APRIL 2020

PROVIDER QUALITY NEWSLETTER

*Visit **MedPOINTManagement.com** for important materials and resources in this newsletter!*
See instructions on page 2.

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

COVID-19 Coronavirus

MedPOINT Management has taken immediate steps to address the challenges of COVID-19 and to promote the health, safety and well-being of our providers and members. Please see the following important resources that may provide assistance and guidance as we navigate through this difficult time.

COVID-19 Materials included in this newsletter:

1. **MedPOINT** - on behalf of our contracted IPAs/ Medical Groups – **Updated Telehealth Services & Coronavirus** (COVID-19) FAQ – dated 3-25-20.
2. **COVID 19 CODING Resources** - Includes Official Coding Guidance from CDC (Centers for Disease Control and Prevention), coding advice and charts from the AMA (American Medical Association), codes for lab tests from CMS (Centers for Medicare & Medicaid Services), and a Telehealth Fact Sheet from APG (America's Physician Groups).
3. **COVID for Members** - Includes flyers that can be given to patients on "Immediate Crisis Counseling," "Do I Need to get Tested?" and "Caring for COVID in the Home."
4. **CDPH** - California Department of Public Health for VFC (California Vaccines for Children) providers – recommendations for **routine childhood immunizations** during the pandemic.
5. **CPCA** - California Primary Care Association - **"Telephone Visits: How, What, Where"** PowerPoint dated 3-25-20 on reimbursable **Medi-Cal services by telephonic/virtual visits.** *This will be useful to share with your providers and clinical staff.*
6. **DHCS** - **Medi-Cal Payment for Telehealth** and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus(COVID-19 dated 3-18-20.
7. **Health Net** - Provider Updates on **State of Emergency** and **Coronavirus Q&A.**
8. **Quest Diagnostics** - Launch of **Coronavirus Disease** 2019 (COVID-19) **Test press release** dated 3-5-20 and Healthcare **Provider Information** with testing details and email address for additional information.

COVID-19 Websites to Keep You Up to Date (Check for updates often as this information is changing rapidly):

DHCS - COVID 19 Response page:
https://www.dhcs.ca.gov/Pages/DHCS-COVID%E2%80%9119-Response.aspx

Los Angeles Community Resources - with real-time updates:
https://docs.google.com/document/d/1S-WJaMa4q3yNrEBfSFKEdSQArcNc_MTI2LiUA63Ycyg/edit

CDC - Information for Healthcare Professionals
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

CDPH - California Department of Public Health – Guidance Documents page
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Guidance.aspx

NCQA - COVID-19 Response page:
https://www.ncqa.org/covid/?utm_medium=email&utm_source=sf&utm_campaign=covid-digest&utm_term=20200326

CPCA - California Primary Care Association – Latest news, daily updated web links of resources from Federal and State and testing resources, **FAQ. https://www.cpca.org/cpca/EPresources**

Other Topical Materials Included with the Newsletter

1. Molina 2020 Pay for Performance/HEDIS Performance Bonus Program – "Just the Fax" (JTF) Update and Revision dated 3-17-20.
2. "Behavioral Health Toolkit" for providers - Molina JTF notice dated 2-28-20. This includes guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting. To access the Toolkit, go to **www.molinahealthcare.com, then providers/wa/medicaid/resource/Pages/bh_toolkit.aspx.**
3. "Language Access Services for Telehealth Appointments" – Molina JTF notice dated 3-25-20.
4. "Medicare Opioid Treatment Programs Benefit" - Molina JTF notice dated 2-28-20. Instructions on coverage and how to receive payment is included.
5. "Provider Checklist to Support CAHPS and HOS Improvement" from Health Net. This is a great form to help increase patient satisfaction and helps you touch on all the required subjects that are included in the patient surveys.
6. "MCAS Updates" – Health Net Provider Update with measure changes dated 3-23-20.

Interpreta - portal.interpreta.com

The Coronavirus has brought most offices and health centers to a halt with scheduling HEDIS preventive screenings that are due. However, as resources permit, work can still be done!

The 2020 data is scheduled to be loaded in Interpreta for review the beginning of April so please check during the first few weeks, download your 2020 gap list and use it to identify members that have exclusions (such as hysterectomies and mastectomies), colonoscopies from the last 10 years, and any other records of services done by previous providers. These records can be submitted via the Interpreta Supplemental Data portal to remove them from the denominators for Measurement Year (MY) 2020.

If you need assistance or have any questions about the Interpreta portal, please email **qualitymeasures@medpointmanagement.com** or call **818-702-0100, x1353**.

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To access the materials referenced in this newsletter, go to:
www.medpointmanagement.com/provider-resources

Click on "Quality Management Information" for resources included in the Quality Newsletters (all materials are listed in one PDF document).

NOTE: *Due to the large number of attachments, if you would like us to send specific materials listed above, please contact us directly and we would be happy to email them to you.*

Click on "HEDIS Documents" for MedPOINT's HEDIS Reference guides.

Contact us at **(818) 702-0100**, ex 1353, or **qualitymeasures@medpointmanagement.com** for assistance.

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

March 27, 2020 IZB-FY-19-20-11

TO: California Vaccines for Children (VFC) Providers

FROM: Sarah Royce, MD, MPH, Chief
Center for Infectious Diseases
Division of Communicable Disease Control, Immunization Branch

SUBJECT: Routine Childhood Immunizations during COVID-19 Pandemic

Key takeaways from this letter include:

- Maintaining childhood immunizations during pandemic:
  - ✓ Prioritization of immunizations for children 0-24 months
  - ✓ Strategies for modifying clinic operations
  - ✓ Approval for Alternate/Temporary VFC locations
  - ✓ AAP and CDC resources

BACKGROUND

The COVID-19 pandemic continues to affect communities across the United States. Maintaining childhood immunizations during this period may not be feasible due to current impact of COVID-19 community transmission, staffing, and parental concerns. However, the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) have issued the following recommendations for prioritizing childhood immunizations during this pandemic period, and strategies which can be implemented across pediatric practices to slow the spread of disease.

PRIORITIZING IMMUNIZATIONS OF YOUNG CHILDREN

Because of personal, practice, or community circumstances related to COVID-19, some providers may not be able to provide well child visits, including provision of immunizations, for all patients in their practice.

- If a practice can provide only limited well child visits, healthcare providers are encouraged to **prioritize newborn care and vaccination of infants and young children (through 24 months of age) when possible.**
- Reschedule well visits for those in middle childhood and adolescence to a later date. Keep a list of rescheduled appointments to facilitate patient recall later on.

STRATEGIES TO MODIFY CLINIC STRUCTURE FOR ENSURING DELIVERY OF PRIORITIZED CARE

Ensuring the delivery of newborn and well-child care, including childhood immunization, requires different strategies. The following are strategies recommended by AAP:

- Separating well visits from sick visits. Scheduling well visits in the morning and sick visits in the afternoon.
- Separating patients spatially, such as by placing patients with sick visits in different areas of the clinic.
- Clinics with multiple practice sites may consider using one office location to see all well visits (staffed by those in higher risk categories) and another location for sick visits.
- Collaborating with providers in the community to identify separate locations for holding well visits for children.
- If available, pediatricians are encouraged to increase their capacity to deliver telehealth and utilize "drive through" dedicated COVID-19 testing sites.

IMPORTANT: Local Health Departments (LHDs) immunization clinics may be impacted by current COVID-19 response activities led by public health staff. As a result, some may have also reduced or closed immunization clinics and may not be able to immunize patients at this time. Please check with your LHDs before any referrals.

TEMPORARY RELOCATION OF VFC PARTICIPATING LOCATION

In order to support practices with the implementation strategies to prioritize immunizations of young children, the VFC program will expedite the enrollment of temporary alternative sites, as well as grant approval of the relation of immunization services for an enrolled location. Guidance can be found at https://eziz.org/vfc/enrollment/.

CDC AND AAP GUIDANCE

- AAP: https://services.aap.org/en/pages/covid-19-clinical-guidance-q-a/
- CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html.

QUESTIONS?

If you have any questions, please call the VFC Customer Service Center at 877-243-8832 (877-2GET-VFC).

California Primary Care Association

Telephone Visits: How, What, Where

March 25, 2020

CPCA Team

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Agenda

- Background
- What is a telephone visit?
- What makes it reimbursable?
- Scheduling options
- Best practices

Background

- March 13 President's COVID-19 national emergency declaration
- March 16 Department of Health Care Services (DHCS) submits a 1135 waiver to CMS requesting greater flexibilities in delivering care via telehealth and telephonic
- March 19 DHCS releases guidance to Medi-Cal providers outlining:
  - The current Medi-Cal policies
  - The specific 1135 waiver requests related to COVID-19

DHCS Guidance:

Background *(Continued)*

- March 23 CMS approved the first 1135 for CA
  - CMS still working with DHCS on additional waiver requests that include the flexibility with telehealth/telephone
- DHCS is saying that we proceed with the guidance absent CMS formal approval
- CPCA developed a summary sheet on DHCS guidance - *outdated*
- Today, DHCS is releasing updated guidance with FAQ at the end. Updates are throughout the document.

Background *(Continued)*

- Today, we will concentrate on telephonic visits only
- Next week a separate webinar on telehealth
  - Telehealth Guidance : Tuesday, March 31 @ 2:00pm
    - https://www.cpca.org/cpca/CPCA/Training_Events/Event_Display.aspx?EventKey=1WI033120

Poll:

- Are you are currently doing telephone (only) visits based on the new guidelines from DHCS?
  - –Yes
  - –No

Medi-Cal vs Medicare

- For Medi-Cal a telephonic/virtual visit **is a reimbursable service at PPS rate** for FQHC/RHC billable providers if provided and billed consistently with in-person visit
- Medicare reimburses for Virtual check-in (i.e. 5 minute check in with patients on the phone), but **Virtual check-ins are not the same as telephonic for Medicaid under new DHCS guidance**.

COVID-19 Guidance for Telehealth and Virtual/Telephonic Communications: http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.asp

What is a telephone visit?

For Medi-Cal a telephonic/virtual visit ***is a reimbursable service at PPS rate*** for FQHC/RHC billable providers if provided and billed consistently with in-person visit

What makes a telephone visit PPS reimbursable by Medi-Cal?

For ***new*** telephonic service, FQHCs **must follow the below guidance** in order to bill at the PPS rate:

- FQHCs **must document circumstances involved** that prevent the visit from being conducted face-to-face. For example:
  - The patient is quarantined at home,
  - Local or state guidelines direct that the patient remain at home, or
  - The patient lives remotely and does not have access to the internet or the internet does not support HIPAA compliance.
- FQHC provider **must document the telephone visit to take place of a face-to-face visit** in the patient record.
- FQHC provider **must document the service is medically necessary and clinically appropriate** to be delivered via telephonic communication.

What makes a telephone visit PPS reimbursable for Medi-Cal? *(Continued)*

- FQHC provider **must meet all other procedure and technical components** similar to an in-person visit, including providing a patient history, complete description of provided services, assessment/examination notes, diagnosis, treatments, etc.
- FQHC provider **must ensure sufficient documentation be in the medical records** that satisfies the requirements of the specific CPT or HCPCS.

Medi-Cal Billing Specifications

For ***new*** telephonic services that meet the documentation criteria in the previous slides, FQHCs can bill at the PPS rate using the following mechanisms:

- Medi-Cal FFS (not Medi-Cal managed care patients)
  - Use the applicable revenue code corresponding to type of service
    - FQHCs and RHCs to bill with a Revenue Code 0521
    - Tribal 638 Clinics to bill with a Revenue Code 0520
  - Use HCPCS code T1015 in the "payable" claim line, and
  - Use the appropriate and regular CPT (E/M) code that corresponds with the level of service provided on the "informational" line
    - Note the CPT code is not for reimbursement but instead used to track telephone visits related to COVID-19

Medi-Cal Billing Specifications *(Continued)*

- Medi-Cal Managed Care Patients (Claim to Medi-Cal)
  - Bill using the applicable revenue code
  - Bill wraparound claim using procedure code T1015 SE
  - DHCS will ensure the FQHCs and RHCs are made whole with an appropriate wrap payment, consistent with existing DHCS policy

**Most MCPs are notifying providers about requirements for their encounters*

Medi-Cal Billing Specifications - POS 2 and 95/GQ Modifier

- DHCS has confirmed telephone claims sent to Medi-Cal should not be billed with POS 2 or the 95/GQ Modifier.
  - UB does not have a field for a POS

- If your MCP is requiring their encounters to have POS 2 and 95/GQ Modifier, you will need to follow their guidance.

- Health centers may need to implement a mapping that allows the POS and modifier for their MCP claims and NOT for the wrap around claims for Medi-Cal

Medi-Cal Billing Specifications

Telephonic services that do not meet the documentation guidance/criteria above will not be reimbursed at PPS rate.

Medi-Cal FFS (not Medi-Cal managed care patients)

- Use HCPCS code G0071 on the "payable" claim line and do not include a corresponding CPT code.
- The FFS rate for virtual/telephonic communications is $13.69.
- Mechanism in place allowing claims to process separate from PPS

Dental Telephone Visits

Telephonic Dental Visits

- DHCS has confirmed that a dental telephone visit does not meet all the requirements of an applicable CDT code in order to bill PPS
- FQHCs/RHCs should bill using HCPCS code G0071 ($13.69) for dental telephone visits

Telehealth (Teledentistry)

- 1135 Waiver waives existing restrictions/requirements around telehealth
  - Patients are not required to be established or with a provider to initiate an asynchronous visit
- CPCA is working to identify ways health centers can provide dental services via telehealth – *more to come in the near future*

Highlights you will find in the DHCS FAQ section

- Billing the Medi-Cal FFS rate (HCPCS code G0071) does not apply to Medi-Cal managed care
  - DHCS' updated guidance provides more details for MCP reimbursement
- Telephonic communication is not billable for RNs in a FQHC/RHC.
  - Medi-Cal has not changed its policies on billable providers for telephonic visits
- Bill a telephone visit the same as if it was in-person - the services satisfy all of the identified conditions outlined in the guidance, FQHC/RHC provider would submit claims to Medi-Cal using the applicable Revenue Code, HCPCS T1015 or T1015 SE and appropriate CPT code
- Telephone visits are still subject to the same program restrictions, limitations, and coverage that exist when the service is provided face-to-face

Highlights you will find in the DHCS FAQ section

continued

- FQHC providers that simply triage a patient-initiated telephone call for a future visit would not satisfy the criteria/guidance for being in lieu of face-to-face visit
- CPSP services via telephone
  - To be PPS billable by the provider, must meet all requirements of the corresponding CPSP covered HCPCS codes as if visit being done in-person, and satisfy all the criteria outlined in guidance

Options for Scheduling Telephone Visits

- Leave half or part of every day unstructured (both PCPs and MA/care coordinators). Phone call visits can be added during the unstructured part of the day if something is a same day/next day issue.
- Scheduled planned care telephone visits intermittently during the flow of the day.

Options for Scheduling Telephone Visits

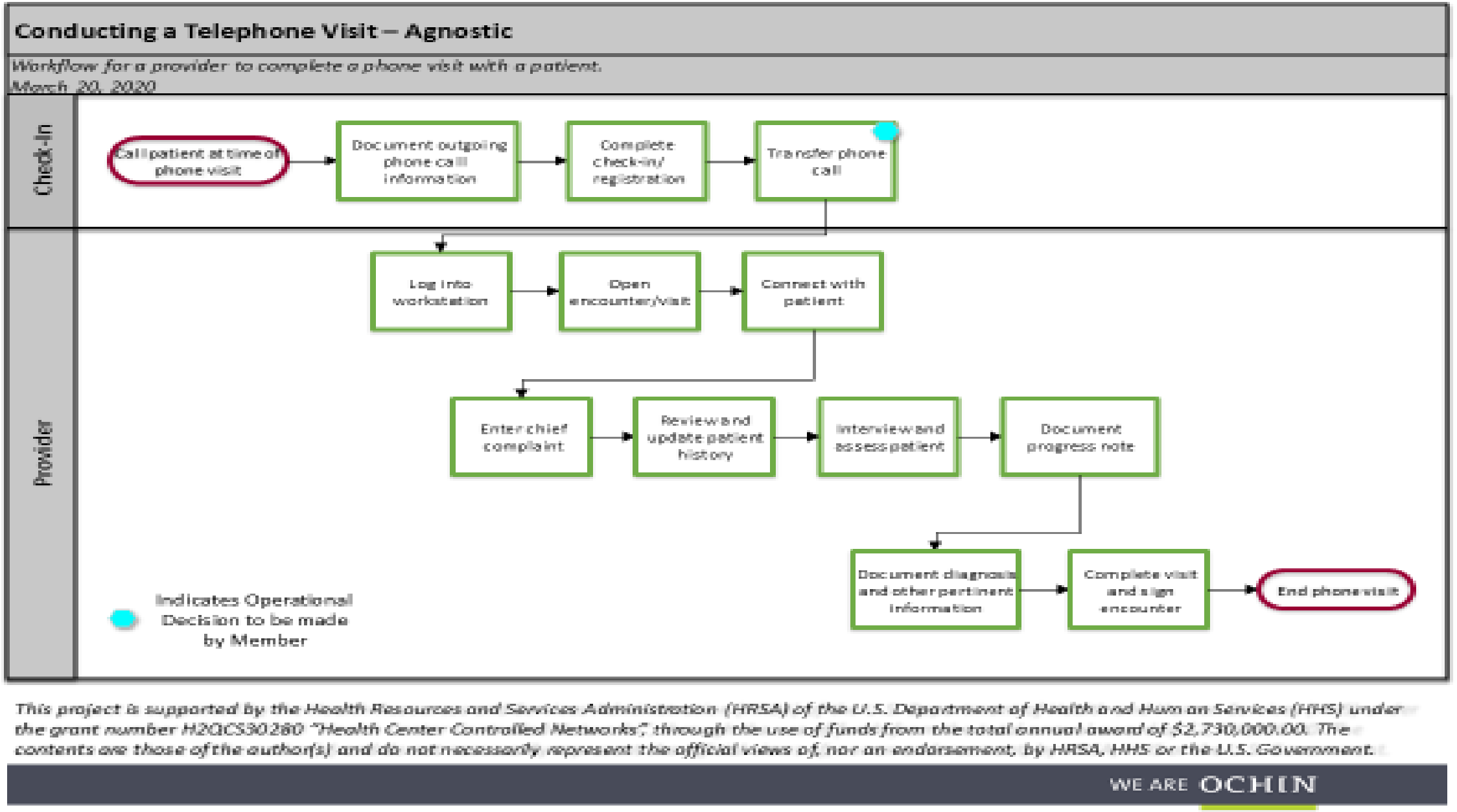
- Have specific providers assigned to do only telephone visits.
  - If you have providers that need to work from home because perhaps they are in a high risk category this could be an way to utilize those staff. Their day could be scheduled to do a series of morning phone visits, break for lunch and catch up charting from the morning and then 2 hours of calls in the afternoon with the end of the day as catch up or unexpected visits.

