Policy:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	10/01/1995
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima Health shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Health Policy GG.1608: Full Scope Site Reviews.

C. CalOptima Health shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima Health's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Health Policy GG.1618: Member Request for Medical Records.

E. Practitioners shall appropriately document Medical Records for Members and that Medical Records are available to Practitioners at each encounter, in accordance with 28 CCR section 1300.67.1(c), 42 USC section 1396a(w) and Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017: Site Reviews: Facility Site Review and Medical Record Review.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. Medical Records shall be available to Practitioners at each Member encounter.

b. Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

c. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service.

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.c. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory tests;

b. Diagnostic studies;

c. X-ray reports;

d. Electroencephalograms (EEGs);

e. Echocardiograms (EKGs);

f. Consultation summaries;

g. Hospital reports (admission, inpatient/outpatient reports); and

h. Emergency department and urgent care reports.

3. Any abnormal results and/or "STAT" reports shall have an explicit notation including follow-up or outreach.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. An individual record shall include Member identification on each page.

    a. Member Record shall include personal/biographical information.

    b. Member identification includes first and last name, and a unique identifier established for use at clinical site.

    c. Electronically maintained records and printed records from electronic systems must contain Member identification.

3. The record shall be in a Legible hand-written or a printed format.

4. All Medical Record documentation shall be in English.

5. The record shall reflect the findings of each visit or encounter, including, but not limited to:

    a. Recording date of service;

    b. History of present illness or reason for visit;

    c. Unresolved and/or continuing problems addressed in subsequent visit(s);

    d. Tests or therapies ordered, as appropriate;

    e. Instructions for follow-up care is documented;

    f. Treatment plan and working diagnoses or medical impression;

        i. Working diagnoses shall be consistent with findings.

        ii. Plan of action/treatment shall be consistent with diagnosis(es).

    g. Any physical, psychosocial, or educational needs identified during the encounter; and

    h. Abnormal results.

    i. For timed services, the duration (start and end times) shall be documented.

6. The following data sets shall be included in each Medical Record:

    a. Biographical information, including, but not limited to:

        i. First and last name;

        ii. Current address;

iii. Age and date of birth;

iv. Home and/or work telephone numbers;

v. Emergency contact person and nearest relative (names and telephone numbers for each);

vi. If the Member is a minor, the primary emergency contact person must be a parent or legal guardian. All other persons may be listed as additional emergency contacts;

vii. Name of Authorized Representative if Member is a minor;

viii. The assigned and/or rendering PCP is identified when there is more than one (1) PCP on site or if the Member has selected care from a non-physician medical Practitioner;

ix. Health Plan Identification number;

x. Medi-Cal Member ID number, as applicable;

xi. Member's primary/preferred language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

xii. Requests for language and/or interpretation services by a non-or limited-English proficient Member are documented, as applicable. Member's refusal of free Interpreter services and their request to use family members, friends, or a in an emergency only, a minor child as an Interpreter shall be documented in the Member's Medical Record;

xiii. Person or entity providing medical interpretation is identified, as applicable for each encounter;

xiv. Signed copy of the Notice of Privacy Practices (NPP); and

xv. Missed primary care appointments and outreach efforts/follow-up contacts.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

a) Height;

b) Weight and Body Mass Index (BMI);

c) Temperature;

d) Pulse and respirations;

e) Blood pressure screening if the Member is at least three (3) years of age; and

f) First initial, last name and title of health care personnel performing these functions.

iv. Allergies and adverse reactions listed in a prominent, easily identified, and consistent location;

    a) If the Member has no known allergies or history of adverse reactions, this is appropriately noted.

v. Chronic problems and/or significant conditions are listed and current. All chronic or significant problems are considered current if no end date is documented;

vi. List of current, continuous medications including:

    a) Medication name;

    b) Strength;

    c) Dosage;

    d) Route (if other than oral) and;

    e) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

    a) Significant health problems;

    b) Reactions to drugs; and

    c) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

    a) History and physical;

    b) Discharge summary;

    c) Operative reports; and

    d) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

    a) Assessment;

    b) Treatment;

c) Discharge instructions; and

d) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

a) All pediatric Members under twenty-one (21) years of age must receive well child assessments, screenings, and services, in accordance with CalOptima Health Policy GG.1116: Pediatric Preventative Services.

b) All adult Members must receive periodic health evaluations, in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment.

c) All perinatal Members must receive assessments in accordance with CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program.

d) Member refusal of screenings or other preventive screenings must be documented.

iii. Health education behavioral assessments and referrals to health education services, where appropriate.

iv. Initial Health Appointment (IHA):

a) IHA must be completed in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment.

v. Immunizations

a) Timely provision of immunizations in accordance with the most recent schedule and recommendations according to CDC's most recent ACIP guidelines, regardless of Member's age, sex, or medical condition, including pregnancy;

b) Immunization status is assessed at each health assessment visit;

c) Complete record of immunizations. Immunizations shall be recorded with name, date of administration, manufacturer, lot number, and expiration date and Vaccine Information Statement (VIS) documentation. VIS documentation includes the date the VIS was given and the VIS publication date;

d) Evidence of member-specific immunization information is reported to California Immunization Registry (CAIR) within fourteen (14) calendar days and in accordance with state and federal laws and with Health and Safety Code (H&S) 120440 and 16 CCR 1746.4(e) for both children and adults.

