JULY 2020

PROVIDER QUALITY NEWSLETTER

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

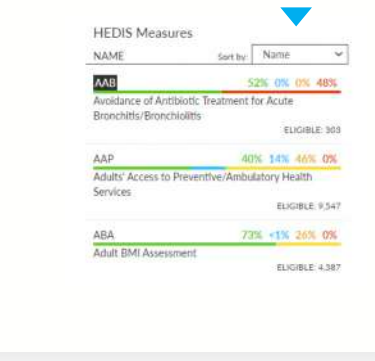
To access the materials referenced in this newsletter, go to:

- medpointmanagement.com/provider-resources
- Click on "Quality Management Information" and then "2020 Quality Newsletters."
- All materials are listed in one PDF document.
- Please also note that MedPOINT's Reference Guides are available under "HEDIS Documents."

Tip: Interpreta Member Gap Reports

When planning member outreach, remember that Interpreta Member Gap Reports include all health plans and all HEDIS measures. To help narrow down the Member Gap Report, follow these steps:

Filter the measures by clicking on the HEDIS measures you want on the **right side of the Interpreta screen**.



- Use the attached HEDIS/Stars Member Gap Report Measures Guide to identify the outreach measures.
- To pull the member list, click on any highlighted and underlined number of alerts in the dashboard on the upper left side by the circle.
- The member list will come up. Select "ALL" from the dropdown in the upper left corner to export all the data.
- Filter your list by Due and Overdue and start your calls!

For other helpful tips or to schedule an Interpreta training or refresher, please contact your HEDIS/Stars Specialist or at **qualitymeasures@medpointmanagement.com** or **(818) 702-0100, ext. 1353**.

NCQA 2020-21 HEDIS Measure Set Changes Released July 1!

NCQA has released the "HEDIS Measurement Year 2020 & Measurement Year 2021 Technical Specifications for Health Plans" document. We are working closely with Interpreta to determine when the program can be updated to reflect the new changes.

We are also waiting to hear from the DHCS (Department of Health Care Services) and the health plans on how they will implement the well child measure changes. Proper coding is essential to ensure you receive credit for the services you provide as these measures are now Administrative only.

Highlights of the changes you should know about include:

- NCQA has released two years of Technical Specifications for 2020 and 2021 to bring the measure specifications to the HEDIS community sooner.
- The former Well-Child Visits in the First 15 Months of Life (W15) measure was revised to Well-Child Visits in the First 30 Months of Life (W30) (see details below).
- The former Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) measures have been

combined into Child and Adolescent Well-Care Visits (WCV).

- The Adult BMI Assessment (ABA) measure has been retired but it is recommended to continue to code BMI until it has been confirmed if the change will be permanent.
- Medication Reconciliation Post-Discharge (MRP) has been retired but is still collected as an indicator in the Transitions of Care Measure so please continue to code 1111F to show the medications have been reconciled.

New HEDIS Well Child Measure Requirements Guide – W30 & WCV

Please see the attached "2020-21 HEDIS Measures Review Guide" which has details and codes for the two new well adolescent/child measures: Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV).

- **Coding is now critical!** Proper and timely coding W30 and WCV encounters is essential since NCQA has designated these measures as administrative rather than hybrid, meaning a chart sample will not be obtained to improve rates and use of supplemental data (EHR extracts or medical records) may be limited at health plan discretion.
- Keep this coding tip sheet handy, share it and revisit your coding workflows for these measures.
- Get started now by properly documenting and coding well child visits for members 7-11 years old

Changes to Comprehensive Diabetes Care (CDC)

The main changes for the CDC measure are as follows (see Tech Specs for further details):

- Only A1c Test, A1c >9 and A1c <8 are reported. The "HbA1c control (<7.0%) for a selected population" indicator has been retired.
- The "Medical Attention for Nephropathy" indicator for Commercial and Medi-Cal has been retired. The Medicare product line remains unchanged.
- For Blood Pressure (BP), telephone visits, e-visits and virtual check-ins were added to the Administrative Specification as appropriate settings for BP readings and the requirements for remote monitoring devices were removed to allow BPs taken by any digital device. In addition, the exclusion of BP readings reported or taken by the member was removed so this is also acceptable in closing the BP care gap.

HEDIS Telehealth Information in New Tech Specs

Synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) are considered separate modalities for HEDIS reporting.

- Synchronous telehealth requires real-time interactive audio and video telecommunications.
- A measure indicates when telephone visits are eligible for use by referencing the Telephone Visits Value Set.
- Asynchronous telehealth (sometimes referred to as an e-visit or virtual check-in) is not "real-time" but still requires two-way interaction between the member and provider, such as a patient portal, secure text messaging or email.

Important Resources

The attachments this month include the following important information:

1. Physician Guide to Reopening from the AMA.
2. CAHPS and HOS Patient Experience Surveys Guide and a HEDIS Guide for Providers from Anthem Blue Cross.
3. COVID Updates and a Telehealth update from Anthem.
4. "Due Date Plus Program" flyer from Blue Shield Promise.
5. Molina notices on risk adjustment data collection, Model of Care Training and Maternal mental health screening.
6. Telehealth Reimbursement Guide for California from Calif. Telehealth Resource Center (TRC).
7. For Telehealth coding guidance from CMS, please click this link: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.
8. For new Relief Funds available (deadline 7/20/20), see: https://www.lacare.org/providers/thepulse/funding-alert-medicaid-provider-relief-funds-now-available.

MedPOINT MANAGEMENT
Pointing Healthcare in the Right Direction

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

AMA AMERICAN MEDICAL ASSOCIATION

Updated: 05/01/20

COVID-19

A Physician Practice Guide to Reopening

As public health experts determine that it is safe to see patients and stay-at-home restrictions are relaxed, physician practices should strategically plan when and how best to reopen. The American Medical Association believes that four signposts must exist before state and local governments relax stay-at-home orders:

- Minimal risk of community transmission based on sustained evidence of a downward trend in new cases and fatalities
- A robust, coordinated and well-supplied testing network
- A public health system for surveillance and contact tracing
- Fully resourced hospitals and healthcare workforce

The Centers for Medicare & Medicaid Services (CMS) has published a Phase 1 guide for reopening facilities to provide non-emergent, non-COVID care. Building upon that guidance, the AMA suggests using the following checklist to ensure that your medical practice is ready for reopening:

Comply with governmental guidance
States and the federal government have outlined guardrails that should be in place before reopening. On the federal level, the White House has published guidelines for "Opening Up America Again." At the state level, governors have begun to detail what reopening will look like; for example, California's Gov. Newsom recently released a "Roadmap to Modify the State Stay-at-Home Order". Some states and cities have recently enacted, extended, or modified previously issued stay-at-home orders that detail essential services permitted while the order is in place, including medical care. These state and city guidelines should be closely reviewed and followed. The AMA has also developed a chart and fact sheet detailing state-specific delays, and where applicable, resumption of elective or non-urgent procedures.

Make a plan
Pre-opening planning will be vitally important to the success of your practice reopening. Sit down with a calendar and chart out your expected reopening day and, ideally, a period of "soft reopening" where you can reopen incrementally. Assess your personal protective equipment (PPE) needs and alternatives such as cloth masks, what stockpile you have currently and will need in the future, and place the necessary orders. As much as possible, have supplies delivered in advance before you reopen so that sporadic deliveries and other visitors do not disrupt the order of your daily plan. Plan in advance how you will handle staffing and cleaning if an employee or patient or visitor is diagnosed with COVID-19 after being in the clinic. Develop guidelines for determining when and how long employees who interacted with a diagnosed patient will be out of the clinic.

Open incrementally
Consider a step-wise approach to reopening so that the practice may quickly identify and address any practical challenges presented. Identify what visits can be done via telehealth or other modalities and continue to perform those visits remotely. Begin with a few in-person visits a day, working on a modified schedule. Direct administrative staff who do not need to be physically present in the office to stay at home and work remotely. Consider bringing employees back in phases, or working on alternating days or different parts of the day, as this will reduce contact. Communicate your weekly schedule clearly to the practice's patients, clinicians and staff.

Institute safety measures for patients
To ensure that patients are not coming into close contact with one another, utilize a modified schedule to avoid high volume or density. Designate separate waiting areas for "well" and "sick" patients in practices where sick patients need to continue to be seen (much like many pediatric practices have longtime used). Consider a flexible schedule, with perhaps a longer span of the day with more time in between visits to avoid backups.

Limit patient companions to individuals whose participation in the appointment is necessary based on the patient's situation (e.g., parents of children, offspring, spouse or other companion of a vulnerable adult). Consistent with U.S. Centers for Disease Control and Prevention (CDC) guidance, practices should require all individuals who visit the office to wear a cloth face covering. This expectation should be clearly explained to patients and other visitors before they arrive at the practice. To facilitate compliance, direct patients to resources regarding how to make a cloth face covering or mask from a household item if needed, such as the CDC webpage. Visitors and patients who arrive to the practice without a cloth face covering or mask should be provided with one by the practice if supplies are available.

Ensure workplace safety for clinicians and staff

Communicate personal health requirements clearly to clinicians and staff. For example, the employee should know that they should not present to work if they have a fever, have lost their sense of taste or smell, have other symptoms of COVID-19, or have recently been in direct contact with a person who has tested positive for COVID-19. Screen employees for high temperatures and other symptoms of COVID-19. Records of employee screening results should be kept in a confidential employment file (separate from the personnel file). Minimize contact as much as possible. This includes during the employee screening process, as employees conducting temperature checks have been the potential sources of spread in some workplaces. Consider rearranging open work areas to increase the distance between people who are working. Also, consider having dedicated workstations and patient rooms to minimize the number of people touching the same equipment. Establish open communication with facilities management regarding cleaning schedules and protocols regarding shared spaces (e.g. kitchens, bathrooms), as well as reporting of COVID-19 positive employees in the office building. To learn more about health care institutions' ethical obligations to protect health care professionals, see this piece from AMA ethics.

Implement a tele-triage program

Depending on a patient's medical needs and health status, a patient contacting the office to make an in-person appointment may need to be re-directed to the practice's HIPAA-compliant telemedicine platform, a COVID-19 testing site or to a hospital. Utilize a tele-triage program to ensure that patients seeking appointments are put on the right path by discussing the patient's condition and symptoms. If the practice had already engaged a tele-triage service to handle after-hours calls pre-COVID, contact this service to see if the service can be expanded to tele-triage daytime calls, or consider redeploying the practice's own clinicians or staff to manage this service.

Screen patients before in-person visits

Before a patient presents in the office, the practice should verify as best it can that the patient does not have symptoms of COVID-19. Visits that may be conducted via telemedicine should be. For visits that must take place in person, administrative staff should contact the patient via phone within 24 hours prior to the office visit to 1) review the logistics of the reopening practice protocol and 2) screen the patient for COVID-19 symptoms. Utilize a script for your administrative staff to follow when conducting these calls. (See the sample script the AMA has developed below.) Once the patient presents at the office, the patient should be screened prior to entering. Some practices may utilize text messaging or another modality to do such screening, subject to patient consent and relevant federal and state regulations. Others may deploy staff in a designated part of the parking lot or an ante room of the practice to screen patients before they enter the practice itself. The practice should strictly limit individuals accompanying patients but, in instances where an accompanying individual is necessary (e.g. a parent of a child), those individuals should be screened in the same manner as a patient.

Coordinate testing with local hospitals and clinics

There will be instances where your patients require COVID-19 testing. Contact your public health authority for information on available testing sites. Identify several testing sites in your catchment area. Contact them to ensure that tests are available and to understand the turnaround time on testing results. Provide clear and up to date information to patients regarding where they can be tested and how the process works. Some health systems have instituted the practice of testing all patients who are being scheduled for elective or high-intensity procedures (such as outpatient surgeries or services requiring close contact). Depending on the nature of your practice, you may consider doing the same.

Limit non-patient visitors
Clearly post your policy for individuals who are not patients or employees to enter the practice (including vendors, educators, service providers, etc.) outside the practice door and on your website. Reroute these visitors to virtual communications such as phone calls or videoconferences (for example, a physician may want to hold "office hours" to speak with suppliers, vendors or salespeople). For visitors who must physically enter the practice (to do repair work, for example), designate a window of time outside of the practice's normal office hours to minimize interactions with patients, clinicians or staff.

Contact your medical malpractice insurance carrier
To ensure that clinicians on the front line of treating COVID-19 patients are protected from medical malpractice litigation, Congress has shielded clinicians from liability in certain instances. As the practice reopens, however, there may be heightened risks caused by the pandemic that do not fall under these protections. Contact your medical malpractice liability insurance carrier to discuss your current coverage and whether any additional coverage may be warranted. As much as is practicable, you should protect your practice and your clinicians from liability and lawsuits resulting from current and future unknowns related to the COVID-19 pandemic. The AMA is also advocating to governors that physicians be shielded from liability for both COVID treatment and delayed medical services due to the pandemic.

Establish confidentiality / privacy
Institute or update confidentiality, privacy and data security protocols. Results of any screenings of employees should be kept in employment records only (but separate from the personnel file). Remember that HIPAA authorizations are necessary for sharing information about patients for employment purposes. Similarly, coworkers and patients can be informed that they came into contact with an employee who tested positive for COVID-19, but the identity of the employee and details about an employee's symptoms cannot be shared with patients or co-workers without consent. While certain HIPAA requirements related to telemedicine are not being enforced during the COVID-19 public health emergency, generally, HIPAA privacy, security and breach notification requirements must continue to be followed. Answers to frequently asked questions are provided at the end of this document.

Consider legal implications
New legal issues and obligations may arise as the practice reopens. For example, some practices may not have had to make decisions about paid sick leave (per the "Families First Coronavirus Response Act") because they were on furlough; as the practice reopens, these sorts of employment obligations should be considered and decisions about opting out or procedures for requesting these leaves communicated to employees. The AMA has additional resources for physician practices related to employees and COVID-19. Lastly, coordinate with your local health department as provided for by law; provide them with the minimum necessary information regarding COVID-19 cases reported in your practice, and stay informed of local developments.

Pre-visit screening script template

Introduction: I would like to speak to [name or patient with scheduled visit]. I'm calling from [XYZ practice] with regard to your appointment scheduled for [date and time]. The safety of our patients and staff is of utmost importance to [XYZ practice]. Given the recent COVID-19 outbreak, I'm calling to ask a few questions in connection with your scheduled appointment. These are designed to help promote your safety, as well as the safety of our staff and other patients. We are asking the same questions to all practice patients to help ensure everyone's safety. So that we can ensure that you receive care at the appropriate time and setting, please answer these questions truthfully and accurately. All of your responses will remain confidential. As appropriate, the information you provide will be reviewed by one of our practice's medical professionals who will provide additional guidance regarding whether any adjustments need to be made to your scheduled appointment.

Question	Yes/No	Details
Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, when the symptoms stopped.)		
Have you or a member of your household been tested for COVID-19? (If yes, obtain the date of test, results of the test, whether the person is currently in quarantine and the status of the person's symptoms.)		
Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the testing occurred, when any symptoms started and stopped and the current health status of the person who was advised.)		
Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the person quarantined, when any symptoms started and stopped and the current health status of the person who was advised.)		
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? (If yes, obtain the facility name, location, reason for visit/treatment and dates.)		
Have you or a member of your household traveled outside the U.S. in the past 30 days? (If yes, obtain the city, country and dates.)		
Have you or a member of your household traveled elsewhere in the U.S. in the past 21 days? (If yes, obtain the city, state and dates.)		
Have you or a member of your household traveled on a cruise ship in the last 21 days? (If yes, determine the name of the ship, ports of call and dates.)		
Are you or a member of your household healthcare providers or emergency responders? (If yes, find out what type of work the person does and whether the person is still working. For example, ICU nurse actively working versus a furloughed firefighter.)		
Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? (If yes, obtain the status of the person cared for, when the care occurred, what the care was.)		
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, obtain information about the believed source of the potential exposure and any signs that the person acquired the virus.)		
To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? (If yes, obtain information about when the contact occurred, what the contact was, how long the people were in contact and when the diagnosis occurred.)		

Thank you.

I will share this information with a medical professional in our practice. Please note that our office requires that all patients and visitors follow CDC guidance regarding face coverings to prevent the spread of COVID-19. For that reason, we ask that you please wear a cloth face covering or mask to your appointment. Unless you hear otherwise from us, we look forward to seeing you at your appointment on [date/time].

Practice staff action steps:

- If patient responds "Yes" to any of the above, questionnaire must be reviewed by designated medical leadership to assess whether the patient can keep the scheduled appointment. Patient will be contacted again after decision-making.
- If patient responds "No" to all of the above, do you believe any further inquiry with the patient is appropriate before the scheduled visit? If yes, what type of inquiry and why?
- If you have any questions, please contact _____ [designated medical leadership] to discuss.

Note: This sample script is designed to collect information that can be used to inform decisions about whether it is advised for patients to receive care from the practice. This sample should be reviewed, modified as appropriate, and ultimately approved for use by practice medical leadership who have responsibility for remaining current on applicable COVID-19-related guidelines from the CDC and other appropriate resources.

Privacy & confidentiality FAQ

Q1. If a practice is collecting medical information about its employees upon arrival at work as condition of work (e.g., temperature, symptoms, COVID-19 exposure), where does this information go and who is authorized to see it?

A1. The Equal Employment Opportunity Commission (EEOC) has issued guidance for employers on the collection of employee medical information related to COVID-19. Generally, this employee health screening information goes in a file that is an "employee file," like the separate employee medical file that must be created for employees seeking ADA accommodations. It is kept separate (either physically if it is a paper file or in a different electronic file) from the regular personnel file (which has onboarding paperwork, reviews, W4 forms, etc.). Only a limited number of people in the practice's administration or human resources personnel can have access to that file. The information in the file should *only* be disclosed to supervisors, managers, first aid and safety personnel, and government officials *if absolutely necessary*.

Q2. If a practice's employee is also a patient of the practice, or a patient of an on-site medical clinic owned by the practice, where does health screening information go and who is authorized to see it?

A2. For employees who are also patients of the practice, medical information collected to determine whether an employee is fit to work may be disclosed to the employer, provided that the practice has a written, signed HIPAA authorization on file. This information would go in the "employee file." If medical information is collected as part of the employee's treatment as a patient, HIPAA privacy protections would apply, and the employer may be authorized to obtain such information *only* if the patient has consented to its disclosure through a written, signed HIPAA authorization.

Q3. Where should visitor screening logs be kept and what information should be collected?

A3. Information collected in a visitor screening log should be limited to only that which is necessary for maintaining the safety of the practice, public health authority reporting, and other purposes articulated in the policies and procedures of the practice. Visitor screening logs should be kept separately from all HIPAA protected health information (PHI); as soon as this information is "comingled" with any HIPAA PHI, it arguably becomes protected by HIPAA, and can be disclosed only as permitted by HIPAA. Note also that state data privacy, security and breach notification requirements would apply, depending on the state of residence of the individual. Consider consulting with legal counsel with expertise in data privacy and security requirements, including the HIPAA laws, to advise on your particular situation.

Q4. Can the practice require that its employees be tested for COVID-19 prior to presenting to work and/or disclose a COVID-19 diagnosis or symptoms?

A4. Practices can require employee testing and disclosure even if it is not addressed in a contract or handbook. Screening and testing measures can be announced in a memo, policy or broader response plan.

20-447338:4/20

Information from Anthem for Care Providers About COVID-19 (Updated April 10, 2020)

Published: Apr 10, 2020 - **Administrative**

Coronavirus (COVID-19) Updates: For the latest COVID-19 information, please check our websites:
Commercial: *Provider News Home*
Medicaid: *Medicaid Provider News & Announcements*
Medicare: *Important Medicare Advantage Updates*

Please note that the following information applies to Anthem's Commercial health plans. Medicare and Medicaid plans are included when not otherwise required under State and/or Federal mandates. Please review the Medicare and Medicaid specific sites noted above for details about these plans.

Information from Anthem for Care Providers about COVID-19

Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company (collectively "Anthem") are closely monitoring COVID-19 developments and what it means for our customers and healthcare provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) to help us determine what action is necessary on our part.

To help address care providers' questions, Anthem has developed the following frequently asked questions:

Waiver of Member Cost Shares

Will Anthem waive member cost shares related to COVID-19 including screening, testing, and treatment?

- **Screening & Testing:** Yes, as of March 5, 2020 and until further notice, cost shares, inclusive of copays, coinsurance and deductibles for COVID-19, will be waived by Anthem or its delegated entities for screening and testing for COVID-19. Tests samples may be obtained in many settings including a doctor's office, urgent care, ER or even drive-thru

testing once available. While a test sample cannot be obtained through a telehealth visit, the telehealth provider can help a member get to a provider who can do so. The waivers apply to members who have individual, employer-sponsored, Medicare and Medicaid plans.

- **Treatment**: Yes, effective April 1, 2020 through May 31, 2020, Anthem and its delegated entities will waive cost shares for members undergoing treatment related to a COVID-19 diagnosis.

Anthem will reimburse health care providers according to standard reimbursement rates, depending on provider participation and benefit plan, for fully insured, individual, Medicaid and Medicare members. Anthem will continue to monitor and comply with state and federal guidelines. Self-insured plan sponsors will have the choice to participate.

Prior Authorization

Does Anthem require a prior authorization for screening or testing for COVID-19?
No, prior authorization is not required from Anthem or its delegated entities for screening or testing related to COVID-19 testing.

Is Anthem changing its requirements for prior-authorization?
Anthem recognizes the intense demands facing doctors, hospitals and all health care providers in the face of the COVID-19 pandemic. As of March 27, 2020 and until further notice, Anthem and its delegated entities will suspend select prior authorization requirements, to allow health care providers to focus on caring for patients diagnosed with COVID-19. These adjustments apply to members of all lines of business, including self-insured plan members. The suspension of select prior authorization is inclusive of the following:

Inpatient and respiratory care

- **Prior authorization requirements are suspended for patient transfers:** All hospital inpatient transfers to lower levels of care (by land only). Although prior authorization is not required, Anthem requests voluntary notification via the usual channels to aid in our members' care coordination and management.

- **The 21-day inpatient requirement** before transferring a patient to a long-term acute care hospital is suspended.
- **Concurrent review for discharge planning** will continue unless required to change by federal or state directive.

- **Prior authorization requirements are suspended for COVID-19 Durable Medical Equipment** including oxygen supplies, respiratory devices and continuous positive airway pressure (CPAP) devices for patients diagnosed with COVID-19, along with the requirement for authorization to exceed quantity limits on gloves and masks.
- **Respiratory services** for acute treatment of COVID-19 will be covered. Prior authorization requirements are suspended where previously required.

Telehealth and Telephonic Services

Will Anthem waive member cost shares for telehealth services?
Yes, as of March 17, 2020 and until further notice, Anthem and its delegated entities will waive cost sharing for members using Anthem's telemedicine service, LiveHealth Online, as well as care received from other in-network providers delivering virtual care through internet video + audio services for our fully insured employer plans, individual plans, Medicare plans and Medicaid plans. Self-insured plan sponsors may opt out of this program.

Member cost shares for telehealth services will not be waived for out of network providers, except for COVID-19 screening.

Will Anthem cover telephonic only services in addition to telehealth via video + audio?
Yes, as of March 19, 2020, in order to address the concerns we have heard from providers about the need to support care for Anthem members during extended periods of social distancing, Anthem and its delegated entities will cover telephone-only medical and behavioral health services from in-network providers and out-of-network providers when appropriate. Self-insured plan sponsors may opt out of this program.

Is the option to deliver services via telehealth available for all types of services?
Yes, until further notice, so long as it is medically appropriate to render the services via telehealth.

Exceptions for Medi-Cal members include chiropractic services, physical, occupational, and speech therapies. At this time the DHCS has not authorized these services for telehealth or telephone.

Does the provider have to be physically present in their office when providing services via telehealth?
No. If the provider can effectively deliver services via telehealth from another location (e.g., the provider's home), while also maintaining the patient's privacy the services are payable.

What is the reimbursement rate for telehealth and telephonic services?
As required by the State of California, telehealth and telephonic services must be paid at the same rate, whether a service is provided in-person or through telehealth or telephonically, 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.

Can all contracted providers provide telehealth and telephonic services?
Yes. All Anthem contracted providers can provide telehealth and telephonic services if clinically appropriate.

Is Anthem's vendor, LiveHealth Online, prepared for the number of visits that will increase to telehealth?
As there is a heightened awareness of COVID-19 and more cases are being diagnosed in the United States, LiveHealth Online is increasing physician availability and stands ready to have doctors available to see the increase in patients, while maintaining reasonable wait times.

What is the best way that providers can get information to Anthem's members on Anthem's alternative virtual care offerings?
Anthem.com/ca is a great resource for members and providers with questions and are being updated regularly.
Anthem members have access to telehealth 24/7 through LiveHealth Online. Members can access LiveHealth Online at https://livehealthonline.com/ or by downloading the LiveHealth Online app from the App Store or Google Play.
Anthem members also can call the Anthem 24/7 NurseLine at the number listed on their Anthem ID card to speak with a registered nurse about health questions.

As of March 17, 2020 Anthem and its delegated entities will waive, until further notice, any member cost share for telehealth or telephonic visits provided by in-network provider, including visits for mental health, for our fully insured employer, individual, Medicare and Medicaid plans. Cost shares will be waived for members using Anthem's telemedicine service, LiveHealth Online, as well as care received from other telehealth providers. Self-insured plan sponsors will have the choice to participate.