Cautions with Phone Visits

- Generally organizations have an MA/care coordinator take notes, which allows them to do better follow-up with whatever issue arise (fewer handoffs), plus the patient knew they heard what the visit was about, which builds trust.
- Doing continuous calls plus charting is difficult with a high number of telephone visits/hour, plus patients won't tolerate sitting in silence when the provider is charting rather than listening/responding.

Potential Best Practices

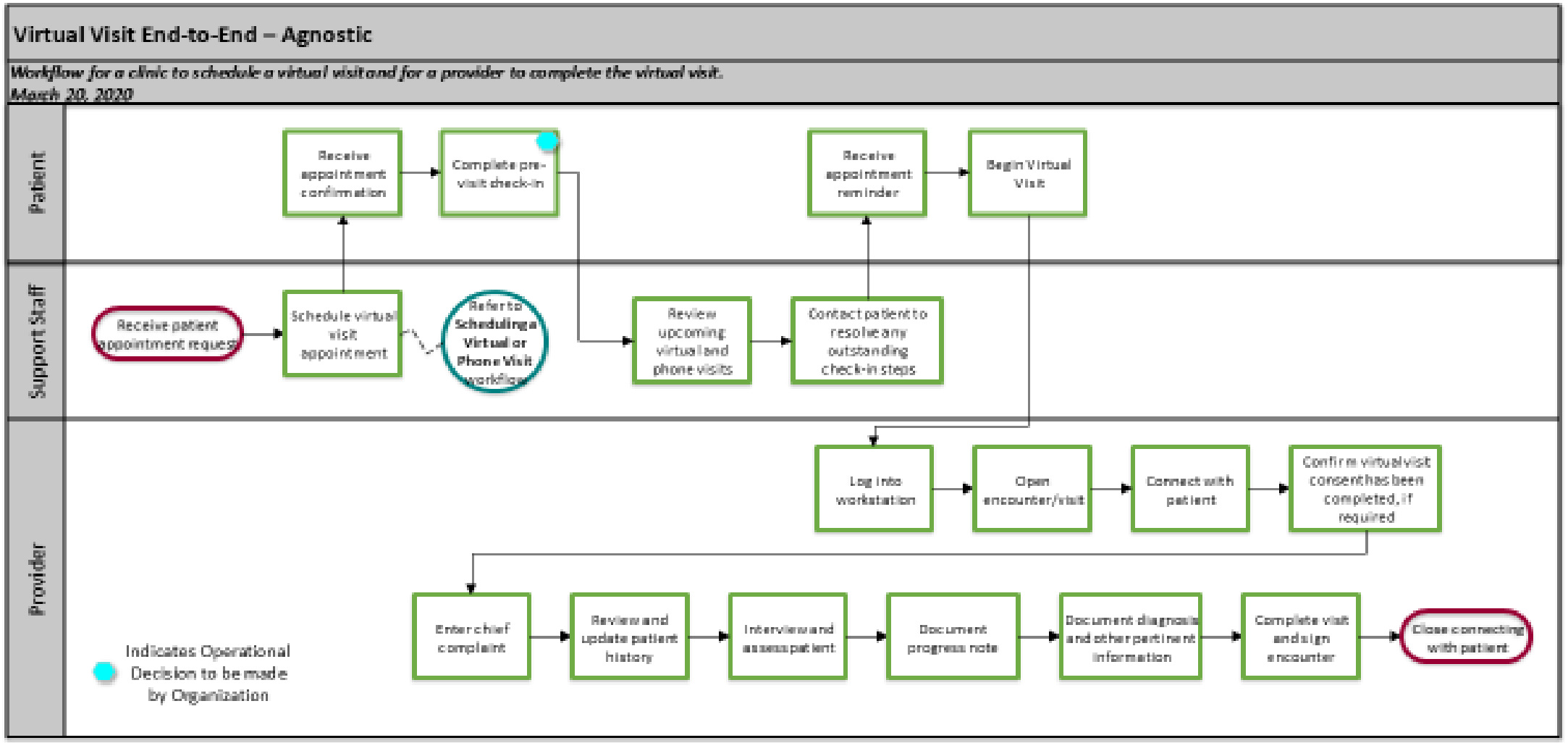
- Protect Confidentiality
- Return Calls/Keep Phone Appointments Timely
- Know your Documentation Requirements
- Provide Individualized Care
- Think Holistically
- Get Organized
- Use Teach Back Methods for Patient Education



This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the grant number H2QCS30280 "Health Center Controlled Networks", through the use of funds from the total annual award of $2,730,000.00. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

WE ARE OCHIN

https://caltrc.org/knowledge-center/covid-19-telehealth/



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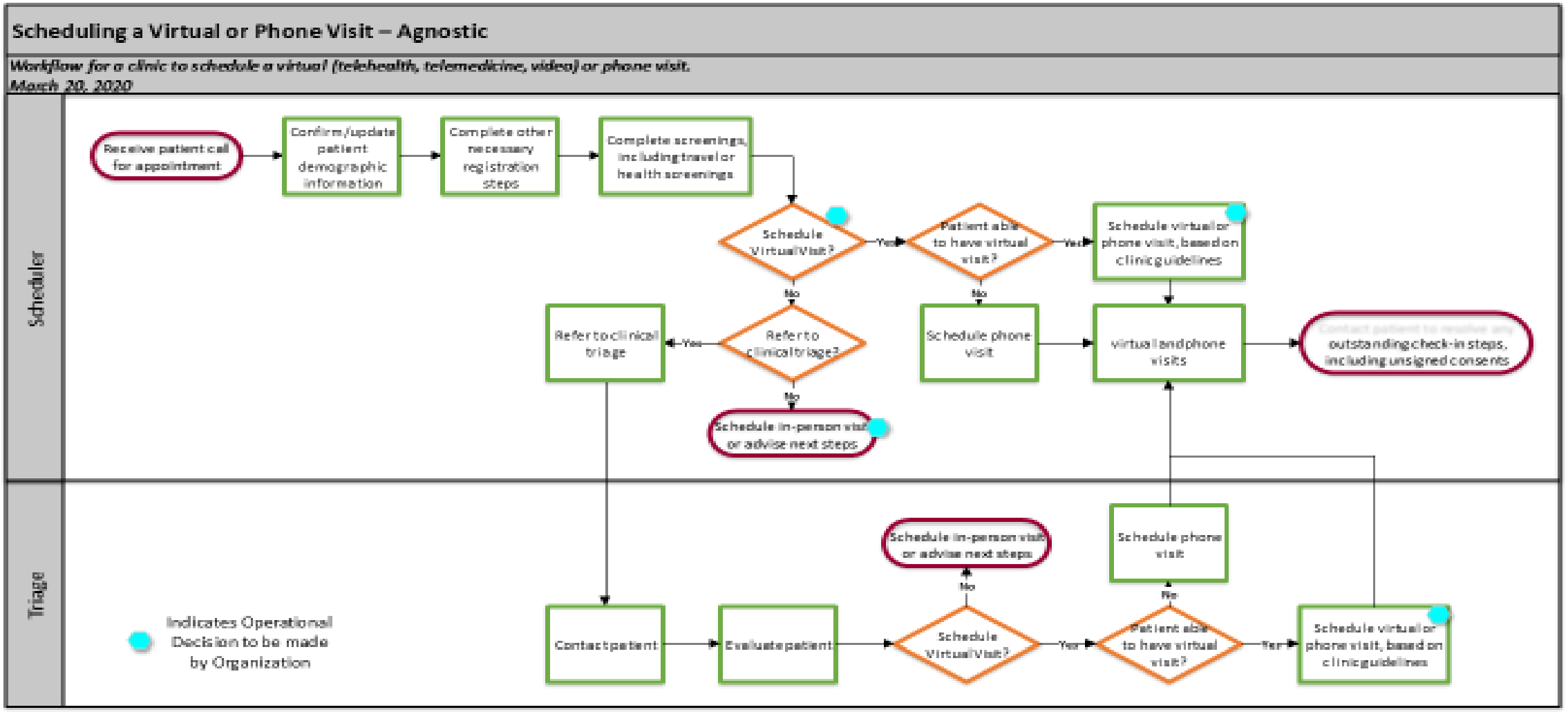
WE ARE OCHIN



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https://caltrc.org/knowledge-center/covid-19-telehealth/

Poll:

What additional support do you need for implementing telephonic visits?

1. Training for providers on how to do phone visits with doc
2. Training for MAs and other support staff on phone visits
3. Training on billing the telephonic claims
4. Other – share in the chat box


Questions are the path to learning

CPCA Contacts

- Questions on billing
  - Bao Xiong, bxiong@cpca.org
- Questions on best practices and workflows
  - Cindy Keltner, ckeltner@cpca.org
- Copies of today's webinar slides and recording will be shared
  - Charlotte Reische, creische@cpca.org

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
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GAVIN NEWSOM
GOVERNOR

Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)

March 24, 2020 (*Supersedes March 19, 2020 Guidance*)

Overview

In light of both the federal Health and Human Services Secretary's January 31, 2020, public health emergency declaration, as well as the President's March 13, 2020, national emergency declaration relative to COVID-19, the Department of Health Care Services (DHCS) is issuing additional guidance to enrolled Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists – as well as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal 638 Clinics. This guidance is relative to all of the following:

- **Section I: Current Medi-Cal Policy for Enrolled Medi-Cal Providers:** As outlined in the Medi-Cal Provider Manual (Medicine: Telehealth) and/or posted to the Medi-Cal Rates Information Page:
  - Traditional telehealth modalities, i.e., synchronous two-way interactive, audio-visual communication and asynchronous store and forward, inclusive of e-consults
  - Other virtual/telephonic communication modalities
- **Section II: Current Medi-Cal Policy for FQHCs, RHCs, Tribal 638 Clinics:** As outlined in various sections of the Medi-Cal Provider Manual (Federally Qualified Health Centers/Rural Health Clinics, and Indian Health Services Memorandum of Agreement 638 Clinics), and/or posted to the Medi-Cal Rates Information Page:
  - Traditional telehealth modalities, i.e., synchronous two-way interactive, audio-visual communication and asynchronous store and forward.
- **Section III: DHCS' Section 1135 Waiver Request Related to the Novel Coronavirus Disease (COVID-19), Submitted March 16, 2020**
  - Additional flexibilities and options relative to traditional telehealth modalities, i.e., synchronous two-way, audio-visual communication and asynchronous store and forward, inclusive of e-consults
  - Additional flexibilities and options relative to other virtual/telephonic communication modalities

Frequently Asked Questions (FAQ)

DHCS compiled a list of "Frequently Asked Questions" (FAQ) with responses below to provide additional guidance and clarification to Medi-Cal providers regarding both the

current telehealth and virtual/telephonic communications outlined in Sections I and II as well as the Section 1135 Waiver temporary flexibilities relative to telehealth and virtual/telephonic communications outlined in Section III. As DHCS receives additional questions, the FAQ section will continue to be updated.

SECTION I: CURRENT MEDI-CAL POLICY FOR ENROLLED MEDI-CAL PROVIDERS

Traditional Telehealth - Overview

For enrolled Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists, etc., the below policy applies. Please note that this does not apply to FQHCs, RHCs, and Tribal 638 Clinics, for which the policy is described below.

- Medi-Cal providers may bill DHCS or their managed care plan as appropriate for any covered Medi-Cal benefits or services using the appropriate procedure codes, i.e., Current Procedural Terminology (CPT) or Health Care Procedures Coding System (HCPS) codes, as defined by the American Medical Association (AMA) in the most current version of the billing manual that are appropriate to be provided via a telehealth modality. The CPT or HCPCS code(s) must be billed using Place of Service Code "02" as well as the appropriate telehealth modifier, as follows:
    - Synchronous, interactive audio and telecommunications systems: Modifier 95
    - Asynchronous store and forward telecommunications systems: Modifier GQ

  Please note that DHCS will use the telehealth modifiers to identify that the Medi-Cal covered benefit or service was provided via a telehealth modality for tracking and reporting purposes relative to COVID-19. As a result, DHCS requests that all providers ensure the appropriate modifier is included on all submitted claims.

Behavioral health exception: As described in Behavioral Health Information Notice 20-009, Specialty Mental Health providers should add the modifier GT for SMHS services provided via a telehealth or telephone modality. Drug Medi-Cal Organized Delivery System (DMC-ODS) services provided via a telehealth or telephone modality do not require a modifier.

Synchronous Telehealth

Medi-Cal benefits or services, inclusive of things such as medical, mental health, substance use disorder, and more, provided via a synchronous telehealth modality (two-way interactive, audio-visual communication) must meet all of the below criteria. Please note the teledentistry policy is included separately below.

- The treating health care practitioner at the distant site believes that the Medi-Cal benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth, subject to oral or written consent by the beneficiary. Below are some examples (not exhaustive) of benefits or services that would not be appropriate for a delivery via a telehealth modality:
    - Benefits or services that are performed in an operating room or while the patient is under anesthesia

    - Benefits or services that require direct visualization or instrumentation of bodily structures
    - Benefits or services that involve sampling of tissue or insertion/removal of medical devices
    - Benefits or services that otherwise require the in-person presence of the patient for any reason
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the AMA, associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual.
- The benefits or services provided via telehealth satisfies all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render limited services via synchronous/live transmission teledentistry, so long as such services are within their scope of practice, when billed using Current Dental Terminology (CDT) code D9999 for dates of service on or before May 15, 2020. For dates of service on or after May 16, 2020, CDT code D9999 is being replaced with CDT code D9995. The following is Medi-Cal's teledentistry policy for synchronous/live transmissions.

- CDT code D9999 is reimbursed at 24 cents per minute, up to a maximum of 90 minutes, i.e., up to $21.60 maximum reimbursement. CDT code D9999 may only be used once per date of service per beneficiary, per provider. As noted above, CDT code D9999 is being replaced with CDT code D9995, as of May 16, 2020.

<u>Asynchronous Store and Forward, inclusive of E-Consults</u>
Medi-Cal benefits or services including, but not limited to, teleophthalmology, teledermatology, teledentistry, and teleradiology, may be provided via asynchronous store and forward, including E-Consults, when all of the following criteria are satisfied:

- Health care practitioners must ensure that the documentation, typically images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the CPT or HCPCS code that is billed.

<u>E-Consults</u>
For e-consults, the health care practitioner at the distant site (consultant) may use the following CPT code in conjunction with the modifier GQ:

- CPT Code 99451: Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render, so long as such services are within their scope of practice, limited services via asynchronous store and forward using CDT code D9996, which identifies the services as teledentistry. CDT code D9996 is not reimbursable; instead, the billing dental provider would be reimbursed based upon the applicable CDT procedure code to be paid according to the Schedule of Maximum Allowance (SMA). The following CDT codes may be billed under Medi-Cal's teledentistry policy for asynchronous store and forward:

- D0120: Periodic oral evaluation — established patient
- D0150: Comprehensive oral evaluation – new or established patient
- D0210: Intraoral — complete series of radiographic images
- D0220: Intraoral — periapical first radiographic image
- D0230: Intraoral — periapical each additional radiographic image
- D0240: Intraoral — occlusal radiographic image
- D0270: Bitewing — single radiographic image
- D0272: Bitewings — two radiographic images
- D0274: Bitewings — four radiographic images
- D0330: Panoramic radiographic image
- D0350: Oral/Facial photographic images

Originating Site and Transmission Fee

The originating site facility fee is reimbursable only to the originating site when billed with HCPCS code Q3014 (telehealth originating site facility fee). Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with HCPCS code T1014 (telehealth transmission, per minute, professional services bill separately).

Restrictions for billing originating site fee and transmission costs are as follows:

- HCPCS code Q3014 – Billable by originating site; once per day; same patient, same provider.
- HCPCS code T1014 – Originating site and distant site; maximum of 90 minutes per day (1 unit = 1 minute), same patient, same provider
- Originating site fee and transmission costs are not available for telephonic services.

If billing store and forward, including e-consult, providers at the originating site may bill the originating site fee with HCPCS code Q3014, but may not bill for the transmission fee. Please note, the originating site and transmission fee restrictions are not applicable for FQHCs, RHCs or Tribal 638 clinics.

Other Virtual/Telephonic Communication

For enrolled Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists, etc., the below policy applies.

Virtual/telephonic communication includes a brief communication with another practitioner or with a patient, who in the case of COVID-19, cannot or should not be

physically present (face-to-face). Medi-Cal providers may be reimbursed using the below Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications.

- HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
    - Medi-Cal Fee-For-Service (FFS) Rate: $10.87
- HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.
    - Medi-Cal FFS Rate: $12.48

Behavioral health exception: As described in Behavioral Health Information Notice 20-009, Specialty Mental Health providers should add the modifier GT for SMHS services provided via a telehealth or telephone modality. DMC-ODS services provided via a telehealth or telephone modality do not require a modifier.

SECTION II: CURRENT MEDI-CAL POLICY FOR FQHCs, RHCs, TRIBAL 638 CLINICS

Traditional Telehealth (Synchronous or Asynchronous)

For FQHCs, RHCs, and Tribal 638 Clinics, billable providers may provide Medi-Cal covered benefits or services via synchronous telehealth (audio-visual, two-way communication) to “established” patients. Please note that services rendered via telehealth must be FQHC, RHC, or Tribal 638 covered services.

- **Synchronous Telehealth:** Services provided through synchronous telehealth for an “established patient” are subject to the same program restrictions, limitations, and coverage that exist when the service is provided in-person. For purposes of FQHCs, RHCs, and Tribal 638 Clinics, “established patients” are defined as follows:
    - In FFS, “established patients” are those who have been seen at the FQHC, RHC, or Tribal 638 Clinic within the last three (3) years.
    - In Managed Care, if the patient is “assigned” by the Medi-Cal managed care plan (MCP) to a particular clinic, then the patient is considered to be “established” even if s/he has never been seen in the FQHC, RHC, or Tribal 638 Clinic. Please note that the majority of clients are MC, so the majority would be assigned and eligible to receive Medi-Cal covered benefits and services via a synchronous telehealth modality.

  For Medi-Cal covered benefits or services that may be provided via synchronous telehealth, FQHCs, RHCs, and Tribal 638 Clinics would bill using the applicable Revenue Code and HCPCS code, as described below in detail, which would be

paid at the Prospective Payment System (PPS) or All-Inclusive Rate (AIR), respectively. Below is a non-exhaustive list of examples based upon the type of service being provided:

- For medical visits and mental health visits, FQHCs and RHCs bill using Revenue Code 0521 and T1015 for Medi-Cal FFS and T1015SE for managed care.
- For medical visits, Tribal 638 Clinics bill using Revenue Code 0520 and T1015 for Medi-Cal FFS. Managed care visits should be billed consistent with existing DHCS policy.
- For mental health visits, Tribal 638 Clinics bill with Revenue Code 0561 and the appropriate modifier corresponding to the practitioner providing the services.
- For drug and alcohol visits, Tribal 638 Clinics bill using Revenue Code 0520 and HCPCS code H0047

Please note that outside of the four walls of the FQHC, RHC, or Tribal 638 Clinic, Medi-Cal covered benefits or services may be provided via synchronous telehealth for certain populations pursuant to applicable federal law, including migrant/seasonal workers, homeless individuals, and homebound individuals Note: Tribal 638 Clinics can provide services outside of the four walls to homeless individuals only.

- **Asynchronous Store and Forward:** For FQHCs, RHCs, and Tribal 638 Clinics, billable providers may provide services via asynchronous store and forward to "established" patients, as defined above. Asynchronous store and forward can be used to provide teledermatology, teleophthalmology, teledentistry via store and forward, using the applicable Revenue Code and HCPCS or CPT codes.

  <u>E-Consults and Other Virtual/Telephonic Communication</u>
  FQHCs, RHCs, and Tribal 638 Clinics cannot bill for e-consult or virtual/telephonic communication visits.

  <u>Originating Site and Transmission Fee</u>
  FQHCs, RHCs, and Tribal 638 Clinics are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the PPS/AIR rate, as applicable.

SECTION III: DHCS' SECTION 1135 WAIVER REQUEST RELATED TO COVID-19

<u>Overview</u>
DHCS has requested additional flexibilities in terms of the available modalities for delivering Medi-Cal covered benefits and services, as part of its Section 1135 Waiver. DHCS recognizes that in addition to traditional telehealth/telemedicine modalities (i.e., synchronous two-way interactive, audio-visual communication, and/or asynchronous store and forward/e-consults), as outlined in existing Medi-Cal coverage policy and above, there are extraordinary circumstances under which both face-to-face visits as well as traditional telehealth modalities are not an option.

Under these limited and extraordinary instances (such as COVID-19), DHCS recognizes the need for Medi-Cal providers – including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, FQHCs, RHCs, and Tribal 638 Clinics – to utilize other methods such as telehealth and virtual/telephonic communication to provide medically necessary health care services.

Unless otherwise agreed to by the Managed Care Plans (MCP) and provider, DHCS and MCPs must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. DHCS and MCPs must provide the same amount of reimbursement for a service rendered via telephone or virtual communication, as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

<u>Other Virtual/Telephonic Communications</u>
Medi-Cal providers, – including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, FQHCs, RHCs, and Tribal 638 Clinics, will provide and bill for virtual/telephonic visits consistent with in person visits as follows:

- For Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, bill using the appropriate and regular CPT or HCPCS codes that would correspond to the visit being done in-person, and include POS 02 and Modifier 95
- For FQHCs, RHCs, and Tribal 638 Clinics, bill using the applicable revenue code and HCPCS code, as per standard billing procedure, as well as the corresponding CPT code on the "informational line", as described below in detail. Below is a non-exhaustive list of examples based upon the type of service being provided:
    - For medical visits and mental health visits, FQHCs and RHCs bill using Revenue Code 0521 and T1015 for Medi-Cal FFS and T1015SE for managed care.
    - For medical visits, Tribal 638 Clinics bill using Revenue Code 0520 and T1015 for Medi-Cal FFS. Managed care visits should be billed consistent with existing DHCS policy.
    - For mental health visits, Tribal 638 Clinics bill with Revenue Code 0561 and the appropriate modifier corresponding to the practitioner providing the services.
    - For drug and alcohol visits, Tribal 638 Clinics bill using Revenue Code 0520 and HCPCS code H0047

Please note that for all services, the virtual/telephonic visit must meet all requirements of the billed CPT or HCPCS code and must meet the following conditions:

- There are documented circumstances involved that prevent the visit from being conducted face-to-face, such as the patient is quarantined at home, local or state guidelines direct that the patient remain at home, the patient lives remotely and does not have access to the internet or the internet does not support Health Insurance Portability and Accountability Act (HIPAA) compliance, etc.

- The treating health care practitioner is intending for the virtual/telephone encounter to take the place of a face-to-face visit, and documents this in the patient's medical record.
- The treating health care practitioner believes that the Medi-Cal covered service or benefit being provided are medically necessary.
- The Medi-Cal covered service or benefit being provided is clinically appropriate to be delivered via virtual/telephonic communication, and does not require the physical presence of the patient.
- The treating health care practitioner satisfies all of the procedural and technical components of the Medi-Cal covered service or benefit being provided except for the face-to-face component, which would include but not be limited to:
    - a detailed patient history
    - a complete description of what Medi-Cal covered benefit or service was provided
    - an assessment/examination of the issues being raised by the patient
    - medical decision-making by the health care practitioner of low, moderate, or high complexity, as applicable, which should include items such as pertinent diagnosis(es) at the conclusion of the visit, and any recommendations for diagnostic studies, follow-up or treatments, including prescriptions

Sufficient documentation must be in the medical record that satisfies the requirements of the specific CPT or HCPCS code utilized. The provider can then bill DHCS or the MCP as appropriate.

For virtual/telephonic visits that do not meet the requirements above, the billing entity should bill the corresponding virtual/telephonic visit CPT or HCPCS code(s) listed in Section I and will be reimbursed the Medi-Cal FFS rate on file for the applicable procedure code or bill their managed care plan as appropriate.

The information below is specific to FQHCs, RHCs and Tribal 638 clinics that had additional restrictions related to their ability to provide telehealth or virtual/telephonic services.

Traditional Telehealth (Synchronous / Asynchronous) for FQHCs, RHCs and Tribal 638 Clinics

For Medi-Cal covered benefits and services provided via traditional telehealth (synchronous, two-way interactive, audio-visual communication, or asynchronous store and forward), DHCS has proposed to waive through its Section 1135 Waiver request existing restrictions/requirements in Medi-Cal's current telehealth policy due to various federal laws/Medicaid State Plan language, relative to "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. Waiving these limitations will allow FQHCs, RHCs, and Tribal 638 Clinics greater flexibility under DHCS' existing telehealth policy, which is described above.

Billing & Procedure Coding Requirements for Virtual/Telephonic Communications
Where FQHCs, RHCs, and Tribal 638 Clinics satisfy the above guidelines/criteria, those entities will be able to bill the Prospective Payment System (PPS) rate or All-Inclusive

Rate (AIR), as applicable. Below is a chart that outlines the associated procedure codes (i.e., HCPCS or CPT codes) for purposes of billing either the Medi-Cal FFS rate or PPS/AIR rate, as applicable.

Satisfies Guidance/Criteria					**Does not Satisfy Guidance/Criteria**
PPS/AIR Rate					**FFS Rate**
Applicable Revenue Code*	**+**	**HCPCS code T1015* (FFS)/ T1015 SE (Managed Care)*** **	**+**	**CPT code 99201-99205** (new patient) **CPT code 99211-99215** (established patient)	**HCPCS code G0071**** ($13.69)

**Corresponding to the type of service being provided, e.g., medical, mental health, alcohol and drug, etc., and whether by an FQHC/RHC or Tribal 638 Clinic*
** T1015 *Clinic visit/encounter, for PPS and AIR*
****T1015 SE for PPS Wrap for FQHCs and RHCs only.*
*****Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an FQHC/RHC/Tribal 638 Clinic practitioner and new or established patient, or 5 minutes or more of remote evaluation of recorded video and/or images*

- Medi-Cal FFS: For the PPS/AIR rate, FQHCs, RHCs, and Tribal 638 Clinics would need to list HCPCS code T1015 in the "payable" claim line in conjunction with one of the appropriate corresponding CPT codes (i.e., 99201-99203 for "new" patients, and 99212-99214 for "established patients) on the "informational" line relative to the complexity of the virtual/telephonic communication. Please note that the corresponding CPT codes are not separately reimbursed, but instead will be used to identify the virtual/telephonic communication visit as well as by DHCS for tracking and reporting purposes related to COVID-19. Clinics should review the billing guidelines in the Indian Health or FQHC/RHC provider manual. For the Medi-Cal FFS rate when billing with the HCPCS code G0071, clinics should only list the HCPCS code on the "payable" claim line and should not include a corresponding CPT code.
- Medi-Cal Managed Care: FQHCs, RHCs, and Tribal 638 Clinics would receive the PPS rate or AIR, as applicable, for rendering a Medi-Cal covered benefit or service – whether provided through telehealth or virtual/telephonic communication – if they meet the above-established criteria/guidance. DHCS will ensure the FQHCs and RHCs are made whole with an appropriate wrap payment, consistent with existing DHCS policy. Likewise, Tribal 638 Clinics will be reimbursed the AIR consistent with existing DHCS policy.

Frequently Asked Questions

(Current as of March 24, 2020)

CURRENT MEDI-CAL TELEHEALTH AND VIRTUAL/TELEPHONIC COMMUNICATION POLICY

1. **Does Medi-Cal allow FQHCs, RHCs, and Tribal 638 Clinics to provide covered services via telehealth?**
   Yes, billable providers may utilize a telehealth modality to provide FQHC, RHC, or Tribal 638 covered services via synchronous telehealth (audio-visual, two-way communication) to "established" patients. Please see the Provider Manuals for RHCs, FQHCs and Tribal 638 Clinics for scenarios about billing for services provided by telehealth.

2. **Do FQHCs, RHCs, or Tribal 638 Clinics bill their telehealth claims the same as if the visit was in-person?**
   Yes, FQHC, RHC, or Tribal 638 covered services provided via a synchronous telehealth modality to an established patient are subject to the same program restrictions, limitations, and coverage that exist when the service is provided in-person.

3. **Can FQHCs, RHCs, and Tribal 638 Clinics bill for originating site or transmission fees?**
   No, FQHCs, RHCs, and Tribal 638 Clinics may not bill for originating site or transmission fees.

4. **Can FQHCs, RHCs, and Tribal 638 Clinics bill for e-consults?**
   No, FQHCs, RHCs, and Tribal 638 Clinics may not bill for e-consults.

5. **Can FQHCs, RHCs, and Tribal 638 Clinics submit claims for Medi-Cal covered benefits or services provided via a virtual/telephonic communication modality using HCPCS codes G2012 or G2010 and be paid?**
   No. FQHCs, RHCs, and Tribal 638 Clinics cannot bill using HCPCS codes G2012 or G2010.

6. **Are Medi-Cal covered Comprehensive Perinatal Services Program (CPSP) services able to be provided via telehealth?**
   Yes. Medi-Cal's telehealth policy applies to all Medi-Cal providers – which includes CPSP providers – subject to any specific requirements and/or limitations as articulated in the policy.

(Continued on next page)

ADDITIONAL SECTION 1135 WAIVER TEMPORARY FLEXIBILITIES FOR TELEHEALTH AND VIRTUAL/TELEPHONIC COMMUNICATIONS

7. **Are any existing Health Insurance Portability and Accountability Act (HIPPA) requirements relaxed during the COVID-19 situation?**
   Yes. On March 17, 2020, the federal Health and Human Service agency issued a limited waiver of certain HIPAA sanctions to improve data sharing and patient care during the pandemic. Similarly, on March 18, 2020, HHS' Office for Civil Rights announced it would not impose penalties for noncompliance with HIPAA regulations against providers leveraging telehealth platforms that may not comply with the privacy rule during the COVID-19 pandemic. DHCS recommends you review that guidance relative to providing services via telehealth and virtual/telephonic communications during the COVID-19 situation.

8. **Can physicians/health care practitioners in a FQHC, RHC, and Tribal 638 Clinic provide FQHC, RHC, Tribal 638 covered services via a virtual/telephonic communication and receive the Medi-Cal fee-for-service (FFS) rate for HCPCS code G0071?**
   Yes, the billing/reimbursement policy for HCPCS code G0071 applies to Medi-Cal FFS. For the Medi-Cal FFS rate when billing with HCPCS code G0071, FQHC, RHC, and Tribal 638 Clinic should only list the HCPCS code on the "payable" claim line and should not include a corresponding CPT code.

9. **Can physicians/health care practitioners in FQHCs, RHCs, and Tribal 638 Clinics provide FQHC, RHC, Tribal 638 covered services via a virtual/telephonic communication and receive the Medi-Cal FFS rate for HCPCS code G0071 in the managed care delivery system? For example, if the patient were enrolled in managed care, then the Medi-Cal MCP would be billed.**
   No, the billing/reimbursement policy for HCPCS code G0071 does not apply to Medi-Cal managed care; however, unless otherwise agreed to by the MCP and the provider, MCPs must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim.

   Further, please note that MCPs must offer members and providers the option to utilize telehealth services to deliver care when medically appropriate. In addition, MCPs must act proactively to ensure members can access all medically necessary screening and testing of COVID-19, which includes working with their contracted providers to use telehealth services to deliver care when medically appropriate, as a means to limit members' exposure to others who may be infected with COVID-19, and to increase provider capacity. Additionally, DHCS strongly encourages MCPs to offer covered benefits and services utilizing telehealth and other virtual/telephonic communication modalities, and must be compliant with existing timely access standards. For more information, please refer to Supplement to All Plan Letter 19-009, which discusses reimbursement requirements relative to MCPs, as well as DHCS' March 16, 2020 Memorandum to all Medi-Cal MCPs, which also discusses telehealth.

10. **Are Registered Nurses (RNs) able to provide Medi-Cal covered benefits or services via a virtual/telephonic communication modality and bill the Medi-Cal FFS rate?**
No. Virtual/telephonic communication modalities are billable by FQHCs, RHCs, and Tribal 638 Clinics only when the discussion requires the skill level of an FQHC, RHC, or Tribal 638 practitioner, which includes physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers, and marriage and family therapist. If the virtual/telephonic communication were conducted by a RN, health educator, or other clinical personnel, it would not be billable. Medi-Cal has not changed its policies on billable providers/practitioners.

11. **Are licensed Vocational Nurses (LVNs) able to provide Medi-Cal covered benefits or services via a virtual/telephonic communication modality and bill the Medi-Cal FFS rate?**
No, virtual/telephonic communication modalities are billable by FQHCs, RHCs, and Tribal 638 Clinics only when the discussion requires the skill level of an FQHC, RHC, or Tribal 638 practitioner, which includes physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers, and marriage and family therapist. If the virtual/telephonic communication were conducted by a LVN, health educator, or other clinical personnel, it would not be billable. Medi-Cal has not changed its policies on billable providers/practitioners.

12. **Do FQHCs, RHCs, or Tribal 638 Clinics bill using Place of Service (POS) Code 02 and/or Modifier 95 modifier for telehealth claims?**
No, FQHC, RHC, and Tribal 638 Clinics do not bill with POS 02 or Modifier 95.

13. **Do FQHCs, RHCs, or Tribal 638 Clinics bill covered services provided via a virtual/telephonic communication modality the same as if it was in-person?**
Yes, if the services provided satisfy all of the identified conditions outlined in the above Section III guidance then the FQHC, RHC, or Tribal 638 provider would submit claims using the applicable Revenue Code, HCPCS T1015 or T1015 SE (managed care patient only), and appropriate CPT code for reimbursement at PPS/AIR. In those instances, FQHC, RHC, or Tribal 638 covered services provided via a virtual/telephonic communication modality are subject to the same program restrictions, limitations, and coverage that exist when the service is provided face-to-face.

