/Behavioral Assessment**
  - Alcohol and Drug Use Assessment: Information regarding a recommended screening tool (CRAFFT) was added.
  - Depression: Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

- **Changes to Procedures**
  - Dyslipidemia screening: An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
  - Hematocrit or hemoglobin: A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
  - STI/HIV screening: A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled “STI Screening.”
  - Cervical dysplasia: Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (http://pediatrics.aappublications.org/content/126/3/583.full).
  - Critical Congenital Heart Disease: Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (http://pediatrics.aappublications.org/content/128/1/190.full).

See www.aap.org/periodicityschedule for additional updates made to footnotes and references in March 2014.
This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindication.htm) or by telephone (800-CDC-FIX) (800-232-4636). This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
TABLE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind - United States, 2016.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age.

Always use this table in conjunction with Figure 1 and the footnotes that follow.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Children age 4 months through 6 years</th>
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<tr>
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<td>Dose 1 to Dose 2</td>
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<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Birth</td>
<td>4 weeks</td>
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<tr>
<td>Rotavirus&lt;sup&gt;2&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;2&lt;/sup&gt;</td>
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<tr>
<td>Diphtheria, tetanus, and acellular pertussis&lt;sup&gt;3&lt;/sup&gt;</td>
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<td>4 weeks</td>
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</table>

Children and adolescents age 7 through 18 years

<table>
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<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
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<th>Children and adolescents age 7 through 18 years</th>
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<td>Dose 1 to Dose 2</td>
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<td>Meningococcal&lt;sup&gt;11&lt;/sup&gt; (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥ 9 mos; MenACWY-CRM ≥ 2 mos)</td>
<td>6 weeks</td>
<td>8 weeks&lt;sup&gt;17&lt;/sup&gt;</td>
<td>See footnote 11</td>
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<tr>
<td>Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis&lt;sup&gt;11&lt;/sup&gt;</td>
<td>7 years&lt;sup&gt;11&lt;/sup&gt;</td>
<td>4 weeks</td>
<td>4 weeks</td>
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<tr>
<td>Human papillomavirus&lt;sup&gt;11&lt;/sup&gt;</td>
<td>9 years</td>
<td>Routine dosing intervals are recommended&lt;sup&gt;11&lt;/sup&gt;</td>
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NOTE: The above recommendations must be read along with the footnotes of this schedule.
Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

• For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
• For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
• Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated at age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see MMWR, General Recommendations on Immunization and Reports / Vol. 60 / No. 2; Table 1. Recommended and minimum ages and intervals between vaccine doses available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
• Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
Routine vaccination:
At birth:
• Administer monovalent HepB vaccine to all newborns before hospital discharge.
• For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HIBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 through 18 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed; CDC recently recommended testing occur at age 9 through 12 months; see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm.
• If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HIBIG in addition to HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HIBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:
• The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
• Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.

• Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the first dose. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks.
• Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:
• Unvaccinated persons should complete a 3-dose series.
• A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
• For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])
Routine vaccination:
Administer a series of RV vaccine to all infants as follows:
1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
2. If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
3. If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:
• The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
• The maximum age for the final dose in the series is 8 months, 0 days.
• For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix, Quadracel]; 4 years)
Routine vaccination:
• Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
• Inadvertent administration of 4th DTaP dose early: If the fourth dose of DTaP was administered at least 4 months, but less than 6 months, after the third dose of DTaP, it need not be repeated.
• For other catch-up guidance, see Figure 2.

For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
4. Haemophilus influenzae type b (Hib) conjugate vaccine (cont’d)
   • Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with HIV infection.
   *Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.

5. Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)
   Routine vaccination with PCV13:
   • Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months. For children aged 12 through 15 months who have already received an appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).
   Catch-up vaccination with PCV13:
   • Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   • For other catch-up guidance, see Figure 2.
   • Vaccination of persons with high-risk conditions with PCV13 and PPSV23:
   • All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
   • For children aged 2 through 11 months of age with any of the following: Extensive cyanotic congenital heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebral spinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
     1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     2. Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series was received previously.
     4. The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
   • For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
   • For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
     1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
     2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
     3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
   • For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
   • A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks) (cont’d)
   • If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child’s current age. If only OPV were administered, and all doses were given prior to 4 years of age, one dose of IPV should be given at 4 years or older, at least 4 weeks after the last OPV dose.
   • IPV is not routinely recommended for U.S. residents aged 18 years or older.
   • For other catch-up guidance, see Figure 2.

7. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])
   Routine vaccination:
   • Administer influenza vaccine annually to all persons aged 6 months and older. For the 2016-17 season, follow dosing guidelines in the 2016-17 ACIP influenza vaccine recommendations.
   • For children aged 2 through 4 years of age, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations. For children aged 4 through 18 years and those aged 19 years and older, the recommended vaccine doses are 3 doses.
   • For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations.

For persons aged 9 years and older:

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
   Routine vaccination:
   • Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   • Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months; the second at least 4 weeks later.
   • Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.
   • For the 2016-17 season, following dosing guidelines in the 2016 ACIP influenza vaccine recommendations.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)
   Routine vaccination:
   • Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   • For children aged 4 through 12 years of age with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency, the minimum interval between doses is 4 weeks.
   • The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   • For children aged 12 years and older, the minimum interval between doses is 4 weeks.

10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)
    Routine vaccination:
    • Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
    • Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    • For children aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.
    • For children aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.
    • The minimum interval between the 2 doses is 6 months.
10. **Hepatitis A (HepA) vaccine (cont’d)**

Special populations:
- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household, or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with a high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

11. **Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACYW-D [Menactra], 2 months for MenACYW-CRM [Menveo], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero] and MenB-FHbp [Trumenba])**

**Routine vaccination:**
- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

**Catch-up vaccination:**
- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

**Clinical discretion:**
- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) may be vaccinated with either a 2-dose series of Bexsero or a 3-dose series of Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

**Vaccination of persons with high-risk conditions and other persons at increased risk of disease:**

**Children with anatomic or functional asplenia (including sickle cell disease):**

**Meningococcal conjugate ACWY vaccines:**

1. Menveo
   - Children who initiate vaccination at 8 weeks: Administer doses at 2, 4, 6, and 12 months of age.
   - Unvaccinated children who initiate vaccination at 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.

2. MenHibrix
   - Children who initiate vaccination at 6 weeks: Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

3. Menactra
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart. If Menactra is administered to a child with asplenia (including sickle cell disease), do not administer Menactra until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.

**Meningococcal B vaccines:**

1. Bexsero or Trumenba
   - Persons 10 years or older who have not received a complete series. Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

**Children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properdin, factor D, factor H, or taking eculizumab (Soliris®):**

**Meningococcal conjugate ACWY vaccines:**

1. Menveo
   - Children who initiate vaccination at 8 weeks: Administer doses at 2, 4, 6, and 12 months of age.
   - Unvaccinated children who initiate vaccination at 7 through 23 months: Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - Children 24 months and older who have not received a complete series: Administer 2 primary doses at least 8 weeks apart.

2. MenHibrix
   - Children who initiate vaccination at 6 weeks: Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

**References:**

- Administration of meningococcal conjugate vaccines: see http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For further guidance on the use of the vaccines mentioned below, see: MMWR 2013 / 62(RR02);1-22, available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf, and MMWR October 23, 2015 / 64(41); 1171-1176 available at http://www.cdc.gov/mmwr/pdf/pdf/wk/mm6441.pdf.

12. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)**

**Routine vaccination:**
- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap vaccine may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

**Catch-up vaccination:**
- Persons aged 7 years and older who are not fully immunized with DTap vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTap vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.

For other catch-up guidance, see Figure 2.

13. **Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 2vHPV [Cervarix], 4vHPV [Gardasil] and 9vHPV [Gardasil 9])**

**Routine vaccination:**
- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. 9vHPV, 4vHPV or 2vHPV may be used for females, and only 9vHPV or 4vHPV may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose 16 weeks after the second dose (minimum interval of 12 weeks) and 24 weeks after the first dose.
- Administer HPV vaccine beginning at age 9 years to children and youth with any history of sexual abuse or assault who have not initiated or completed the 3-dose series.

**Catch-up vaccination:**
- Administer the vaccine series to females (2vHPV or 4vHPV or 9vHPV) and males (4vHPV or 9vHPV) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.