Coding & Billing

How should a provider bill for services delivered via telehealth or telephone during the State of Emergency, when the provider would normally deliver the services in-person?

During the COVID-19 State of Emergency, when a provider delivers a service via telehealth that the provider would normally deliver in-person, the provider should document and bill the service(s) as follows:

- Thoroughly document the visit as if the visit had occurred in person.
- Use the CPT code(s) for in-office visit for the particular service(s) rendered. DO NOT USE telehealth or telephonic CPT codes.
- Use Place of Service "02" to designate telehealth.
- Use modifier 95 or GT for synchronous rendering of services, or GQ for asynchronous.
    - **Medi-Cal Exception** – use modifier 95 for synchronous rendering of services, or GQ for asynchronous.

What diagnosis codes would be appropriate to consider for a patient with known or suspected COVID-19?
The CDC has provided coding guidelines related to COVID-19:
https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

Claims Audits, Retrospective Review and Policy Changes

Anthem will adjust the way we handle and monitor claims to ease administrative demands on providers:

- **Hospital claims audits** requiring additional clinical documentation will be limited for next 90 days, though Anthem reserves the right to conduct retrospective reviews with expanded lookback recovery periods. To assist providers, Anthem can offer electronic submission of clinical documents through the provider portal.
- **Retrospective utilization management review** will also be limited during this 90-day period, and Anthem reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.
- **Our special Investigation programs** targeting provider fraud will continue, as well as other program integrity functions that ensure payment accuracy.
- **New payment and utilization management policies and policy updates** will be minimized for the next 90 days, unless helpful in the management of the COVID-19 pandemic.

Anthem will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials and appeals where applicable. Our timely filing requirements remain in place, but Anthem is aware of limitations and heightened demands that may hinder prompt claims submission.

Provider Credentialing

Anthem will continue to process provider credentialing within the standard timeframe. If we are unable to verify provider application data due to disruptions to licensing boards and other agencies then we will verify this information when available.

If Anthem finds that a practitioner fails to meet our minimum criteria because of sanctions, disciplinary action etc., we will follow the normal process of sending these applications to committee review which may add to the standard timeframe. We will monitor and comply with state and federal directives regarding provider credentialing.

Prescription Drugs

Can members obtain an extra 30-day refill of a prescription drug?
Yes. We are also allowing members to obtain an extra 30-day supply of medication when medically appropriate and permitted by state and federal law. We are also encouraging that when member plans allow that they switch from 30-day home delivery to 90-day home delivery.

General Questions

Does Anthem have recommendations for reporting, testing and specimen collection?
The CDC updates these recommendations frequently as the situation and testing capabilities evolve. See the latest information from the CDC:
https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

In case of mass epidemic, how can you ensure that your contracted providers can still provide services?
Anthem is committed to working with and supporting its contracted providers. Our benefits already state that if members do not have appropriate access to network doctors that we will authorize coverage for out-of-network doctors as medically necessary.

In addition, Anthem's telehealth provider, LiveHealth Online, is another safe and effective way for members to see a doctor to receive health guidance related to COVID-19 from their home via mobile device or a computer with a webcam.

Are you aware of any limitations in coverage for treatment of an illness/virus/disease that is part of an epidemic?
Our standard health plan contracts do not have exclusions or limitations on coverage for services for the treatment of illnesses that result from an epidemic.

Does Anthem expect any slowdown with claim adjudication because of COVID-19?
We are not seeing any impacts to claims payment processing at this time.

If you have additional questions or need more information, please call the phone number on the member's ID card.

URL: https://providernews.anthem.com/california/article/information-from-anthem-for-care-providers-about-covid-19-5

Featured In:
COVID-19 Information

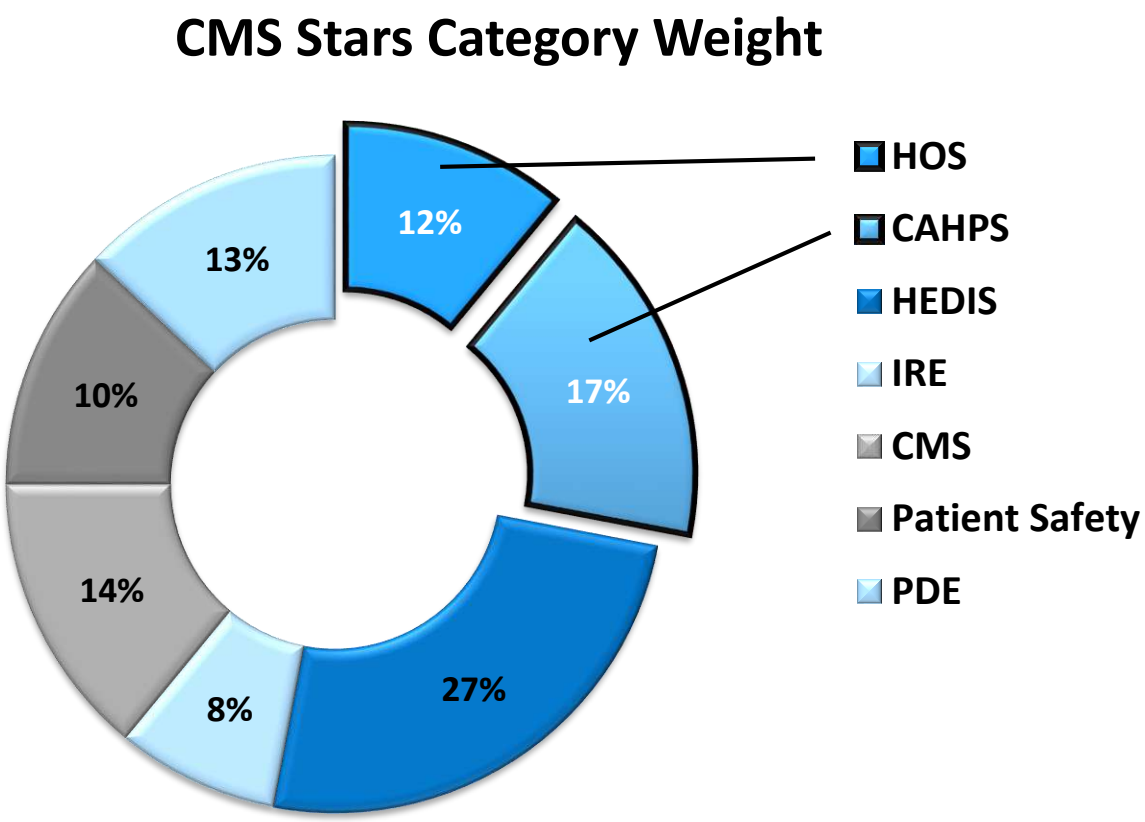
CAHPS and HOS Surveys

Enhancing the Patient Experience

Anthem BlueCross

CMS Stars Quality Rating System

- **HEDIS** – Healthcare Effectiveness Data & Information Set
- **CAHPS** – Consumer Assessment of Healthcare Providers & Systems
- **CMS** administrative data on plan quality and member satisfaction
- **HOS** – Health Outcomes Survey
- **IRE** – Independent Review Entity
- **PDE** – Prescription Drug Event



CAHPS and HOS Surveys

- Members are randomly annually from each health plan to participate
    - CAHPS: 800 – 2,000
    - HOS: 500 – 1,200

- Five attempts are made to survey the member
    - Two paper and three telephonic

CAHPS – Consumer Assessment of Healthcare Providers and Systems

95 survey questions

Assesses patient experiences with different topics related to their health care provider and services provided by the health plan and PDP

CAHPS Survey Question Domains

Weight	Measure	Components
1.5	Getting Care Quickly	• Scheduling an appointment • 15 Minute Wait Time
1.5	Coordination of Care	• Review medications • Informed about Specialist care
1.5	Getting Needed Care	• Getting Specialist appointment • Care, Tests, treatments through the plan
1.5	Customer Service	• Customer Service courteous and informative • Health plan forms
1.5	Getting Needed Prescription Drugs	• Ease of getting Prescribed Medications • Obtaining medications at Retail or via Mail
1	Annual Flu Vaccine	• Obtaining Flu Vaccination during prior season
1.5	Rating Healthcare Quality	• 0-10 Rating of Healthcare
1.5	Rating the Health Plan	• 0-10 Rating of Health Plan
1.5	Rating the Drug Plan	• 0-10 Rating of Drug Plan

HOS - Health Outcomes Survey

68 survey questions

Assesses the ability of providers and Medicare Advantage organizations to maintain or improve the physical and mental health of their patients

Members are selected to receive a **baseline** survey and a **follow-up** survey 2 years later

HOS Survey Measure Domains

Weight	Measure	Components
3	Physical Health	• Self-assessment (past 4 weeks) • Accomplishing daily activities
3	Mental Health	• Self-assessment (past 4 weeks) • Daily mood, emotional state
-	Bladder Control	• Issue (past 6 months) • Physician discussion • Treatment
1	Fall Risk	• Issue (past 12 months) • Physician discussion (past 12 months) • Treatment
1	Physical Activity	• Physician Discussion (past 12 months) • Recommendation – start, increase, maintain activity level (past 12 months)

Improvement **Discussion**

Timeline

Blackout Period: February–June.

The health plan is *prohibited* from conducting any CAHPS-related questions during this time period that could influence survey responses, however, physicians may continue to have discussions on CAHPS and HOS quality topics with patients.

	January	February	March	April	May	June	July
CAHPS Survey			Pre-notification letter 1st Paper Questionnaire mails	2nd Paper Questionnaire mails Telephonic outreach begins	Interim data files due to CMS	Follow-up calls end Cutoff for phone and mail surveys Final data files due to CMS	
HOS Survey				**HOS Baseline** Cohort survey begins	**HOS Follow-Up** Cohort survey begins	**HOS Baseline** Cohort survey ends	**HOS Follow-Up** Cohort survey ends

Clinical and Business Case

Clinical Case

- ✓ Adherence to medical treatment and advice
- ✓ Improved coordination of care
- ✓ Better health outcomes

Business Case

- ✓ Leads to patient retention
- ✓ Lower risk of malpractice or other legal activity
- ✓ Keeps employees engaged with less turnover

EXAMPLE QUESTION TYPES

Question #	Measure	Question	Related Survey
1	Getting Care Quickly	Did you experience any difficulty scheduling your appointment?	CAHPS
2	Getting Care Quickly	How long after your scheduled appointment time did you wait to see the person you came to see?	CAHPS
3	Getting Needed Care	Did you have any trouble getting a referral to see a specialist from your personal doctor?	CAHPS
4	Getting Needed Prescription Drugs	Did you have trouble with your prescription drug plan covering any medication your doctor prescribed?	CAHPS
5	Getting Needed Care	Did you have any problem getting approval through your health plan for any tests, care or treatment your doctor said you needed?	CAHPS
6	Coordination of Care	Did your personal doctor talk about all of the prescription medicines you were taking?	CAHPS
7	Coordination of Care	Did your personal doctor seem informed an up to date about the care you got from specialists?	CAHPS
8	Reducing the Risk of Falls	Did your doctor or other health provider talk to you about falling or problems with balance or walking?	HOS
9	Reducing the Risk of Falls	Did you doctor or other health provider suggest any treatment, such as using a cane or walker, having your blood pressure checked or having regular vision or hearing tests?	HOS
10	Improving Bladder Control	Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?	HOS
11	Improving Bladder Control	Did your doctor, nurse, or other health care provider talk to you about ways to control or manage the leakage of urine?	HOS
12	Monitoring Physical Activity	Did your doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?	HOS
13	Rating of Mental Health / Improving & Maintaining Mental Health	Did your doctor or other health provider ask you about your mental or emotional health?	CAHPS & HOS

Category	Description
Access to Care	Average of: Q1, Q2, Q3 scores
Coordination of Care	Average of: Q6, Q7 scores
Patient Discussion	Average of: Fall Risk Score (Q8 & Q9 average), Bladder Score (Q10 & Q11 average), Physical Activity (Q12), Mental Health (Q13)

Patient Experience – Thresholds EXAMPLE

Thresholds are based on the industry cut points for the related measures on the CAHPS and HOS surveys

		1-Star		2-Star		3-Star		4-Star		5-Star	
		Low	High	Low	High	Low	High	Low	High	Low	High
1	Difficulty Scheduling Appointment	0	71	71	73	73	77	77	79	79	100
2	Doctor Wait Time	0	71	71	73	73	77	77	79	79	100
3	Referral for Specialist	0	79	79	81	81	84	84	86	86	100
4	Insurance Covering Medications	0	87	87	89	89	91	91	92	92	100
5	Approval - Tests and Procedures	0	79	79	81	81	84	84	86	86	100
6	Doctor Review Medications	0	84	84	86	86	88	88	91	91	100
7	Doctor Informed - Specialist Care	0	84	84	86	86	88	88	91	91	100
8	Fall Risk - Discussion	0	53	53	60	60	67	67	73	73	100
9	Fall Risk - Treatment	0	53	53	60	60	67	67	73	73	100
10	Bladder Control - Discussion	0	31	31	36	36	60	60	71	71	100
11	Bladder Control - Treatment	0	31	31	36	36	60	60	71	71	100
12	Physical Activity	0	44	44	49	49	55	55	62	62	100
13	Mental Health	0	75	75	77	77	80	80	82	82	100

Enhancing the Patient Experience

Appointment Scheduling

Patient Experience #1: Did you experience any difficulty setting up your appointment?

		PCP	Staff
Early Scheduling	Encourage the patient to schedule their next visit as soon as possible	✓	✓
Follow-up Visits	When possible, schedule the patients' follow-up visit before they leave your office		✓
Appointment Reminder Calls	Begin reminder calls 2-3 days in advance of the appointment to allow for rescheduling if necessary		✓
Records Check	Ensure that demographic and insurance information is current before the patient arrives		✓
Wellness Checks	Reach out to patients who have not been in for 6-12 months to schedule wellness visits		✓

Appointment Scheduling – Best Practices

Patient Experience #1: Did you experience any difficulty setting up your appointment?

Appointment Reminder Card

Scheduling a follow-up appointment for the patient prior to them leaving the office and giving them a reminder card can ease the administrative stress and encourage compliance with treatment.

Patient Wait Time

Patient Experience #2: How long after your scheduled appointment time did you wait to see your healthcare provider?

		PCP	Staff
Early arrival	Remind the patient to arrive prior to their scheduled appointment in time to complete necessary paperwork		✓
Comfortable Environment	Provide a clean, comfortable, and visually appealing environment for patients to wait		✓
Educational Materials	Flyers, pamphlets, posters, and other education items can be made available to patients. Install TVs with pre-recorded healthcare programs		✓
Food and Drink	Vending machines can be placed in the office or healthy snacks, coffee, and water could be made available (be aware of fasting patients)		✓
Surveys	Short surveys may prompt patient thinking on important health topics to discuss with their provider	✓	✓
Staff Training	Provide staff education on customer service basics, managing patient wait time, and improved patient perception of services	✓	✓

Patient Wait Time – Best Practices

Patient Experience #2: How long after your scheduled appointment time did you wait to see your healthcare provider?

Clean and comfortable reception area

Beverage station and snack machine

Educational materials

Patient Wait Time – 15 Minute Poster

We Value Your Time

If you have been waiting more than **15 minutes** beyond your scheduled appointment time, please let us know.

- Provides accountability to the standard set in the CAHPS survey

Specialist Referral

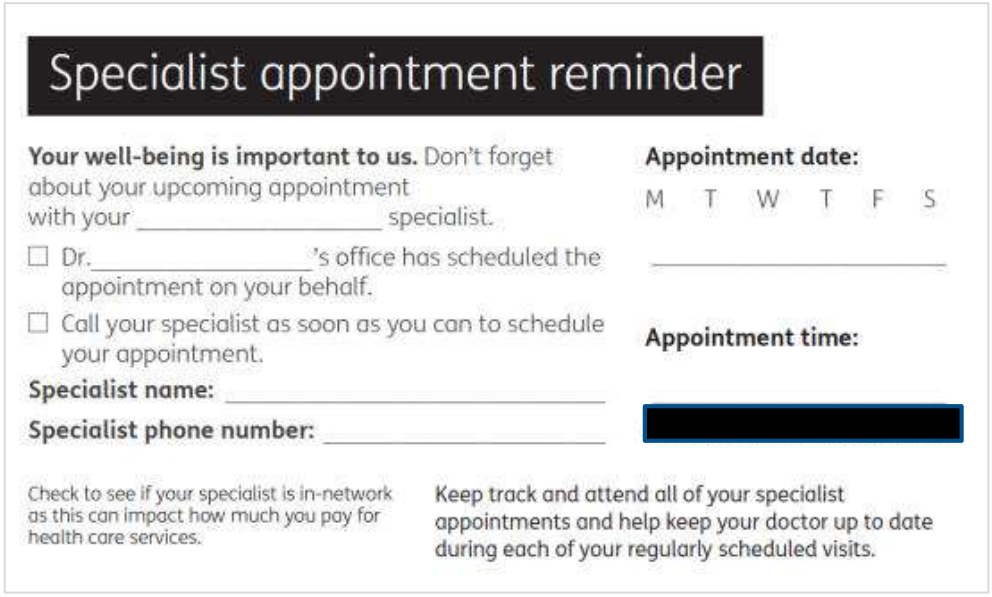
Patient Experience #3: Did you have any trouble getting a referral to see a specialist from your personal doctor?

		PCP	Staff
Specialist Coverage	Verify the specialist coverage in the patient's health plan and inform them of any copay or additional financial responsibility		✓
Set Expectations	Remind the patient that it could take several weeks or months to get in to see a specialist for the follow-up care they need	✓	✓
Schedule the specialist visit	Schedule any specialist appointments on behalf of the patient before they leave the office		✓
Specialist Pads	Specialist Appointment Reminder Pads can serve as a reminder	✓	✓
Appointment reminder call	If an appointment was not made before they left your office, call to remind the patient to schedule with the specialist.		✓

Specialist Referral – Best Practices

Patient Experience #3: Did you have any trouble getting a referral to see a specialist from your personal doctor?

Specialist Appointment Reminder Pads



Specialist appointment reminder

Your well-being is important to us. Don't forget about your upcoming appointment with your _____ specialist.

☐ Dr._____'s office has scheduled the appointment on your behalf.

☐ Call your specialist as soon as you can to schedule your appointment.

Specialist name: _____

Specialist phone number: _____

Appointment date:

M T W T F S

_____

Appointment time:

[redacted]

Check to see if your specialist is in-network as this can impact how much you pay for health care services.

Keep track and attend all of your specialist appointments and help keep your doctor up to date during each of your regularly scheduled visits.

Prescription Medications

Patient Experience #4: Did you have trouble with your prescription drug plan covering any medication your doctor prescribed?

		PCP	Staff
Mail Order	Recommend contracted mail order whenever possible to improve adherence, convenience, and possibly reduce medication cost	✓	✓
Review Formulary	Understand what is covered by the patient's prescription Part D plan	✓	
Prior Authorization	If a prior authorization is required, complete and return all forms promptly. Follow-up when necessary.	✓	✓
Generic or Equivalent Rx	Verify lowest tier formulary equivalent medication that could be prescribed	✓	
Copay	Obtain any available copay discount cards from pharmaceutical representatives and websites.	✓	✓

Prescription Medications – Best Practices

Patient Experience #4: Did you have trouble with your prescription drug plan covering any medication your doctor prescribed?

Keep a directory of locally contracted pharmacies. Assist patients with directions or registration for mail order pharmacy.

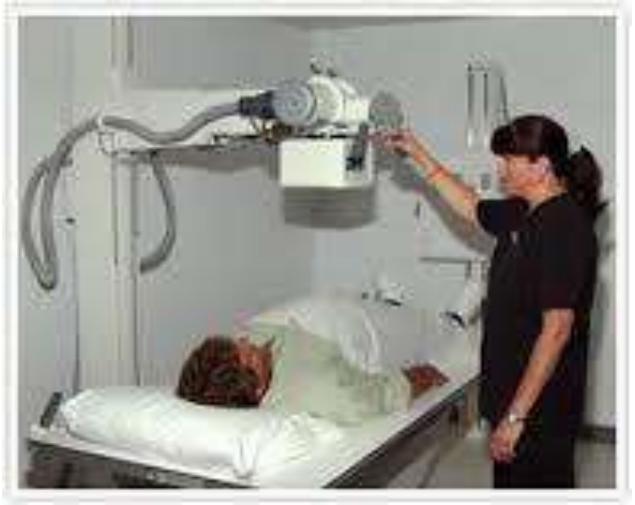
Tests or Treatments

Patient Experience #5: Did you have any problem getting approval through your health plan for any test or procedure your doctor said you needed?

		PCP	Staff
Set expectations	Help the patient understand that it could take several weeks to get into a specialist or facility for the necessary treatment or test	✓	✓
Coverage	Verify health plan coverage for recommend treatments, tests, or procedures		✓
Treatment Location	Assist the patient in locating a convenience testing facility		✓
Schedule Appointments	When possible, schedule the appointments for tests or treatment before they leave the office.		✓
Referral Paperwork	Complete and send any referral forms and authorizations to the test or treatment facility. Respond promptly to any requests for additional information.	✓	✓

Tests or Treatments – Best Practices

Patient Experience #5: Did you have any problem getting approval through your health plan for any test or procedure your doctor said you needed?



Assist patients with benefits information for laboratory, x-ray and special testing procedures.

Medication Review

Patient Experience #6: Did your personal doctor talk about all of the prescription medicines you are taking?

		PCP	Staff
Medication list	Encourage patients to write down all of their prescriptions, quantity, and frequency and bring to every visit. Include injection and infusion medication received at other provider facilities.		
Prescription Bag	Patients can physically bring pill bottles of all prescriptions in to their appointment for more thorough review with the physician		
Prescription Analysis	Look for duplicate medications, negative drug interactions, eliminate unnecessary prescriptions, and switch down to less costly alternatives		
Educational material	Provide educational material to stress the importance of physician-patient conversations around reviewing prescription medications		

Medication Review– Best Practices & Materials

Patient Experience #6: Did your personal doctor talk about all of the prescription medicines you are taking?

Reconcile all medications at each visit and give the patient a list to take home along with their treatment plan.

Medication	Instructions
albuterol HFA 90	2 puffs every 4 hours as needed
aspirin 81 mg	1 daily
beclomethasone HFA 40	2 puffs twice a day
carvedilol 25 mg	1 twice daily
chlorthalidone 25 mg	1 daily
citalopram 20 mg	1 daily
gabapentin 600 mg	1 twice daily
insulin glargine 28 units	28 units at bedtime
losartan 100 mg	1 daily
metformin 1000 mg	1 twice daily
naproxen 500 mg	1 twice daily
omeprazole 40 mg	1 daily
prednisone 20 mg	2 daily
simvastatin 40 mg	1 daily
terbinafine 250 mg	1 daily for 12 weeks
zolpidem 5 mg	1 at bedtime

Informed About Specialist Care

Patient Experience #7: Did your personal doctor seem informed and up to date about the care you got from specialists?

		PCP	Staff
Request records	Follow up with the specialist's office to be sure that any results of patient care are sent over to your practice		✓
Close discussion loop	Discuss results of the specialist appointment, treatment, or procedure and recommend next steps	✓	
Specialist Pads as reminder	Encourage patient to keep Specialist Reminder tear-offs to jog their memory of the appointment leading up to PCP follow-up visit		✓
Educational material	Provide educational material to stress the importance of PCP-patient conversations around specialist care results	✓	✓
Patient Chart notes	Keep detailed records in patient charts about specialist care recommended and expected results that should be reviewed	✓	✓

Informed about Specialist Care – Best Practices

Patient Experience #7: Did your personal doctor seem informed and up to date about the care you got from specialists?

Obtain all specialist correspondence prior to the patient visit. Review the results with the patient and include the specialist recommendations in their overall treatment plan.

Falls Risk Discussion

Patient Experience #8: Did your doctor or other health provider talk to you about falling or problems with balance or walking?

		PCP	Staff
Problem level Assessment	Assess severity of the issue through dialogue with the patient	✓	
Educational Material	Hand out questionnaires and materials to assist patients in evaluating the issue and its severity prior to seeing the physician	✓	✓
Tripping hazards	Advise patient to move or secure rugs, wires, or other tripping hazards	✓	✓
Night Light	Advise patient to hang a night light to avoid falls in the middle of the night	✓	✓
Educational Media	Consider using other visual media displays to help educate patients in the waiting room	✓	✓
Reinforce Discussion	Provide reinforcement once the physician has addressed this as a topic of concern		✓

Falls Risk Discussion – Best Practices

Patient Experience #8: Did your doctor or other health provider talk to you about falling or problems with balance or walking?

Patient questionnaire pads and exam room posters encourage patients to discuss falls, bladder control, emotional health and physical activity

We care about your health and well-being. Please take a moment to answer these questions and discuss any concerns with your healthcare provider.

1.) Have you fallen or lost your balance in the last 12 months?
☐ Yes ☐ No

2.) Do you use a cane or walker (even occasionally)?
☐ Yes ☐ No

3.) Is bladder control (leaking urine) a problem for you?
☐ No ☐ Sometimes ☐ Often

4.) Does your physical health interfere with your daily activities?
☐ No ☐ Sometimes ☐ Often

5.) How would you describe your emotional health?
☐ Calm ☐ Energetic ☐ Downhearted, depressed or "blue"

Falls Treatment

Patient Experience #9: Did your doctor or other health provider suggest any treatment, such as using a cane or walker, having your blood pressure checked or having regular vision or hearing tests?

