

MHM HEALTHCARE, INC. QUALITY MANAGEMENT

Topic:

Adult Preventive Services

DATE: 2/2025**Revised:****APPROVED BY QMC: signature on file****I SCOPE:**

- A. This policy applies to all Medi-Cal members.

II POLICY:

- A. For adult Members, Primary Care Providers (PCPs) are required to deliver Adult Preventive Services consistent with the most recent edition of the United States Preventive Services Task Force (USPSTF) guidelines, unless specified differently by the Health Plan. All preventive services with a grade of “A” or “B” must be offered or provided and do not require prior authorization from the IPA. The IPA must implement processes to ensure that prior authorization are not required.
- B. The IPA requires all network Providers to provide immunization services according to the most recent U.S. Public Health Service’s Advisory Committee on Immunization Practice (ACIP) recommendations. When the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers are to administer immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria. Providers must also adhere to the recommendations of current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) and /or Health Plan Preventive Health Guidelines.

III DEFINITIONS:

- A. Adverse Childhood Experience (ACE) – For the purpose of this policy, this is defined as events, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.

IV PROCEDURE:**Health Assessments**

- A. PCPs are required to provide an initial health assessment (IHA) within 120 days of enrollment to all Medi-Cal Members assigned to them (see Policy, “Initial Health Assessment”).
- B. PCPs are required to provide targeted history and physical examinations focused on the needs and risk factors of Members on an annual basis. History and physical examinations must include, at a minimum:

1. Comprehensive (initial) or interim medical history including history of illness, past medical history, social history, and review of organ systems;
2. Staying Healthy Assessment (SHA) using the age appropriate “Staying Healthy Assessment” tool.
3. Physical exam - Either comprehensive (initial) or targeted (interim) addressing all appropriate parts of the body and organ systems, including screening for high blood pressure, pulse, respiratory rate, temperature, height and weight, and BMI;
4. Dental screening – An oral survey for teeth, gum or oral cavity related illnesses or injuries; and
5. Vision and hearing screening as appropriate for age

- C The IPA understands that in certain cases Members do not come in for physical exams for reasons beyond the control of the PCP. The expectation is that the PCPs make reasonable efforts to schedule the examinations for Members that are seeing them on an episodic basis. For members that they have never seen, PCPs are required to actively outreach to Members when they first enroll to schedule the 120-day Initial Health Assessment (see Policy, “Initial Health Assessment”).
- D. If a Member does not receive the appropriate services as required, the PCP must document attempts made to contact the Member and the Member’s non-compliance.

Laboratory and Diagnostic Testing

- A. TB Testing- Members must be assessed for TB risk factors at the initial and interim health assessments. Any members determined to be at risk must receive a Mantoux skin test (see Policy, “Initial Health Assessment”).
- B. STD Testing- Members must be assessed for TB risk factors at the initial and interim health assessments. All members at risk [see Policy, “Sexually Transmitted Disease (STD) Services”] must receive appropriate STD screening, including:
1. VDRL test
 2. Chlamydia Test (culture or urine)
 - a. PCP shall screen all females age 24 years and younger, who have been determined to be sexually active, for Chlamydia.
 - b. Follow-up of positive results must be documented in the medical record.
 - c. PCP shall make reasonable attempts to contact the appropriately identified Members and provide screening for Chlamydia. All attempts shall be documented. Documented attempts that demonstrate the PCP’s unsuccessful efforts to contact a member and screen for Chlamydia shall be considered evidence in meeting this requirement.
 - d. If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member’s Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member’s Medical Record.

- e. Sexually active female members should be screened initially and then annually if they have new or multiple partners in the past three months and do not consistently use barrier protection.
 - 3. Gonorrhea test
 - 4. Other testing as appropriate.
- C. Cholesterol Testing- All male members age 35 and older and all female members age 45 and older should be screened routinely for lipid disorders. All male members age 20-35 and female members age 20-45 should be screened if they have other risk factors for heart disease such as tobacco use, diabetes, a family history of heart disease, high cholesterol, high blood pressure, or female members on progesterone (including contraceptives). Clinicians should measure HDL and total cholesterol
- D. Other laboratory or diagnostic testing should be performed based on risk factors, noted on history or during physical exam.

Clinical Preventive Services

- A. All female Members over the age of 20 must receive instruction in Self Breast Examination at the IHA, and interim assessments, if appropriate.
- B. All Female Members over the age of 40 must receive annual clinical breast exams by the practitioner.
- C. All female Members over the age of 40 must undergo mammography screening annually, or more often if medically indicated, up to the age of 75.
- D. All sexually active female Members, or female Members over the age of 18 must receive PAP smear testing annually, beginning at the age time of sexual intercourse is initiated or at age 18, up to the age of 65. After three consecutive normal PAP smears, testing frequency can be reduced to every one to three years based on the Members risk status. Risk factors indicating more frequent PAP smears include:
 - 1. HIV infection
 - 2. History of cervical condyloma
 - 3. Multiple sex partners
 - 4. Early (less than 16 years old) onset of sexual activity
 - 5. History of multiple STDs.
- E. Cervical Cancer Screening-
 - 1. The coverage for Cervical Cancer Screening test shall include the conventional Pap test, a human papillomavirus (HPV) screening test recommended by the U.S. Preventive Services Task Force (USPSTF), upon the referral (or self-referral) of the member's health care provider, (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee).
 - 2. IPA shall ensure that routine referral processes are followed when the member, in addition to the conventional Pap test, requests a human papillomavirus screening test (HPV) recommended by the U.S. Preventive

