FREQUENTLY ASKED QUESTIONS (FAQ)

Initial Health Appointment FAQ

General Questions

What is an Initial Health Appointment (IHA)?

An Initial Health Appointment (IHA) is a comprehensive health assessment required for newly enrolled Medi-Cal and D-SNP managed care members. The IHA establishes care, identifies physical and behavioral health needs, assesses risks, and initiates preventive services and care coordination.

Why is the IHA required?

The IHA ensures that members receive timely, comprehensive care and allows health plans and providers to meet Medi-Cal access, quality, and compliance standards established by the California Department of Health Care Services (DHCS).

What if I have a question about the IHA that isn't covered in the material I've read?

Questions about Facility Site Review and Medical Record Review requirements, Initial Health Appointment (IHA) criteria, email fsr@sfhp.org

Portal questions, submit a request via providerportal@sfhp.org

General questions, email provider.relations@sfhp.org or call 1(415) 547-7818 ext. 7084

What if I'd like to take or assign my staff to take a self-paced tutorial: IHA Provider and Staff Training?

San Francisco Health Plan (SFHP) is transitioning to an enhanced training approach that provides providers and staff with convenient, 24/7 access to learning opportunities through the Litmos Learning Management System (LMS).

A highly recommended IHA training will be available soon on Litmos to help strengthen your knowledge of IHA requirements. As a reminder, the Department of Health Care Services (DHCS) actively oversees the IHA measure to ensure compliance with state standards. Providers are encouraged to utilize the current guidance and resources available on the SFHP website. These resources are designed to support your understanding of IHA requirements and serve as a key tool in helping you meet DHCS compliance expectations.

To get started and prepare for upcoming training:

- Create a Litmos account: https://sfhp.litmos.com/self-signup
- Save your login credentials for future access
- Sign up for the provider newsletter to receive updates when training becomes available at https://www.sfhp.org/providers/provider-newsletter/

For additional information and answers to frequently asked questions about Litmos and provider trainings, visit: https://www.sfhp.org/providers/training/

SFHP's Litmos training platform will continue to expand, with additional courses becoming available in the near future. Until then, please refer to the SFHP website for the most up-to-date training materials and resources.

New vs. Established Patient Status

What defines a "new patient" for IHA purposes?

A "new patient" is defined by plan enrollment history, not by whether the provider has previously seen the patient. A member is considered new if they are newly enrolled or re-enrolled after a gap of more than 12 months with the managed care plan.

What defines an "established patient"?

A patient is considered established if they have received professional services from the same physician—or from a physician of the same specialty within the same group—within the past three years.

If a patient has seen the same PCP for years but renews coverage and is coded as new, is an IHA required?

Not necessarily. If the PCP determines that a comprehensive assessment meeting all IHA requirements was completed within the previous 12 months, the existing documentation may satisfy the IHA requirement. This determination must be clearly documented in the medical record.

Identifying Members Who Require an IHA

How do providers identify which patients require an IHA?

Delegated groups receive eligibility lists and IHA-due rosters from the health plan. If these are not cascaded to the providers, providers are responsible for regularly downloading and reviewing the new member rosters from the Provider Portal. Providers are expected to proactively review these lists and initiate outreach to newly enrolled members. Instructions on how to download lists can be found on the Provider Portal User Guide (starting page 15).

How can providers track IHA compliance internally?

Provider groups should assign staff to track new member enrollment, outreach attempts, appointment completion, and documentation. Staff should follow standardized outreach and scheduling workflows.

How does pregnancy and OB care align with the Initial Health Appointment (IHA) for an eligible member?

When the patient is both a new member and pregnant, the provider they are most likely to visit, such as an OB/GYN for a pregnant member, must bill the IHA as an age-appropriate preventive CPT. Include relevant pregnancy diagnoses to capture risk and the care plan, but code the visit as preventive (IHA), not prenatal care.

Timeliness and Completion Requirements

What is the timeframe for completing an IHA?

The IHA must be completed within 120 calendar days of the member's enrollment with the health plan unless a complete assessment from the prior 12 months exists in the medical record.

Can an IHA be completed over multiple visits?

Yes. The IHA may be completed across multiple visits as long as all required components are completed and documented within 120 calendar days.

IHA Documentation & Coding Guidelines

i. Documentation Requirements
   a. Interim Visits: Must include the phrase: "IHA components initiated."
   b. Closing Visit: Must include the statement: "Initial Health Appointment completed. Comprehensive history, preventive screening assessment, risk identification, and plan of care completed."

i. Billing & Coding
    a. Billing Rule: Only the closing visit is billed as the IHA.
    b. Preceding Visits (1-2): Code as appropriate for services rendered:
        i. CPT: Problem-oriented E/M or Preventive visit codes.
        ii. Diagnosis: Codes for specific conditions addressed during the visit.

