

## MEDI-CAL PROVIDER EDUCATION

**SUBJECT: Medi-Cal Sensitive Services**

**No. 105**

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**PURPOSE:** To provide guidelines for the coordination of care for all Medi-Cal Sensitive Services

**I. DEFINITION OF SERVICES:** Medi-Cal Sensitive services are services that require some form of confidentiality in the way services are provided and the way medical records are disclosed for the Medi-Cal member. These services must be administered with the following guidelines in mind.

1. Sensitive Services are provided in confidence to adolescents and adults without barriers (e.g., can't require parental consent, including prior authorization)
2. Prior authorization for all Sensitive Services is not required.
3. Adult members may self-refer without prior authorization for Sensitive Services except in cases where those services require hospitalization.
4. Parental consent for children age 12 years and older is not required to obtain Sensitive Services
5. Provider Group will not at any time inform parents or legal guardians of a minor's Sensitive Services care and information without minor's permission, except as allowed by law

Medi-cal benefits which are by definition Sensitive Services are as follows:

Sexually transmitted Diseases  
Family Planning services for network or out of plan providers  
Abortion Services (Physician provided services)  
Sterilization and Informed consent  
Human Immunodeficiency virus (HIV) Testing and Counseling  
Minor Consent Services

**A. Sexually Transmitted Diseases (STD)**

Sexually transmitted disease (STD) services are allowed for Medi-Cal members without prior authorization for both in and out of network providers. REGAL and its contracted providers must make available timely access to appropriate STD prevention, screening, counseling, diagnosis and treatment services. REGAL and its contracted providers must ensure to maintain strict confidentiality safeguarding STD member records and also reporting and disclosure of member medical information at all times. Members are allowed to access out of network STD

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services through the local health department (LHD) clinics, family planning clinics, or through other community STD service providers.

**B. Family Planning Services for in network or out of network providers**

Medi-Cal Members have the right to access family planning services through any family planning provider without Prior Authorization. Services include:

- Pregnancy testing and counseling
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical exam
- Lab tests if medically indicated as part of decision-making process to choose a contraceptive method
- Follow-up care for complications related to contraceptive methods issued by the family planning practitioner
- Provision of contraceptive pills, devices, and suppliers

**C. Abortion Services**

Abortion is a physician provided service available to Medi-Cal members. REGAL Medical Group and its' contracted providers must ensure confidentiality and ready access to abortion services to all its Medi-Cal members without prior medical justification/Authorization.

**\*\*\* Prior authorization is required for abortion services that require Inpatient Hospitalization.**

**D. Sterilization and Informed Consent**

Sterilization is defined as any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations, which are performed because pregnancy would be life threatening to the mother (so-called "therapeutic" sterilizations, are included in this definition. The term sterilization, as used in Medi-Cal regulations, means only human reproductive sterilization.

Sterilization as a sensitive service does not require prior authorization but has specific guidelines that need to be met in order for sterilization procedure to be performed.

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- Prior to performing any sterilization procedures, practitioners must complete the **PM 330 Consent for Sterilization Form**, as required by law. **See Appendix A for copy of the form.**
- Patient to be sterilized must be at least 21 years of age at the time the consent for sterilization is obtained, is not mentally incompetent, is able to understand the content and nature of the informed consent process, and is not institutionalized and **has signed and dated the consent form**
- An interpreter is provided if there is evidence that the patient does not understand the language and/or text of the informed consent process.
- Physician must complete the provider section of the form as applicable, signed and dates the PM 330 consent form.
- Sterilization is performed at least 30 days, but not more than 180 days, after the date upon which informed consent was obtained for the sterilization, except in cases involving emergency abdominal surgery or premature delivery in which specific requirements are documented to have been met
- A copy of the DHCS Booklet on Sterilization is provided to the patient by either a physician or by the physician's designee, as part of the Informed Consent process for Sterilization prior to the member signing the PM 330 Consent form
- The physician or the physician's designee reviewing the informed consent with the member and also provides the member with a copy of the consent form

### **E. Human Immunodeficiency virus (HIV) Testing and Counseling**

The HIV Testing and counseling program integrates HIV prevention counseling with testing for the disease. The following services are available upon referral:

- Confidential HIV testing
- Early intervention services
- HIV/AIDS resources

HIV testing and counseling services can be provided by in and out of network provider depending on the member's preference without prior authorization.

There are laws governing the consent for testing and disclosure of HIV test results for members, these guidelines are provided by the U.S. Public Health Services. As part of the members initial Health Assessment REGAL and its contracted PCPs must ensure to test all members including children and adolescents for risk factors for HIV infection.

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Children confirmed as HIV positive are CCS eligible and care must be coordinated appropriately to ensure approval of condition through the CCS program.