		PCP	Staff
Blood Pressure	Check patient's blood pressure in sitting and standing position	☐	☑
Vision Test	Evaluate patient's vision or refer to a specialist who can assist further if necessary	☑	☑
Physical Therapy	Recommend physical therapy to rehabilitate weak muscles or bones which could make the patient prone to falling	☑	☐
Exercise	Encourage patients in good health to strengthen bones and muscles through exercise	☑	☑
Referral assistance	Assist patient in scheduling any follow-up treatment required for this issue before they leave your office	☐	☑

Falls Treatment – Best Practices

Patient Experience #9: Did your doctor or other health provider suggest any treatment, such as using a cane or walker, having your blood pressure checked or having regular vision or hearing tests?

Include blood pressure monitoring, hearing and vision tests in your falls prevention plan.

Prescribe ambulation assistance devices as necessary and provide training on proper use.

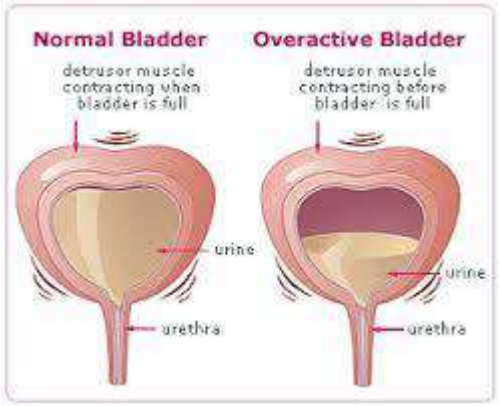
Bladder Control Discussion

Patient Experience #10: Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?

		PCP	Staff
Problem level assessment	Assess the severity of the issue through dialogue with the patient	✓	
Educational Material	Hand out questionnaires and materials to assist patients in evaluating the issue and its severity prior to seeing the physician		✓
Night Light	Advise patient to hang a night light to avoid falls if they need to wake up and quickly make it to the bathroom in the middle of the night	✓	✓
Educational Media	Consider using other visual media displays to help educate patients in the waiting room	✓	✓
Reinforce Discussion	Provide reinforcement once the physician has addressed this as a topic of concern (speaking to the patient as they go back for appointment)		✓

Bladder Control Discussion – Best Practices

Patient Experience #10: Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?



Incorporate a variety of educational media such as projected slides, handouts, posters and patient reminders into your overall patient education program.

Bladder Control Treatment

Patient Experience #11: Did your doctor, nurse, or other health care provider talk to you about ways to control or manage the leakage of urine?

		PCP	Staff
Bladder Exercises	Discuss bladder strengthening exercises with the patient if they have a smaller issue	✓	
Bladder Medication	Decide if medication is appropriate to treat the issue	✓	
Bladder Surgery	In more severe cases, bladder surgery may be recommended and referral assistance can be provided	✓	
Referral assistance	Assist patient in scheduling any follow-up treatment required for this issue before they leave your office		✓

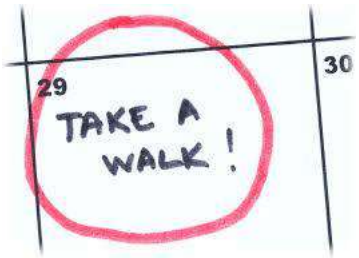
Physical Activity

Patient Experience #12: Did your doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?

		PCP	Staff
Prescribe Exercise	Advise patient to take on whatever level of exercise is appropriate	✓	
Physical Activity Pads	Write down your recommendation on a tear-off pad and encourage patients to take with them	✓	✓
Gym or Club Membership	Encourage patient to review any plan benefits that may allow them to join a gym, health club, or other active group for a discount	✓	✓
Activities calendar	Post a calendar and include any fitness-related events offered at or nearby your office location		✓
Reinforce Discussion	Provide reinforcement once the Physician has addressed this as a topic of concern		✓

Physical Activity – Best Practices

Patient Experience #12: Did your doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?



HEALTHWAYS SilverSneakers® FITNESS

Activity centers and community event calendars

Mental Health Discussion

Patient Experience #13: Did your doctor or other health provider ask you about your mental or emotional health?

		PCP	Staff
Educate the patient	Many patients need help understanding that emotional health is a part of their primary care	✓	
Provider Information	Make use of physician educational material provided with subject matter expertise	✓	
Mental Health Screens	Encourage patients to take mental health pre-assessments while they wait to assist in their discussion		✓
Educational Material	Provide patients with material that educates them on signs of depression or encourages them to stay upbeat	✓	✓

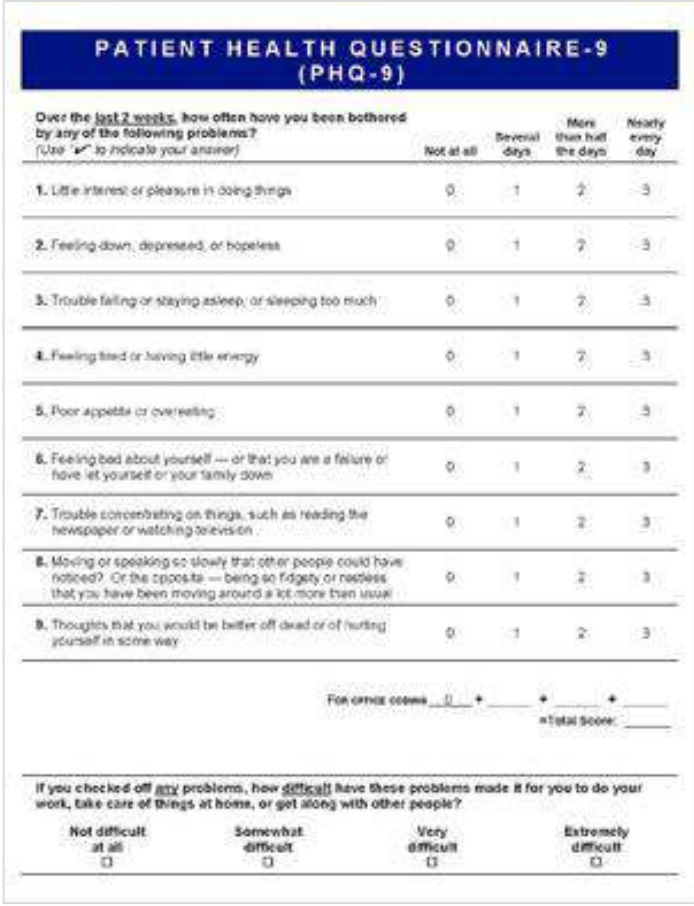
Mental Health Discussion – Best Practices

Patient Experience #13: Did your doctor or other health provider ask you about your mental or emotional health?

The **Patient Heath Questionaires-2** and **9** can give providers better insight into the mental health status of their patients.

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use ✓ to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + ____ + ____ + ____ = Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Next Steps - It Takes a Team!

Enhancing the Patient Experience Process

- ✓ Review current patient service policies.
- ✓ Identify opportunities to integrate CAHPS / HOS into office routines.
- ✓ Distribute responsibilities.
- ✓ Follow through and follow up.

Thank You!

72048MUPENMUB 05/14/2018

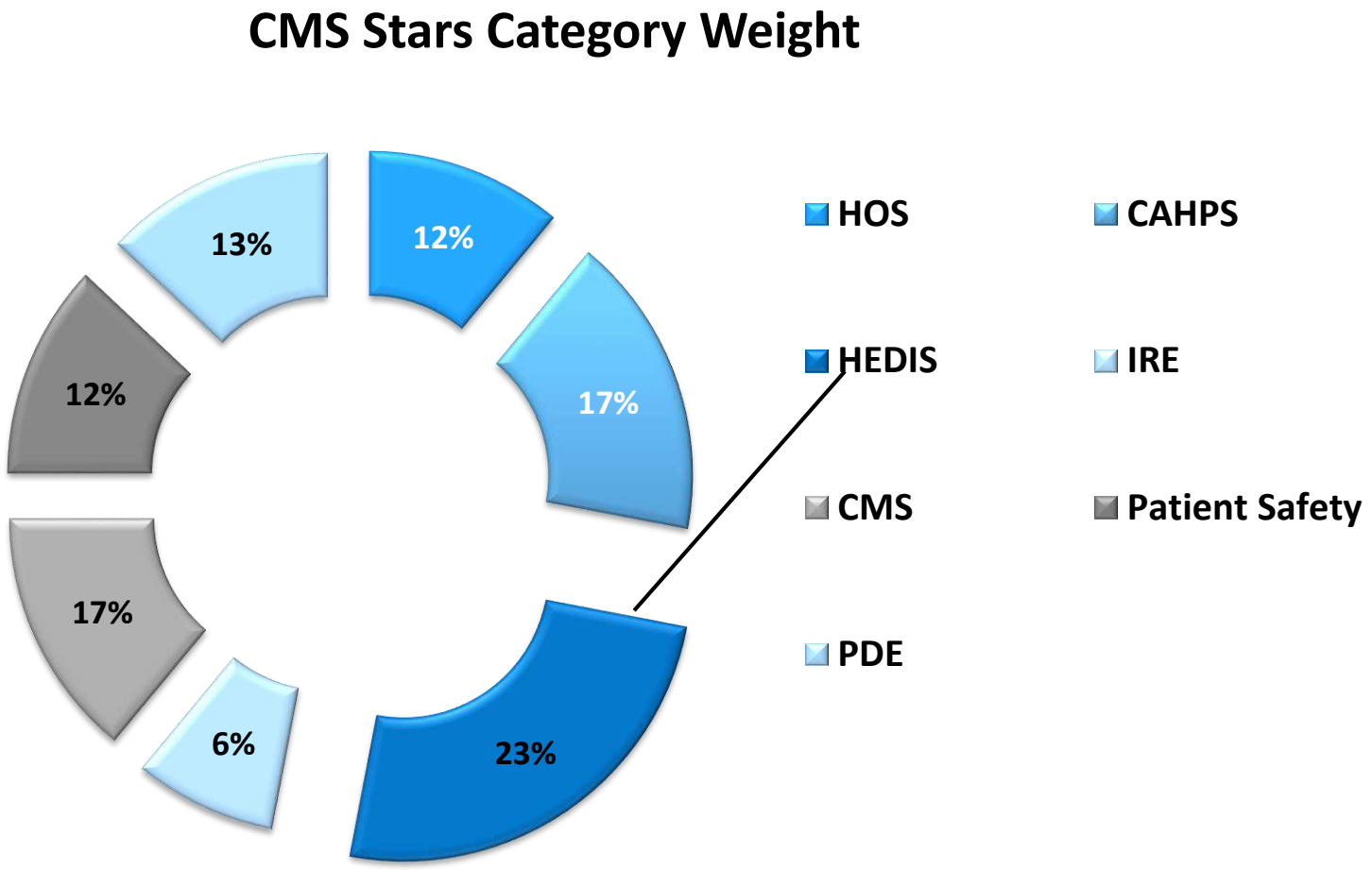
2020 HEDIS Measures Guide

HEDIS – **H**ealth **E**ffectiveness **D**ata and **I**nformation **S**et

- Developed and governed by the National Committee for Quality Assurance (NCQA)
- Services and values designed to measure quality of care
- Used toward overall CMS STARs ratings for health plans and providers

CMS STARs Quality Rating System

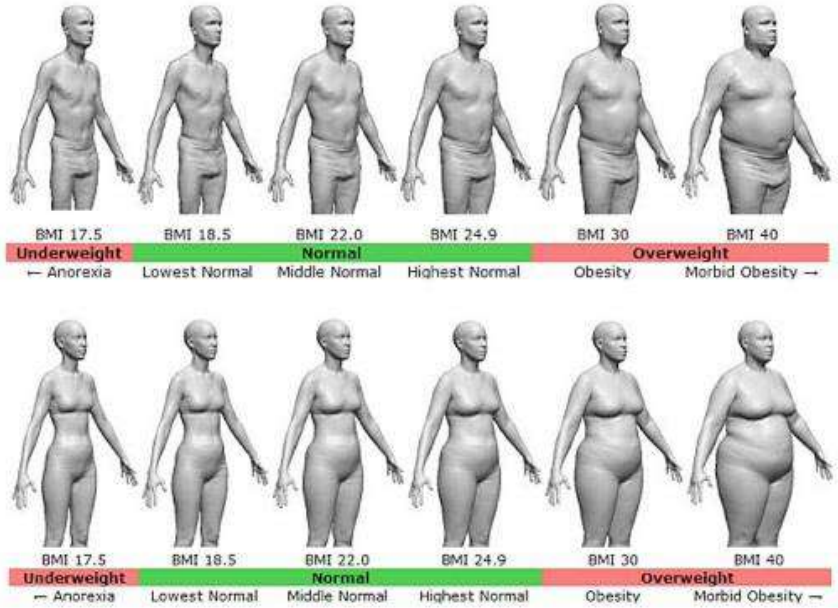
- **HEDIS** – Healthcare Effectiveness Data & Information Set
- **CAHPS** – Consumer Assessment of Healthcare Providers & Systems
- **CMS** administrative data on plan quality and member satisfaction
- **HOS** – Healthcare Outcomes Survey
- **IRE** – Independent Review Entity
- **PDE** – Prescription Drug Event



HEDIS MEASURES

Adult Body Mass Index (BMI) assessment (ABA)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of members 18 to 74 years old who had an outpatient visit and who had a BMI documented during the measurement year or the year prior to the measurement year **Weight = 1** Exclusion: Pregnancy.	Documented weight **and** BMI for outpatient visits in **2019 or 2020** *Note: The weight and BMI must be from the same data source.*	**ICD-10-CM diagnosis code:** Z68.1, Z68.20-29, Z68.30-39, Z68.41-45



1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<78%	≥78% to <92%	≥92% to <96%	≥96% to <99%	≥99%

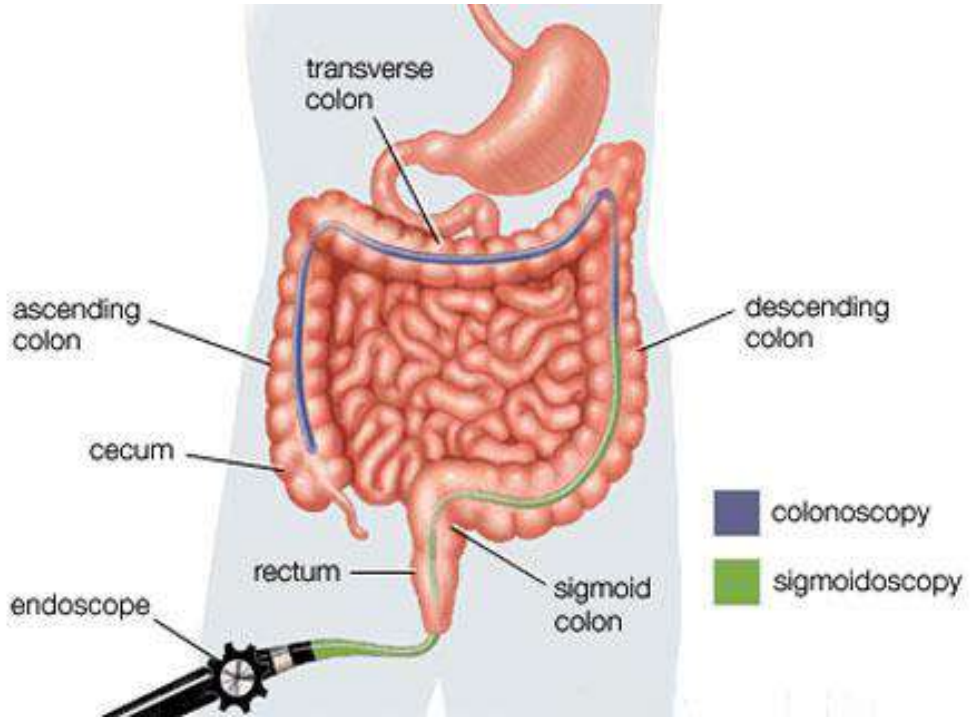
Breast Cancer Screening (BCS)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
Percentage of women 50 to 74 years old who had a screening for breast cancer within the reporting period. **Weight = 1** Exclusions: Documented history of bilateral mastectomies, Advanced illness **and** frailty	Mammogram or breast tomosynthesis between Oct. 1, 2018, and Dec. 31, 2020	Copy of a radiology report **OR** Medical record documentation of month/year performed within the current reporting period.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<50%	≥50% to <66%	≥66% to <76%	≥76% to <83%	≥83%

Colorectal Cancer Screening (COL)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of members 50 to 75 years old who have had an appropriate screening for colorectal cancer.	One of the following screening tests:	**CPT Codes**: **82270** - **g**FOBT (eg: guaiac) 1 determination. **82274** - FOBT, hemoglobin, qualitative, 1-3 simultaneous.
Weight = 1 Exclusions: Documented history of colorectal cancer or total colectomy. Advanced illness **and** frailty. *D*o *not count* FOBT tests performed in office collected via DRE.	Fecal Occult Blood Test (FOBT, gFOBT or iFOBT) in **2020**	**HCPCS II Code: G0328** Colorectal cancer screening; fecal occult blood test, **immunoassay**; 1-3 simultaneous. (**i**FOBT)
	or	
	Fecal (FIT) DNA test in the past **3 years** (eg: Cologuard)	Copy of the fecal DNA result, flexible sigmoidoscopy, CT colonography, colonoscopy or pathology report **OR** **Clear** medical record documentation of the test including year performed within the reporting period.
	or	
	Flexible sigmoidoscopy or CT colonography in the past **5 years**	
	or	
	Colonoscopy, advanced beyond the splenic flexure, in the past **10 years**	



1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<43%	≥43% to <62%	≥62% to <73%	≥73% to <80%	≥80%

Controlling Blood Pressure (CBP)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of members 18 to 85 years old **diagnosed with hypertension** whose blood pressure was adequately controlled during the measurement year based on the following criteria**:**	At least **two** visits on different dates in 2019 or 2020 with documented diagnosis of hypertension or hypertensive disease. Only one of the two visits may be a telephone, online or telehealth service.	Diagnosis of Hypertension or Hypertensive disease **ICD-10-CM Codes: I10 – I16**
* Members **18 to 85** years old whose blood pressure was less than **140/90** mmHg. Exclusions: White-Coat hypertension, pregnancy, ESRD, nephrectomy, kidney transplant, advanced illness **and** frailty, enrolled in an I-SNP or living long-term in an institution. Also exclude from the eligible population all members who had a **nonacute** inpatient admission during the measurement year.	**AND**	**AND**
	The most recent ***controlled*** blood pressure reading in 2020. *Systolic and diastolic values may be from different readings on the SAME day.	**CPT Category II Codes:** **3074F**: Systolic < 130 **3075F**: Systolic 130-139 **3077F**: Systolic ≥ 140 **AND** **3078F**: Diastolic < 80 **3079F**: Diastolic 80-89 **3080F**: Diastolic ≥ 90

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<51%	≥51% to <62%	≥62% to <75%	≥75% to <82%	≥82%

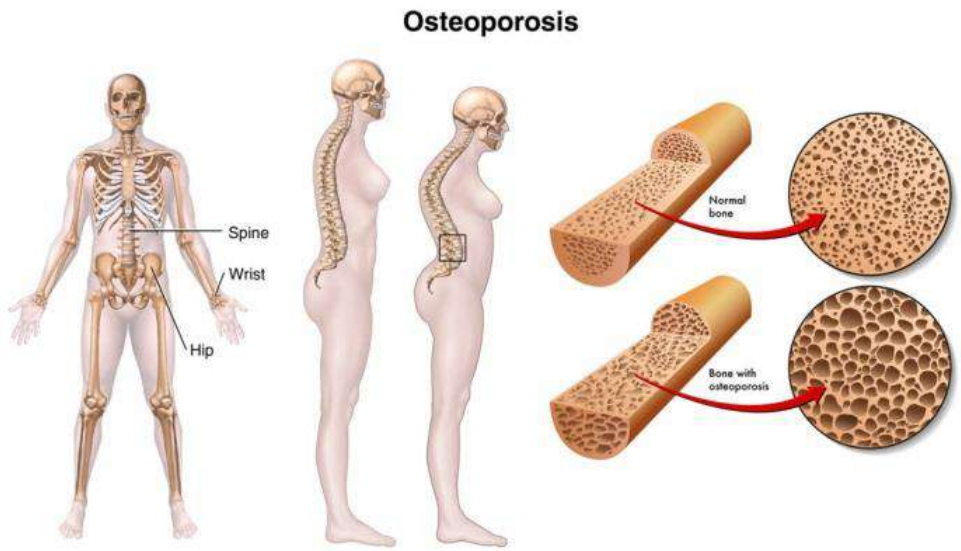
Disease-Modifying Antirheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis (ART)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
Percentage of members who were diagnosed with Rheumatoid Arthritis (or other inflammatory arthropathy) and were dispensed at least one ambulatory prescription for a DMARD in 2020. ***NOTE:** NSAID medications will **not** satisfy this measure. **Weight = 1** Exclusions: Advanced illness **and** frailty.	Assess all patients with diagnosis of Rheumatoid Arthritis (or other inflammatory arthropathy) for DMARD treatment in 2020. **Diagnoses may include**: *Rheumatoid Arthritis* *Reiter's Disease* *Felty's Syndrome* *Rheumatoid Lung* *Inflammatory Polyarthropathy* *Systemic Lupus Erythematosus* *Sjogren's Syndrome* *Sicca Syndrome* *Ankylosing Spondylosis* *Polymyalgia Rheumatica*	A copy of the progress note or Rheumatology consult note within 12 months. Include a dated copy of the medication list showing the DMARD. May include a photo of the dispensed medication bottle or carton. If the diagnosis was made in error, submit a corrected claim removing the RA associated diagnosis. Refer all patients not currently treated with a DMARD for Rheumatology consultation.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<60%	≥60% to <74%	≥74% to <79%	≥79% to <84%	≥84%

Osteoporosis Screening and Management After Fracture (OMW)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
Percentage of females 67 to 85 years old who suffered a fracture* and had either a bone mineral density (BMD) test within 24 months or prescription to treat or prevent osteoporosis within 12 months before the fracture or 180 days after the fracture.	Perform bone mineral density testing within 180 days of fracture date.	**HCPCS II Code: G0130** Single Energy X-Ray Absorptiometry **(SEXA)**, bone density study, peripheral (eg: radius, wrist, heel)
*Any fracture except finger, toe, face or skull. **Weight = 1** Exclusions: Advanced illness **and** frailty.	**OR**	**OR**
	Prescribe a medication to treat osteoporosis and dispense within 180 days of fracture date.	**CPT Code: 77080** Dual-energy X-Ray absorptometry **(DEXA)**, bone density study, axial (eg: hips, pelvis, spine)
		OR
		Dated copy of BMD or dated medication list showing the osteoporosis medication.