14. **Can FQHCs, RHCs, or Tribal 638 Clinics bill for a RN's telephone visit (Medi-Cal FFS beneficiary) and an eligible PPS/AIR visit with a billable provider for the same patient on the same day?**
No, RN visits are not reimbursable in FQHCs, RHCs, or Tribal 638 Clinics. Additionally, physicians/health care practitioners who simply triage a patient-initiated telephone call for a future visit would not satisfy the criteria/guidance for being in lieu of a face-to-face visit, and thus not be eligible for reimbursement at PPS/AIR, as applicable. In that case, FQHCs, RHCs, and Tribal 638 Clinics would bill for services delivered to fee for service patient using HCPCS G0071 code, and be reimbursed at $13.69, for the telephone call. That said, a subsequent physician's visit either face-to-face or via telehealth that meets all of the

criteria/guidance for being lieu of a face-to-face visit, would be eligible for reimbursement at PPS/AIR, as applicable.

15. **How should FQHCs, RHCs, and Tribal 638 Clinics bill for virtual/telephonic communications when the service satisfies criteria/guidance, as outlined in Section III, for being in lieu of a face-to-face visit?**
For purposes of the temporary flexibilities under this policy, FQHCs and RHCs would continue to bill with a Revenue Code (0521) in conjunction with a HCPCS code (T1015/T1015 SE), but would also include the appropriate corresponding CPT codes (i.e., 99201-99205 for "new" patients, and 99211-99215 for "established" patients) on the "informational" line relative to the complexity of the virtual/telephonic communication.

Similarly, for purposes of the temporary flexibilities under this policy, Tribal 638 Clinics would continue to bill with a Revenue Code (0520) in conjunction with a HCPCS code (T1015), but would also include the appropriate corresponding CPT codes (i.e., 99201-99205 for "new" patients, and 99211-99215 for "established patients") on the "informational" line relative to the complexity of the virtual/telephonic communication.

16. **How do FQHCs, RHCs, or Tribal 638 Clinics bill for virtual/telephonic communications when the service does not satisfy the criteria/guidance, as outlined in Section III, for being in lieu of an in-person visit?**
DHCS will establish a method to enable FQHCs, RHCs, and Tribal 638 Clinics to bill for appropriate Medi-Cal covered benefits or services provided via a virtual/telephonic communication modality for Medi-Cal FFS beneficiaries utilizing HCPCS code G0071 when the service does not meet the Section III criteria/guidelines for reimbursement at the PPS/AIR. This method will allow for claiming separate from the PPS/AIR. In Medi-Cal managed care, unless otherwise agreed to by the MCP and FQHC, RHC, or Tribal 638 Clinic, MCPs must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim.

17. **How should FQHCs, RHCs, and Tribal 638 Clinics bill for a dental visit provided via a virtual/ telephonic communication modality?**
For dental services provided via a virtual/telephonic communication modality, FQHCs, RHCs, and Tribal 638 Clinics should bill using HCPCS code G0071 ($13.69) since dental services provided via virtual/telephonic communication would not meet all requirements of the applicable CDT code that would correspond to the visit being done in-person, and would also not satisfy all of the identified conditions outlined in the guidance. As a result, it would not be appropriate to bill using Local Code 03 (dental visit) and be reimbursed at PPS/AIR.

18. **For specialty services, such as prenatal visits, behavioral health, etc., provided via virtual/telephonic communication modalities, how should FQHCs, RHCs, and Tribal 638 Clinics bill?**
Please see response to question 15 above.

19. **Can Medi-Cal covered CPSP services be provided via a virtual/telephonic communication modality?**
    In order for a CPSP service via virtual/telephonic communication to be billed and reimbursed at PPS/AIR, it would have to be rendered by a billable provider, meet all requirements of the corresponding CPSP-covered HCPCS codes that would correspond to the visit being done in-person, and satisfy all of the identified conditions outlined in the above Section III guidance. If the CPSP visit does not satisfy the conditions for a face-to-face visit, FQHC, RHC, Tribal 638 Clinics can be reimbursed using HCPCS code G0071 ($13.69) for FFS patients.

20. **Where can I find information specific to Specialty Mental Health Services (SMHS), i.e. those contracted with county Mental Health Plans, and the Drug Medi-Cal Organized Delivery System (DMC-ODS)?**
    For information specific to SMHS and DMC-ODS, please see Behavioral Health Information Notice 20-009 and FAQs on the DHCS COVID-19 Response website.

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COVID-19 (Coronavirus) Questions and Answers

What you need to know to address COVID-19

Health Net* continues to closely monitor the evolving COVID-19 pandemic. We are committed to providing you with important information and public health guidance from various public health agencies as it's released to ensure we can quickly address and support the prevention, screening and treatment of COVID-19.

In order to provide you with real-time updates and information, we are posting *COVID-19 (Coronavirus) Questions and Answers for Health Net of California Network Providers* on the provider portal on the provider alerts page. This approach allows us to make immediate changes to the questions and answers (Q&As) in real time. The alerts page allows you to access all updates about COVID-19 digitally in one location without delay and is your best source to stay abreast of critical information.

For a list of updated Q&As regarding the following topics on COVID-19, go to **provider.healthnet.com** and access the *Health Net Alerts: COVID-19* link in the yellow bar > *COVID-19 (Coronavirus) Questions and Answers for Health Net of California Network Providers*.

- Mitigating risk to operations – business continuity
- Access to telehealth services
- COVID-19 testing and screening billing information
  - Billing codes (HCPCS/CPT)
  - Diagnoses codes
  - Claims filing timelines
  - Balance billing
- Screening and testing
  - Prior authorization, precertification, prior notification, or step therapy protocols
  - Cost-share amounts for screening and testing
  - Where to go for testing
  - Screening and testing guidelines
- Prescription information
- Coping assistance for members
- Offices and facilities impacted by COVID-19
- Where to obtain the latest information and guidance on COVID-19
- Additional information, requirements and guidance

For questions, contact the applicable Health Net Provider Services Center listed in the right-hand column. We will continue to update the Q&As as more information becomes available.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- HMO/POS/HSP
- PPO
- EPO
- Medicare Advantage (HMO)
- Medi-Cal
  - Kern
  - Los Angeles
    - Molina
  - Riverside
  - Sacramento
  - San Bernardino
  - San Diego
  - San Joaquin
  - Stanislaus
  - Tulare

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Health Net

COVID-19 (Coronavirus)
Questions and Answers
for
Health Net of California Network Providers

HEALTH NET'S BUSINESS CONTINUITY PLAN

What is Health Net doing to mitigate risk to its operations?

As the COVID-19 situation escalates, we have taken the necessary steps to ensure the health of our employees so they can continue to perform their important work, and protect our business operations through actions such as implementing work from home policies where possible, providing enabling technology and limiting travel.

These and other measures further reinforce existing contingency plans Health Net has in place to preserve operations, provide our employees with the resources they need to stay safe, and support the health and well-being of our members during this critical time.

While this pandemic is unprecedented, we are prepared for this challenge through our long-standing business continuity plans that safeguard the integrity of our operations.

As we have experienced in recent years as a result of seasonal wildfires and other natural disasters, Health Net regularly reviews and updates its emergency business continuity protocols. As part of these efforts, we continue to measure and refine our call center, utilization management and claims processing operations. We are doing everything we can during the nationally declared emergency for COVID-19 to support ongoing operations. In particular:

- Health Net's Provider Network Management (PNM) and Provider Relations personnel remain available to providers, with no current impact in their ability to assist with provider issues.
    - However, on-site meetings are being replaced with telephonic and other forms of support.
- Our key operational units will continue to provide updates to PNM leadership if and when challenges arise.
- We have created the following website link, "*Health Net Alerts: COVID-19*," on provider.healthnet.com to provide regular updates.

TELEHEALTH

Will Health Net allow access to telehealth services to increase access to care? And what is the reimbursement rate?

To limit members' risk of COVID-19 infection, Health Net encourages use of telehealth to deliver care when medically appropriate and capable through telehealth modalities for all services.

During the course of this declaration of emergency for Commercial and Medi-Cal members, Health Net's coverage for telehealth services will be temporarily expanded in accordance with regulatory requirements, and

will be reimbursed whether the telehealth service is delivered via audio/video technology or via audio-only technology (when deemed medically appropriate for the patient's medical condition).

During the course of this declaration of emergency for Medicare and MMP/Cal MediConnect members, Health Net's coverage for telehealth services will follow guidance released by CMS which includes telecommunications involving **both** audio and video technology (with the only exception being for "virtual check-ins", which is defined in the CMS fact sheet available in the online link immediately below).

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Health Net will reimburse fee-for-service providers the same contracted rate, whether service is provided in person or through telehealth technology.
- Services that cannot be appropriately delivered remotely are not eligible for telehealth coverage and reimbursement.
- Capitated physician groups or IPAs are required to support, cover and enable telehealth services and to abide by regulatory requirements for coverage and payment of telehealth services as outlined above.

In addition to telehealth services offered through our network of providers, Health Net is diligently working to offer expanded access to telehealth services through third parties. We will provide updated information on vendor arrangements once available.

Additional details on telehealth billing and coverage requirements for commercial, Medicare and Medi-Cal products will soon be posted to the *Health Net Alerts: COVID-19* link on provider.healthnet.com.

COVID-19 TESTING AND SCREENING BILLING INFORMATION

What billing codes should be used to bill for COVID-19 testing?

The following guidance can be used to bill for COVID-19 testing.

Starting April 1st, 2020, providers performing the COVID-19 test can begin billing Health Net for services that occurred after February 4, 2020, using the following newly created HCPCS and CPT codes:

- **HCPCS U0001 –** For CDC developed tests only: 2019-nCoV Real-Time RT-PCR Diagnostic Panel.
- **HCPCS U0002 –** For all other commercially available tests: 2019-nCoV Real-Time RT-PCR Diagnostic Panel. (It is not yet clear if the Centers for Medicare & Medicaid Services (CMS) will rescind the more general HCPCS Code U0002 for non-CDC laboratory tests that the Medicare claims processing system is scheduled to begin accepting starting April 1, 2020.)
- **CPT 87635** - Effective March 13, 2020 (the industry standard for reporting of novel coronavirus tests across the nation's health care system).

All member cost-share requirements (copayment, coinsurance and/or deductible amounts) related to the screening and testing for COVID-19 will be waived across all products.

- Health Net will absorb the costs for waived copayments for COVID-19 screening and testing to support our network providers.
- Waivers for cost-sharing responsibility **DO NOT** apply to members receiving treatment and care resulting from their diagnosis of COVID-19.

In addition to cost-share requirements, authorization requirements will be waived for any claim that is received with these specified codes.

Providers may bill these codes regardless of provider type or contracting status.

What diagnosis codes should be used to bill for services related to COVID-19 screening and testing?

For complete and up-to-date diagnosis coding for COVID-19, visit the NCHS website at www.cdc.gov/nchs/icd/icd10cm.htm.

The following diagnosis codes can be used to bill for screening and testing services related to COVID-19.

- Z20.828 – Contact with and (suspected) exposure to other viral communicable diseases.
- Z03.818 – Encounter for observation for suspected exposure to other biological agents ruled out.

What is the deadline to file claims?

The deadline to file claims for providers impacted by COVID-19 will be extended to 90 calendar days beyond standard filing timelines or the timeline in your Health Net *Provider Participation Agreement (PPA)*. This also applies to Medi-Cal late filing penalties.

Can providers balance bill members for fees related to screening and testing for COVID-19?

Balance billing is strictly prohibited by state and federal law and Health Net's *PPA*. Providers may not bill members for any fees related to screening and testing for COVID-19.

SCREENING AND TESTING

Is Health Net requiring prior authorization, precertification, prior notification, or step therapy protocols for COVID-19 screening and testing?

Health Net is not requiring prior authorization, precertification, prior notification, or step therapy protocols for COVID-19 screening and testing services at this time.

Participating Physician Groups (PPGs) delegated by Health Net to authorize services related to COVID-19 screening and testing are required to ensure members receive the care they need as quickly as possible by not requiring prior authorization, precertification, prior notification, or step therapy protocols for COVID-19 screening and testing services at this time.

Is Health Net waiving cost-share requirements for screening and testing?

Health Net covers screening and testing for COVID-19. Health Net is waiving all member cost-sharing requirements including, but not limited to, copayments, deductibles, or coinsurance for all medically necessary screening and testing for COVID-19, including hospital (including emergency department), urgent care visits, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19.

Where is COVID-19 testing available?

LabCorp, Quest Diagnostics™ and Bio Reference are currently offering testing for COVID-19. Providers are encouraged to visit the following sites for more information on registration and specimen collection requirements:

- LabCorp – www.labcorp.com/information-labcorp-about-coronavirus-disease-2019-covid-19. Physicians who send laboratory testing to LabCorp, will require an active account. Please contact LabCorp at 1-800-859-6046 and speak to a customer service representative to set up account.
- Quest Diagnostics – www.questdiagnostics.com/home/Covid-19/ or call 1-866-697-8378. Providers can open an account at https://secure.questdiagnostics.com/ViewsFlash/servlet/viewsflash?cmd=page&pollid=contactus!physician.
- BioReference – Providers do not need to sign up. Tests can be sent through courier or FedEx depending on area. Providers can open an account at www.bioreference.com/physicians/resources/open-an-account or contact BioReference via telephone at 1-833-684-0508 or 1-800-229-5227.

Testing can be ordered only by physicians or other authorized health care providers.

- Members seeking testing for COVID-19 should consult with their physician or health care provider who may order the test if they determine the patient meets testing criteria.

The Lab Patient Service Centers will not be collecting specimens for COVID-19 testing. **DO NOT** refer patients to Lab Patient Service Centers. Please contact specific labs for instructions for specimen collection and transport, and to obtain specimen collection supplies.

Providers can also refer members for testing to their county's public health department at www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx.

What are the screening and testing guidelines for COVID-19?

On March 19, 2020, the state of California launched a new coronavirus awareness website at https://covid19.ca.gov/. This site provides the following updated testing recommendations:

California is expanding the coronavirus testing capacity daily.

Currently, testing is being prioritized for people who:

- Have the coronavirus symptoms AND
- Have one of these risk factors:
    - Have had contact with a person who has tested positive for COVID-19, OR
    - Are health care providers or work with vulnerable populations (such as a long term care facility), OR
    - Traveled to an affected country in the past 14 days, OR
    - Are over age 60, have a compromised immune system or have serious chronic medical conditions

PRESCRIPTION INFORMATION

How do members obtain an emergency supply of a prescription?

To obtain an emergency supply of a prescription medication, affected members can return to the pharmacy where the original prescription was filled. In addition, we are waiving prescription refill limits for medically necessary drugs and relaxing restrictions on home or mail delivery of prescription drugs. If the pharmacy is not open due to the state of emergency, affected members can contact the Emergency Response line at 1-800-400-8987, 8 a.m. to 6 p.m. Pacific Time (PT) for questions or assistance.

COPING ASSISTANCE FOR MEMBERS

Is coping assistance offered to members impacted by COVID-19?

Members impacted by COVID-19 may contact MHN, our behavioral health subsidiary, for referrals to mental health counselors, local resources or telephonic consultations to help them cope with stress, grief, loss, or other trauma resulting from COVID-19. For the duration of the COVID-19 public health emergency period and its immediate aftermath, affected members may contact MHN 24 hours a day, seven days a week at 1-800-227-1060, or the telephone number listed on the member's identification (ID) card.

REPORTING COVID-19 IMPACTS TO OFFICES AND FACILITIES

What if my office or facility is impacted by COVID-19?

If your office or facility is impacted by COVID-19 and this affects your ability or capacity to provide services and access to members, please contact your provider network regional representative immediately. If you are affiliated with a participating physician group or IPA (PPG), please contact your PPG immediately. Health Net contracted PPGs must notify their Health Net designated network representative of any changes in access to their provider panel.

WEBSITES WITH INFORMATION AND GUIDANCE ON COVID-19

Where can I obtain the latest information and guidance on COVID-19?

To obtain the latest updates and guidance on assisting patients and when to take action, visit provider.healthnet.com where you will see a link to *Health Net Alerts: COVID-19* in the yellow bar. You can also visit the websites below for more information about COVID-19 and the latest guidance from public health officials:

- UpToDate – www.uptodate.com/contents/coronavirus-disease-2019-covid-19?
  Once on this site, you can also refer to Patient education: Coronavirus disease 2019 (COVID-19) (The Basics) or Society guideline links: Coronavirus disease 2019 (COVID-19) topics under Related Topics
- California Department of Public Health – www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx
- Centers for Disease Control and Prevention – www.cdc.gov/coronavirus/2019-ncov/index.html
- World Health Organization – www.who.int/health-topics/coronavirus

ADDITIONAL INFORMATION, REQUIREMENTS AND GUIDANCE

- All participating providers must continue to provide health care services and perform delegated functions. However, the CDC, CMS and other health authorities recommend delaying elective inpatient and outpatient surgical and procedural cases. The delay of elective surgeries or other non-urgent procedures during this time is allowed and is recommended by CMS. The referring or treating provider must have determined and noted in the relevant record that when considering COVID-19 implications during this public health emergency period, a longer waiting time will not have a detrimental impact on the health of the member.
- Telehealth services during this emergency period may be used to determine medical necessity for someone to come into the office, emergency room or urgent care center. Refer to the **TELEHEALTH** section above for more information.
- For Commercial and Medi-Cal, where mailing hard-copy notices to members and providers as required by law is delayed due to personnel shortages and/or safety precautions enacted, please contact the member or provider electronically or by telephone. If the provider or PPG, as the case may be, does not have personnel available to mail hard-copy information, it is sufficient to communicate with members and providers electronically and/or by telephone, so long as a log or record of such communications is maintained. (Note: CMS has not yet communicated a similar relaxation of its regulatory requirements for Medicare Advantage.)
- Health care workers, including those supporting healthcare operations, are considered essential workers and are exempt from the “stay at home,” “shelter in place,” and “shelter at home” recommendations and orders recently announced.

PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | MARCH 17, 2020 | UPDATE 20-312 | 2 PAGES

State of Emergency: Coronavirus (Known as COVID-19) in the State of California

Here's what you need to know about COVID-19

The Department of Health Care Services (DHCS) memorandum dated March 16, 2020, is under review. We will communicate out additional information as needed.

On March 4, 2020, Governor Gavin Newsom declared a state of emergency in the state of California due to the spread of COVID-19. On Sunday, March 15, 2020, the Governor's office provided additional guidance through an executive order. Health Net* is providing assistance to members in all counties affected by COVID-19.

Health Net COVID-19 alerts page and public health guidance

To obtain the latest updates and guidance on assisting patients and when to take action, visit **provider.healthnet.com** where you will see a link to *Health Net Alerts: COVID-19* in the yellow bar.

You can also visit the websites below for more information about COVID-19 and the latest guidance from public health officials:

- California Department of Public Health – www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx
- Centers for Disease Control and Prevention – www.cdc.gov/coronavirus/2019-ncov/index.html
- World Health Organization – https://www.who.int/health-topics/coronavirus

Is your office impacted?

If your office or facility is impacted by COVID-19 and this affects your ability to provide services and access to Health Net members, please contact your provider network regional representative **immediately**. If you are affiliated with a participating physician group (PPG), please contact your PPG **immediately**.

Waiver of screening and testing cost-sharing amounts

For all members, Health Net is waiving all associated member cost-share amounts for medically necessary COVID-19 screening and testing, and doctor office, urgent care and outpatient hospital (including emergency departments) visits.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- HMO/POS/HSP
- PPO
- EPO
- Medicare Advantage (HMO)
- Medi-Cal
  - Kern
  - Los Angeles
    - Molina
  - Riverside
  - Sacramento
  - San Bernardino
  - San Diego
  - San Joaquin
  - Stanislaus
  - Tulare

PROVIDER SERVICES
provider_services@healthnet.com

EnhancedCare PPO (IFP)
1-844-463-8188
provider.healthnetcalifornia.com
EnhancedCare PPO (SBG)
1-844-463-8188
provider.healthnet.com
Health Net Employer Group HMO, POS, HSP, PPO, & EPO
1-800-641-7761
provider.healthnet.com
IFP – CommunityCare HMO, PPO, PureCare HSP, PureCare One EPO
1-888-926-2164
provider.healthnetcalifornia.com
Medicare (individual)
1-800-929-9224
provider.healthnetcalifornia.com
Medicare (employer group)
1-800-929-9224
provider.healthnet.com
Medi-Cal – 1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com

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Where can members go for COVID-19 testing?

Providers can refer members to their county's public health department at www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx. Additionally we are aware that Quest Diagnostics and Laboratory Corporation of America started offering COVID-19 tests earlier this week. We expect expansion of such testing capabilities to continue to evolve.

Prior authorization and precertification

To ensure members receive the care they need as quickly as possible, Health Net is not requiring prior authorization, precertification, prior notification, or step therapy protocols for COVID-19 screening and testing services at this time.

Delegated PPGs

PPGs delegated by Health Net to authorize services related to COVID-19 screening and testing are required to ensure members receive the care they need as quickly as possible by not requiring prior authorization, precertification, prior notification, or step therapy protocols for COVID-19 screening and testing services at this time.

Filing claims

The deadline to file claims for providers impacted by COVID-19 will be extended to three months beyond standard filing timelines or the timeline in your Health Net *Provider Participation Agreement (PPA)*. Providers may contact the **Provider Services Center** using the contact information listed in the right-hand column of page 1 for additional guidance on claims extension time frames.

Balance billing

As a reminder, balance billing is strictly prohibited by state and federal law and Health Net's *PPA*. Providers may not bill members for any fees related to screening and testing for COVID-19.

Prescription information

Providers should inform their Health Net patients that to obtain an emergency supply of a prescription medication, affected members can return to the pharmacy where the original prescription was filled. In addition, we are waiving prescription refill limits for medically necessary drugs, and relaxing restrictions on home or mail delivery of prescription drugs. If the pharmacy is not open due to the state of emergency, affected Health Net members can contact Health Net's **Emergency Response line** at 1-800-400-8987, 8 a.m. to 6 p.m. Pacific time (PT) for questions or assistance.

Coping assistance

Health Net members impacted by COVID-19 may contact MHN, Health Net's behavioral health subsidiary, for referrals to mental health counselors, local resources or telephonic consultations to help them cope with stress, grief, loss, or other trauma resulting from COVID-19. For the duration of the state of emergency and its immediate aftermath, affected Health Net members may contact MHN 24 hours a day, seven days a week at 1-800-227-1060.

Telehealth service options

Telehealth service options are under review. Additional information will be distributed at a later time.

Additional information

Depending on how COVID-19 progresses, Health Net may make additional changes to its policies to ensure members have access to necessary health care services. Please refer to **provider.healthnet.com** where you will see a link to *Health Net's COVID-19* in the yellow bar for regular updates.

For questions, contact the applicable Health Net Provider Services Center listed in the right-hand column of page 1.

MEMORANDUM

DATE: **March 25, 2020**

FROM: MedPOINT Management on behalf of our managed IPAs/Medical Groups

SUBJECT: **UPDATED** TELEHEALTH SERVICES & CORONAVIRUS (COVID-19)

Do You Have Questions?

We understand that Providers are trying to address a multitude of concerns at this time, including caring for patients related to Coronavirus (COVID-19) in addition to balancing the needs of entire patient populations and ensuring the safety of your office staff. To that extent, we want to remind our Primary Care Providers (PCPs) that they are still required to attend to assigned Members whether in-person, telephonically or via telehealth.

If any Primary Care, Specialty Care or Ancillary Provider (PCP/SCP/ANC) is unable to provide services to Members due to temporary office closure, please ensure that the appropriate notification is submitted to MPM on behalf of our Client IPAs. Notifications should be submitted via email to ProviderServices@medpointmanagement.com.

Please be advised that effective March 17, 2020, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has waived potential HIPAA penalties for good faith use of telehealth during the current nationwide public health emergency due to COVID-19.

Please find attached an FAQ outlining the telehealth guidance implemented by MedPOINT Management (MPM) on behalf of its Clients.

PLEASE NOTE: COVID-19 is a mandated reportable condition by law in accordance with Title 21 Health and Safety Code. Providers must report positive COVID-19 lab results to public health departments within the Member's jurisdiction, within one day. Additionally, please report this information to MPM via email at sopi@medpointmanagement.com so that mandatory reporting can be completed at the IPA level as well

MEDPOINT MANAGEMENT (MPM): TELEHEALTH SERVICES & COVID-19 FREQUENTLY ASKED QUESTIONS

MedPOINT Management (MPM) has outlined important answers to our Providers' questions regarding the utilization of telehealth services. Telehealth is becoming an increasingly significant tool allowing patients to connect with their health care providers by eliminating the need for an in-person visit, and thereby reducing both participants' risk of exposure to COVID-19.

Please note: The originating site requirement associated with telemedicine modalities has been waived in conjunction with the Public Health Emergency (PHE) declaration by the President and the Department of Health and Human Services (HHS) Secretary. Health care providers must still comply with State telehealth laws and regulations, including professional licensure, scope of practice, standard of care, patient consent (https://www.cchpca.org/) as well as other payment requirements for non-Medicare beneficiaries. It must also be emphasized that Members **must** consent (verbal or written) prior to receiving a telehealth consultation and that consent must be documented. The authorization process will remain the same when requesting services; regardless of whether services are being provided in-person or via telehealth.

Q. Can I provide telehealth services to reduce the risk of exposure to COVID-19?

A. Yes. IPAs and Medical Groups managed by MPM have adopted DHCS (https://www.dhcs.ca.gov/services/medical/Documents/mednetele_27966_m01o03.pdf) and CMS guidelines(https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth) related to the provision of telehealth services. If a Provider determines that the service is medically appropriate to provide via telehealth and the Member has consented (verbal or written) to receive the service via telehealth, Providers may render telehealth services following these guidelines. These guidelines may be updated frequently in this changing environment, so Providers are encouraged to refer to the links often for the most updated information.

Q. Am I qualified to provide telehealth services to patients at their homes?

A. Yes. You are qualified to provide telehealth services that are within your scope of practice and consistent with Medicare benefit rules.

Q. What types of telehealth services can I offer?

A. Providers may only provide particular services that are considered to be clinically appropriate based upon evidence-based medicine and/or established practices that are appropriate to be delivered via telephone consultation or audio-visual, two-way, real-time communication. If there are treatments, exams, procedures or other services that cannot be adequately provided via telehealth, those services are not eligible to be provided using this method. Additionally, CMS maintains a list of services that are applicable to Medicare telehealth for your guidance: (https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

Please note: On-site services conducted via video or through a window in the clinic suite are not considered as telehealth services.

Q. Do I need to be at an authorized healthcare facility to provide telehealth services?

A. No. Under the expansion of Medicare telehealth coverage during the COVID-19 crisis, Providers can temporarily furnish telehealth services from their homes.

Q: How long does the telehealth waiver last?

A: The telehealth waiver will be effective until the Public Health Emergency (PHE) declared by the HHS Secretary on January 31, 2020 ends.

Q. Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A. No. Billing for telehealth services is limited to professionals.

Q. Is the Member's consent required prior to receiving telehealth?

A. Yes. State law requires the health care provider initiating the use of telehealth needs to inform the Member, obtain consent, and maintain appropriate documentation. If a Member refuses to have services provided via telehealth, the Member has a right to obtain the services in person.

Q. What are the minimum documentation requirements for a telehealth visit?

A. The documentation in the Member's medical record should include the following:

- Notation that patient consented to the consult held via telephone
- Names of all people present during a telemedicine consultation and their role
- Chief complaint or reason for telephone visit
- Relevant history, background, and/or results
- Assessment
- Plan and next steps
- Total time spent on medical discussion

Q. Are different rates paid for services provided through telehealth vs. the same services provided in-person?

A. No. The rates are the same for the professional medical services provided by telehealth or in-person. It is important to remember when billing telehealth services for Medi-Cal Members to use a POS 02 (telehealth) and a modifier 95 for services provided via synchronous, interactive audio/video and telecommunication systems. (https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth_Other_Virtual_Telephonic_Communications_V3.0.pdf)

For Medicare/Commercial Members, please use POS 02, modifier GT and refer to CMS billing guidelines (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet).

Q. Do I need to obtain authorization for telehealth services?

A. For services that normally require authorization, the standard pre-authorization requirements apply regardless of whether the services are being provided via telehealth or in-person. **Your current authorizations are valid, and you do not need to do anything further to change these authorizations**. You do not need to request a new auth with a POS 02.

Please follow your normal authorization processes with your contracted IPAs and contact them directly with any questions or concerns about telehealth. Services provided in an Urgent Care or Emergency Department setting do not require prior authorization. When submitting claims for authorized services, medical records must be attached via the MPM web-portal to the approved authorization. For assistance please contact Provider Network Operations (ProviderServices@medpointmanagement.com) or the IT Help desk (ITSupport@medpointmanagement.com).

Q. What types of technology products do I use to provide telehealth diagnosis or treatment related to COVID-19?

A. During the nationwide public health emergency, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA rules and regulations in connection with the good faith provision of telehealth using such **non-public facing** audio or video communication products. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

Please note: Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks, and Providers should enable all available encryption and privacy modes when using such applications.

Providers may use the following **non-public facing** popular applications that allow for video chats for telehealth services:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

Providers may **not** use the following **public facing** applications for telehealth services:

- Facebook Live
- Twitch
- TikTok
- similar video communication applications

The list below includes some vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA Business Associate Agreements (BAA).

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet

Please note: OCR has yet to review the BAAs by these vendors and therefore; this list, does not constitute an endorsement, certification, or recommendation of specific technology, software, applications, or products.

Thank you very much for continuing to care for our mutual Members during these difficult times. We appreciate your dedication and collaboration. Should you have any additional questions related to telehealth visits coverage please feel free to contact our Provider Network Operations Department via email at ProviderServices@medpointmanagement.com.

Quest Diagnostics Newsroom

Quest Diagnostics to Launch Coronavirus Disease 2019 (COVID-19) Test

Aim of new service is to supplement public health response in the United States

SECAUCUS, N.J., March 5, 2020 /PRNewswire/ -- Quest Diagnostics (NYSE: DGX), the world's leading provider of diagnostic information services, today announced it will launch a coronavirus (COVID-19) test service. The new test service aids the presumptive detection of nucleic acid in respiratory specimens of patients meeting CDC's clinical criteria for COVID-19 testing.

Quest will be in position to receive specimens for testing, and begin to provide testing on Monday, March 9, 2020. With the new service, Quest Diagnostics will provide access to a COVID-19 test service for patients in the United States.

The new test service will be provided as a laboratory developed test, pending review by the FDA under emergency use authorization (EUA) which the company will submit per FDA guidance within 15 days of clinical testing. The test is a molecular based assay which detects viral RNA in respiratory specimens.

"In times of national health crises, quality laboratory testing is absolutely critical to mobilizing effective public health response," said Steve Rusckowski Chairman, CEO and President, Quest Diagnostics. "Quest's national scale, diagnostic expertise and innovation, and relationships with half the country's physicians and health systems is a vital complement to the efforts of the CDC and other public health labs to contend with a growing number of suspected COVID-19 cases in the United States. We applaud the FDA for providing the flexibility for innovative, quality lab developed tests to be brought to patients and providers quickly to advance effective response to the coronavirus outbreak."

The new service is expected to employ respiratory specimens collected in appropriate health care settings, such as hospitals and physician offices. Quest Diagnostics patient service centers and phlebotomy sites do not collect respiratory specimens on suspected COVID-19 cases. Patients suspected of, or confirmed to have, COVID-19

should consult with a physician regarding the best way to provide a specimen for testing by Quest.

Coronavirus Disease 2019 or COVID-19 (formally known as 2019-nCoV) is the name for the respiratory syndrome caused by infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Quest Diagnostics is a leader in infectious disease testing services, with a broad menu of molecular, antibody, and other test services to aid diagnosis, treatment and monitoring.

For more information about the company's response to COVID-19, visit www.questdiagnostics.com/home/Coronavirus/

About Quest Diagnostics
Quest Diagnostics empowers people to take action to improve health outcomes. Derived from the world's largest database of clinical lab results, our diagnostic insights reveal new avenues to identify and treat disease, inspire healthy behaviors and improve health care management. Quest Diagnostics annually serves one in three adult Americans and half the physicians and hospitals in the United States, and our 47,000 employees understand that, in the right hands and with the right context, our diagnostic insights can inspire actions that transform lives. www.QuestDiagnostics.com.

SOURCE Quest Diagnostics

For further information: Wendy Bost, Quest Diagnostics (Media): 973-520-2800; Shawn Bevec, Quest Diagnostics (Investors): 973-520-2900

Coronavirus (COVID-19)
healthcare provider information

This document contains important information regarding COVID-19. Please read it in its entirety.

On January 30, 2020 the World Health Organization declared the COVID-19 outbreak a public health emergency of international concern.

Quest Diagnostics is monitoring the situation closely, and is committed to helping you provide the best care for your patients. Our priority is the health and safety of our employees, patients, and the communities we serve. We encourage healthcare providers to periodically check **QuestDiagnostics.com/COVID19/HCP** for updates on our response to the outbreak.

Important information for our clients:

- On March 5, 2020 Quest Diagnostics announced it will launch a COVID-19 test.
- Quest is launching the test service nationally using a phased approach. Due to expectations of high demand, our initial focus is providers in states closest to our performing laboratory in California, including Washington, Oregon, Nevada and California. We are scaling up testing at other Quest Diagnostics high-complexity laboratories across the U.S. to broaden availability nationally. The locations where our test is available is continually updated on our website.
- Quest is asking healthcare providers to initially prioritize patients in at-risk communities as we scale up COVID-19 testing to service growing national demand.
- The new test aids the presumptive detection of nucleic acid in respiratory specimens of patients meeting the CDC's clinical criteria for COVID-19 testing.
- Patients should be prioritized for testing of COVID-19 if they meet the CDC criteria, including those who may have been exposed to the virus or had contact with someone confirmed to have COVID-19, who show signs and symptoms (eg, fever, cough, difficulty breathing), or who live in or recently traveled to a place where transmission of COVID-19 is prevalent.
- COVID-19 specimens can ONLY be collected in physician offices and hospitals. Quest Diagnostics Patient Service Centers and Quest's in-office phlebotomists do not collect respiratory specimens, including those from patients suspected of having COVID-19.
- The test has not been FDA cleared or approved or authorized. The test has been validated according to CLIA, but FDA's independent review of this validation is pending.

For additional information on Quest's COVID-19 testing, please visit **QuestDiagnostics.com/COVID19/HCP**

Additional information ▸

What to know about Quest's COVID-19 testing

What is coronavirus (COVID-19)?
COVID-19 is the name for the respiratory syndrome caused by infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

What is the test name and test code?
The test name in the Test Directory is SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR and the test code is 39433.

What is Quest's COVID-19 test?
The SARS-CoV-19 test is a qualitative molecular assay, which amplifies the RNA of the SARS-CoV-2 virus in human specimens such as nasopharyngeal or throat swabs (upper respiratory). Alternative specimens, including bronchial lavage/wash, nasopharyngeal aspirate/wash, or sputum/tracheal aspirate are also acceptable. The technique is a real-time reverse transcription PCR assay.

How do I order the COVID-19 test?
Physicians may order the test using test code 39433 (CPT code TBD*). The COVID-19 test must be ordered on a separate requisition from other tests.