To send an authorization for a child who is HIV positive: PCP can fill out the online authorization form located at [www.regalmed.com](http://www.regalmed.com) under the provider section with their **Regal Express Access**

### **G. Minor Consent Services Medi-Cal**

Minor Consent Medi-Cal is a program that provides limited services to people under age 21, regardless of their immigration status, without parental consent or notification. Adolescents between the age of 12 and 18 years of age can go to any doctor or clinic, in or out of the **REGAL** network, without consent from their parents or legal guardian for the following **Sensitive Services**

- Outpatient behavioral health for
  - Sexual or physical abuse
  - When they may hurt themselves or others
- Pregnancy
- Family planning
- Sexual assault
- HIV/AIDS Testing
- Sexually Transmitted Infections (STIs)
- Drug and alcohol abuse

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### **II. REFERRAL PROCESS:**

In the event that member requests sensitive services at the provider's office, Member must be educated on the no prior authorization requirement and also the member's ability to self refer to any licensed provider of their choosing for services to be provided.

#### **Prior Authorization Process**

If a prior authorization request is submitted for any of the sensitive services listed above

- REGAL's prior authorization department will ensure that all authorization requests for sensitive services are withdrawn. A notice of cancellation will be sent to the provider using the following language:

*This letter serves as notification that tracking number (tracking #) has been withdrawn because the services request is a sensitive service. According to Medi-Cal Regulations, prior authorization for all Medi-Cal sensitive services is not required. The member is able to self-refer to any licensed provider for Medi-Cal sensitive services. The requirement extends to all providers, attending physicians or surgeons, assistant surgeons, anesthesiologists and facilities*

\* Any letter to a member involving sensitive services shall respect and comply with that patient's request as to instructions as to how and where to direct mailed correspondence in order to protect and respect patient/member's stated or known privacy needs and requests

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- Withdrawal letter for Sterilization procedures will be sent as follows:

*This letter serves as notification that tracking number (tracking #) has been withdrawn because: According to Medi-Cal Regulations, prior authorization for Human Sterilization is not required. However, a completed consent form, Department of Health Services' Consent Form (PM 330), must accompany all claims for sterilization services. The requirement extends to all providers, attending physicians or surgeons, assistant surgeons, anesthesiologists and facilities. However, only claims directly related to the sterilization surgery require consent documentation. Claims for pre-surgical visits and tests or services related to postsurgical complications do not require consent documentation. Department of Health Services' Consent Form (PM 330).*

For your convenience, consent for PM330 is attached. See APPENDIX A for sample form.

### **III. CLAIMS PROCESS**

Since Medi-Cal Sensitive services can be provider through both in and out of network providers, it requires detailed documentation for claims to be paid and sometimes consent form is required by law: The following are sensitive services that require specific detailed documentation for claims to be paid.

#### **Sterilization**

- Both in and out of network claims for sterilization procedures must include a copy of the member's signed PM 330 Consent Form before payment can be issued.
- The signed PM 330(human Sterilization) Consent form must show the member's signature and the date signed within a minimum of 30 calendar days prior to the date of the procedure.

#### **HIV & STD**

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**Release Date: 05/25/2016**

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All HIV& STD testing and counseling services must be provided by a licensed provider for the specific scope of practice. All claims must include the appropriate consent for disclosure of medical information obtained from the member. The consent of disclosure of medical information may be in the form of:

- Signed release of confidential information to the PCP. The medical records released must contain sufficient documentation regarding the services rendered to allow the plan to meet case management responsibility. If this is not met REGAL may decline the claim.
- Member may allow billing information to be sent to REGAL but refuse to release medical records
- Member may choose complete anonymity and refuse to release any information. This refusal to disclose must be documented to ensure continuity of care



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### **References**

Family Planning Services:  
[www.dhcs.ca.gov/services/ofp](http://www.dhcs.ca.gov/services/ofp)

HIV Counseling/Testing:  
[www.cdph.ca.gov/programs/aids](http://www.cdph.ca.gov/programs/aids)

Medi-Cal All Plan Letters:  
<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>



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### APPENDIX A

State of California – Health and Human Services Agency

### CONSENT FORM PM 330

Department of Health Services

**NOTICE:** YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

#### ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from **REQUIRED FIELD**. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a **REQUIRED FIELD**.

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on **REQUIRED FIELD**.

I, **REQUIRED FIELD**

**REQUIRED FIELD**

hereby consent of my own free will to be sterilized by **REQUIRED FIELD** by a

method called **REQUIRED FIELD**.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services.
- Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

**REQUIRED FIELD** Date: **REQUIRED F**

#### ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized, I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent

form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Date: / /  
Signature of Interpreter

#### ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before **REQUIRED FIELD** signed the consent form, I explained to him/her the nature of the sterilization operation **REQUIRED FIELD**, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

**REQUIRED FIELD** Date: **REQUIRED FIELD**

**REQUIRED FIELD**

**REQUIRED FIELD**

#### ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon \_\_\_\_\_ on

(Name of individual to be sterilized)

Mo Day Yr (Date of Sterilization), I explained to him/her the nature of the sterilization operation \_\_\_\_\_

the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of Alternative Final Paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph below which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box below and fill in information requested.)

A  Premature delivery date: / / Individual's expected date of delivery: / / (Must be 30 days from date of patient's signature).

B  Emergency abdominal surgery, describe circumstances: \_\_\_\_\_