Which date is used to determine timeliness if plan enrollment and PCP effective dates differ?

Reviewers generally use the most recent plan enrollment date or the PCP effective date when assessing timeliness during audits.

Who May Complete the IHA

Who is allowed to complete the IHA?

The IHA must be completed in a primary care medical setting by one of the following:

- Primary Care Providers (PCPs)
- General Practitioners
- Internal Medicine, Pediatrics, Family Practice
- OB/GYN
- Perinatal Care Providers
- Nurse Practitioners
- Certified Nurse Midwives
- Physician Assistants

Required Components of an IHA

What are the required components of an IHA?

An IHA is considered complete only when all five components are documented:

1. History of Physical and Behavioral Health
    a. Physical exam or review of systems (ROS)
    b. History of present illness (HPI)
    c. Past medical history (PMH)
    d. Behavioral health screening using standardized tools
2. Identification of Risks
    a. At least one validated risk assessment domain, such as:
        i. Health Risk Assessment (HRA)
        ii. Social Determinants of Health (SDOH)
        iii. Adverse Childhood Experiences (ACEs / PEARLS)
        iv. Cognitive assessment (required for members age 65+)
3. Health Education and Anticipatory Guidance
    a. Age- and risk-appropriate health education and counseling
4. Assessment of Preventive Screening Needs
    a. Preventive care based on USPSTF, Bright Futures, ACOG, and ACIP guidelines

5. Diagnosis and Plan of Care
    a. Diagnosis of identified conditions
    b. Treatment plans, referrals, and follow-up care

Are follow-up referrals and care coordination part of the IHA requirement?

The IHA must include the identification of needed specialty care and the initiation of appropriate referrals. Care coordination is a foundational component of the IHA to ensure the member actually receives the follow-up services identified during the exam.

Closed-loop processes must be applied to both referrals and ordered labs/diagnostics, meaning they are not only initiated but tracked through completion. The PCP or care team is responsible for confirming that:

- The member schedules and completes referred specialty appointments and completes all ordered labs and diagnostic tests.
- Results from specialists, labs, and diagnostic studies are received, reviewed, and documented in the medical record.
- Findings are incorporated into the member's care plan and communicated to the member as appropriate.
- Any missed, delayed, or incomplete referrals or lab services are actively followed up with documented outreach efforts and interventions to address barriers (e.g., scheduling, transportation, health literacy).

All components of the closed-loop process, including referrals, lab completion status, outreach attempts, barrier resolution, and follow-up actions—must be clearly documented in the medical record to demonstrate continuity of care and compliance with care coordination standards.

Behavioral Health and Substance Use Screening

Does the IHA require a formal behavioral health evaluation?

No. The IHA requires behavioral health screening and assessment, not a full evaluation, unless the screening results indicate the need for further assessment or referral.

What behavioral health screening tools are acceptable?

Validated, age-appropriate tools may be used, including but not limited to PHQ-2, PHQ-9, GAD-7, ACEs/PEARLS, and other approved screening instruments.

Can PHQ-2 and PHQ-9 be administered together?

Yes. If the PHQ-2 score is 3 or higher, further assessment with PHQ-9 is appropriate and may be documented and billed as applicable.

Telehealth, Sick Visits, Home Visits, and Facility Visits

Can the IHA be completed via telehealth?

Partially. One or more components of the IHA may be completed via telehealth; however, a subsequent in-person comprehensive physical exam is required. The telehealth and in-person visits together count as one IHA and should be billed once. For billing telehealth services, Place of Service (POS) codes and specific modifiers are used to identify the patient's location and the technology used. These are: (POS) 02, 10, 93, 95.

Can the IHA be completed during a sick visit?

Yes. If a member presents for episodic care, the provider should complete the IHA during the visit when resources permit and document all required components.

Can home visits satisfy IHA requirements?

Only if the health plan recognizes home-based primary care as an approved primary care medical setting. Otherwise, home visits do not fulfill IHA requirements.

How are Skilled Nursing Facility (SNF) visits applied to the IHA?

For a new member in a SNF, you must use nursing facility evaluation and management (E&M) codes instead of standard office visit codes for services provided by a physician or other qualified healthcare professional. In addition, you must use a diagnosis code from the Z00 or Z02 series (e.g., Z00.00 for a general adult medical examination) to indicate the visit fulfills the IHA requirement. For Medicare, also select the correct Place of Service (POS) code: POS 31 or POS 32.