What facilities can collect specimens?
Specimens are to be collected by hospitals, physician offices, and clinics. Quest Diagnostics Patient Service Centers and Quest's in-office phlebotomists do not collect respiratory specimens, including those from patients suspected of having COVID-19.

What type of specimen is collected?
Currently, nasopharyngeal (NP) or oropharyngeal (OP) swab testing is being performed. Lower respiratory specimen tests, including bronchial lavage/wash, nasopharyngeal aspirate/wash, or sputum/tracheal aspirate samples can also be ordered but will be frozen upon receipt, with testing initiating on 3/16/2020. One COVID-19 test will be performed per swab.

What type of swab should be utilized to collect the upper respiratory sample?
Upper respiratory samples should be collected using 1 nasopharyngeal swab in M4, VCM, or UTM media or 1 oropharyngeal swab in another M4, VCM or UTM media. Only sterile Dacron® or Rayon swabs should be used. Do not use calcium alginate or wooden shaft swabs as they may contain substances that inhibit PCR testing.

How do I order appropriate supplies for COVID-19 testing?
Please follow your standard process for ordering Quest supplies.

What is the specimen stability?
Specimens have a 72-hour stability refrigerated.

Are there any special storage or transport procedures for COVID-19 specimens?
COVID-19 specimens must be refrigerated. Clients should follow standard procedure for storage and transport of refrigerated samples. Cold packs/pouches must be used if placing specimens in a lockbox for courier pick-up. COVID-19 is not a STAT test and a STAT pick-up cannot be ordered.

What is expected turnaround time?
Test results are typically available 3-4 days from the time of specimen pick-up, and may be impacted by high demand.

How do I get my results?
Results will be delivered in the same manner as other Quest test results.

For additional information on Quest's COVID-19 testing, please visit **QuestDiagnostics.com/COVID19/HCP**
For questions, contact your Quest Diagnostics representative or call **1.866.MYQUEST**.

*The CPT codes provided are based on American Medical Association guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

QuestDiagnostics.com

Quest Diagnostics®

AMA
AMERICAN MEDICAL ASSOCIATION

Special coding advice during COVID-19 public health emergency

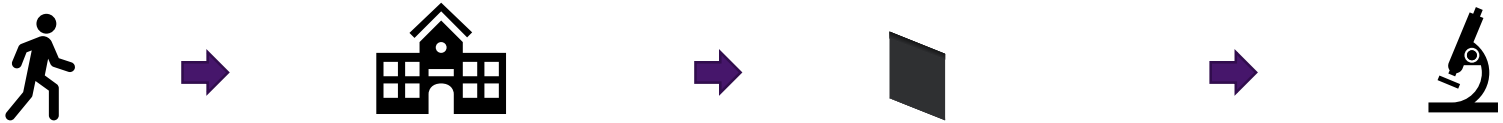
Information provided by the American Medical Association does not dictate payer reimbursement policy and does not substitute for the professional judgement of the practitioner performing a procedure, who remains responsible for correct coding.

COVID-19 UPDATE

Special coding advice during COVID-19 public health emergency

- The coding scenarios in this document are designed to apply best coding practices. The American Medical Association (AMA) is working to ensure that all payors are applying the greatest flexibility to our physicians in providing care to their patients during this public health crisis.
- The Centers for Medicare & Medicaid Services (CMS) lifted Medicare restrictions on the use of telehealth services during the COVID-19 emergency. Key changes include:
    - Effective March 6 and throughout the national public health emergency, Medicare will pay physicians for telehealth services at the same rate as in-person visits for all diagnoses, not just services related to COVID-19.
    - Patients can receive telehealth services in all areas of the country and in all settings, including at their home.
    - CMS will not enforce a requirement that patients have an established relationship with the physician providing telehealth.
    - Physicians can reduce or waive cost-sharing for telehealth visits.
    - Physicians licensed in one state can provide services to Medicare beneficiaries in another state. State licensure laws still apply.
- HHS Office for Civil Rights offers flexibility for telehealth via popular video chat applications, such as FaceTime or Skype, during the pandemic.
- AMA's telemedicine quick guide has detailed information to support physicians and practices in expediting implementation of telemedicine.
- Disclaimer: Information provided by the AMA contained within this Guide is for medical coding guidance purposes only. It does not (i) supersede or replace the AMA's Current Procedural Terminology® manual ("CPT Manual") or other coding authority, (ii) constitute clinical advice, (iii) address or dictate payer coverage or reimbursement policy, and (iv) substitute for the professional judgement of the practitioner performing a procedure, who remains responsible for correct coding.
- To learn more about CPT licensing click here.

Scenario 1: Patient comes to office for E/M visit, is tested for COVID-19 during the visit



Action	In-office E/M visit	Patient swab sample collected	COVID-19 test performed
Who is performing	Physician/QHP	Clinical staff (e.g., RN/LPN/MA)	Laboratory
Applicable CPT Codes	99201-99205 (New Patient) 99212-99215 (Established Patient)	Included in E/M	87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Applicable ICD-10 codes	Possible exposure to COVID-19 Z03.818 Actual exposure to COVID-19 Z20.828		
Place of Service (POS)	11 Physician Office	N/A	11 Physician office 19 Off Campus Outpatient Hospital 22 On Campus Outpatient Hospital 81 Independent Laboratory

Scenario 2: Patient comes to office for E/M visit re: COVID-19 and is directed to a testing site

Action	In-office E/M visit	Patient swab sample collected	COVID-19 test performed
Who is performing	Physician/QHP	Testing Site	Laboratory
Applicable CPT Codes	99201-99205 (New Patient) 99212-99215 (Established Patient)	99001 Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Applicable ICD-10 codes	Possible exposure to COVID-19 Z03.818 Actual exposure to COVID-19 Z20.828		
Place of Service (POS)	11 Physician Office	15 Mobile Unit 17 Walk-in Retail Health Clinic 20 Urgent Care Facility 23 Emergency Room Hospital	11 Physician office 19 Off Campus Outpatient Hospital 22 On Campus Outpatient Hospital 81 Independent Laboratory

Scenario 3: Patient received telehealth visit re: COVID-19, and is directed to come to physician office or physician's group practice site for testing

Action	Patient evaluated for COVID-19 testing need: E/M telehealth OR telephone visit *(Flexibility: permit audio only for E/M Telehealth)*	Pt goes to office	Throat swabs taken in office	Swab sent to lab	COVID-19 test performed
Who is performing	Physician / QHP		Clinical Staff (e.g., RN/LPN/MA)		Laboratory team
Applicable CPT Code(s)	New Patient: E/M Telehealth* 99201 99202 99203 99204 99205 *Established Patient: E/M Telehealth **OR** Telephone Evaluation (independent of E/M)** 99212 (typical time 10 min) 99213 (typical time 15 min) 99214 (typical time 25 min) 99215 (typical time 40 min) 99441 (5-10 min) 99442 (11-20 min) 99443 (21-30 min)	Patient directed to proceed to office for COVID-19 testing	99211		87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Applicable ICD-10 codes	Possible exposure to COVID-19 - Z03.818 Actual exposure to COVID-19 - Z20.828				
Place of Service (POS)	02 Telehealth		11 Physician Office		11 Physician office 19 Off Campus Outpatient Hospital 22 On Campus Outpatient Hospital 81 Independent Laboratory
Notes	*Payors may require the use of Modifier 95 for telehealth services Office for Civil Rights at HHS provides flexibility on audio/visual tools Medicare will pay telehealth at office visit rates and not conduct audits to ensure prior relationship with patient		*Add modifier 25 if same date of service as Physician/QHP assessment*		

Scenario 4: Patient received telehealth visit re: COVID-19, and is directed to unaffiliated testing site

Action	Patient Evaluated for COVID-19 testing need: E/M telehealth OR telephone visit *(Flexibility: permit audio only for E/M telehealth)*		Pt goes to testing site	Throat swabs taken at remote testing site, delivered to lab	Coronavirus test performed
Who is performing/reporting	Physician / QHP			Testing Site	Laboratory team
Applicable CPT Code(s)	*New Patient: E/M Telehealth**			99001 Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
	99201 99203 99205 99202 99204				
	*Established Patient: E/M Telehealth **OR** Telephone Evaluation (independent of E/M)**				
	99212 (typical time 10 min)	99441 (5-10 min)			
	99213 (typical time 15 min)	99442 (11-20 min)			
	99214 (typical time 25 min)	99443 (21 – 30 min)			
	99215 (typical time 40 min)				
Applicable ICD-10 codes	Possible exposure to COVID-19 - Z03.818 Actual exposure to COVID-19 - Z20.828				
Place of Service	02 Telehealth			15 Mobile Unit 17 Walk-in Retail Health Clinic 20 Urgent Care Facility 23 Emergency Room Hospital	11 Physician office 19 Off Campus Outpatient Hospital 22 On Campus Outpatient Hospital 81 Independent Laboratory
Notes	*Payors may require the use of Modifier 95 for telehealth services Office for Civil Rights at HHS provides flexibility on audio/visual tools Medicare will pay telehealth at office visit rates and not conduct audits to ensure prior relationship with patient **COVID-19 test orders given to patient**			**Patient presents physician/QHP test orders to testing personnel**	

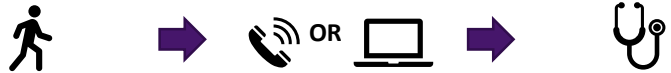
Scenario 5: Patient receives virtual check-in/online visit re: COVID-19 (not related to E/M visit), and is directed to come to physician office for testing

Action	Patient evaluated for COVID-19 testing need: Online digital E/M	Pt goes to office	Throat swab taken in office	Swab sent to lab	COVID-19 test performed
Who is performing	Physician / QHP		Clinical Staff (e.g. RN/LPN/MA)		Laboratory team
Applicable CPT Code(s)	New Patient: N/A Established Patient: 99421 (5-10 min) 99422 (11-20 min) 99423 (21-30 min) G2010 Remote Image G2012 Virtual Check-In	Patient directed to proceed to office for COVID-19 testing	99211		87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Applicable ICD-10 codes	Possible exposure - Z03.818 Actual exposure - Z20.828				
Place of Service (POS)	11 Physician Office		11 Physician Office		11 Physician office 19 Off Campus Outpatient Hospital 22 On Campus Outpatient Hospital 81 Independent Laboratory
Notes	- For Established Patients - Patient Initiates communication		*Add modifier 25 if same date of service as Physician/QHP assessment*		

Scenario 6: Patient receives virtual check-in/online visit re: COVID-19 (not related to E/M visit) and is directed to unaffiliated testing site

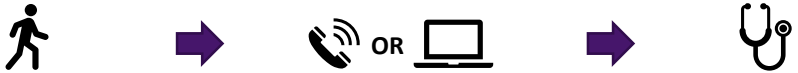
Action	Patient evaluated for COVID-19 testing need: Online digital E/M	Pt goes to testing site	Throat swab taken at testing site, delivered to lab	COVID-19 test performed
Who is performing	Physician / QHP		Testing Site	Laboratory team
Applicable CPT Code(s)	New Patient: N/A Established Patient: 99421 (5-10 min) 99422 (11-20 min) 99423 (21-30 min) G2010 Remote Image G2012 Virtual Check-In		99001 Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Applicable ICD-10 codes	Possible exposure - Z03.818 Actual exposure - Z20.828			
Place of Service	11 Physician Office		15 Mobile Unit 17 Walk-in Retail Health Clinic 20 Urgent Care Facility 23 Emergency Room Hospital	11 Physician office 19 Off Campus Outpatient Hospital 22 On Campus Outpatient Hospital 81 Independent Laboratory
Notes	- For Established Patients - Patient Initiates communication **COVID-19 test orders given to patient**		**Patient presents physician/QHP test orders to testing personnel**	

Scenario 7: Telehealth visit for a COVID-19 diagnosed patient



Action	Communication method	Patient assessed: E/M telehealth, telephone assessment (*Flexibility: permit audio only for E/M telehealth*)	
Who is performing		Physician / QHP	
Applicable CPT Code(s)	**Audio**	*New Patient: E/M Telehealth**	
	or	99201 99202 99203 99204 99205	
		*Established Patient: E/M Telehealth **OR** Telephone Evaluation (independent of E/M)**	
	Audio/Video	99212 (typical time 10 min)	99441 (5-10 min)
		99213 (typical time 15 min)	99442 (11-20 min)
		99214 (typical time 25 min)	99443 (21-30 min)
		99215 (typical time 40 min)	
Applicable ICD-10 codes		U07.1, COVID-19 *Effective April 1, 2020* CDC Announcement	
Place of Service		02 Telehealth	
Notes		*Payors may require the use of Modifier 95 for telehealth services	

Scenario 8: Patient with COVID-19 receives virtual check-in **OR** on-line visits via patient portal/e-mail (not related to E/M visit) **OR** telephone call from qualified nonphysician (those who may not report E/M)

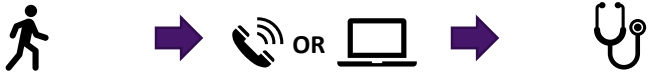


Action	Communication method	Patient evaluated	
Who is performing		Physician / QHP	Qualified nonphysician (may not report E/M)
Applicable CPT Code(s)	Virtual Check-In Other Phone Call	G2010 Remote Image G2012 Virtual Check-In	98966 (5-10 min) 98967 (11-20 min) 98968 (21-30 min)
	Online Visits (eg EHR portal, secure email; allowed digital communication)	99421 (5-10 min) 99422 (11-20 min) 99423 (21-30 min)	98970/G0261 (5-10 min) 98971/G0262 (11-20 min) 98972/G0263 (21-30 min)
Applicable ICD-10 codes		U07.1, COVID-19 *Effective April 1, 2020* CDC Announcement	
Place of Service		11 Physician Office or other applicable site of the practitioner's normal office location	
A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit			

Scenario 9: Physician orders remote physiologic monitoring following patient quarantined at home after receiving COVID-19 diagnosis

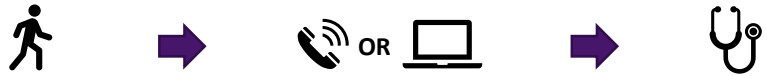
Action	**Patient receives initial set-up of monitoring device and education on its use**		Remote physiologic monitoring treatment management services **(First 20 minutes)**	Remote physiologic monitoring treatment management services **(Each additional 20 minutes)**		Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient to physician/QHP **(Minimum of 30 minutes)**
Who is performing	Physician/QHP/Clinical Staff		Physician/QHP	Physician/QHP		Physician/QHP
Applicable CPT Code(s)	99453 Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	+	99457 Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	99458 Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)	OR	99091 Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
Place of Service	11 Physician Office		11 Physician Office	11 Physician Office		11 Physician Office
Notes	Do not report 99453 for monitoring of less than 16 days		Bill once per calendar month, regardless of number of parameters monitored	Use 99458 in conjunction with 99457		*Bill once per 30 days* *Do not report in conjunction with 99457 or 99458*

Scenario 10 – (Non-COVID-19 case): Telehealth visit for a non-COVID-19 patient



Action	Communication method	Patient assessed: E/M telehealth, telephone assessment (*Flexibility: Permit audio only for E/M telehealth)*	
Who is performing		Physician / QHP	
Applicable CPT Code(s)	**Audio**	*New Patient: E/M Telehealth**	
	or	99201 99202 99203 99204 99205	
		*Established Patient: E/M Telehealth **OR** Telephone Evaluation (independent of E/M)**	
	Audio/Video	99212 (typical time 10 min)	99441 (5-10 min)
		99213 (typical time 15 min)	99442 (11-20 min)
		99214 (typical time 25 min)	99443 (21-30 min)
		99215 (typical time 40 min)	
Applicable ICD-10 codes		Report relevant ICD-10 code(s) related to reason for call or online interaction	
Place of Service		02 Telehealth	
Notes		*Payors may require the use of Modifier 95 for telehealth services	

Scenario 11 – (Non-COVID-19 case): Patient receives virtual check-in OR on-line visits via patient portal/e-mail (not related to E/M visit) OR telephone call from qualified nonphysician (those who may not report E/M)



Action	Communication method	Patient evaluated	
Who is performing		Physician / QHP	Qualified nonphysician (may not report E/M)
Applicable CPT Code(s)	Virtual Check-Ins Other Phone Call	G2010 Remote Image G2012 Virtual Check-In	98966 (5-10 min) 98967 (11-20 min) 98968 (21-30 min)
	Online Visits (eg EHR portal, secure email; allowed digital communication)	99421 (5-10 min) 99422 (11-20 min) 99423 (21-30 min)	98970/G0261 (5-10 min) 98971/G0262 (11-20 min) 98972/G0263 (21-30 min)
Applicable ICD-10 codes		Report relevant ICD-10 code related to reason for call or online interaction	
Place of Service		11 Physician Office or other applicable site of the practitioner's normal office location	

A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit

Telehealth Fact Sheet with Codes

Received on 3/27/20 from America's Physician Groups (APG).
Telehealth Fact Sheet PDF online:

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. With the emergence of the COVID-19, there is an urgency to expand the use of technology to maintain access to needed care, while also keeping vulnerable patients with minor/mild symptoms in their homes. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.

Under the expansion of the telehealth 1135 waiver, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services. Documentation guidelines still apply.

Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. Waiving cost-sharing is optional and will not be considered an illegal inducement by the OIG.

Health and Human Services (HHS) will not conduct audits to ensure that a prior relationship (new vs. established patient) existed for claims submitted during the public emergency. All of these new flexibilities are subject to review and renewal in 90 days.

This fact sheet summarizes three main types of virtual services: telehealth visits, virtual check-ins and e-visits, based on the respective line of business.