1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<31%	≥31% to <41%	≥41% to <50%	≥50% to <67%	≥67%

Diabetes-HbA1c Screening and Control (CDC-HBATEST and CDC-HBAPOOR)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of diabetic members 18 to 75 years old who have evidence of HbA1c testing and adequate control. **Weight = 3** Exclusions: Gestational diabetes or Steroid-induced diabetes, dispensed dementia medication, advanced illness **and** frailty.	At least one HgA1c test in 2020 for all eligible members. To pass, the **most recent** HgA1c level in 2020 must **9.0%** or less.	**CPT category II codes :** **3044F** HgA1c < 7.0% **3051F*** HgA1c ≥ 7.0% and < 8.0% **3052F*** HgA1c ≥ 8.0% and ≤ 9.0% **3046F** HgA1c > 9.0% *Note: These codes count for both the HgA1c test **and** HgA1c control measures* *New code for 2020

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<37%	≥37% to <61%	≥61% to <72%	≥72% to <85%	≥85%

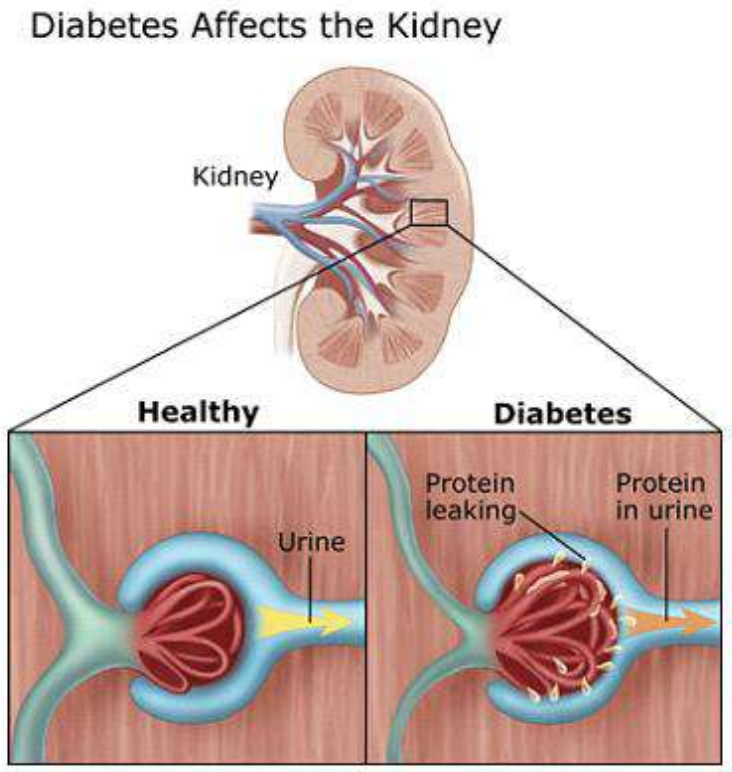
Diabetes-dilated or retinal eye exam (CDC-EYE)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of diabetic members 18 to 75 years old who have received a dilated or retinal eye exam. **Weight = 1** Exclusions: Advanced illness and frailty	Refer member to see an eye care professional for a dilated or retinal eye exam during 2020. **OR** Perform fundus photography with interpretation and report Obtain the report of a dilated or retinal eye exam* performed in 2020 or bilateral eye enucleation performed anytime in the members' history through 12/31/2020 from an ophthalmologist or optometrist. Retain a copy of the report in the member's medical record. **Note: the presence or absence of **retinopathy** must be documented.*	**CPT Category II codes:** **2022F** - Dilated retinal exam with interpretation by an ophthalmologist or optometrist *documented and reviewed;* with retinopathy** **OR** **2023F*-** Dilated retinal exam with interpretation by an ophthalmologist or optometrist *documented and reviewed;* without retinopathy** **OR** **3072F** - Low risk for retinopathy (no evidence in prior year). **CPT Code:** **92250** - Fundus photography with interpretation and report. • New code for 2020 ** Revised description for 2020

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<63%	≥63 to <69%	≥69% to <73%	≥73% to <78%	≥78%

Diabetes-Nephropathy (CDC-NPH)

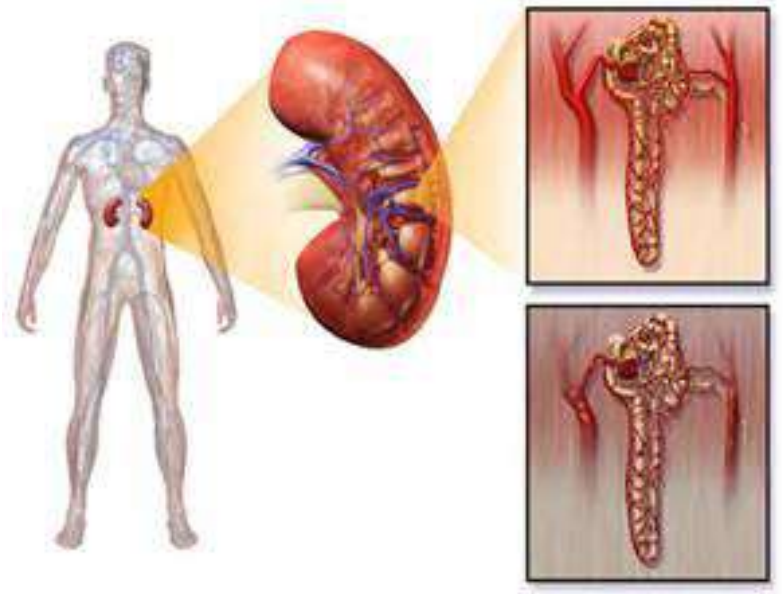
POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of diabetic members 18 to 75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy)	Nephropathy testing on all diabetic members in 2020 or referral to Nephrologist. Any of the these tests may be ordered:	***CPT category II codes:*** **3060F** - <u>Positive</u> microalbuminuria test result *documented and reviewed.* **3061F** - <u>Negative</u> microalbuminuria test result *documented and reviewed.* **3062F** - Positive macroalbuminuria test result *documented and reviewed.*
Weight = 1 Exclusions: Advanced illness and frailty.	● Timed urine for microalbumin. ● 24-hour urine for albumin or total protein ● Urine for microalbumin / creatinine ratio ● Random urine for protein/creatinine ratio ● Spot urine (e.g. dipstick or test strip) for protein	



1 Star	2 Stars	3 Stars	4 Stars	5 Stars
NA	NA	≥80% to <95%	≥95% to <97%	≥97%

Diabetes-Nephropathy (CDC-NPH) (continued)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of diabetic members 18 to 75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy)	Documented evidence of nephropathy: Any positive test result for microalbumin or macroalbumin.	**3066F -** Documentation of treatment for nephropathy (eg: nephrectomy, kidney transplant, patient receiving dialysis, patient being treated for ESRD, CKD, ARF or renal insufficiency, any visit to a nephrologist).
	OR Medical attention for nephropathy: ● Nephrology visit in 2020 (include if primary care physician also is a Nephrologist)	**4010F** - ACE or ARB therapy prescribed or currently being taken.
	OR A dispensed prescription for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blockers (ARB) therapy in 2020.	**ICD-10-CM Codes:** **N18.4** - CKD stage 4 **N18.5** - ESRD **N18.6** - ESRD on dialysis **Z99.2 -** Dialysis status **Z91.15** - Noncompliance with dialysis



Statin Therapy for Patients with Cardiovascular Disease (SPC)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one **high** or **moderate-intensity** statin medication during the measurement year. Members must have remained on a high or moderate-intensity statin medication for at least 80% of the treatment period. **Weight = 1**	• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers to identify and resolve them. • Encourage adherence by providing 90-day prescriptions. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed.	No reporting required from a healthcare provider's perspective. The health plan evaluates prescription claims data for this measure.
Exclusions: Pregnancy, ESRD, Cirrhosis, Myalgia, Myositis, Myopathy or rhabdomyolysis. Advanced illness and frailty.		

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<75%	≥75% to <79%	≥79% to <83%	≥83% to <87%	≥87%

Care for Older Adults - COA

Special Needs Plan Only: Medicare/Medicaid members or Medicare with certain chronic conditions or members who live in an institution.

Can be performed by anyone in the office or via telephone:

- ✓ Advanced Care Planning – Living will, medical power of attorney
- ✓ Functional Status – Basic and/or instrumental ADLs
- ✓ Pain Screen (non-traumatic) – Measured 0-10

Must be performed by a qualified healthcare provider:

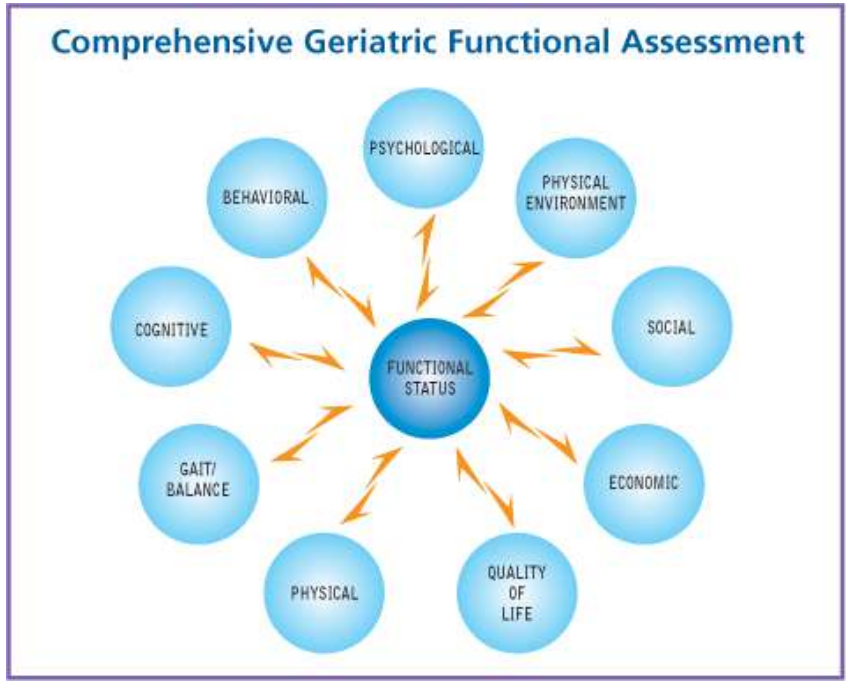
- ✓ Medication Review – Includes a medication list and review

Care for Older Adults-Advanced Care Planning (COA-ACP)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of adults 66 years old and older who had advance care planning (advance directive, living will, power of attorney, health care proxy, actionable medical decision-maker or surrogate decision-maker) during the measurement year.	Documentation of advance care planning in 2020. Evidence of advance care planning must include: Advance care planning discussion documented and dated in the medical record. **OR** Notation that the member has previously executed an advance care plan that meets criteria.	**CPT Category II Codes:** **1123F**-Advanced care plan discussed or surrogate decision maker documented in the medical record. **1124F**-Advance care plan discussed, patient did not wish or was not able to name a surrogate or provide advance care plan. **1157F** - Advance care plan or similar legal document present in the medical record. **1158F** - Advance care plan discussion documented in the medical record. OR **HCPCS II code:** **S0257 -** Counseling and discussion regarding advance directives or end of life care planning and decisions with patient and/or surrogate. **CPT Code:** **99497 –** Advance care planning including explanation of directives such as standard forms (with completion of forms when performed) by the physician.

Care for Older Adults-Functional Status (COA-FSA)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of adults 66 years old and older who had documentation in the medical record of at least one complete functional status assessment in 2020. **Weight = 1**	At least one complete functional status assessment in 2020. The functional status assessment must include the date it was performed. Assessment of basic activities of daily living (ADL), such as bathing, dressing, eating, transferring, using toilet, walking. **OR**	**CPT Category II Code:** **1170F -** Functional status assessed. Notations for a complete functional status assessment may include: Results using a standardized functional status assessment tool **OR** Documentation that **three of the four** following components were assessed:
NOTE: A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) **does not** meet criteria for a comprehensive functional status assessment.	Assessment of instrumental activities of daily living (IADL), such as shopping for groceries, driving, using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications or handling finances	● Cognitive Status ● Ambulation Status ● Sensory ability (must include hearing, vision, speech) ● Other functional independence(e.g.: exercise, ability to perform job)



1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<55%	≥55% to <71%	≥71% to <85%	≥85% to <93%	≥93%

Care for Older Adults-Pain Screening (COA-PNS)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of adults 66 years old and older who had documentation in the medical record of at least one pain screening assessment for more than one system in 2020. ***Weight = 1***	Documentation in the medical record of at least one pain assessment **or** pain management plan in 2020, including the date it was performed. Notations may include: • A comprehensive pain assessment or results of a screening using a standardized tool (may include positive or negative findings). **OR**	**CPT category II codes:** **1125F** - Pain severity quantified; **pain present** **1126F -** Pain severity quantified; **no pain present**
A pain assessment or management plan limited to an acute or single condition, event or body system does not meet criteria.	• Evidence of a pain management plan, such as notation of no pain, intervention and the rationale, notation of plan for pain treatment (pain meds, psychological support and patient/family education) or notation of plan for reassessment of pain, including time interval.	

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<59%	≥59% to <81%	≥81% to <86%	≥86% to <94%	≥94%

Care for Older Adults-Medication Review (COA-MDR)

POPULATION	SERVICE NEEDED	WHAT TO REPORT
Percentage of adults 66 years old and older who had at least one medication review in 2020 conducted by a prescribing practitioner or clinical pharmacist **along with** a medication list or documentation of no medications.	A medication list present in the same medical record. If patient is not taking any medication, dated notation should be documented in the chart in 2020.	**CPT Category II Codes:** **1159F** - Medication list is documented in the medical record. **AND** **1160F** - Review of all medications by a **prescribing practitioner or clinical pharmacist.**
Weight = 1	Documentation of at least one **dated** medication review conducted by a **prescribing practitioner or clinical pharmacist** in 2020**.** **NOTE:** *A review of side effects for a single medication at the time of prescription alone is <u>not</u> sufficient.*	**CPT Codes:** **90863** - Pharmacologic management when performed with psychotherapy services. **99605** - Medication therapy management service(s) provided by a **pharmacist**; initial 15 minutes, new patient. **99606** - initial 15 minutes, established patient.
	(Transitional care management services code counts for both the medication review and medication list).	**99495** - Transitional care management services; within 14 days of discharge. **99496** - Transitional care management services; within 7 days of discharge.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<63%	≥63% to <77%	≥77% to <87%	≥87% to <95%	≥95%

Medication Reconciliation Postdischarge (MRP)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
The percentage of discharges from January 1 to December 1 of the measurement year for patients 18 years old and older for whom medications were ***reconciled*** on the date of discharge through 30 days after discharge (31 total days). **Weight = 1**	A type of review in which medications are ***reconciled*** in 2020 with the most recent medication list in the outpatient medical record	**CPT Category II Code:** **1111F** - Discharge medications reconciled with the current medication list in the outpatient medical record. **CPT Codes:**
		99495 - Transitional care management services; within 14 days of discharge. **99496** - Transitional care management services; within 7 days of discharge.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<48%	≥48% to <62%	≥62% to <71%	≥71% to <84%	≥84%

Transitions of Care – (TRC)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
The percentage of discharges for Medicare members 18 years of age and older who had an inpatient admission and discharge with each of the four rates reported during the measurement year.	1. Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission or the following day. 2. Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge or the following day. 3. Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. 4. Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	Medical record documentation with *dated* notifications of admission and discharge information. **AND** **99495**-TCM: 14 days or **99496**-TCM: 7 days **OR** Appropriate E&M outpatient visit* within 30 days after discharge **AND** **1111F**-MRP within 30 days after discharge. **NOTE**: If Telemedicine: **99441-99443**-Physician via telephone. **98966-98968**-Non-Physician via telephone. ***Add Modifier -GT** to E&M outpatient visit if via real-time Audiovisual telecommunication.

Plan All-Cause Readmissions (PCR)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
Percent of patients 18 years and older, continuously enrolled for at least 395 days, discharged from an acute hospital stay with an unplanned acute readmission to a hospital within 30 days, either for the same or a different reason. Patients may have been readmitted to the same hospital or a different one. **Weight = 3** Exclusion: Pregnancy or puerperium related diagnoses, nonacute inpatient stays, same day admit/discharge.	● Be aware of the daily discharge census. ● Promote health plan services (eg: transition of care, care coordination, home health, etc.) ● Assist patient with resources to prevent readmission (eg: transportation for follow-up appointments and necessary medications).	No reporting from a health care provider's perspective.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
>10%	>8% to ≤10%	>7% to ≤8%	>3% to ≤ 7%	≤ 3%

Part D - Medication Adherence and SUPD

The measures for Medication Adherence start the year out with 5 stars and decrease as the criteria is affected. Data is obtained through pharmacy claims. No reporting is required from a physician's perspective.

Medication Adherence

Patients must fill their prescriptions often enough to cover at least 80% of the time they are to be taking the medication.

Medication Adherence – Diabetes Medications

Taking diabetes medication as directed (Weight = 3) Percentage of Medicare Part D beneficiaries 18 years old or older with a prescription for diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication Note: In this measure, "diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic or a meglitinide drug. Plan members who take insulin are not included.	• Assess proactively whether the patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.	• No reporting required from a health care provider's perspective. The health plan evaluates prescription claims data for this measure.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<74%	≥74% to <78%	≥78% to <81%	≥81% to <83%	≥83%

Medication Adherence – B/P Medications

Taking blood pressure medication as directed (Weight = 3) • Medicare Part D beneficiaries 18 years old or older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication. Note: In this measure, "blood pressure medication" means an ACE (angiotensin-converting enzyme) inhibitor or an ARB (angiotensin receptor blocker) drug, or a direct renin inhibitor drug.	• Assess proactively assess whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.	• No reporting required from a health care provider's perspective. The health plan evaluates prescription claims data for this measure.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<80%	≥80% to <83%	≥83% to <86%	≥86% to <88%	≥88%

Medication Adherence – Cholesterol Medications

Taking cholesterol medication as directed (Weight = 3) • Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for a cholesterol medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication Note: In this measure, "cholesterol medication" means a statin drug.	• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers with your patients to identify and resolve them. • Encourage adherence by providing 90-day prescriptions for maintenance drugs. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed since his/her original prescription.	• No reporting required from a health care provider's perspective. The health plan evaluates prescription claims data for this measure.

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<72%	≥72% to <80%	≥80% to <84%	≥84% to <87%	≥87%

Statin use in Persons with Diabetes (SUPD)

POPULATION	SERVICE NEEDED	WHAT TO SUBMIT
This measure is defined as the percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period, and who remained on a statin medication of **any** intensity for at least 80% of the treatment period. **Weight = 3**	• Assess proactively whether patient is taking medication as prescribed. Discuss patient-specific adherence barriers to identify and resolve them. • Encourage adherence by providing 90-day prescriptions. • Provide an updated prescription to the pharmacy if your patient's medication dose has changed.	No reporting required from a healthcare provider's perspective. The health plan evaluates prescription claims data for this measure.
Exclusions: Advanced illness and frailty, ESRD		

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
<74%	≥74% to <78%	≥78% to <81%	≥81% to <83%	≥83%

Questions?

70130MUPENMUB 02/24/2020

Anthem

Medicare Advantage

Provider Bulletin
May 2020

Telehealth services for risk adjustment payments
Coronavirus (COVID-19) update: May 8, 2020

Dear Valued Provider:

As a result of the 2020 COVID-19 pandemic, CMS released **new** guidance regarding **risk adjustment data** submissions for telehealth services on April 10, 2020. CMS authorized Medicare Advantage (MA) organizations to submit diagnoses for risk adjustment from telehealth encounters, **only when those encounters meet all criteria for risk adjustment data submission**. More specifically, diagnoses must be a result of an allowable inpatient, outpatient, or professional service, rendered by an acceptable provider type, and based on a face-to-face encounter. **To meet the risk adjustment face-to-face requirement for telehealth encounters, CMS requires the provider to use an interactive audio and video telecommunications system that permits real-time communication between the provider and patient.**

To report virtual evaluation and management (E&M) services to Anthem Blue Cross (Anthem) for an audio and video encounter, please use applicable E&M CPT© code, CPT Telehealth modifier "95," **and** any applicable place of service (POS) code. An audio-only encounter does not satisfy the criteria for risk adjustment data eligibility. Therefore, **you must include CPT Telehealth modifier "95" in addition to the POS** so Anthem can identify the encounter as a face-to-face telehealth encounter. This guidance applies to eligible face-to-face telehealth encounters within open data submission periods, which include 2019 and 2020 dates of service (DOS).

Diagnoses submitted for risk adjustment purposes from a telehealth encounter must meet the following requirements:

- Encounter must be face-to-face using an interactive audio and video telecommunications system that permits real-time communication between the provider and patient.
- Provider must use CPT Telehealth modifier "95."
- Services rendered must be those which are allowable by CMS, included within the Anthem plan benefit package, and clinically appropriate to furnish via a face-to-face telehealth encounter; and
- Encounter must meet all other criteria for risk adjustment eligibility, which include, but are not limited to, being from an allowable inpatient, outpatient, or professional service.

Please feel free to contact [insert applicable contact information].

Thank you for your continued partnership.

Sincerely,

Anthem Blue Cross

Sources: Centers for Medicare & Medicaid Services (CMS) – Dept. of Health & Human Services (HHS), HPMS memo, *Applicability of Diagnoses from Telehealth Services for Risk Adjustment*, April 10, 2020*;* and *CMS* – HHS, *Stakeholder Call on the CY 2021 Rate Announcement and MA and Part D COVID-19 Guidance*, April 29, 2020.

Internal use only- Please do not distribute to members

Lifestyle Medicine Member Resources

Quarter 3 (July- September 2020)

SilverSneakers Programs

No cost and exclusive to Medicare and CMC members

1. **SilverSneakers Connect** *(English only)*
   - A digital platform where members can share their experiences with others
   - Connect via Zoom meetings and see members' faces
   - Social event topics can include- game night, book club, crafts/hobbies, pet club, etc.
   - To get a member started, please direct them here: SilverSneakers.com/ConnectCA

2. **Find Your Fit** *(English only)*
   - A video series designed for members to engage in exercise at home
   - Members can choose from beginner, balance, emotional health or pain management
   - Member will receive a new video each week for four weeks
   - To get a member started, please direct them here:
     BSC Member: SilverSneakers.com/BSC
     Promise Member: SilverSneakers.com/Promise

3. **SilverSneakers Go app** *(free to any member) (English only)*
   - Video-based exercise programs that can be tailored to the member level
   - Direct member to download the app from **Apple App Store** or **Android Google Play**

Wellvolution

No cost and exclusive to Medicare and CMC members
(bilingual health coaches vary by program)

- Personalized digital health programs
- Smartphone apps and in-person options
- Learn how to eat healthier, move more, manage stress, sleep better, ditch cigarettes and even prevent or reverse disease
- To get a member started, please direct them here:
  Medicare & CMC: www.wellvolution.com/medicare
  Medi-Cal: (coming soon)

For questions or more information on SilverSneakers and Wellvolution programs, please contact **Paulina Montalvo** at **Paulina.Montalvo@blueshieldca.com**.

Internal use only- Please do not distribute to members

Due Date Plus

(English and Spanish)

***No cost mobile app for expectant Medi-Cal members ***

- Tracks pregnancy progress and the growth of children ages 0-2
- Offers a week-by-week "what to expect" pregnancy guide, ability to log upcoming appointments, kick count tracker, daily tips to stay healthy and more
- Links to health plan and community resources
- Promise members who register for the app are eligible for a $50 gift card
- Search Blue Shield Promise in the app store or text the word "BABY" to **619.940.1064 (San Diego)** or **323-310-5118 (Los Angeles)**

Diabetes Prevention Program (DPP)

(English and Spanish)

No cost for Medi-Cal, Medicare and CMC members that are Pre-Diabetic

- An evidence-based lifestyle program to prevent or delay the onset of type 2 diabetes for those members diagnosed with pre-diabetes
- Members have the choice of an in-person or digital program
- Program includes 16 weekly sessions over 6 months and monthly sessions for the remaining 6 months
- To confirm eligibility and get a member started, please direct them here:
  Medi-Cal: www.solera4me.com/blueshieldpromisemedical
  or call **(866) 692-5059**, TTY 711
  CMC & Medicare: www.wellvolution.com/medicare

Q3 Health Education Classes

No cost to Medi-Cal, Medicare and CMC members

Blue Shield members can access health education classes by telephone or computer.
Health education classes listed on the next page.

***Option 1:* Connect by telephone (*audio only*)**
Please instruct members to:
1) Dial WebEx at **1-800-948-1333** (toll-free)
2) Enter the **access code**, then enter the pound sign (#)
3) Enter the meeting **password**, then the pound sign (#) to connect to the class

***Option 2:* Connect by computer or other electronic device**
To view these classes on a computer or other electronic device such as a cellphone or tablet, a Cisco WebEx Meetings app or class link is needed. Members must enter the **access code** and **password** to join the class. Please direct members to call the Health Education department for support with this option.

For questions or more information on Due Date Plus, the Diabetes Prevention Program or health education classes, including support with WebEx, please contact **Health Education** at **323-827-6801** or e-mail **BlueShieldofCAHealthEducation@blueshieldca.com**.

Internal use only- Please do not distribute to members

Eating Healthy on a Budget

Eating healthy does not have to be expensive. This class will discuss ways to make healthy budget friendly meals at home. Topics include meal planning and ways to save at the grocery store.

Date	Language	Time	Access Code	Password
Tuesday July 28, 2020	English	10:00 AM	145 195 7431	2312
	Cantonese	10:00 AM	145 734 3883	2244
Thursday July 30, 2020	Spanish	2:00 PM	145 423 7894	2328
	Mandarin	10:00 AM	145 575 1200	2244

Summer Safety

The summer months offer many opportunities for fun and outdoor activities. This class will give practical tips to ensure a safe and enjoyable experience. Topics covered include heat injuries, water safety, outdoor safety, skin and eye safety, and personal vehicle safety.

Date	Language	Time	Access Code	Password
Tuesday August 25, 2020	English	10:00 AM	145 501 8829	2312
	Cantonese	10:00 AM	145 369 5307	2244
Thursday August 27, 2020	Spanish	2:00 PM	145 728 2479	2328
	Mandarin	10:00 AM	145 856 3144	2244

Caring for Children with Asthma

Asthma is the most common condition among children and if it is not well controlled, it can be life-threatening. This class will provide tools to help manage childhood asthma. Topics include asthma symptoms, triggers, correct use of asthma medicines, creating an asthma action plan, and more.

Date	Language	Time	Access Code	Password
Tuesday September 22, 2020	English	10:00 AM	145 422 2774	2312
	Cantonese	10:00 AM	145 317 4502	2244
Thursday September 24, 2020	Spanish	2:00 PM	145 972 2491	2328
	Mandarin	10:00 AM	145 022 5448	2244

Welcome to Due Date Plus – a free app for expecting and new parents. Due Date Plus is available to all Blue Shield of California Promise Health Plan members.

Expecting parents can:

- Learn about pregnancy health issues and symptoms
- Speak to a nurse 24/7 for any pregnancy or baby questions
- View baby growth videos
- Track pregnancy weight
- Set appointment reminders
- Get daily tips on how to have a healthy pregnancy
- Learn about community resources available to parents and baby
- Explore birth plan choices

New parents can:

- Speak to a nurse 24/7 for any postpartum- or baby-related questions
- Use trackers to monitor:
  - Feeding
  - Diaper changes
  - Baby growth
  - Vaccines
- Explore topics like infant nutrition and developmental milestones
- Get daily tips for raising a newborn
- Learn about the "baby blues" and postpartum depression
- Learn about breastfeeding support

Get the app

Search for "DueDatePlus" by Blue Shield of California Promise on the App Store® or Google Play™

OR

Text "Baby" to (619) 940-1064 for a link to the app

GET IT ON Google Play

Download on the App Store

blue california
Promise Health Plan

Medi_20_889_SD

App Store is a service mark of Apple Inc.
Google Play is a trademark of Google LLC.
Powered by Wildflower.