- 99304 - Initial visit for low-complexity care. Requires a detailed history and exam, and straightforward or low-complexity medical decision-making.
- 99306 - Initial visit for high-complexity care. Requires comprehensive history and exam and high complexity medical decision-making
- 99305 - Initial visit for moderate-complexity care. Involves a comprehensive history and exam and moderate complexity medical decision-making.

Outreach, Refusals, and Missed Appointments

How many outreach attempts are required to schedule an IHA?

Providers must make at least three documented outreach attempts, including:

- At least two telephone calls
- At least one written outreach (letter, postcard, or equivalent)

What if the member refuses or misses the IHA appointment?

- Refusals must be documented in the medical record
- Missed appointments require additional outreach attempts (1 telephone call and 1 written)

What details must be documented for outreach attempts?

Providers are required to make at least two documented outreach attempts by phone and one written outreach to contact new members for scheduling the IHA.

All efforts, including refusals or no-shows, must be recorded in the medical record.

We encourage provider groups/providers to download their new member rosters from Provider Portal. Instructions on how to download lists can be found on the Provider Portal User Guide (starting page 15).

Documentation must include:

- Date and time of the attempt
- Method of contact

- Outcome
- Staff member name or initials

Coding and Billing

Is there a required CPT code for the IHA?

While DHCS lacks a mandated CPT code for IHAs, health plans provide coding 'tip sheets' for appropriate E&M or preventive codes based on services rendered. SFHP has published an IHA Clinical Guide with coding suggestions that best reflect the clinical services provided during an IHA. The IHA Clinical Guide with Coding Tips is available under Provider Resources at the top.

How should labs and screenings be coded?

Labs and screenings must be supported by appropriate diagnoses and documentation. Supplemental codes are required for specific screenings such as ACEs and SDOH.

Documentation Requirements

What documentation is required for IHA compliance?

Providers must document:

- All five required IHA components
- Screening tools and results
- Referrals and follow-up plans
- Outreach attempts, refusals, and no-shows

Documentation must be legible, dated, and signed. You may use a sample EMR template to complete the documentation. Handwritten documentation must be signed, dated, and legible. Legibility means the record entry is readable by a person other than the writer.

Is there a required documentation form?

No specific form is required. Practices may use EMR templates or other formats as long as all required components are documented.

Monitoring, Audits, and Compliance

How is IHA compliance monitored?

SFHP conducts annual evaluations of IHAs completed in the previous calendar year for our medical groups through policy and medical record review. Findings are used for quality improvement and education.

Sample resources for the Delegation Oversight Audit (DOA):

- IHA Delegate Policy
- IHA Policy and Medical Record Review Checklist
- IHA Provider Newsletter
- Medical Group IHA Provider Alert

SFHP also checks for compliance with IHA visits during the Facility Site Review and Medical Record Review. For more information, please visit: https://www.sfhp.org/providers/facility-site-reviews/

How can providers remain compliant and track their IHA performance?

SFHP has a "Knowledge Hub" of resources on the sfhp.org website with tools to support providers and staff in achieving successful IHA compliance. Below is a summary of resources that can be accessed to ensure a Primary Care Practice is prepared to fulfill IHA responsibilities:

- IHA Toolkit for Providers & Staff
- IHA PCP Sample Policy
- IHA Clinical Guide (Includes coding tips and documentation requirements)
- IHA EMR Templates
- IHA Screening Resource
- Provider Update Newsletter: IHA Excellence Article Series
- IHA Workflow Samples
- IHA Provider Inservice Template (All IHA requirements summarized)
- IHA Provider Training PPT (self-paced) through Litmos (coming soon)
- Provider Portal User Guide
- Member Roster
- IHA Rate Report

Exceptions to IHA Requirements

Are there exceptions to completing an IHA?

Yes. These include the following:

- If the member's PCP determines that all of the components of the IHA are complete in the member's medical record within the previous 12 months and meet the requirements.
- The member disenrolled before IHA could be performed.
- The member or appropriate delegate, e.g., Parent/guardian refuses an IHA, and this is documented in the member's medical record.
- The member does not schedule an IHA or show up to a planned IHA, and the provider makes reasonable attempts to outreach to the member and documents in the member's medical record.

Are there exceptions for infants?

For members less than 18 months old, the IHA must be completed:

Within 120 days of enrollment into the plan OR According to the AAP Bright Futures periodicity timelines,

Whichever is sooner. Essentially, if a newborn or infant is due for a well-child visit (e.g., at 2, 4, or 6 months) before the 120-day window closes, that visit serves as the required timeframe for the IHA.