Line of Business	Type of service	What is the service?	Is it covered? How much?	HCPCS/ CPT Code
Medicare	Telehealth Visit	Visit with a provider that uses telecommunication systems between a provider and a patient. (For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.)	Yes	99201-99205 (office/outpatient visits for new patients) 99211-99215 (office/ Outpatient visits for established patients) List POS 02 G0425-G0427 (Telehealth consultations, ED or initial inpatient) G0406-G0408 (F/U inpatient tele-health consultations furnished to patients in hospitals or SNFs) Here is a complete list.
Medicare	Virtual Check-In	a. For established patient, brief (5-10 mins) check in with practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. • Confirm patient identity (e.g., name, date of birth or other identifying information as needed, in particular if documenting independently from the patient's electronic or paper record). • Confirm that the patient is an established patient to the practice. • Detail what occurred during the communication (e.g., patient problem(s), details of the encounter as warranted) to establish medical necessity.	a. Yes, $14.81 Medicare Part B	a. HCPCS code G2012 List POS 11

		• Document the total amount of time spent in communicating with the patient and only submit code G2012 if a minimum of five minutes of direct communication with the patient was achieved. • Document that the nature of the call was not tied to a face-to-face office visit or procedure that occurred within the past seven days. • Document that a subsequent office visit for the patient's problems were not indicated within 24 hours or the next available appointment. • Include that the patient provided consent for the service. b. Remote evaluation of recorded video and/or images submitted by an established patient.	b. Yes, $11.91 Medicare Part B	b. HCPCS code G2010 List POS 11
Medicare	E-Visits	A communication between patient and their provider through an online patient portal, for an established patient, for up to 7 days, cumulative time during the 7 days. Not to be used for: • Scheduling appointments • Conveying test results Consider HIPAA compliant secure platforms. *Non-HIPAA compliant platforms are allowed during the public emergency as long as they are not public facing. Examples of non-public facing remote communication products would include platforms such as Apple Face Time, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, or Skype. Such products also would include commonly using texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts, Whatsapp, or iMessage. (HIPAA Flexibility)	Yes $15.52 (5-10 mins) $31.04 (10-20 mins) $50.16 (21+ mins)	99421* 99422* 99423* For qualified nonphysician healthcare professionals: G2061 G2062 G2063 List POS 02
Medicare Resources		CMS Information Current COVID-19 Emergency Medicare FFS Response to Public Health Emergency COVID-19 General Provider Telehealth and Telemedicine Tool Kit Medicare Telemedicine Health Care Provider Fact Sheet		
Medicaid Resources:		Since Medicaid programs are state-run, they follow state-specific telemedicine regulations, which can vary widely. Some states have expansive policies that will allow for telehealth to be used when an emergency like COVID-19 occurs; others will follow CMS adjustments during this time. To learn more about current state laws and reimbursement policies in your state for Medicaid, visit the Center for Connected Health Policy. CMS has provided tools that will permit states to assess emergency administrative relief, make temporary modifications to Medicaid eligibility and benefit requirements, relax rules to ensure that individuals with disabilities and the elderly can be effectively served in their homes, and modify payment rules to support health care providers impacted by the outbreak. The Administration has called on states to allow Medicaid beneficiaries to receive services through telehealth. While this doesn't require federal approval in many cases, these tools can also help states quickly remove state-specific restrictions on telehealth: Medicaid Telemedicine Policy Options for Paying Medicaid Providers for Telehealth Services Tools to Accelerate Relief for State Medicaid & CHIP Programs Section 1135 Waiver Template for State and Territory Medicaid CMS FAQs for State Medicaid and Children's Health Insurance Program (CHIP) Agencies California DHCS Telehealth FAQs Here is a list of approved state 1135 waivers and Appendix K waivers.		

Managed Medicaid	Telehealth Visit	Visit with a provider that uses telecommunication systems between a provider and a patient. (For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.)	Yes	99201-99205 (office/outpatient visits for new patients) 99211-99215 (office/ Outpatient visits for established patients) List POS 02
Managed Medicaid	Virtual Check-In	a. For established patient, brief (5-10 mins) check in with practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. • Confirm patient identity (e.g., name, date of birth or other identifying information as needed, in particular if documenting independently from the patient's electronic or paper record). • Confirm that the patient is an established patient to the practice. • Detail what occurred during the communication (e.g., patient problem(s), details of the encounter as warranted) to establish medical necessity. • Document the total amount of time spent in communicating with the patient and only submit code G2012 if a minimum of five minutes of direct communication with the patient was achieved. • Document that the nature of the call was not tied to a face-to-face office visit or procedure that occurred within the past seven days. • Document that a subsequent office visit for the patient's problems were not indicated within 24 hours or the next available appointment. • Include that the patient provided consent for the service. b. Remote evaluation of recorded video and/or images submitted by an established patient.	a. Yes b. Yes	a. HCPCS code G2012 b. HCPCS code G2010
Managed Medicaid	E-Visits	A communication between patient and their provider through an online patient portal, for an established patient, for up to 7 days, cumulative time during the 7 days. Not to be used for: • Scheduling appointments • Conveying test results Consider HIPAA compliant secure platforms. *Non-HIPAA compliant platforms are allowed during the public emergency as long as they are not public facing. Examples of non-public facing remote communication products would include platforms such as Apple Face Time, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, or Skype. Such products also would include commonly using texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts	No	Not Covered
Commercial	Telehealth Visit	Visit with a provider that uses telecommunication systems between a provider and a patient. (For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.)	Coverage varies per health plan	99201-99205 (office/outpatient visits for new patients) 99211-99215 (office/ Outpatient visits for established patients) G0425-G0427 (Telehealth

				consultations, ED or initial inpatient) G0406-G0408 (F/U inpatient tele-health consultations furnished to patients in hospitals or SNFs) Here is a complete list. Add Modifier 95 (depending on Commercial Payer)
Commercial	Virtual Check-In	a. For established patient, brief (5-10 mins) check in with practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. • Confirm patient identity (e.g., name, date of birth or other identifying information as needed, in particular if documenting independently from the patient's electronic or paper record). • Confirm that the patient is an established patient to the practice. • Detail what occurred during the communication (e.g., patient problem(s), details of the encounter as warranted) to establish medical necessity. • Document the total amount of time spent in communicating with the patient and only submit code G2012 if a minimum of five minutes of direct communication with the patient was achieved. • Document that the nature of the call was not tied to a face-to-face office visit or procedure that occurred within the past seven days. • Document that a subsequent office visit for the patient's problems were not indicated within 24 hours or the next available appointment. • Include that the patient provided consent for the service. b. Remote evaluation of recorded video and/or images submitted by an established patient.	a. Coverage varies per health plan b. Coverage varies per health plan	a. HCPCS code G2012 b. HCPCS code G2010
Commercial	E-Visits	A communication between patient and their provider through an online patient portal, for an established patient, for up to 7 days, cumulative time during the 7 days. Not to be used for: • Scheduling appointments • Conveying test results Consider HIPAA compliant secure platforms. *Non-HIPAA compliant platforms are allowed during the public emergency as long as they are not public facing. Examples of non-public facing remote communication products would include platforms such as Apple Face Time, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, or Skype. Such products also would include commonly using texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts, Whatsapp, or iMessage. (HIPAA Flexibility)	Coverage varies per health plan	99421* (5-10 mins) 99422* (10-20 mins) 99423* (21+ mins) For qualified nonphysician healthcare professionals: G2061 G2062 G2063 List POS 02 List Modifier 95 (for synchronous telemedicine service via a real-time interactive audio and video telecommunication system) List Modifier GQ (for asynchronous

				telemedicine services rendered by both originating site and distant provider)
Other resources	• Expansion of Telehealth Access to Combat COVID-19 • Telehealth for Private Coverage FAQs • AHIP: Health Insurance Plans Respond to COVID-19 • Aetna Health Plan Guidance for COVID-19 • Anthem Health Plan Guidance for COVID-19 • BCBSA Health Plan Guidance for COVID-19 • Blue Shield CA Health Plan Guidance for COVID-19 • Bright Health Plan Guidance for COVID-19 • CareFirst Health Plan Guidance for COVID-19 • Centene Health Plan Guidance for COVID-19 • Cigna Health Plan Guidance for COVID-19 • Health Net Health Plan Guidance for COVID-19 • Health Care Service Corporation Health Plan Guidance COVID-19 • Humana Health Plan Guidance for COVID-19 • Kaiser Permanente Health Plan Guidance for COVID-19 • UnitedHealthcare Health Plan Guidance for COVID-19 • Center for Connected Health Policy Billing for Telehealth Encounters			

CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10-CM Official Coding Guidelines - Supplement
Coding encounters related to COVID-19 Coronavirus Outbreak
Effective: February 20, 2020

Introduction

The purpose of this document is to provide official diagnosis coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV.

The COVID-19 caused an outbreak of respiratory illness, and was first identified in 2019 in Wuhan, Hubei Province, China. Since then, thousands of cases have been confirmed in China, and COVID-19 has also spread internationally, including in the United States. Investigations are ongoing. The most recent situation updates are available from the CDC web page, About 2019 Novel Coronavirus (COVID-19).
https://www.cdc.gov/coronavirus/2019-ncov/index.html

The confirmed COVID-19 infections can cause a range of illness, from little to no symptoms, to those affected being severely ill and even dying. Symptoms can include fever, cough, and shortness of breath. Symptoms may appear from 2 to 14 days after exposure, based on the incubation period for other coronaviruses, such as the MERS (Middle East Respiratory Syndrome) viruses.
https://www.cdc.gov/coronavirus/2019-ncov/about/symptoms.html

This guidance is intended to be used in conjunction with the current ICD-10-CM classification and the *ICD-10-CM Official Guidelines for Coding and Reporting* (effective October 1, 2019) and will be updated to reflect new clinical information as it becomes available.
https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.

The ICD-10-CM codes provided in this document are intended to provide information on the coding of encounters related to coronavirus. Other codes for conditions unrelated to coronavirus may be required to fully code these scenarios in accordance with the *ICD-10-CM Official Guidelines for Coding and Reporting*. A hyphen is used at the end of a code to indicate that additional characters are required.

General Guidance

Pneumonia
For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Acute Bronchitis
For a patient with acute bronchitis confirmed as due to COVID-19, assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29, Other coronavirus as the cause of diseases classified elsewhere. Bronchitis not otherwise specified (NOS) due to the COVID-19 should be coded using code J40, Bronchitis, not specified as acute or chronic; along with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Lower Respiratory Infection
If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, this should be assigned with code J22, Unspecified acute lower respiratory infection, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be appropriate to assign code J98.8, Other specified respiratory disorders, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

ARDS
Acute respiratory distress syndrome (ARDS) may develop in with the COVID-19, according to the Interim Clinical Guidance for Management of Patients with Confirmed 2019 Novel Coronavirus (COVID-19) Infection.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

Cases with ARDS due to COVID-19 should be assigned the codes J80, Acute respiratory distress syndrome, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Exposure to COVID-19
For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.

For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

Signs and symptoms
For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
• R05 Cough

• R06.02 Shortness of breath

• R50.9 Fever, unspecified

Note: Diagnosis code B34.2, Coronavirus infection, unspecified, would in generally not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be “unspecified.”

If the provider documents “suspected”, “possible” or “probable” COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

This coding guidance has been developed by CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

Reference:

COVID-10 clinical presentation:
https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects
Official CMS news from the Medicare Learning Network®

SPECIAL EDITION

Friday, March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states

provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

Like the newsletter? Have suggestions? Please let us know!

World Health Organization Guidelines: How to Be Safe at Home When Someone in Your House Has Mild Symptoms of CORONAVIRUS (COVID-19)

What is COVID-19?

COVID-19 is a lung infection. Typical symptoms are fever greater than 100.5 F, dry cough, and sore throat.

Can I stay home if I have COVID-19? Or do I have to go to the hospital?

Staying Home:
If you do not have underlying health conditions such as COPD, Heart Disease, High Blood Pressure, or Diabetes, and you have mild symptoms (fever less than 101 and are otherwise not feeling too run down), you can stay home.

Going to the hospital:
Hospitalization is necessary if you have difficulty breathing or your fever is above 101. Follow these steps if you need to go to the hospital

- Call ahead and tell them you are coming
- Avoid taking public transportation (taxis, Uber, Lyft, bus). Drive with all windows open

General rules for the sick person

- The mouth and nose should be covered with a disposable paper tissue when coughing or sneezing, then the tissue should be thrown in the trash and hands should be thoroughly washed with hot soapy water.
- The sick person should stay separated from others in the house while sick and for an additional 2 weeks.
- If the sick person must be in a shared spaced with others in the house, the sick person must keep at least 3 feet distance while sick and for an additional 2 weeks.
- Do not share toothbrushes, cigarettes, eating utensils, dishes, drinks, towels, and bed linens. After the person is done being sick and 2 additional weeks have passed, replace the sick person's toothbrush.

How can I prepare for when someone in my home is sick with COVID-19?

It is important to keep in touch with a Brand New Day Nurse or Care Manager while caring for someone in your home who has COVID-19**.** To get connected, if you do not already have a Brand New Day Nurse call Member Services at (866) 255-4795, TTY 711 Monday-Friday 8am-8pm from April 1-September 30, and 7 days a week 8am-8pm from October 1-March 31.

There are several steps to take to prepare your home for a sick person. It is recommended to do these steps while the person is sick and <u>for an additional 2 weeks after the person is no longer sick</u>.

***Important:** Have only one person do the caregiving to lower risk of everyone getting sick. The one person who does the caregiving should not also be sick and should not have underlying health conditions. Do not have multiple members of the house caring for the sick person.

General rules while the person is sick and for the additional 2 weeks

- For shared spaces, such as the kitchen, keep windows open.
- There should be no visitors allowed in the home.
- Wash hands thoroughly with hot soapy water when preparing food, eating, touching any shared surfaces, and using the bathroom. If hands are not visibly dirty, an alcohol-based hand rub can be used. For visibly dirty hands, use soap and water.
- Use dedicated bed linens, towels, and eating utensils for the sick person. These items should be cleaned with soap and water after each use.

Where will the sick person live while sick and for the additional 2 weeks?

The sick person should be separated from other household members. This could be a bedroom that no one else will go in to, or a sectioned off area of the living room that is separated by drape. The separate space for the sick person should have an open window. If possible, the healthy person should keep at least 3 feet from the sick person and should sleep in a separate bed.

What do I need to have on-hand while the person is sick and for the additional 2 weeks?

It is important to have enough hand sanitizer and spray sanitizer such as Lysol so that each time you are in contact with the sick person and their belongings you can thoroughly sanitize yourself and anything you may have touched.

What needs to be cleaned often while the person is sick and for the additional 2 weeks?

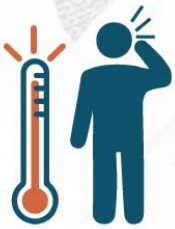
Using hand sanitizer and spray sanitizer like Lysol, clean shared high-touch surfaces such as toilets, door knobs, light switches, TV remote, phones, computers, door handles on the refrigerator, and faucets. Also, the sick person's bed-side table, bed frame, and other bedroom furniture.

DO I NEED TO GET TESTED FOR COVID-19?

Are you experiencing:
Fever, Coughing **or** Shortness of Breath?

Call your physician

- Doctor advises you to come in
  - Specimen is collected via swab and sent to lab to be tested
    - Doctor should have test results within **24 hours**
- Doctor identifies mild symptoms and advises home isolation
  - Isolate / Stay at home
- You didn't get an immediate response, and you're experiencing **severe symptoms**?
  - Go to your local urgent care/ ER or call **9-1-1**



MORE INFORMATION - Follow the California Department of Public Health: @capublichealth and www.cdph.ca.gov/covid19

CDPH

Immediate Crisis Counseling
for people experiencing emotional distress related to any disaster

The Disaster Distress Helpline, 1-800-985-5990, is a 24/7, 365-day-a-year, national hotline dedicated to providing immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster. This toll-free, multilingual, and confidential crisis support service is available to all residents in the United States and its territories. Stress, anxiety, and other depression-like symptoms are common reactions after a disaster. Call **1-800-985-5990** or text **TalkWithUs to 66746** to connect with a trained crisis counselor.

Call or Text

From the United States and its territories, call **1-800-985-5990** to connect with a trained crisis counselor, 24/7. **Spanish-speakers can call the hotline and press "2"** for 24/7 bilingual support.

Callers to the hotline can also connect with counselors in over 100 other languages via 3rd-party interpretation services; to connect with a counselor in your primary language, simply indicate your preferred language to the responding counselor and she/he will connect to a live interpreter (interpretation in less commonly-spoken languages may require calling back at an appointed time). Learn more and download information about the Disaster Distress Helpline in 30 of the most commonly-spoken languages in the U.S.

To connect with a live DDH crisis counselor 24/7 via SMS, **from the 50 states text "TalkWithUs" for English or "Hablanos" for Spanish to 66746. Spanish-speakers from Puerto Rico can text "Hablanos" to 1-787-339-2663.**

SAMHSA
Substance Abuse and Mental Health Services Administration
https://www.samhsa.gov/

Health Net®
MEDICARE PROGRAMS

Provider Checklist to Support CAHPS and HOS Improvement

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey and Health Outcomes Survey (HOS) gather feedback about a patient's experience with the health plan, health plan providers and quality of care received. Improving patient experience has many benefits. It helps to boost patient retention, increases compliance with provider recommendations and supports improved outcomes.

Here are some tips and reminders to guide your discussion on key CAHPS and HOS topics with patients during their office visit.