Services Task Force, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

- F. All female members who are at an increased risk for osteoporotic fractures should be screened for osteoporosis initially at age 60, and all female members age 65 and older should be routinely screened. Female members with other risk factors including surgical menopause may have indication for earlier screening based on physician assessment.
- G. All male Members between ages 13 and 39 must receive instruction in testicular self-examination at the IHA, and interim assessments if appropriate.
- H. All male Members over age 40 must receive a digital rectal examination for prostate cancer screening annually as medically necessary.
- I. All male Members over age 40 must receive a Prostate Specific Antigen (PSA) test as medically necessary.
- J. All Members over age 50 must receive an annual fecal occult blood test.
- K. All Members over age 50 must receive a sigmoidoscopy screening every 5 years.
- L. All Members must be assessed for all age and risk appropriate immunizations in accordance with findings from the Initial Health Appointment (IHA), other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment. Examples include:
 - 1. Measles vaccine- if born after 1956 and only received on MMR, no laboratory evidence of immunity or history of physician diagnosed measles.
 - 2. Rubella vaccine- given once from age 18 and above if not pregnant, lacking adequate laboratory evidence of immunity.
 - 3. Influenza vaccine- given annually for Members age 50 or older, or with risk factors including chronic illness (e.g., diabetes, heart disease, asthma).
 - 4. Pneumococcal vaccine- given once for Members over age 65 of Members with specified risk factors for pneumococcal illness including:
 - a. Splenic dysfunctions or post-splenectomy
 - b. Immunodeficiency due to illnesses or chemotherapeutic agents
 - c. Other serious chronic illnesses (cirrhosis, heart or lung disease, etc.)
 - 5. Tetanus (Td)- every 10 years unless potentially contaminated wound then every five years.
 - 6. Hepatitis B vaccine- a series of three injections, this vaccine is appropriate for individuals at risk of exposure to Hepatitis B.
- M. PCP's shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of vaccines in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate PPG's unsuccessful efforts to provide immunization shall be considered sufficient in meeting this requirement.

Adverse Childhood Experience (ACE) Screening

- A. ACE screenings in all inpatient and outpatient settings are only reimbursable for contracted Providers who complete the certified core ACEs Aware online training and who self-attest that they have completed this training; and have used the ACE Questionnaire for Adults, which can be found in various languages at: <https://www.acesaware.org/learn-aboutscreening/screening-tools/screening-tools-additional-languages>.
- B. The Provider must maintain the following documentation in the Member's medical record, and make these available to IPA and/or DHCS, upon request:
 - 1. The screening tool that was used;
 - 2. That the completed screen was reviewed;
 - 3. The results of the screen;
 - 4. The interpretation of results; and
 - 5. What was discussed with the Member and/or family, and any appropriate actions taken.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

- A. SABIRT services may be provided by Providers in a primary care setting and within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
- B. PCPs, within their scope of practice, must provide SABIRT services for Members 11 years of age and older, including pregnant women as follows:
 - 1. When the Member responds affirmatively to the alcohol pre-screen question on the SHA, the PCP must conduct screening for unhealthy alcohol and drug use using validated screening tools, including but not limited to:
 - a. Alcohol Use Disorders Identification Test (AUDIT-C) (see Attachment, "AUDITC" in Section 12);
 - b. Brief Addiction Monitor (BAM) (see Attachment, "Brief Addiction Monitor (BAM)");
 - c. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID);
 - d. Tobacco Alcohol, Prescription Medications and other Substances (TAPS);
 - e. National Institute on Drug Abuse (NIDA) Quick Screen for Adults (The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening);
 - f. Drug Abuse Screening Test (DAST-10);
 - g. Parents, Partner, Past and Present (4Ps) for pregnant women; and
 - h. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.
 - 2. When the Member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use disorder is present. Validated alcohol and drug assessment tools include, but are not limited to:
 - a. Alcohol Use Disorders Identification Test (AUDIT);

- b. Brief Addiction Monitor (BAM) (see Attachment, “Brief Addiction Monitor (BAM)”)
 - c. NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST); and
 - d. Drug Abuse Screening Test (DAST-20).
- 3. The PCP must offer immediate brief misuse counseling when a Member reveals unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to Members whose brief assessment demonstrates possible alcohol use disorder (AUD) or substance use disorder (SUD). Brief interventions must include the following:
 - a. Providing feedback to the Member regarding screening and assessment results;
 - b. Discussing negative consequences that have occurred and overall severity of the problem;
 - c. Supporting the Member in making behavioral changes; and
 - d. Discussing and agreeing on plans for follow-up with the Member, including referral to other treatment if indicated.
- 4. The PCP must ensure the Member’s medical record include the following:
 - a. The service provided (e.g., screen and brief intervention);
 - b. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);
 - c. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record);
 - d. If and where a referral to an AUD or SUD program was made.
- 5. The IPA and PCP will make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment. If a Member does not receive referred treatments, the PCP will follow up with the Member to understand barriers and adjust the referrals as needed.

Tobacco Prevention and Cessation

- A. Providers must identify and track all tobacco use, both initial and annually, through the following activities:
 - 1. Completion of the IHA and SHA questionnaire, which asks about smoking status and/or exposure to tobacco smoke;
 - 2. Annual assessment of tobacco use based on the SHA periodicity schedule, unless an assessment needs to be readministered; and
 - 3. Asking Members about their current tobacco use and documenting in their medical record at every visit.
- B. Providers must review the questions on tobacco with the Member, which constitutes individual counseling.
- C. PCPs are encouraged to use a validated behavior change model to counsel Members who use tobacco products.
 - 1. Use of the 5 A’s” – Ask, Advise, Assess, Assist, and Arrange;
 - 2. Use of the “5 R’s” – Relevance, Risks, Rewards, Roadblocks, and Repetition.

3. Counseling referrals- individual, group
4. California Smoker's Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline's web referral, or if available in their area, the Helpline's e-referral system.