Blue Shield of California Promise Health Plan complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

You can get this document for free in other formats, such as large print, Braille, or audio. Call 1-855-699-5557 (TTY: 711), 8:00a.m. to 6:00p.m., Monday through Friday. The call is free.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-855-699-5557 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-699-5557 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-699-5557（TTY：711）。

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.

A52128-SD (12/19)

HEDIS Outreach Measures Guide

Initials	Measure	Age range	Due
Adults:			
BCS	Breast Cancer Screening	50-74	Mammogram every 27 mos.
CCS	Cervical Cancer Screening	21-64	Pap smear every 3 years (every 5 years if over 30)
CDC1	Diabetes - HbA1c Test	18-75	Blood sugar test yearly
CDC4	Diabetes - Eye Exams	18-75	Retinal eye exam yearly
CDC7	Diabetes - Nephropathy	18-75	Kidney test yearly
CHL	Chlamydia Screening	16-24	Urine test every year
COL	Colorectal Cancer Screening	50-75	FIT test every year, colonoscopy every 10 years
Under 21:			
AWC	Adolescent Well Care	12-21	Wellness visit every year
W34	Well Child Visit age 3-6	3-6	Wellness visit every year
CIS	Child Immunization Status	0-2	Vaccinations by age 2
IMA	Immunizations for Adolescents	9-13	Vaccinations by age 13

Interpreta Website:
https://portal.interpreta.com

For login assistance:
Interpreta@medpointmanagement.com
818-702-0100, x1353

HEDIS/Stars Member Gap Report Measures Guide

Initials	Measure	Age range	Due
Adults:			
ABA	Adult BMI Assessment	18-74	Every two years but code BMI with every visit
BCS	Breast Cancer Screening	50-74	Mammogram every 27 months
CCS	Cervical Cancer Screening	21-64	Pap smear every 3 years (every 5 years if over 30)
CDC1	Diabetes - HbA1c Test	18-75	Blood sugar test yearly
CDC4	Diabetes - Eye Exams	18-75	Retinal eye exam yearly
CDC7	Diabetes - Nephropathy	18-75	Kidney test yearly
CHL	Chlamydia Screening	16-24	Urine test every year
COA1	Care for Older Adults – Advance Care Planning	66+	All 4 components every year (Submit 1157F or 1158F on encounter.)
COA2	Care for Older Adults – Medication Review	66+	All 4 components every year (Submit 1160F or 1159F on encounter.)
COA3	Care for Older Adults – Functional Status Assessment	66+	All 4 components every year (Submit 1170F on encounter.)
COA4	Care for Older Adults – Pain Assessment	66+	All 4 components every year (Submit 1125F or 1126F on encounter.)
COL	Colorectal Cancer Screening	50-75	FIT test every year, colonoscopy every 10 years
Under 21 years:			
AWC	Adolescent Well Care	12-21	Wellness visit every year
CISCMB10	Child Immunization Status	0-2	Vaccinations by age 2
IMA	Immunizations for Adolescents	9-13	Vaccinations by age 13
W34	Well Child Visit age 3-6	3-6	Wellness visit every year
WCCA	BMI - Weight Assessment and Counseling for Nutrition and Physical Activity	3-17	Every year at wellness visit. (Submit BMI code on encounter.)
WCCB	Nutrition - Weight Assessment and Counseling for Nutrition and Physical Activity	3-17	Every year at wellness visit. (Submit Nutrition code Z71.3 on encounter.)
WCCC	Physical Activity - Weight Assessment and Counseling for Nutrition and Physical Activity	3-17	Every year at wellness visit. (Submit Physical Activity code Z71.82 or Sports Physical code Z02.5 on encounter.)

Interpreta Website:
https://portal.interpreta.com

For login assistance:
Interpreta@medpointmanagement.com
818-702-0100, x1353

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
X125682

San Diego County
X121735

Imperial County
X125682

2019 & 2020 RISK ADJUSTMENT DATA COLLECTION

This is an advisory notification to Molina Healthcare of California (MHC) network providers and office managers.

The Centers for Medicare & Medicaid Services (CMS) uses Risk Adjustment diagnosis codes and demographic data to appropriately report and produce complete and accurate diagnosis and the health status of Medicare enrollees.

Molina Healthcare of California (Molina Healthcare), with your assistance, will facilitate medical record review and begin collecting and compiling **Risk Adjustment** data. MHC staff will contact you, beginning **July 13, 2020** to arrange a convenient collection method of required medical record information.

In order to provide adequate time to prepare the requested information, a member list with required medical record information will be provided and communicated to you. We welcome you to send records fast, quick and secure by utilizing our Secure Email: MHCHEDISDepartment@MolinaHealthCare.Com. MHC can also coordinate site visits to access medical records as well, please contact us at **1-888-562-5442, extension 129578.**

As a reminder, providers must follow all HIPAA, State, and Plan contractual requirements when submitting member records that contain PHI electronically via email.

We appreciate your cooperation and professional courtesy to Molina Healthcare Quality Improvement staff, as they begin this year's medical record review process.

Thank you for your assistance in this effort and for your continued work to improve the health of our members and communities.

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 to the left.

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
X125682

San Diego County
X121735

Imperial County
X125682

Maternal Mental Health Screening

This is a reminder notification to Molina Healthcare of California (MHC) network providers regarding Maternal Mental Health Screening Requirements and Guidelines.

Requirements

AB 2193 Maternal Mental Health requires a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. “Health care practitioner means a physician and surgeon, naturopathic doctor, nurse practitioner, physician assistant, nurse midwife, or a midwife licensed … who is acting within his or her scope of practice.” This legislation applies to Medi-Cal, Marketplace, and MMP lines of business.

Screening Pregnant Members

Molina requires the use of a validated tool or set of tools to assess the member’s mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire (PHQ-9) form https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218, and the Edinburgh Postnatal Depression Scale (EPDS) form https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf, both of which are widely utilized.

Claim Codes for Maternal Mental Health Screening

Molina requires healthcare providers to document mental health screening using the claim codes below:

USPSTF Recommendation Topic	CPT/HCPCS Codes: Medi-Cal, Marketplace, MMP
Depression screening Pregnant or postpartum	**G8431 (positive)** *with modifier HD for Medi-Cal members **G8510 (negative)** *with modifier HD for Medi-Cal members

Provider Follow-Up Responsibilities

- Pregnant/postpartum members with positive screening results may be treated by the Provider within the Provider's scope of practice.
- When the condition is beyond the Provider's scope of practice, the Provider must refer the member to a mental health provider within the Molina network. Molina providers may screen further for referrals into the County system of care if clinically indicated.
- Medi-Cal and MMP Members: OBs, PCPs, and mental health providers in Molina's network must refer pregnant/postpartum members with significant impairment resulting from a covered mental health diagnosis to the County Mental Health Program. *Per DHCS APL 17-018, "Significant impairment in an important area of life functioning or a reasonable probability of significant deterioration in an important area of life functioning would qualify for referral to the County Mental Health Plan."* Additionally, when the member has a significant impairment and the diagnosis is uncertain, Molina providers must ensure the member is referred to the County MHP for further assessment.
- **Molina High Risk OB Program:** In addition to treatment by the provider or referral to a mental health provider, practitioners may also refer to Molina's High Risk OB Program for case management support and follow-up. The program utilizes a collaborative team approach that includes risk screening and identification by Molina nurses, clinical case management for members with positive screenings, and member education to promote optimal pregnancy outcomes for Molina pregnant members. Please call the number below.
  - Molina High Risk OB Program: (866) 891-2320

Molina Health Education Materials

- Clear and Easy Booklets on Postpartum Depression (#17) and Stress and Depression (#3) are available free to members and providers online at: https://www.molinahealthcare.com/members/common/en-US/healthy/Pages/clear-and-easy.aspx or by calling the **Member and Provider Contact Center**:
  - Medi-Cal: (888) 665-4621, 7am-7pm, Monday - Friday
  - MMP: (855) 665-4627, 8am-8pm, Monday – Friday
  - Marketplace: (888) 858-2150, 8am–6pm, PT Monday – Friday
- Online health education materials on a variety of topics including pregnancy and postpartum depression can be found at: http://www.molinahealthcare.com/providers/ca/medicaid/comm/Pages/Health-Education-Materials.aspx.

QUESTIONS

If you have any questions regarding the notification, please contact Victoria Luong: Victoria.luong@molinahealthcare.com, or call 562-901-1032.

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
X125682

San Diego County
X121735

Imperial County
X125682

MODEL OF CARE (MOC) TRAINING 2020

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding the 2020 Model of care (MOC) Training.

MHC is required to provide annual training to our entire Medicare contracted provider network, regarding its Model Of Care program for dual eligible enrollees. The Model Of Care is the architecture for Molina's care management policy, procedures and operational systems for our dual eligible population.

In order to ensure MHC remains compliant with CMS regulatory requirements for Model Of Care training, receipt of completed Attestation Form is due to MHC no later than October 31, 2020.

Model Of Care Training Link:
https://www.molinahealthcare.com/providers/common/medicare/PDF/2020-MOC-Provider-Training.pdf

Model Of Care Quick Reference Guide:
https://www.molinahealthcare.com/providers/common/medicare/PDF/2020-Provider-Training-QRG.pdf

Mode of Care Training Attestation Form:
https://www.molinahealthcare.com/providers/common/medicare/PDF/model-of-care-ca-2020.pdf

Please email the signed attestation form to the following Provider Services Inbox e-mail addresses.

Imperial County - MOC_Imperial@MolinaHealthcare.com
Los Angeles – MOC_LosAngeles@MolinaHealthcare.com
Riverside San Bernardino – MOC_InlandEmpire@MolinaHealthcare.com
San Diego – MOC_SanDiego@MolinaHealthcare.com

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 to the left.

Telehealth Reimbursement Guide For California

Spring 2020

Compiled by the California Telehealth Resource Center and Includes:

Medi-Cal
Denti-Cal
Medicare
Managed Care Health Plans
FQHC/RHC Billing Scenarios

CALIFORNIA TELEHEALTH RESOURCE CENTER

Your resource for telehealth success

caltrc.org | 877.590.8144

Part of the OCHIN Family of Companies

This document is intended as a guide to assist providers in obtaining information on telehealth reimbursement. This document does not constitute legal advice. Many factors affect the appropriateness of submitting a particular claim for reimbursement. The information should be used in consultation with your billing specialist and other advisers in initiating telehealth billing.

Reimbursement information can become outdated quickly and is subject to change without notice. We recommend review of this material on a regular basis to assure the information is up to date. Please visit www.caltrc.org to download the latest version. CTRC does not guarantee payment for any service.

The California Telehealth Resource Center is a leading source of expertise and comprehensive knowledge on the development and operation of telemedicine and telehealth programs. CTRC has received national recognition since 2006 as one of fourteen federally designated Telehealth Resource Centers in the country.

This project is made possible by grant number G22RH30349 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Table of Contents

INTRODUCTION

What Is Telehealth?

Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

As state and federal policymakers, private payers, practitioners, and consumers realize telehealth's potential benefits, there is a growing need to create a consistent framework for understanding what is meant by "telehealth," and how the term is accurately applied.

First and foremost, telehealth is a collection of means or methods, not a specific clinical service, to enhance care delivery and education. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The "tele-"descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.

While "telemedicine" has been more commonly used in the past, "telehealth" is a more universal term for the current broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical therapy, home health, and many other domains. Further, telehealth practice has expanded beyond traditional diagnostic and monitoring activities to include consumer and professional education.

While the State of California now uses the term "telehealth", some providers and payer organizations still use the term "telemedicine" when referring to the provision of clinical care over a distance.

Note that while a connection exists between health information technology (HIT), health information exchange (HIE), and telehealth, neither HIE nor HIT are considered to be telehealth.

What Is Telemedicine?

Telemedicine generally refers to the provision of clinical services from a distance. The Institute of Medicine of the National Academy of Science defines telemedicine as "the use of electronic information and communication technologies to provide and support health care when distance separates the participants". Telemedicine is a component of telehealth.

How Does Telehealth Work?

Today, telehealth encompasses many distinct domains of applications. Note, however, that each state's Medicaid program and private insurers vary in their use and reimbursement of these applications. These are commonly known as:

- **Synchronous Live Videoconferencing**: Live, two-way interaction between a person and a provider using audiovisual telecommunications technology.
- **Asynchronous Store-and-Forward**: Store and Forward services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time.
- **eConsult:** E-consult services fall under the auspice of store and forward services. Electronic messages are exchanged (including clinical question and related diagnostic data) initiated by the primary care physician to a specialist. Specialist can convert an eConsult to a referral if necessary.
- **Remote Patient Monitoring** (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.
- **Mobile Health** (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks, to name a few examples.

Is Telehealth a Billable Service?

In many cases telehealth services are covered benefits and are billable by government programs and private payers. This guide provides information on major telehealth reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more public, private and commercial payers may begin to cover telemedicine. It is important that you check with your payers on a regular basis to see if additional services have been added for reimbursement. CTRC can provide updates on many of the major payers but may not be aware of all payer policies.

Reimbursement Information By Program Disclaimer

The following pages provide details on reimbursement for many of the major payers within the state of California. It should be noted that telehealth is a rapidly expanding field and changes in telehealth covered services and reimbursement occur every year. It will be necessary for programs to review new reimbursement provisions on a regular basis. CTRC publishes changes to this reimbursement guide as often as possible. This document can be found on our website and is distributed to those on the CTRC email list.

Traditional Medicare

Reimbursement for Traditional Medicare telehealth has five criteria for payment:

1. **The patient was seen from an "originating site" as defined by CMS**. An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are:

   - Physician and practitioner offices
   - Hospitals
   - Critical Access Hospitals (CAHs)
   - Rural Health Clinics (RHC)
   - Federally Qualified Health Centers (FQHC)
   - Hospital-based Renal Dialysis Centers (including satellites)
   - Skilled Nursing Facilities
   - Community Mental Health Centers (CMHCs)
   - Renal Dialysis Facilities
   - Patient Homes w/ End-Stage Renal Disease (ESRD) getting home dialysis
   - Mobile Stroke Units

2. **The Originating Site is located in one of the following geographic areas**:

   a. Rural Health Professional Shortage Areas (HPSAs) located in a rural census tract;
   -OR-
   b. Counties located outside Metropolitan Statistical Areas (MSA),

   Determining an eligible Originating Site location:

   HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This tool, the Medicare Telehealth Payment Eligibility Analyzer, is available at https://data.hrsa.gov/tools/medicare/telehealth

   NOTE: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites. Independent Renal Dialysis Facilities are not eligible originating sites.

   NOTE: Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke.

3. **The encounter was performed at the "distant site" as defined by CMS as the site where the health care provider is located. Eligible distant site practitioners are as follows:**

   - Physicians
   - Nurse practitioners (NPs)
   - Physician assistants (PAs)
   - Nurse-midwives
   - Clinical nurse specialists (CNSs)
   - Certified registered nurse anesthetists
   - Clinical psychologists (CPs) and clinical social workers (CSWs)*
   - Registered dieticians or nutritional professionals
   - Opioid Treatment Programs (OTP)

*CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838

4. **The patient was present, and the encounter involved interactive audio and video telecommunications** that provides real-time communication between the practitioner and the Medicare beneficiary.

5. **Type of Service provided** as specified in the Medicare Eligible Services located in Table 1.

Billing and Reimbursement

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2020, the payment amount is "80% of the lesser of the actual charge or $26.65". The site receives a flat reimbursement rate, outside of any other reimbursement arrangements such as inpatient DRGs or RHC per-visit payments.

- Originating sites are to use **Q3014** when submitting facility fee claims.
- The type of service is 9 - other items and services.
- The place of service code is 02 - Telehealth
- Bill the MAC for the originating site facility fee which is a separately billable Part B payment.

Traditional Medicare provides specific instructions for different originating facility types:

- For FQHC and RHCs: the originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- For Critical Access Hospitals, the payment amount is 80 percent of the originating site facility fee.
- For CMHC, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.
- In addition to FQHCs, RHCs and CAHs, Chapter 12 of the Medicare Claims Processing Manual, Section 190.6 describes payment methodologies for hospital outpatient departments, hospital inpatient, physicians' and practitioners' offices, renal dialysis centers, skilled nursing facilities and community mental health centers.

Distant Site Clinical Services Fees

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Distant site claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided.

Distant sites will submit the appropriate CPT code and use Place of Service 02 (Telehealth) for all encounters.

*Distant site practitioners billing telehealth services under the CAH Optional Payment Method (Method II) will continue to submit institutional claims using the GT modifier.

***NOTE: FQHCs and RHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.**

The table below provides a listing of all eligible services with CPT and HCPCS codes effective January 2020.

Synchronous Live Video Service	CPT or HCPCS Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420, G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	G0108, G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791, 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age	90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270 or 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436–G0437 99406–99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396 G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495

Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160 and 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839 and 90840
Prolonged preventative services	G0513-G0514

- Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for codes 90792, 90833, 90836, and 90838
- For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the beneficiary’s vascular access site.

CMS Expansion of Telehealth – Advancing Virtual Care

In 2019 CMS put forth new regulations to help advance virtual care. The intent of these regulations is to support access to care using communication technologies. Please note that none of these services are considered “traditional telehealth” for Medicare, therefore, they do not have the same restrictions as traditional telehealth services.

CMS will reimburse for the following under the Virtual Care programs:

- Opioid Use Disorder and MAT treatment
- Virtual Check-Ins
- Remote evaluation of patient submitted photos or recorded video
- Interprofessional Internet Consultation

FQHCs and RHCs will be reimbursed for Virtual Visits and Remote Evaluation services that are furnished by an FQHC or RHC practitioner when there is no associated billable visit. They are not eligible for reimbursement of Interprofessional Internet Consultations (eConsult), as the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT)

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removed the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder via live video.

In the finalized Physician Fee Schedule for 2020, Medicare added three bundled payments for MAT treatment. The codes are:

- G2086: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.

- G2087: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.

- G2088: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure).

Brief communication technology-based service, e.g. Virtual Check-In

Virtual Check-Ins are billed with code **G2012**. *

These interactions are patient initiated telephone or live video interactions. They involve a physician or non-physician practitioner having a brief, at least 5-minute, check-in with an established patient to assess whether the patient needs to come in for an office visit. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The virtual check-in must be for a condition not related to an E/M service provided within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment. There are no frequency limitations at this time.

Billable providers are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

* FQHCs and RHCs are allowed to bill for a Virtual Check-In. Virtual Check-Ins at an FQHC or RHC are billed with code **G0071**. The rate charged will be the physician fee schedule rate, not the all-inclusive rate (AIR) or prospective payment system (PPS).

Remote Evaluation of Pre-Recorded, Patient Submitted Photos or Recorded Video

Remote Evaluation Services are billed with code **G2010**. *

Remote evaluation services are patient initiated and consist of a practitioner evaluating an established patient's transmitted information via pre-recorded video or image. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The services can only be billed if the condition is not related to a service provided within the previous 7 days and does not lead to a service provided within the next 24 hours or soonest available appointment. There are no frequency limitations at this time.

Billable by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

*FQHCs/RHCs will be allowed to bill for Remote Evaluation services when an established patient sends recorded video or images to the FQHC/RHC. Remote Evaluation Services are billed with code **G0071**.

Interprofessional Internet Consultation (eConsult)

Interprofessional Internet Consultation is defined by CMS as "Assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when an established patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional." Interprofessional internet consultations covers consultations between professionals performed by a communications technology such as telephone or internet.

Verbal consent and acknowledgement of cost sharing from the patient is required.

Interprofessional Internet Consultations are limited to practitioners that can independently bill Medicare for E/M visits and are billed using the following codes:

99446: Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447: Same as 99446, but 11-20 minutes of medical consultative discussion and review
99448: Same as 99446, but 21-30 minutes of medical consultative discussion and review
99449: Same as 99446, but 31 minutes or more of medical consultative discussion and review
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 or more minutes of medical consultative time
99452: Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes

FQHCs and RHCs are not allowed to bill for interprofessional internet consultations because the AIR and PPS includes all costs associated with a billable visit, including consultations with other practitioners.

Chronic Care Management: Remote Physiological Monitoring

The definition for remote physiological monitoring under the Chronic Care Management Program is "a collection of physiological data (for example; ECG blood pressure glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the Home Health agency".

Under this definition remote patient monitoring will only be reimbursable when reported as a service in the provision of another skilled service.

Home visits for the purpose of supplying, or maintaining, remote physiological monitoring equipment without the provision of another skilled service will not be separately billable but will constitute an allowable administrative cost under the amendments to 42 CFR 409.46.

The Remote Physiological Monitoring CPT codes are as follows:

- CPT Code 99453: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

- CPT Code 99454: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

- CPT Code 99457: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

- CPT Code 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; additional 20 minutes

Principal Care Management Service

Beginning January 1, 2020, CMS finalized a new Principal Care Management Program payment and coding structure, recognizing that there is considerable time needed to manage one chronic condition.

- G2064: CCM for a single high-risk disease, e.g. PCM, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

- G2065: CCM for a single high-risk disease, e.g. PCM, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

CMS also added a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

Additional Resources

CMS Telehealth Services Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

CMS Rural Health Center Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

CMS Federally Qualified Health Center Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf

CMS Virtual Visits FAQ for Federally Qualified Health Centers
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

CMS MLN Matters number: MM10583, Revised September 6, 2018
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10583.pdf

UnitedHealthcare

Medicare and Medicaid Plans

UnitedHealthcare offers telemedicine and telehealth services to UnitedHealthcare patients. Telemedicine and telehealth services are covered for patients under this plan when Medicare coverage criteria are met.

Originating site requirements and allowable practitioners listed in the Medicare section of this manual apply to all telemedicine visits. UnitedHealthcare uses the same billing codes as Medicare for services.

See Medicare section of this manual for detail information on program restrictions.

Virtual Visits – HMP, EPO, POS Plans

The Virtual Visit benefit is designed to reimburse for telemedicine services rendered to a patient who is located at a location that is not a clinical Originating Site, (i.e. their home or workplace). Such services would not normally be covered under the existing telemedicine benefit. However, the addition of the Virtual Visit benefit provides coverage for those services when the member is not at a clinical Originating Site and uses a Designated Virtual Visit provider.

Conditions Required for Virtual Visits

Virtual visits are provided for the diagnosis and treatment of low acuity medical conditions. Examples include, but are not limited to:
Bronchitis

- Seasonal Flu
- Pink Eye
- Sore Throat
- Sinus Problems

The diagnosis and treatment is provided through the use of interactive audio and visual telecommunication and transmissions and audio visual communication technology. The virtual visit must provide communication of medical information in real-time between the patient and a distant physician or health

specialist through the use of interactive audio and video communications equipment outside of a medical facility.

The virtual visit must be provided by a UnitedHealthcare Designated Virtual Network Provider. Services are currently provided by AmWell and Doctor on Demand.

Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary.

Patient Consent

Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

Nothing shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

Telemedicine/Telehealth services are covered only when all of the following criteria are met:

- Member requires services that are usually provided by direct contact with the provider
- Services are authorized by the member's contracting/participating medical group or UnitedHealthcare
- The health care provider has determined telehealth services are appropriate
- Provider obtains verbal consent from member to provide telehealth services

Exclusions

This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

Additional Resources

UnitedHealthcare Telehealth Policy
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Telehealth-and-Telemedicine-Policy.pdf

UnitedHealthcare Advantage Plans – Telehealth Policy
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-coverage-sum/telemedicine-telehealth-services.pdf

UnitedHealthcare Community Plan – Medicaid – Telehealth Policy
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Telehealth-and-Telemedicine-Policy-(R0046).pdf

UnitedHealthcare Policy Number: BIP181.E: TELEMEDICINE/TELEHEALTH SERVICES/ VIRTUAL VISITS
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/signaturevalue-bip/telemedicine-telehealth-ca.pdf

UnitedHealthcare Virtual Visits FAQ
http://uhcvirtualvisits.com/FAQs

Medi-Cal Fee-For-Service

Please note: Most of the information in this section does not apply to FQHC or RHC provider types. Please refer to the FQHC/RHC section starting on page 34 for FQHC/RHC Medi-Cal fee-for-service information.

Medi-Cal Coverage of Telehealth

In-person contact between a health care provider and a patient is not required for services provided through telehealth.

Provider Requirements

The health care provider rendering Medi-Cal covered benefits or services provided via telehealth must meet the requirements of Business and Professions Code (B&P Code), Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed. *For example, BCBA and BCaBA providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission for Certifying Agencies.*

Covered Service: Synchronous - Live Video

1. Health care providers must use interactive audio, video, or data telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site.
2. The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
3. The presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary as determined by the health care provider at the distant site.
4. The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.
5. The health care provider who has the ultimate responsibility for the care of the patient must be licensed in the State of California and enrolled as a Medi-Cal provider.
6. All medical information transmitted during the delivery of health care via telemedicine must become part of the patient's medical record maintained by the licensed health care provider.

Covered Service: Asynchronous - Store and Forward

Store and forward is defined as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. Store and forward includes, but is not limited to teleophthalmology, teledermatology, teledentistry, teleradiology and must meet the following requirements:

1. The images must be specific to the patient's condition and adequate for meeting the procedural definition of the code that is billed.
2. Teleophthalmology and teledermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.