1. Reports shall be made following the recipient's initial health assessment and all other health care visits which result in an immunization being provided; and

e) CalOptima Health will implement the following actions to monitor compliance for immunization reporting.

1. CalOptima Health shall utilize immunization data received from CAIR to monitor reporting compliance, at minimum, annually.

2. CalOptima Health shall utilize the immunization administered date and the reporting date from CAIR to calculate the turnaround time for reporting and determine whether the fourteen (14) calendar day turnaround time is compliant.

3. Immunization reporting performance against the timeliness standard shall be reported to the Quality Improvement Health Equity Committee (QIHEC) on an annual basis.

f) Member refusal of immunizations must be documented.

d. SABIRT Services:

i. The service provided;

ii. The name of the validated screening instrument(s) and the score on the screening/assessment instrument(s) unless the screening tool is embedded in the electronic Health Record;

iii. The name of the assessment instrument (when indicated and the score on the screening instrument(s) unless the screening tool is embedded in the electronic health record; and

iv. If and where a referral to an Alcohol Use Disorder (AUD) or Substance Use Disorder (SUD) program was made.

e. Additional Medical Record components and consents:

i. Adults eighteen (18) years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive;

a) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

b) Advance Health Care Directive Information is reviewed with the Member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed appropriate consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information;

iv. All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 – 51305.6, if applicable and in accordance with CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network;

v. Authorization Request Forms (ARFs);

vi. Referrals, including Complex Care Management, Enhanced Care Management, and Specialist;

vii. Significant telephone advice, documented with date, time, and signature;

viii. For Covered Services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services prior to the initial delivery of services is required. Consent must be documented in the Member's Medical Record and made available to DHCS upon request;

ix. Consultation reports;

x. Adverse Childhood Experiences (ACEs) Screenings Services:

a) Practitioner shall document the following in the Member's Medical Record, and it shall be available upon request by the Member and/or Member's Authorized Representative compliance with all relevant state and federal privacy requirements:

1) The applicable Pediatric ACEs and Related Life-Events Screener (PEARLS) tool that was used;

2) The interpretation of the results;

3) What was discussed with the Member and/or family and any appropriate actions taken.

xi. Annual Cognitive Health Assessment:

a) Practitioner shall document the following in the Member's Medical Record:

1) The cognitive assessment tool(s) used in accordance with DHCS APL 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older;

2) Verification that screening results were reviewed by the Practitioner;

3) The results of the screening;

4) The interpretation of results; and

5) Details discussed with the Member and/or authorized representative and appropriate necessary follow-up services that were provided based on assessment scores.

f. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

iii. Errors are corrected according to legal medical documentation standards.

D. Documentation of Missed Primary Care Appointments and Outreach Efforts

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. Incidents of missed/broken appointments, cancellations, or "no shows."

b. All attempts to contact the Member or Authorized Representative and the results of the follow-up actions.

c. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Health Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Health Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records department manager or office manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Health Policy GG.1618: Member Request for Medical Records, CalOptima Health HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima Health shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Health Policy GG.1608: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code §2290.5
B. California Probate Code §§4701 and 4780-4785
C. California Welfare & Institutions Code §14124.1
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract for Health Care Services
G. CalOptima Health Policy GG.1116: Pediatric Preventative Services
H. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
J. CalOptima Health Policy GG.1613: Initial Health Appointment
K. CalOptima Health Policy GG.1618: Member Request for Medical Records
L. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Revised: May 24. 2023)(Supersedes APL 17-011 and Policy Letters 99-003 and 99-004)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Supersedes APL 18-014)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017: Site Reviews: Facility Site Review and Medical Record Review (Supersedes APL 20-006)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007: Telehealth Services Policy (Supersedes APL 19-009)
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APLs 18-004 AND 16-009)
T. Health and Safety Code (H&S), §120440
U. Title 16, California Code of Regulations (CCR) 1746.4(e)
V. Title 22, California Code of Regulations (CCR), §75055
W. Title 28, California Code of Regulations (CCR), §§1300.67.1(c) and 1300.80(b)(4)
X. Title 42, United States Code, §1396a(w)
Y. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/10/2010	Department of Health Care Services (DHCS)	Approved as Submitted
03/19/2021	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2021	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2022	Department of Health Care Services (DHCS)	File and Use
10/17/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/23/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/01/2019	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	04/07/2022	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	06/01/2023	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	07/01/2024	GG.1603	Medical Records Maintenance	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2024	GG.1603	Medical Records Maintenance	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services);

Term	Definition
	5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract, or Care Coordination or Coordination of Care as defined in the State Medicaid Agency Contract.

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that health network.
Individualized Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Interpreter	A person who renders a message spoken in one language into one or more languages. An Interpreter must be qualified per requirements outlined in Welfare and Institutions Code, section 14029.91(a)(1)(B) and Title 45 Code of Federal Regulations, section 92.101(b)(3).
Legible	For purposes of this policy, the record entries are readable by a person other than the writer.
Medical Record	Medi-Cal: The record of a Member's medical information including, but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima Health legal duties with respect to Protected Health Information.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.