CAHPS TIPS AND REMINDERS	
☐	**Annual flu vaccine:** Administer or remind ALL patients to get the flu vaccine annually. Educate on vaccine benefits. ***Question for patients:*** *Have you had the flu shot?*
☐	**Care coordination:** Call patients about test results promptly and inform the patient if no call will be made when test results are normal. Develop protocols for clinical staff to facilitate chronic medication refills.
☐	Have relevant information and medical history, including appointments with specialists, at hand during appointments. Obtain records from specialists. ***Question for patients:*** *Are you having any issues receiving services?*
☐	**Getting appointments and care quickly:** Encourage patients to schedule routine visits far in advance. ***Question for patients:*** *Would you like to schedule your next routine care visit before you leave our office today?*
☐	Set aside a few time slots each day to accommodate urgent visits and follow-up visits. Offer appointment with a nurse practitioner or physician assistant for urgent issues.

(continued)

PROVIDER COMMUNICATIONS

19-893/FLY035501EH00 (11/19)

Coverage for every stage of life™

Getting needed care:

☐ Include the patient in the decisions made about their care regarding tests and referrals. Refer patients to in-network specialists.

☐ Call the specialist to coordinate the soonest appointment date. Discuss and plan for possible appointment delays.

Question for patients: *Are you experiencing any delays in receiving tests, treatment or services?*

Getting needed prescription medications:

☐ Review current medication list, including patient concerns, side effects, barriers, etc.

Question for patients: *Do you have any questions about the medications you are taking?*

☐ Ensure patient understands medication schedule and encourage adherence.

Question for patients: *Are you having any issues with getting or taking medications?*

HOS TIPS AND REMINDERS

Reducing the risk of falling:

☐ Assess fall risk by asking patients about falling, gait and balance problems. Document the discussion on the My Wellness and Prevention Checklist.

Questions for patients: *Have you had a fall in the past year? If so what caused the fall?*

Improving or maintaining mental health:

☐ It's important to talk about emotions and mental health.

Questions for patients: *Have you been bothered by emotional problems? Can you describe your level of energy? Are you getting out and socializing? Is alcohol use causing personal problems?*

Improving or maintaining physical health:

☐ It's important to talk physical health and if it affects the patient's ability to get around in anyway.

Questions for patients: *How far can you walk? Are you having any difficulty climbing stairs? Are you having any pain that is limiting your activity? Let's set some goals to help improve your health.*

Improving bladder control:

☐ Assess problems with urinary incontinence (UI) in the last six months and document the discussion on the My Wellness and Prevention Checklist.

Questions for patients: *Have you had any leakage in the past six months? If so, how often and when does the leakage problem occur?*

Monitoring physical activity:

☐ Assess your patient's current physical activity level. Discuss health benefits and advise patients to start, maintain or increase physical activity as appropriate for their individual health status. Use the physical activity prescription (Rx) pad.

Questions for patients: *What activities do you enjoy? What is your daily level of workouts?*

Questions?

If you have questions, please contact Health Net's Quality Improvement Department at CQI_Medicare@healthnet.com. For more information about CAHPS and HOS, visit **www.cahps.ahrq.gov and www.cms.gov**.

PROVIDER*Update*

Health Net®

REGULATORY | MARCH 23, 2020 | UPDATE 20-286 | 2 PAGES

Stay Current with MCAS Updates to Be Sure You Meet Performance Levels

Latest changes released for 2020 measurement year

On July 19, 2019, Health Net* notified providers about new quality measures known as the Managed Care Accountability Set (MCAS), released by the Department of Health Care Services (DHCS). You can refer to provider update 19-523, *Help Your Patients Achieve Better Health Outcomes* for more details. DHCS now requires managed care plans and participating providers to meet the national Medicaid 50th percentile minimum performance level (MPL) for each MCAS measure based on the National Committee for Quality Assurance (NCQA) Quality Compass.

New changes for 2020 measurement year

On December 31, 2019, DHCS updated the MCAS list for the 2020 measurement year. New changes to MCAS are outlined in the table on page 2. Providers and plans must still meet the MCAS Measurement Year (MY) 2019/Reporting Year (RY) 2020 requirements as outlined in provider update 19-523.

Timely submissions of claims, encounters and medical records impact your performance rates

We encourage providers to stay up to date with the coding guidelines as outlined in the most recent release of the *HEDIS 2020 Volume 2: Technical Specifications*. You can purchase the guidelines from the NCQA website at www.ncqa.org.

For more information on coding and best practices, providers can access the Healthcare Effectiveness Data and Information Set (HEDIS®) tip sheets and best practices at www.provider.healthnet.com under *Quality* > *Provider Tip Sheets.* Providers can also email the Quality Improvement Department at cqi_dsm@healthnet.com.

Resources for claims and encounters requirements

Participating physician groups (PPGs) and providers are required to report services according to the terms of the *Provider Participation Agreement (PPA)*. Providers can also refer to the Health Net provider operations manuals for more information on billing and reporting requirements, available at www.provider.healthnet.com under *Provider Library* > *Operations Manuals* > *Claims and Provider Reimbursement* > *Billing and Submission.*

Additional information

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Medi-Cal Provider Services Center within 60 days at 1-800-675-6110.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ○ Riverside
  - ● Sacramento
  - ○ San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

Highlights of the 2020 measurement year changes

The complete MCAS list is available online at: www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/Managed-Care-Accountability-Set-Reporting-Year-2021.pdf.

Removed	Added	Changed
Adult Care • Annual Monitoring for Patients on Persistent Medications (MPM) • Comprehensive Diabetes Care Hemoglobin A1c testing (CDC-HT) - HbA1c testing with outcomes > 9.0% (CDC-H9) is still required	**Behavioral Health (pediatric and adult)** • Addition of Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) • Addition of Diabetes Screening for People with Schizophrenia or Bipolar Disease Using Antipsychotic Medications (SSD-AD)	**Transitional Care** Plan All-Cause Readmissions (PCR) • No longer held to the MPL for RY 2021
Pediatric Care Children and Adolescent Access to Primary Care Practitioners (CAP)	**Pediatric Care** • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: counseling for nutrition (WCC-N), ICD-10 Z71.3 • Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: counseling for physical activity (WCC-PA), ICD-10 Z02.5, Z71.82	

THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☒ Imperial
☒ Riverside/San Bernardino
☒ Los Angeles
☐ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☒ Molina Medi-Cal Managed Care
☐ Molina Medicare Options Plus
☐ Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
☐ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☒ **Medical Group/ IPA/MSO**

Primary Care

☒ IPA/MSO
☒ Directs

Specialists

☐ Directs
☐ IPA

☐ **Hospitals**

Ancillary

☐ CBAS
☐ SNF/LTC
☐ DME
☐ Home Health
☐ Other

FOR QUESTIONS CALL PROVIDER SERVICES:
(888) 562-5442, Extension:

Los Angeles/Orange Counties
X123017

Riverside/San Bernardino Counties
X120613

Sacramento County
X121599

San Diego County
X121735

Imperial County
X125682

****REVISION****

2020 PAY-FOR-PERFORMANCE/HEDIS® PERFORMANCE BONUS PROGRAM

This is an advisory notification to Molina Healthcare of California (MHC) network providers of updates to the Medi-Cal Pay-For-Performance/ HEDIS® Performance Bonus Program (P4P Program).

- Effective 1/1/2020, Federally Qualified Health Centers and Rural Health Centers are no longer eligible for this program.
- Effective 1/1/2020, PCP must have at least 200 Medi-Cal Members assigned at the close of the measurement period in order to qualify for: Well Child Visits, Cervical Cancer Screening and A1C Control performance bonus.
- There is no panel requirement to qualify for: Prenatal, Postpartum, Childhood Immunization or Immunization for Adolescents performance bonus.
- Effective 1/1/2020, qualifying Cervical Cancer Screening, Diabetic HbA1c Control, and Well Child Visit incentives will follow quarterly payment cycle for services rendered in Quarter 1 and Quarter 2. Services rendered in Quarter 3 and Quarter 4, will be paid out in June 2021 if final HEDIS rate achieves the Minimum (50th percentile) Performance Level. If final HEDIS rate does not achieve the Minimum Performance Level, no bonus will be issued.
- Removed: Breast Cancer Screening, Asthma Medication Ratio, Adolescent Well-Care Visit, and Childhood Immunization Status (Combination 3) HEDIS measures from this bonus program.
- Added: Immunizations for Adolescents to select counties and expanded Cervical Cancer Screenings to all counties for this bonus program.
- Effective 10/1/2019, qualifying Initial Health Assessment/Staying Healthy Assessment incentives will be paid through the PAY-FOR-PERFORMANCE/HEDIS® PERFORMANCE BONUS PROGRAM. See below for specifications.

Please review the updated Medi-Cal HEDIS Metrics and Bonus Amounts below:

Medi-Cal HEDIS® Metrics and Bonus Amounts*				
Measure	**Performance Bonus**	**Eligible Counties**	**Panel Requirement**	**Bonus Frequency**
Cervical Cancer Screening	$25 per test/up to one payment per member per three years	Imperial Los Angeles Sacramento San Diego Riverside San Bernardino	Minimum 200 Medi-Cal Members	Qualifying 2020 Quarter 1 and Quarter 2 dates of service will be paid out following quarterly payment cycle below (see Payment Timeline included in section 1.1.6). Quarter 3 and Quarter 4 dates of service bonus will be made based off of final rate and NCQA benchmark achieved. If final Measurement Year 2020 rate achieves the 50th Percentile, Quarter 3 and Quarter 4 bonus will be issued. For final rate not achieving the 50th Percentile, no payment will be issued.
Comprehensive Diabetes Care: HbA1c Control	$75 per HbA1c control test result less than 8.0 /one-time payment in Q4 Reporting Period per member per year	Imperial Los Angeles Sacramento San Diego Riverside San Bernardino	Minimum 200 Medi-Cal Members	2020 annual bonus will be made based off of final rate and NCQA benchmark achieved. If final Measurement Year 2020 rate achieves the 50th Percentile, annual bonus will be issued (see Payment Timeline included in section 1.1.6). For final rate not achieving the 50th Percentile, no payment will be issued.
Timeliness of Prenatal Care-First Trimester Visit	$200 per visit /up to one payment per member per year	Imperial Los Angeles Sacramento San Diego Riverside San Bernardino	No minimum panel requirement	All qualifying 2020 dates of service will be paid out following quarterly payment cycle below (see Payment Timeline included in section 1.1.6).
Timeliness of Post-Partum Care (7-84 days post-delivery)	$150 per visit /up to one payment per member per year	Imperial Los Angeles Sacramento San Diego Riverside San Bernardino	No minimum panel requirement	All qualifying 2020 dates of service will be paid out following quarterly payment cycle below (see Payment Timeline included in section 1.1.6).

Childhood Immunization Status – Combination 10	$100 for the completion of combination 10 immunizations before two years of age. *Includes: 4 DTap, 3 IPV, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 1 or 2 RV, 2 FLU*	Imperial Los Angeles Sacramento San Diego Riverside San Bernardino	No minimum panel requirement	All qualifying 2020 dates of service will be paid out following quarterly payment cycle below (see Payment Timeline included in section 1.1.6).
Immunizations for Adolescents - Combo 2	$25 for the completion of combination 2 immunizations on or before 13 years of age. *Includes: 1 meningococcal conjugate vaccine, 1 Tdap or one Td vaccine, Two separate doses of the HPV vaccine with a date of service at least 146 days apart*	Imperial Riverside San Bernardino	No minimum panel requirement	All qualifying 2020 dates of service will be paid out following quarterly payment cycle below (see Payment Timeline included in section 1.1.6).
Well Child Visits 34	$25 per visit /up to one payment per member per year for children ages 3-6 years old.	Imperial Los Angeles Sacramento San Diego Riverside San Bernardino	Minimum 200 Medi-Cal Members	Qualifying 2020 Quarter 1 and Quarter 2 dates of service will be paid out following quarterly payment cycle below (see Payment Timeline included in section 1.1.6). Quarter 3 and Quarter 4 dates of service bonus will be made based off of final rate and NCQA benchmark achieved. If final Measurement Year 2020 rate achieves the 50th Percentile, Quarter 3 and Quarter 4 bonus will be issued. For final rate not achieving the 50th Percentile, no payment will be issued.

Initial Health Assessment with Staying Healthy Assessment Bonus

MHC requires that New/Extended/Routine History of Physicals must be submitted with an Initial Health Assessment (IHA) AND Staying Health Assessment (SHA). Visit must be completed within 120 days of member's enrollment date in order to qualify for incentive. MHC will incentivize complaint services for members age 0-18 years. Timely, accurate and complete submissions will qualify for $50 incentive.

Please review the Medi-Cal HEDIS Bonus Payout Timeline below:

Reporting Period	Months Under Evaluation	Payment Type	Payment Dates
1st Reporting Period	January 1 – March 31	Per Service	September
2nd Reporting Period	April 1 – June 30	Per Service	December
3rd Reporting Period	July 1 – September 30	Per Service	March
4th Reporting Period	October 1 – December 31	Per Service	June

QUESTIONS

If you have any questions regarding the notification, please contact your Molina Provider Services Representative at (888) 562-5442. Please refer to the extensions on page one.

THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☒ Imperial
☒ Riverside/San Bernardino
☒ Los Angeles
☒ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☒ Molina Medi-Cal Managed Care
☒ Molina Medicare Options Plus
☒ Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
☒ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☒ **Medical Group/ IPA/MSO**

Primary Care
☒ IPA/MSO
☒ Directs

Specialists
☒ Directs
☒ IPA

☐ **Hospitals**

Ancillary
☐ CBAS
☐ SNF/LTC
☐ DME
☐ Home Health
☐ Other

FOR QUESTIONS CALL PROVIDER SERVICES:
(888) 562-5442, Extension:

Los Angeles/Orange Counties
X123017

Riverside/San Bernardino Counties
X120613

Sacramento County
X121599

San Diego County
X121735

Imperial County
X125682

Behavioral Health Toolkit

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding the Behavioral Health Toolkit.

MHC has designed this Behavioral Health Toolkit for Providers to offer guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting. Included are chapters addressing:

Assessment and Diagnosis of Behavioral Health Conditions in the Primary Care Setting including:

- Depression
- Suicidality
- Substance Use Disorders (Alcohol and Other Drugs) and Opioid Use Disorders
- Anxiety
- Dementia and Alzheimer's
- Attention Deficit/Hyperactivity Disorder (ADHD)

HEDIS Tips including:

- Antidepressant Medication Management
- Follow-up Care for Children Prescribed ADHD Medication
- Follow-up After Hospitalization for Mental Illness
- Follow-up After Emergency Department Visit for Mental Illness
- Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Schizophrenia Management including:
    - Diabetes Screening and Monitoring
    - Cardiovascular Monitoring
    - Adherence to Antipsychotic Medications
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions
- Use of Opioids
    - at High Dosage
    - from Multiple Providers
    - Risk of Continued Use
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Depression in Adolescents and Adults
    - Screening and Follow-up (DSF)
    - Utilization of the PHQ-9 to Monitor Depression Symptoms (DMS)

Risk Adjustment Education Tools for:

- Major Depression
- Bipolar Disorder
- Substance Use Disorders
- Schizophrenia

We hope the information in this toolkit helps support your clinical practice, please use the link below to access the Behavioral Health Toolkit:
https://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/bh_toolkit.aspx

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Language Access Services for Telehealth Appointments

Due to the COVID-19 pandemic, DHCS has approved the use of telehealth for appointments, whenever possible, to limit potential exposure of all parties. If you will be holding patient appointments over the phone, Molina will provide language services for these appointments. It is important to ensure that all limited English proficient members continue to have access to language services. Please follow the instructions below to access interpreter services:

1. Call the Molina Member and Provider Contact Center at the numbers below based on the member's line of business:
   - For Medi-Cal members call (888) 665-4621 Mon-Fri, 7am-7pm
   - For Marketplace members call (888) 858-2150 Mon-Fri, 8am-6pm
   - For Medicare members call (800) 665-0898 Mon-Fri, 8am-8pm
   - For Cal MediConnect (Duals) members call (855) 665-4627 Mon-Fri, 8am-8pm
   - For after-hours, please call Molina's Nurse Advice Line at (888) 275-8750
2. Tell the Molina agent that you are calling for a telephonic interpreter to speak with a member and mention the member's preferred language.
3. The Molina agent will get the interpreter on the line and then call the member. Once you are connected to the interpreter and member, the agent will then drop off the line.
4. To speak to members who are deaf, hard of hearing, or have a speech difficulty, Providers may use the California Relay Service. Dial 711 and give the Relay Operator (RO) / Communication Assistant (CA) the member's area code and telephone number. The RO/CA will connect and communicate via the member's preferred type of communication (TTY, VCO, Internet, ASCII, etc.).

For critical in-person appointments needing onsite interpreters, please call the Contact Center at the numbers above at least 5 days before the scheduled appointment.

If you have a face-to-face interpreter currently scheduled for an appointment that is cancelled or converted to a telehealth appointment, please call Molina to cancel the onsite interpreter.

QUESTIONS

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Memorandum: Medicare Opioid Treatment Programs Benefit

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding the Memorandum Medicare Opioid Treatment Programs Benefit.

Benefit Effective January 1, 2020

Effective January 1, 2020, Opioid Use Disorder (OUD) treatment serviced provided by Opioid Treatment Programs (OTPs) are now covered as a Medicare Part B benefit (Medical Insurance).

Under the Calendar Year 2020 Physician Fee Schedule final rule, Opioid Treatment Programs will be covered by Molina's Medicare Advantage. For dually eligible beneficiaries who currently get OTP services through Medicaid, Medicare will be the primary payer for OTP services effective January 1, 2020.

In order to bill and receive payment from Medicare for opioid use disorder treatment services at an OTP facility, the OTP provider must be:

1. Certified and accredited by SAMHSA and,
2. Enrolled in the Medicare program as a Medicare OTP provider.

Additional information is published in an OTP Benefit Overview document published on our provider website at the following link:

https://www.molinahealthcare.com/providers/common/medicare/PDF/Opioid-Treatment-Program.pdf

QUESTIONS

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