Covered Service: eConsult

E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions, and recommendations of care. A health care provider at the distant site may bill for an e-consult when the benefits or services delivered meet the procedural definition and components of the CPT code. eConsult is not applicable for FQHCs, RHCs or IHS-MOA clinics.

eConsult is not reimbursable more than once in a seven-day period for the same patient and provider.

Providers should note that eConsult is not separately reportable, or reimbursable, if any of the following are true:

1. The distant site provider (consultant) saw the patient within the last 14 days.
2. The e-consult results in a transfer of care, or other face-to-face service with the distant site provider (consultant), within the next 14 days or next available appointment date of the consultant.
3. The distant site provider did not spend at least five minutes of medical consultative time and it did not result in a written report.

If more than one contact or encounter is required to complete the e-consult request, the entirety of the service and cumulative discussion and information review time should be reported only once.

Documentation Requirements

Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. All documentation should be maintained in the patient's medical record. All health care practitioners providing covered benefits or services to Medi-Cal patients must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes.

Providers should note the following:

1. Health care providers at the distant site must determine that the covered service or benefit meets the procedural definition and components of the CPT or HCPCS code.
2. Health care providers are no longer required to document a barrier to an in-person visit (W&I Code, Section 14132.72[d]).
3. Health care providers at the distant site are no longer required to document cost effectiveness of telehealth to be reimbursed.

For eConsult, Medi-Cal has specific documentation requirements:

The health care provider at the **originating site** must create and maintain the following:

1. A record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management; and
2. A record of a request for an e-consult by the health care provider at the originating site.

The health care provider at the **distant site** must create and maintain the following:

1. A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and
2. A written report of case findings and recommendations with conveyance to the originating site.

Conditions Required for Telehealth Use

Patient Consent

Health care providers (either at the Originating or Distant Site) must inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services. The consent shall be documented in the patient's medical record and should include:

- A description of the risks, benefits and consequences of telemedicine
- The patient retains the right to withdraw at any time
- All existing confidentiality protections apply
- The patient has access to all transmitted medical information
- No dissemination of any patient images or information to other entities without further written consent

If a health care provider, whether at the Originating or Distant site, maintains a general consent that specifically mentions use of telehealth as an acceptable modality for delivery of services, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file.

For benefits delivered via asynchronous store and forward: health care providers must also meet the following requirements:

- A patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request.

- If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation or within 30 days of the patient's notification of the results of the consultation.

Eligible Originating Sites (Patient Site)

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the **patient's home**.

The presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary, as determined by the health care provider at the distant site.

Eligible Distant Site Practitioners (Provider Site)

There are no restrictions on provider types; however, a distant site provider must:

1. Be licensed in the State of California
2. Enrolled as a Medi-Cal provider
3. Be located in California or reside in a border community *
    a. A health care provider who is part of a group, with an office physically located in California, may reside outside California.

* Border communities (see source citation under additional information):
Oregon: Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, Merrill
Nevada: Carson City, Henderson, Incline Village, Las Vegas, Minden, Reno, Sparks, Zephyr Cove
Arizona: Bullhead City, Kingman, Lake Havasu City, Parker, Yuma

Billing and Reimbursement

Place of Service

Health care providers are required to document Place of Service code 02 on the claim, which indicates that services were provided or received through a telecommunications system. The Place of Service code 02 requirement is not applicable for FQHCs or RHCs.

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- 95 for Synchronous live video services.
- GQ for Asynchronous store and forward services, including eConsult.

Originating Site Fee

Sites are instructed to use **Q3014.** Sites fee are limited to once per day, same recipient, same provider. The originating site fee is applicable to sites utilizing synchronous live video, asynchronous store and forward, and eConsult. As of January 2020, the payment amount is $22.94.

FQHCs or RHCs may not bill for an originating site fee.

Transmission Fee: Live Interactive

Sites are instructed to use code **T1014**: telehealth transmission, per minute. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost. Transmission fees are not applicable to asynchronous store and forward or eConsult services.

FQHCs or RHCs may not bill for a transmission fee.

Synchronous Live video and Asynchronous Store & Forward:

Medi-Cal covered benefits or services, as identified by CPT or HCPCS codes, and subject to all existing Medi-Cal coverage and reimbursement policies, including any Treatment Authorization Request (TAR) requirements, may be provided via a telehealth modality, if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth; and
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association, 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; and

- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

Medi-Cal has removed all CPT and HCPC codes from their policy, instead allowing providers the ability to utilize telehealth as an appropriate modality for care for any clinical condition deemed appropriate by the provider.

eConsult:

To bill for e-consults, the health care provider at the distant site (consultant) may use the following CPT code in conjunction with the GQ modifier:

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

Additional Resources

Medi-Cal Telehealth Guidelines
http://files.medi-cal.ca.gov/pubsdoco/DocFrame.asp?wURL=publications%2Fmasters-mtp%2Fpart2%2Fmednetele_m01o03.doc

Medi-Cal & Telehealth: Resources
http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx

CCHP Medi-Cal Telehealth Policy Fact Sheet
https://www.cchpca.org/sites/default/files/2019-08/Medi-Cal%20Fact%20Sheet%20FINAL_0.pdf

Border Communities: Medi-Cal SPA 09-004
https://www.dhcs.ca.gov/formsandpubs/laws/Documents/09-004packageRAI.pdf

Border Communities: Medi-Cal MHSUDS Informational Notice 18-041
https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_IN18-041enclosure_MEDI.pdf

Denti-Cal

The Department of Health Care Services has opted to permit the use of teledentistry as an alternative modality for the provision of select dental services. Therefore, enrolled Denti-Cal billing providers may submit documents for services rendered utilizing teledentistry.

The goal of teledentistry is to:

1. Allow Medi-Cal providers to practice teledentistry, as defined to mean the transmission of medical information to be reviewed at a later time, or in real time, by a licensed dental provider at a distant site; and
2. Authorize modest scope of practice expansions.

Please note that allied dental professionals may render limited services via teledentistry so long as such services are within their scope of practice and are rendered under the general supervision of a licensed dentist.

Documentation Requirements

Providers may use CDT Code **D9999** for reimbursement of live transmission costs associated with teledentistry. Written documentation is required and must include the number of minutes the transmission occurred.

Conditions Required for Use

Patient Consent

Providers must inform the patient about the use of teledentistry and obtain verbal or written consent from the patient for the use of teledentistry as an acceptable mode of delivering dental services. The consent shall be documented in the patient's dental record.

A beneficiary receiving teledentistry services by store and forward may also request to have real-time communication with the distant dentist at the time of the consultation or within 30 days of the original consultation.

Billing and Reimbursement

Asynchronous Store and Forward services

Teledentistry claims are identified CDT code **D0999** ("Unspecified diagnostic procedure, by report") with a date of service on or after July 1, 2015. Claims are billed with D0999 and any additional services provided in the table below.

Providers may bill for teledentistry on the same claim form as other types of procedure codes unless they are in conflict with the Denti-Cal Manual of Criteria (MOC).

The table below provides a listing of all eligible store and forward services with CPT codes effective 2018

Asynchronous Store and Forward Service	CDT Codes
Unspecified diagnostic procedure, by report	D0999
Periodic oral evaluation — established patient	D0120
Comprehensive oral evaluation – new or established patient	D0150
Intraoral — complete series of radiographic images	D0210
Intraoral — periapical first radiographic image	D0220
Intraoral — periapical each additional radiographic image	D0230
Intraoral — occlusal radiographic image	D0240
Bitewing — single radiographic image	D0270
Bitewings — two radiographic images	D0272
Bitewings — four radiographic images	D0274
Panoramic radiographic image	D0330
Oral/Facial photographic images	D0350

Synchronous Live Video Services

Traditionally, teledentistry is conducted by asynchronous store and forward. However, at the beneficiaries request or if health care provider believes the service is clinically appropriate, live transmissions can be conducted and are reimbursable. Teledentistry claims are identified using Current Dental Terminology (CDT) code **D0999** ("Unspecified diagnostic procedure, by report") with a date of service on or after July 1, 2015.

Please note: CDT D0999 is the same code used or Asynchronous Store and forward. However, in this instance, D0999 is used as a stand alone code, or in conjunction with the live transmission code, D9999.

Providers may use CDT Code **D9999** for reimbursement of live transmission costs associated with teledentistry.

When submitting a claim for reimbursement of live transmission costs, CDT Code D9999 will only be payable when CDT Code D0999 has been rendered. The reimbursed rate is 24 cents per minute, up to a maximum of 90 minutes. Procedure D9999 may only be used once per date of service per beneficiary, per provider. Written documentation is required and must include the number of minutes the transmission occurred.

If the live transmission cannot occur at the precise time of the beneficiary request, then a subsequent agreed upon time may be scheduled between the beneficiary and provider within a 30 day time period.

Additional Resources

Denti-Cal Provider Handbook
https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf

Denti-Cal Quick Reference Guide
https://www.denti-cal.ca.gov/DC_documents/providers/teledentistry_quick_reference_guide.pdf

Denti-Cal Teledentistry Tutorial
https://www.denti-cal.ca.gov/DC_media/providers/teledentistry_tutorial.mp4

California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP)

CCS and GHPP programs follow Medi-Cal policies and procedures concerning coverage and reimbursement of telemedicine services.

Additional Resources

CCS Numbered Letter No. 14-123 Telehealth Services for CCS and GHPP Programs
https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl141213.pdf

CCS Numbered Letter No. 16-1217 Telehealth Services Code Update for CCS and GHPP Programs.
https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl161217.pdf

Anthem Blue Cross Telehealth Programs

Anthem Blue Cross has telehealth services available through a variety of programs administered and operated by Anthem Blue Cross. This section outlines the Anthem Blue Cross Telehealth Program provisions and benefits.

Coverage of Telehealth

- Live interactive
- Store and forward

For telehealth services to be eligible for reimbursement, the provider's services must be rendered from one of the following locations:

a. Provider's office
b. Hospital
c. Rural Health Clinic
d. Federally Qualified Health Center
e. Other location with prior plan approval

Conditions Required for Telehealth Use

Verbal and Written Patient Consent
All telehealth encounters require that verbal informed consent be obtained and documented by the Originating Site. This documentation is part of the medical record to be kept with other documentation.

Exclusions

A telephone conversation, email, fax are not considered live interactive or store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

Eligible Member Populations

a. Anthem Blue Cross Medi-Cal Managed Care Plans
b. CalPERS Basic Plan
c. Butte Schools Self-funded Program
d. California's Valued Trust (CVT)
e. Self-Insured Schools of California (SISC)
f. University of California (UC)

Eligible Originating and Distant Sites

Anthem Blue Cross limits participation in its telemedicine program to members of the Blue Cross Open Access Network. All originating (patient) and distant (provider) sites must be a member of this network.

Billing and Reimbursement

Anthem Blue Cross of California uses standardized billing procedures when submitting claims.

Modifiers
To be used by the distant site

- 95 for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Synchronous Live Video and Asynchronous Store and Forward

Specialty sites (also known as distant sites) may not bill for an originating site fee.
Presentation site (also known as originating sites): **Q3014**

Transmission Fees

- Anthem Blue Cross will pay claims for Blue Cross members' telecommunication charges for live interactive consultations only.
- Only the site that initiates the live interactive telemedicine encounter may bill.
- Sites are instructed to bill with code **T1014**
- Each minute (or part thereof) is equal to one (1) unit of occurrence with a maximum of 90 minutes of occurrence (1.5 hours billable maximum).

Synchronous Live Video

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

The table below provides a listing of all eligible live interactive services with CPT codes, effective 2019

Synchronous Live Video Service	CPT Codes
Primary Care Providers	
New patient office visit	99201-99205
Established patient office visit	99211-99215
Specialist	
Consultations	99241-99245
Follow-up visits	99211-99215
Psychiatry	
Psychiatric diagnosis	90801-90809
Individual psychotherapy	90810-90815
Individual psychotherapy (inpt)	90816-90819
Individual psychotherapy (inpt)	90821-90829
Medical psychoanalysis	90853
Pharmacological psychiatric mgt	90862
Consultations	99241-99245
Established member office visits	99211-99215

Asynchronous Store and Forward

Anthem Blue Cross pays for claims for the review of patient files for store and forward under codes:

- **99241-99245** Consultants only

The preparation of the store and forward consult should be billed as part of the primary care provider's office visit.

Store and forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Anthem Blue Cross.

Live Health Online (LHO)

LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to on-demand video visits (medical). It has an urgent care focus and provides convenient access anytime, anywhere in California, even at home, via smartphone, tablet or computer.

LHO connects patients with board-certified physicians supporting physical and behavioral health. Physicians can electronically prescribe to the member's pharmacy. **Note: Only noncontrolled substances can be prescribed.**

It is available at no cost for Anthem Blue Cross (Anthem) members enrolled in Medi-Cal Managed Care (Medi-Cal) beginning September 1, 2018.

Bright Heart Health

Now available to Anthem Medi-Cal members at no cost: Bright Heart Health Medication Assisted Treatment (MAT) program for opioid use disorder and alcohol use disorder.

Bright Heart Health is a website and mobile application that gives members 24/7 access to opioid addiction programs using virtual Substance Use Disorder (SUD) treatment programs. Bright Heart Health provides discrete outpatient treatment programs using your smart phone, tablet or computer.

Patients can access care by utilizing one of the following options:

1. Call Bright Heart Health to complete intake and get an appointment. Phone available 24x7 PHONE: (844) 884-4474
2. Complete Referral Form on Bright Heart Health website. https://www.brightheartheath.com/intake-forms/patient-referral/
3. Member's doctor or an emergency room can fax patient information to Bright Heart Health: FAX: (415) 458-2691

Members will be referred to a BHH services coordinator who will work with them to explore MAT and other treatment options.

Additional Resources

Anthem Blue Cross: Telemedicine Program Provider Operations Manual
https://mediproviders.anthem.com/Documents/CACA_CAID_ProviderManual.pdf

Anthem Blue Cross Telemedicine Website
http://w2.anthem.com/bcc_state/tm/info/index.asp

California Health & Wellness

This section outlines the California Health & Wellness Telehealth Program provisions and benefits.

Coverage of Telehealth

- Live interactive
- Store and forward

Conditions Required for Telehealth Use

Verbal and Written Patient Consent

Prior to each encounter of the delivery of health care services via telehealth, the licensed provider at the originating site must verbally inform the member that telehealth may be used and obtain verbal or written consent from the member. The verbal or written consent must be documented in the member's medical record, including the following elements:

a. A description of the risks, benefits, and consequences of telemedicine
b. The member retains the right to withdraw at any time
c. All existing confidentiality protections apply
d. The member has access to all transmitted medical information
e. No dissemination of any member images or information to other entities without further written consent

Store and Forward Patient Consent

The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a member receives teleophthalmology and teledermatology by store and forward.

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member's notification of the results of the consultation.

Exclusions

Telehealth does not include email, telephone (voice only), text, inadequate resolution video, written communication between the providers, or between patients and providers.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Plan members by any Plan-credentialed licensed provider.

Store and forward (asynchronous) telehealth services can be provided to Plan members by any Plan-credentialed licensed provider. The following licensed providers may provide store and forward services:

a. Ophthalmologists
b. Dermatologists
c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000 of Division 2 of the Business and Professions Code)

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited (Welfare and Institutions Code [W&I Code], Section 14132.72[e]).

Billing and Reimbursement

California Health and Wellness uses standardized billing procedures when submitting claims.

Modifiers
To be used by the distant site

- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 - May be billed with or without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Synchronous Live Video

There are two synchronous models of telehealth services available to Plan members.

a. Live interactive (synchronous) telehealth services, connects the patient with a distant licensed provider through audio-video equipment on a real-time basis.
b. Live interactive (synchronous) patient to provider telehealth services, connects a single licensed provider (primary care or specialty provider) to a member using audio-visual equipment on a real-time basis. The member can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

Table 10 provides a listing of all eligible live interactive services with CPT codes.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99201-99215
Initial hospital care or subsequent hospital care (new or established patient)	99221-99233
Consultations: Office or other outpatient, initial or follow-up inpatient, and	99241-99275
Interactive complexity (List separately in addition to the code for primary	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863

Asynchronous Store and Forward

Asynchronous telehealth services or store and forward services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

The table below provides a listing of all eligible store and forward services with CPT codes.

Asynchronous Store and Forward Service	CPT Codes
Office consultation, new or established patient	99241-99243
Initial inpatient consultation	99251-99253
Office or other outpatient visit	99211-99214
Subsequent hospital care	99231-99233
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists (should not be used if the originating site is submitting claims with this code)	92250

Additional Resources

California Health & Wellness Telehealth Policy
http://caltrc.org/wp-content/uploads/2020/02/CA_CHW_Telehealth_Services_SHP_11.11.19.pdf

Central California Alliance for Health

This section outlines the Central California Alliance for Health (CCAH) Telehealth Program provisions and benefits. The goal of telehealth with the Alliance is to improve both access and quality health services provided in rural and other medically underserved areas through the use of information and telecommunications technologies.

In order to support timely access to care, especially in specialties and regions in which access is limited, the Alliance promotes the use of telehealth when appropriate for the provision of specialty services.

Coverage of Telehealth

- Synchronous Live Video
- Asynchronous Store and forward including eConsult

Conditions Required for Telehealth Use

The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member's verbal or written consent, which will be documented in the member's medical record. The health care provider will disclose to enrollees the use telehealth in the delivery of specialty or other care and, if applicable, directions for how enrollees can elect to use telehealth services for their care. In all circumstances, providers will abide by HIPAA laws, including not disclosing a member's personal health information to any third party without written consent.

Exclusions

The Alliance will not reimburse under this policy for routine e-mail, telephone (voice only), text, written communication between providers or between members and providers, or images with inadequate resolution.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

The Alliance will pay for asynchronous store and forward services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member's Evidence of Coverage (EOC).

Eligible Originating and Distant Sites

Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home, or other settings as necessary. The Alliance does not require face-to-face contact between a member and a provider for reimbursement to occur.

Billing and Reimbursement

Modifiers and Place of Service Code

Place of Service code 02 is to be used on the claim. This is not applicable to FQHCs and RHCs.

Modifiers to be used by the distant site:

- 95 for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014: If a licensed provider is not present at the originating site, a site facility fee may be billed in lieu of the provider fee for the visit.

Transmission Fees

T1014: Transmission cost fees may be billed whether or not a licensed provider is present.

Synchronous Live Video

The table below provides a listing of all eligible live interactive services with CPT codes.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99202-99215
Initial hospital care or subsequent hospital care, critical care (new or established patient)	99221-99233, 99291, 99292
Extended Inpatient Care	99356 – 99357
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99275
Genetic Counseling	96040, S0265
Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)	97802, 97803, 97804, 99539
Interactive complexity (List separately in addition to the code for primary	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863
Originating Site Fee	Q3014
Transmission Fee	T1014

Asynchronous Store and Forward

Store and forward (asynchronous) services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally, an image or picture is taken and forwarded to the distant licensed provider to review at a later time. The following Medi-Cal certified health care providers may provide store and forward services:

a. Ophthalmologists
b. Dermatologists
c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code)
d. Specialist groups contracted with the Alliance to provide eConsult services

The table below provides a listing of all eligible store and forward services with CPT codes.

Asynchronous Store and Forward Service	CPT Codes
Office or other outpatient visit (new or established patient)	99202-99215
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99243, 99231-99233
eConsult, electronic consultation	99451
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists	92250
Originating Site Fee	Q3014
Transmission Fee	T1014

Managed Behavioral Health Organization (MBHO)

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide mild to moderate mental health services and BHT for eligible members from licensed/certified behavioral health providers.

Additional Resources

CCAH Provider Manual
https://www.ccah-alliance.org/providerspdfs/PM/Provider_Manual_Chapters/Provider_Manual.pdf

CCAH Provision of Telehealth Services to Alliance Members Policy 404-1727
http://www.ccah-alliance.org/providerspdfs/pm/20190101/404-1727-Telehealth-Services.pdf

Partnership Health Plan of California

This section outlines the Partnership HealthPlan of California (Partnership) Telehealth Program provisions and benefits. The goal of telehealth with Partnership is to improve both access and quality health services provided in rural and other medically underserved areas through the use information and telecommunications technologies.

Telemedicine services may also be used to provide mild-moderate severity Mental Health Services to Partnership members. Such services are provided through Partnership's contracted Managed Behavioral Health Organization (MBHO).

Partnership Coverage of Telehealth

- Synchronous live video
- Asynchronous store and forward including eConsult

Conditions Required for Telehealth Use

Verbal and Written Patient Consent

Prior to the delivery of health care services via telehealth, the health care provider at the presentation site must verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent must be documented in the patient's medical record.

Store and Forward Patient Consent

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member's notification of the results of the consultation.

eConsult

Verbal consent for telehealth services is a requirement and must be documented by both the originating and distant site in the patient medical record.

Exclusions

PHC does not cover communication between providers outside that described as E-Consult. PHC does not cover patient-provider communication via email, text, or written communication. Video communication of poor resolution and phone communication are only covered if such telephone visits last at least 5 minutes and be documented in the medical record.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited. Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home or

other setting and must be in compliance with all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information.

Live interactive (synchronous) telehealth services can be provided to Partnership members by any PHC credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

Store and forward (asynchronous) telehealth services can be provided by the following Medi-Cal providers:

a. Ophthalmologists
b. Dermatologists
c. Optometrists
d. Specialists participating in PHC's eConsult Program

Billing and Reimbursement

Partnership uses standardized billing procedures when submitting claims.

Modifiers and Place of Service Code

Place of Service code 02 is to be used on the claim. This is not applicable to FQHCs and RHCs.

Modifiers to be used by the distant site:

- 95 for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 – May be billed without a provider present. This is not applicable to FQHCs and RHCs.

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence. This is not applicable to FQHCs and RHCs.

Synchronous Live Video Services

There are two synchronous models of telehealth services available to Plan members:

1. Live interactive (synchronous) Telehealth Services connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as UCSF or UCD with outlying physician offices or community health centers.
2. Live interactive (synchronous) Patient to Provider Telehealth Services connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

The table below provides a listing of all eligible live interactive services with CPT codes.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99201-99215
Initial hospital care or subsequent hospital care, critical care (new or established patient)	99221-99233, 99291, 99292, G0508, G0509
Extended Inpatient Care	99356 – 99357

Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99275
Genetic Counseling	96040, S0265
Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)	97802, 97803, 97804, 99539
Interactive complexity (List separately in addition to the code for primary	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863
Video Visit with provider in office and patient off-site (in lieu of office visit)	G0071 (FQHC/RHC) or G2012 (other providers)
Originating Site Fee	Q3014
Transmission Fee	T1014

Other Covered Procedures that can be provided by Synchronous Live Video

All CPT codes except for these excluded codes: Anesthesia: 00100-01999 and 99100-99157; Surgery: 10021-69990; Speech/Occupational/Physical Therapy: 96101 to 97546, and 97750 to 97799; Wound care: 97597 to 97610; Acupuncture, osteopathic manipulation, chiropractic manipulation: 97810 to 98943) are potentially allowed if they meet requirements as noted*

* Each telehealth provider must be licensed in the State of California, enrolled as a Medi-Cal provider, and must reside in California (or a border community).

PHC covered services, identified by CPT or HCPC codes, and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
2. The services delivered via telehealth meet the procedural definition and components in the CPT-4 or HCPCS code(s) associated with the covered service; and
3. The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Note for FQHCs and RHCs: An FQHC, RHC, or Tribal health site may choose to sub-contract with a specialist and pay them directly. Under these circumstances, the FQHC/RHC would bill for the originating site and the specialty service on two separate claims. The Partnership system would need to be set up for the specific specialty and if not, the Provider Relations Department should be contacted.

Asynchronous Store and Forward Services

Store and forward (asynchronous) services, model connects a patient with a distant provider of radiology, electrocardiography, ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally, an image or picture is taken and forwarded to the specialty provider to review at a later time. This also includes specialty services provided via eConsult, or electronic consultations, which consist of an electronic exchange of information through the E-Consult platform and may include images or photos, labs, and other relevant patient information.

The table below provides a listing of all eligible store and forward services with CPT codes.

Asynchronous Store and Forward Service	CPT Codes
Office consultation (new or established patient)	99201-99215
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99243, 99231-99233
Remote evaluation of recorded video and/or images submitted by the patient.	G2010
eConsult, electronic consultation	99451
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists	92250 (no modifier)
Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral	92227 (no modifier)
Originating Site Fee	Q3014
Transmission Fee	T1014

Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers:

If a provider uses asynchronous telehealth for diabetic eye exam screenings, through the use of a retinal camera located at the originating site, special billing guidelines apply, when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If provider is present during the visit, E&M codes can also be billed as usual. If no provider is present at visit, bill using one of the following CPT codes:

92250: Retinal photography with interpretation for services provided by optometrists or ophthalmologists
92227: Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral

eConsult

Only approved specialists participating in PHC's E-Consult Program can bill. The specialist provider at the distant site must:

1. Create and maintain record of the review and analysis of the transmitted information with written documentation of data of service and time spent (between 5-30 minutes)
2. Record of preparing a written report of case findings and recommendations with conveyance to the originating site
3. Record of maintenance of transmitted medical records in patient's medical record.

Telephone visits

Any clinician eligible to bill for office visits may conduct a telephone visit with a patient in lieu of an office visit. Such telephone visits must last at least 5 minutes, and be documented in the medical record. Note that these are the same codes used for video visits with the patient at home.

G0071 – FQHCs and RHCs G2012 – Other Providers

Additional Resources

Partnership Health Plan Telehealth Policy
http://www.partnershiphp.org/Providers/Policies/Documents/Utilization%20Management/MCUP3113.docx

Partnership Health Plan Telehealth Service Website
http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Services.aspx

Beacon Health Options

Beacon is a Managed Behavioral Health Organization (MBHO). Beacon manages the behavioral health benefits for some of the Medi-Cal Managed Care Plans in California. Specifically, they offer behavioral health, including psychiatry and therapy, substance use disorder, and specialty programs for autism. The services that Beacon offers will vary by Managed Care Plan. Below are a few of the guidelines you should be aware of.

Coverage of Telehealth

Live interactive only

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Beacon members with the following health plan affiliations:

Alameda Alliance for Health
Central California Alliance for Health
Gold Coast Health Plan
Health Plan of San Joaquin
LA Care
Partnership Health Plan
Promise Health Plan
San Francisco Health Plan

Billing and Reimbursement

Beacon uses standardized billing procedures when submitting claims.

Modifiers

To be used by the distant site

- 95 for live interactive telehealth encounters

Originating Site Fee

Q3014 – May be billed without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited.

The table below provides a listing of **potential** live interactive services with CPT codes, based on your individual contract.

Synchronous Live Video Service	CPT Codes
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Family psychotherapy (without the patient present), 50 minutes	90846
Family psychotherapy (conjoint therapy) (with the patient present), 50 minutes	90847
New Patient, office or other outpatient visit	99205
Established patient, office or other outpatient visit	99212 - 99215
Behavioral health day treatment, per hour	H2012
Skills training and development, per 15 minutes	H2014
Therapeutic behavioral services, per 15 minutes	H2019
Home care training; family, per session	S5111
Originating Site Fee	Q3014
Transmission Fee	T1014

Direct to Consumer Option

Beacon offers several platforms for members to be seen in their homes, by a licensed clinician, using their smart phone, laptop, or tablet.

Members must be screened first by a member services representative before they can be referred for services.

This option is not available to all members or all plans that Beacon manages the benefit for. Please check with member services or Provider Relations for availability.

Additional Resources

Beacon Telehealth Program Description
https://www.beaconhealthoptions.com/material/telehealth-program-description/

Beacon Telehealth Program Specifications
https://www.beaconhealthoptions.com/material/telehealth-program-specs/

Beacon Telehealth FAQ
https://www.beaconhealthoptions.com/material/telehealth-faqs/

Beacon Telehealth Site Coordination
https://www.beaconhealthoptions.com/material/telehealth-site-coordination/

Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers (FQHC) And Rural Health Clinics (RHC) play a critical role in the provision of primary care to our rural and underserved populations. Many FQHC/RHSs are patient and / or provider sites for the delivery of telehealth services. Telehealth can improve patient access to specialty care, primary care, and reduce travel hardships when needed services are far away. These valuable healthcare resources have played an important role in the development of telehealth in California.

One of the questions most commonly asked of the CTRC is about allowable billing for telehealth services by an FQHC/RHC. CTRC has worked with many rural clinic administrators and payers to clearly identify the different reimbursement scenarios and the payment rules that surround each scenario. This document has been developed with input from many different stakeholders, health plans, and clinics themselves.

This portion of the guide is designed to assist in maximizing allowable billing for telemedicine and to assist in determining the type of provider relationship that will best meet programmatic needs. It is written for FQHCs and RHCs operating in California under the Prospective Payment System (PPS). Please note that rules for other states may differ.

There are several factors that determine how to bill for telemedicine services. Two principles form the foundation:

- The place determined to be the Distant or provider site is the billing site
- A provider can, under certain circumstances, enter the four walls virtually using telehealth

The factors that determine the billing scenario are:

- Where the patient is physically located at the time of the visit
- Characteristics of the specialty provider site
- Payment arrangement with the distant site provider
- If there is medical reason for a provider to be present with the patient

Fee-For-Service Medi-Cal

Fee-For-Service Medi-Cal has developed specific policies for FQHCs and RHCs that differ from the other provider types. First, let's address a few definitions that will help to clarify the policies we will be diving in to in a bit.

HHMS: Homeless, Homebound, Migratory, or Seasonal Worker.
Homebound: means the patient must have a normal inability to leave home and leaving home must require considerable and taxing effort due to either:

1. An illness or injury where
    a. There is a need for the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; or
    b. The use of special transportation; or
    c. The assistance of another person in order to leave their place of residence.
2. Having a documented condition such that leaving his or her home is medically contraindicated.

Homeless: Shall include all individuals who do not reside in a permanent residence, who do not have a fixed home, or mailing address.
Migratory or seasonal worker: An individual who meets the definition of migratory agricultural worker in Section 330(g)(3)(A) of the Public Health Service Act or seasonal agriculture worker in Section 330(g)(3)(B) of the Public Health Service Act.

Established Patient: is a Medi-Cal eligible recipient who meets one or more of the following conditions:

1. The patient has a health record with the FQHC or RHC that was created, or updated, during a visit that occurred in the clinic within the previous 3 years; or
    a. During a synchronous telehealth visit in a patient's home with a clinic provider and a billable provider at the FQHC or RHC. The patient's health record must have been created or updated within the previous three years.
2. The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit, occurring within the last three years, that was provided outside the FQHC or RHC clinic, but within the FQCHs or RHCs service area. All consent for telehealth services for these patients must be documented.
3. The patient is assigned to the FQHC or RHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.
4. When a health record is maintained among multiple FQHCs or RHCs within the same organization, the patient is an established patient of the organization's FQHCs or RHCs.

Synchronous Live Video Telehealth Services:

Services provided through synchronous, live video telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.

1. FQHCs and RHCs may bill for an office visit if it is medically necessary for a billable provider to be present with a patient during the telehealth visit.
2. An FQHC or RHC billable provider furnishes services as a distant site.
3. FQHCs and RHCs must submit claims for telehealth services using the appropriate all-inclusive billing code sets and related claims submission requirements.

Telehealth to the patient's home:

FQHCs/RHCs are allowed to provide live video telehealth services to the patient home, however, the following conditions will be in place:

1. The patient must be an established patient and either homeless, homebound, or a migratory or seasonal worker.
2. The FQHC or RHC may bill its PPS rate for services provided outside the Four Walls. The FQHC or RHC must maintain documentation demonstrating that the person is homeless, homebound, or a migratory or seasonal worker. The FQHC or RHC shall meet all of the following requirements:
    a. The visit must be at the patient's residence or current location for homeless patients. For RHCs, a patient's residence is the only location outside the Four Walls of an RHC that is eligible for visits to be reimbursed at the RHC's PPS rate.
    b. The person rendering the service must be employed or under contract with the FQHC or RHC at the time the services are rendered.
    c. Services must be rendered within the FQHC's Health Resources and Services Administration's (HRSA) approved service area.

Asynchronous Store and Forward Services:

Reimbursement is permitted for an established patient for teleophthalmology, teledermatology and teledentistry, and furnished by a billable provider at the distant site.

Billing and Reimbursement

Originating site and transmission fees:

FQHCs and RHCs are not eligible to bill an originating site fee, or transmission charges. The cost of these services should be included in the PPS rate.

Synchronous Live Video:

1. If the Originating Site and the Distant Site are FQHCs or RHCs that are part of the same organization, only one site may bill for the visit, even if a billable provider participates at each location.
2. If the Originating Site and the Distant Site are both FQHCs or RHCs but are not part of the same organization, both the Originating Site and Distant Site may each bill for the services at their respective PPS rates if both organizations use medically necessary billable providers. The Originating Site shall not compensate the Distant Site for the Telehealth Services rendered.
3. If the Originating Site is an FQHC or RHC and the Distant Site is not an FQHC or RHC, only the Originating Site can be reimbursed for the Telehealth Service at the PPS rate if a medically necessary billable provider is used. The Originating Site is responsible for reimbursing the Distant Site for the Telehealth Service rendered to its Established patient if a payment arrangement exists.
4. If the Originating Site is not an FQHC or RHC and the Distant Site is a FQHC or RHC, the Distant Site can be reimbursed for the Telehealth Service at the PPS rate. The Originating Site shall not compensate the Distant Site for the Telehealth Services.

Asynchronous Store and Forward:

An FQHC or RHC may bill at its PPS rate for store and forward ophthalmology, dermatology, and dentistry services provided to its established patient, if it meets all of the following requirements:

a. The Originating Site FQHC or RHC shall comply with the informed consent provision for store and forward prior to its established patient receiving ophthalmology, dermatology and dentistry Store and Forward Services
b. If the Distant Site providing Store and Forward Services is also an FQHC or RHC, the Originating Site may only bill for one visit at its PPS rate, even if the services provided at the Distant Site occurred on a different day. Under no circumstances can two visits be billed for a single Store and Forward Service
c. If the Distant Site is not an FQHC or RHC, the following requirements must be met for the Originating Site FQHC or RHC to be reimbursed at the PPS rate:
    i. Only one visit can be reimbursed at the PPS rate regardless of the services rendered at the Originating Site
    ii. The Originating Site FQHC or RHC must have an arrangement or current written agreement with the Distant Site to furnish the Store and Forward Services
    iii. The Originating Site FQHC or RHC must compensate the Distant Site for the Store and Forward Services furnished to its patients
    iv. The Distant Site must not directly bill Medi-Cal for the Store and Forward Services.

Medi-Cal Managed Care

Not all Medi-Cal Managed Care Plans in the state reimburse for telehealth services. You can find the policies for a few of these plans in other sections of the Reimbursement Guide. The CTRC strives to include as many Managed Care Plan policies as possible. In the absence of a policy, please reach out to your specific plans Provider Relations department to inquire about telehealth services.

For those Managed Care Plans that do reimburse for telehealth services, many of them do not have the same restrictions for FQHCs and RHCs as Fee-For-Service Medi-Cal. For example, an FQHC may be able to see a patient who is located in their home, via telehealth, and bill their PPS rate to the plan, regardless of the patient being HHMS.

Keep in mind that if a Managed Care Plan allows an FQHC to provide telehealth services to the patient's home without restrictions, Fee-For-Service Medi-Cal will NOT pay the wrap unless the patient is HHMS!

It is also important to keep contracting in mind when working with your Managed Care Plan around telehealth. As an FQHC, some Managed Care Plans will allow you to be both Distant Site and Originating Site. It is important to be sure that your FQHC is contracted correctly with the plan and that your rates are loaded in to the claims system correctly.

FQHC and RHC Reimbursement Models

The application of some of the factors we have discussed are described in the following fourteen scenarios. While this section has addressed Med-Cal specifically, Medicare scenarios have been added to help FQHC and RHC providers understand their billing options.

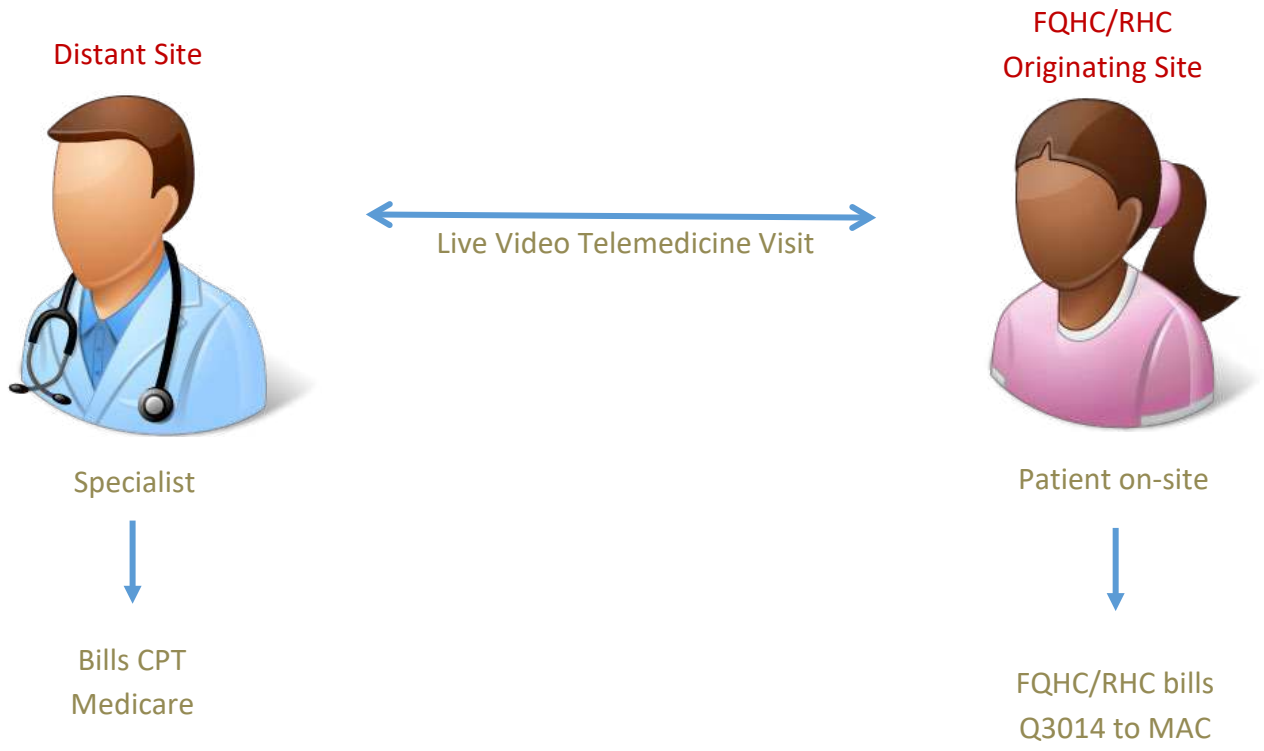
Medicare – Traditional Telehealth Live Video Visit

Scenario 1 FQHC/RHC Originating Site to a Distant Site

- Patient is physically present at the FQHC/RHC located **in an eligible location.**
- Specialist is a Medicare provider not physically present at the FQHC/ RHC.
- FQHC/RHC and specialist have an agreement to provide services, but the FQHC/RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- Medicare specialist is the Distant Site and can bill Medicare for a visit.
- FQHC/RHC is the Originating Site, did not provide an in person medical service, and cannot bill PPS for a face-to-face. However, the FQHC/RHC can bill an Originating Site fee to the Medicare Administrative Contractor (MAC).



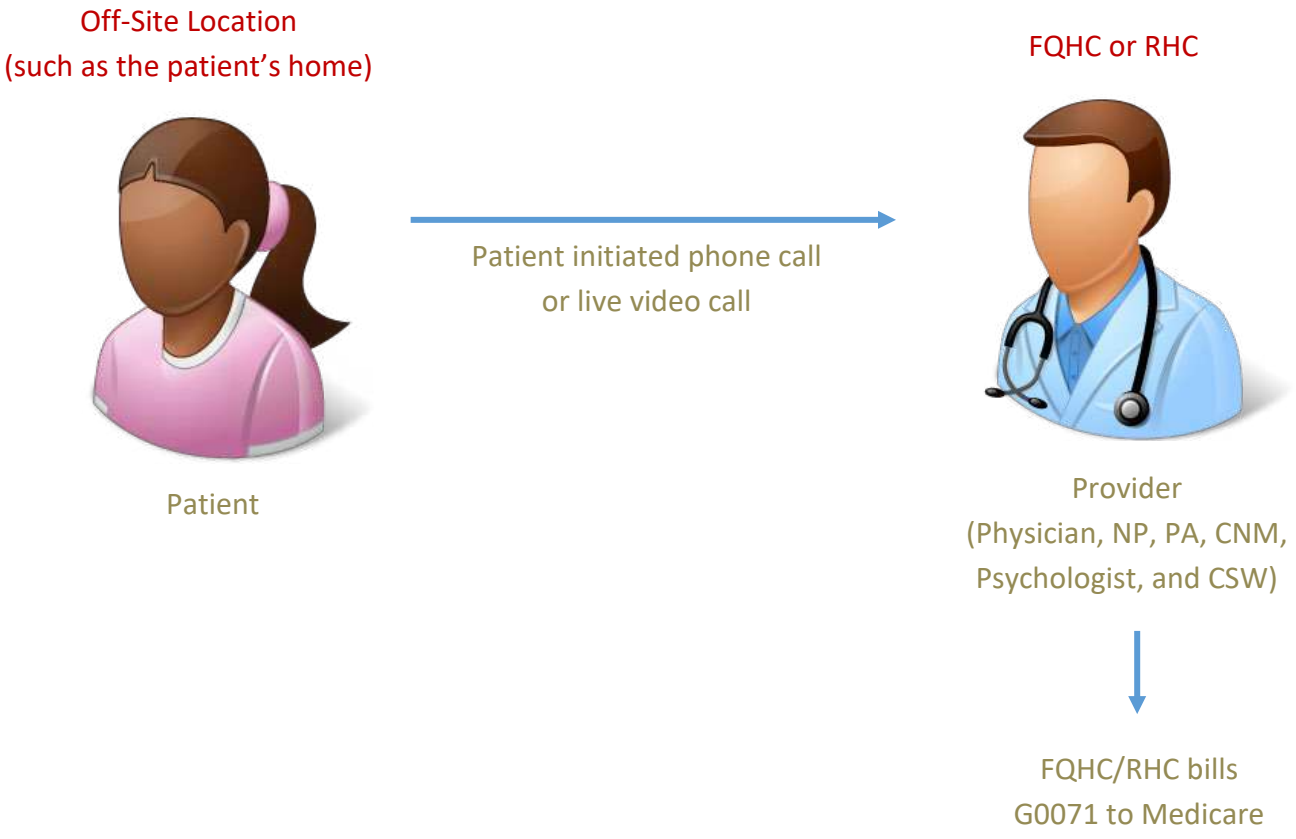
Medicare Virtual Visit

Scenario 2 — Patient (off-site) to an FQHC/RHC

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient is an established patient and initiates a live video or phone call to see if they need to come in to the FQHC/RHC for an in person visit.
- FQHC billable provider spent at least 5 minutes talking to patient.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC or RHC can bill for the Virtual Visit Service.



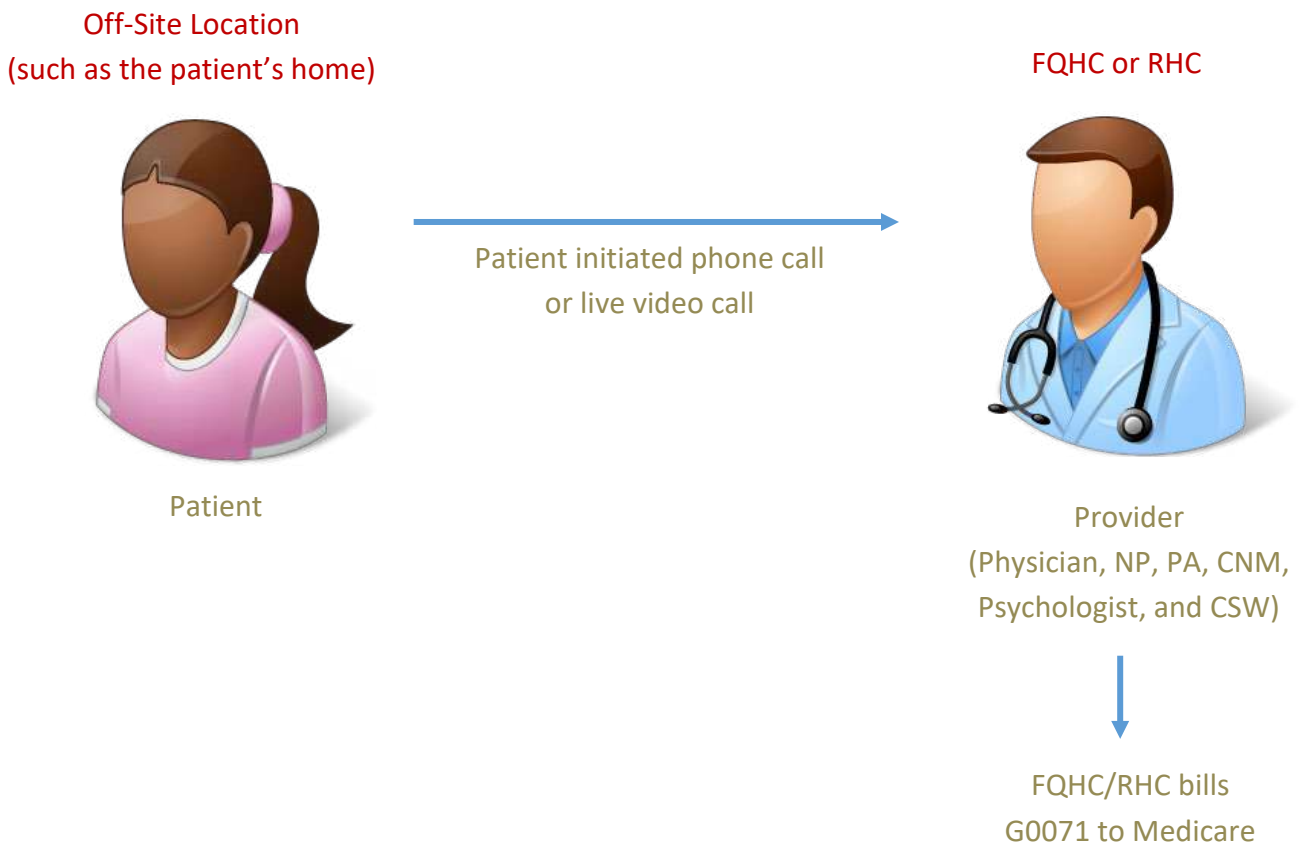
Medicare Remote Evaluation

Scenario 3 — Patient (off-site) to an FQHC/RHC

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient is an established patient and initiates an asynchronous transmission of photos or video to the FQHC/RHC.
- FQHC billable provider evaluated the patient transmitted images or video.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC or RHC can bill for the Remote Evaluation service.



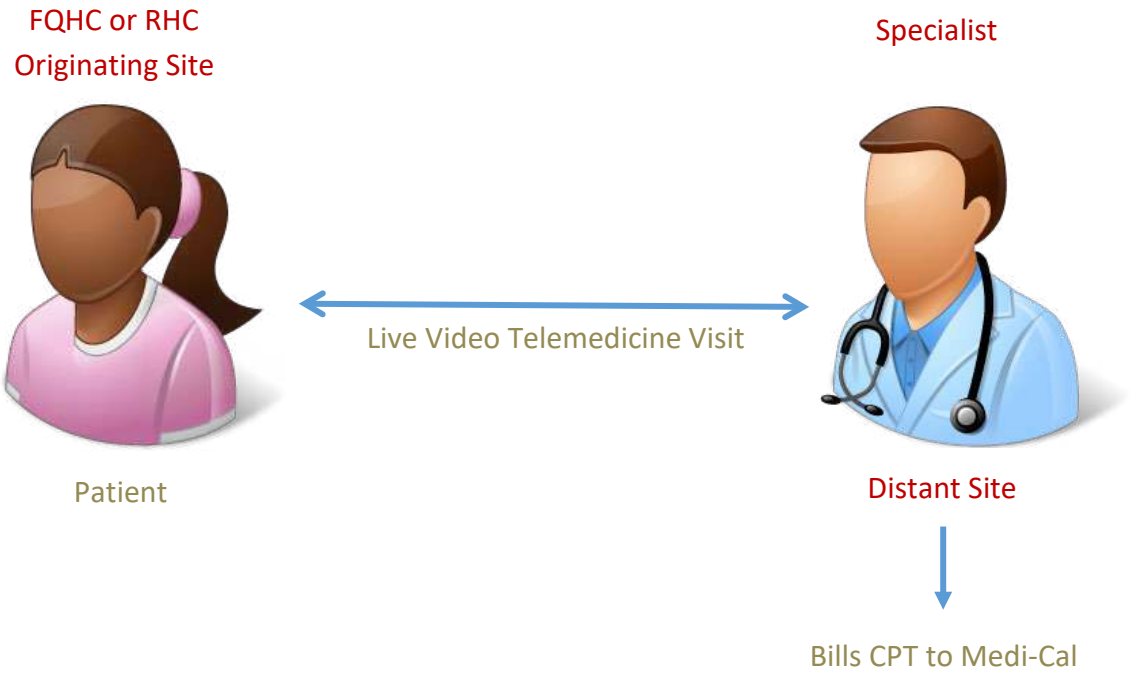
Medi-Cal Fee-For-Service

Scenario 4 FQHC/RHC Originating Site to a Fee-For-Service Distant Site

- Patient is physically present at the FQHC or RHC.
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC.
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site.

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service rate.
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face.



*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

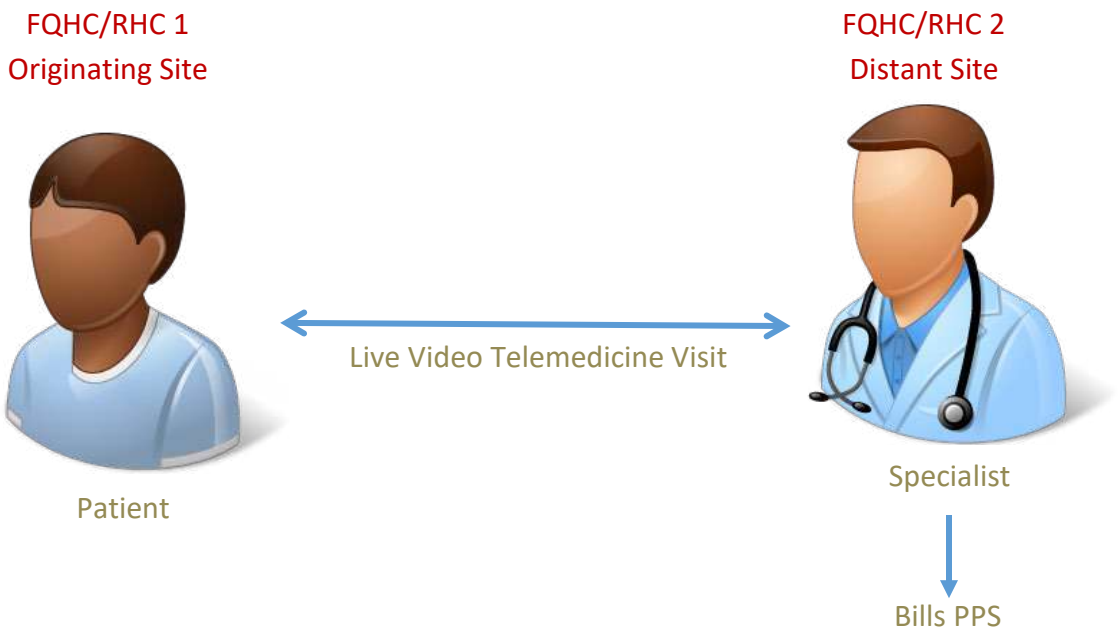
Medi-Cal Fee-For-Service

Scenario 5 — FQHC/RHC to FQHC/RHC (Two Different Organizations)

- Patient is physically present at FQHC/RHC 1.
- Specialist is physically present at and receives compensation from FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, however FQHC/RHC 1 cannot compensate FQHC/RHC 2.
- No medical reason for a provider to be present with the patient at FQHC/RHC 1.

Outcome

- FQHC/RHC 2 is the Distant Site and can bill PPS for a face-to-face visit.
- FQHC/RHC 1 is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face visit.



*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

**Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*

Medi-Cal Fee-For-Service

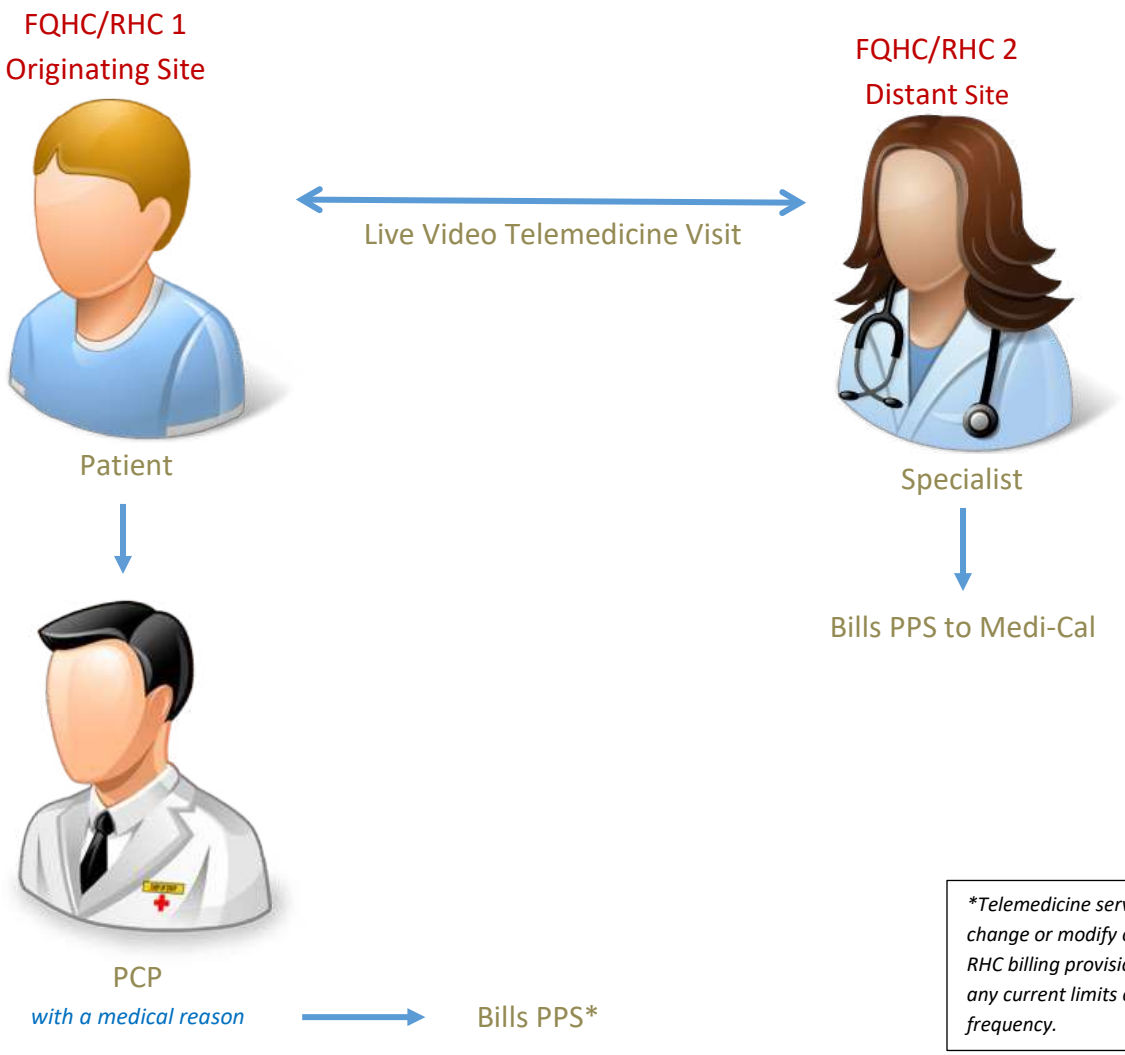
Scenario 6

FQHC/RHC (Provider Present) to FQHC/RHC (Two Different Organizations)

- Patient is physically present at FQHC/RHC 1.
- Specialist is physically present at and receives compensation from FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, but FQHC/RHC1 cannot compensate FQHC/RHC 2.
- Medical reason for a provider to be present with the patient at FQHC/RHC 1.

Outcome

- FQHC/RHC 2 specialist is the Distant Site and can bill PPS for a face-to-face visit.
- FQHC/RHC 1 is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit.



Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

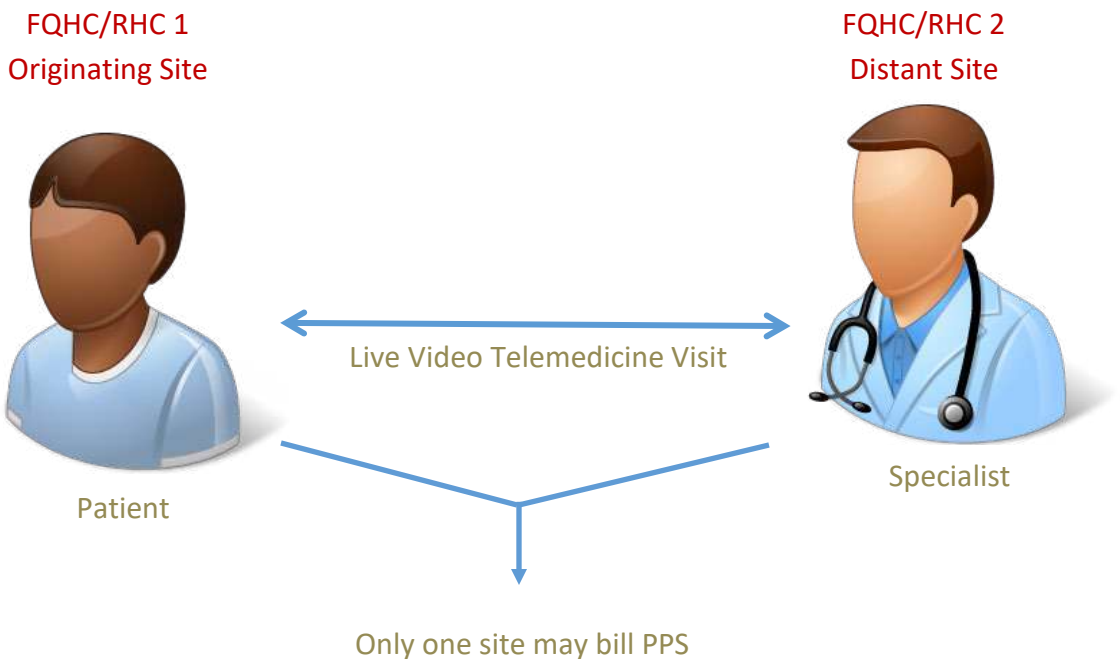
Medi-Cal Fee-For-Service

Scenario 7 FQHC/RHC to FQHC/RHC (Within Same Organization)

- Patient is physically present at FQHC/RHC 1.
- Distant Site Provider is physically at, and receives compensation from, FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services and are part of the same organization.
- No medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site.

Outcome

- FQHC/RHC 2 is the Distant Site.
- FQHC/RHC 1 is the Originating Site.
- In this scenario, only one FQHC/RHC site may bill since they are part of the same organization.



*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

**Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*

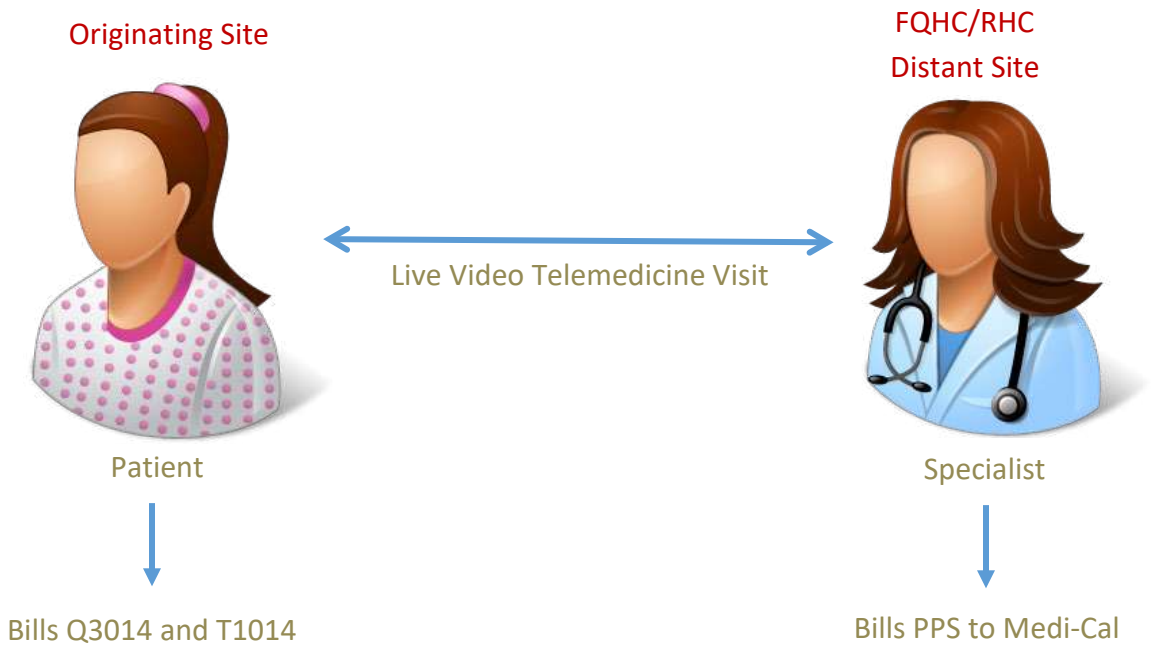
Medi-Cal Fee-For-Service

Scenario 8 Non FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at Originating Site (non FQHC/RHC).
- Specialist is physically located at and receives compensation from FQHC/RHC.
- Originating Site and FQHC/RHC have an agreement to provide services, however Originating Site does not compensate FQHC/RHC.
- No medical reason for a provider to be present with the patient at the Originating Site.

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit.
- Non FQHC/RHC Clinic site is the Originating Site, did not provide a medical service, and cannot bill for a face-to-face visit. However, the clinic site can bill an Originating Site fee and transmission fee.



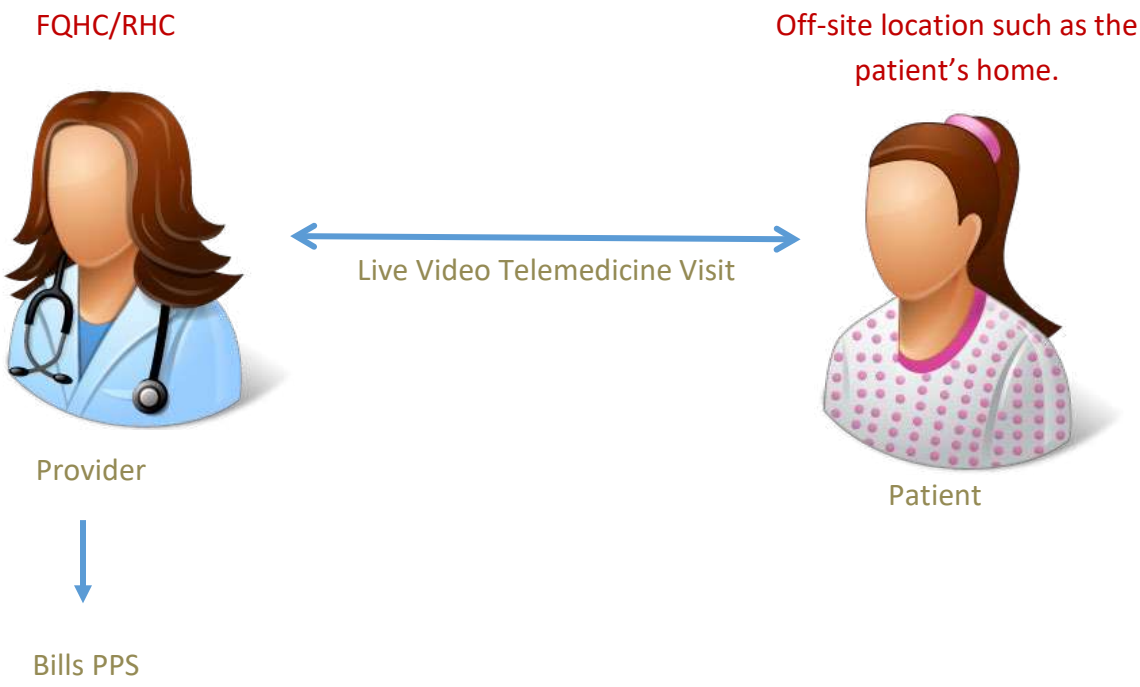
Medi-Cal Fee-For-Service

Scenario 9 FQHC/RHC to HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either ***homebound, homeless, or a migratory or seasonal worker***.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill PPS for a face-to-face visit.



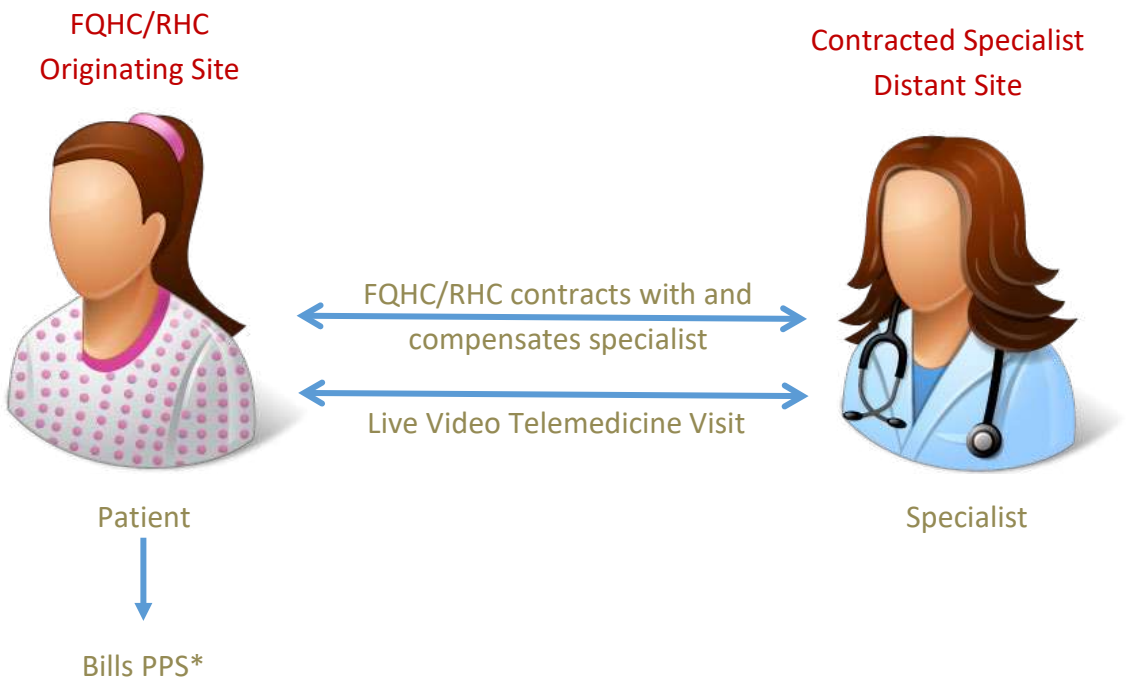
Medi-Cal Fee-For-Service and Multiple Managed Care Plans

Scenario 10 FQHC/RHC Originating Site to Contracted Distant Site

- Patient is physically present at FQHC/RHC Site.
- Specialist is not physically at the FQHC/RHC.
- FQHC/RHC and specialist have a written agreement to provide services. FQHC/RHC compensates specialist outside of an insurance plan.
  - *The agreement should be in writing and clearly state: The time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. (See BPHC Policy Information notice 98-23)*
- FQHC or RHC has credentialed the contracted provider in house and with the health plan (if applicable)
- Specialist virtually enters FQHC site via telemedicine.

Outcome

- FQHC/RHC becomes the Distant Site and can bill PPS for a face-to-face visit.



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

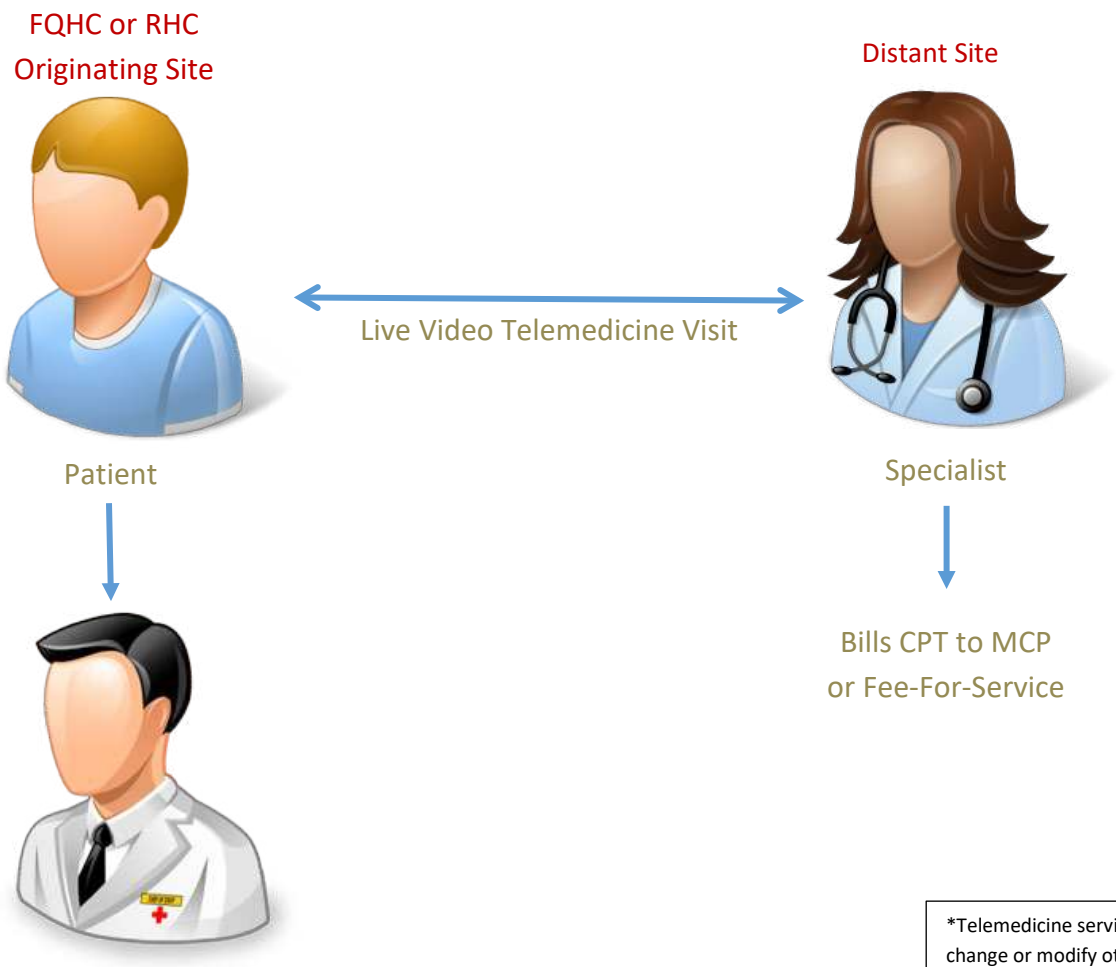
Medi-Cal Fee-For-Service and Multiple Managed Care Plans

Scenario 11 FQHC/RHC Originating Site (Provider Present) to a Distant Site

- Patient is physically present at the FQHC/RHC.
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC/RHC.
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC/RHC does not compensate the specialist.
- Medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service.
- FQHC/RHC is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit.



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

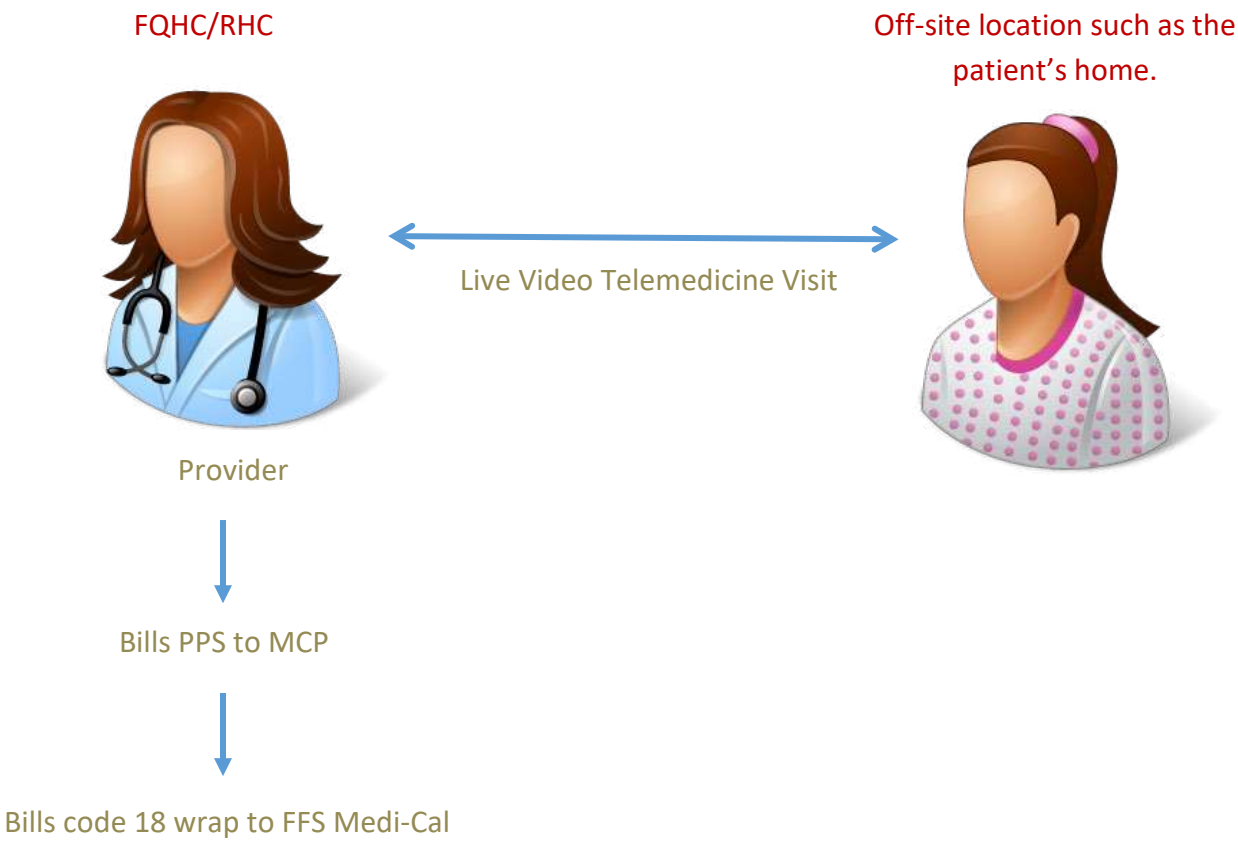
Medi-Cal Managed Care Plan (MCP)

Scenario 12 FQHC/RHC to HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either ***homebound, homeless, or a migratory or seasonal worker***.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is homebound, homeless, or a migratory or seasonal worker, therefore the code 18 wrap CAN be billed to the state.



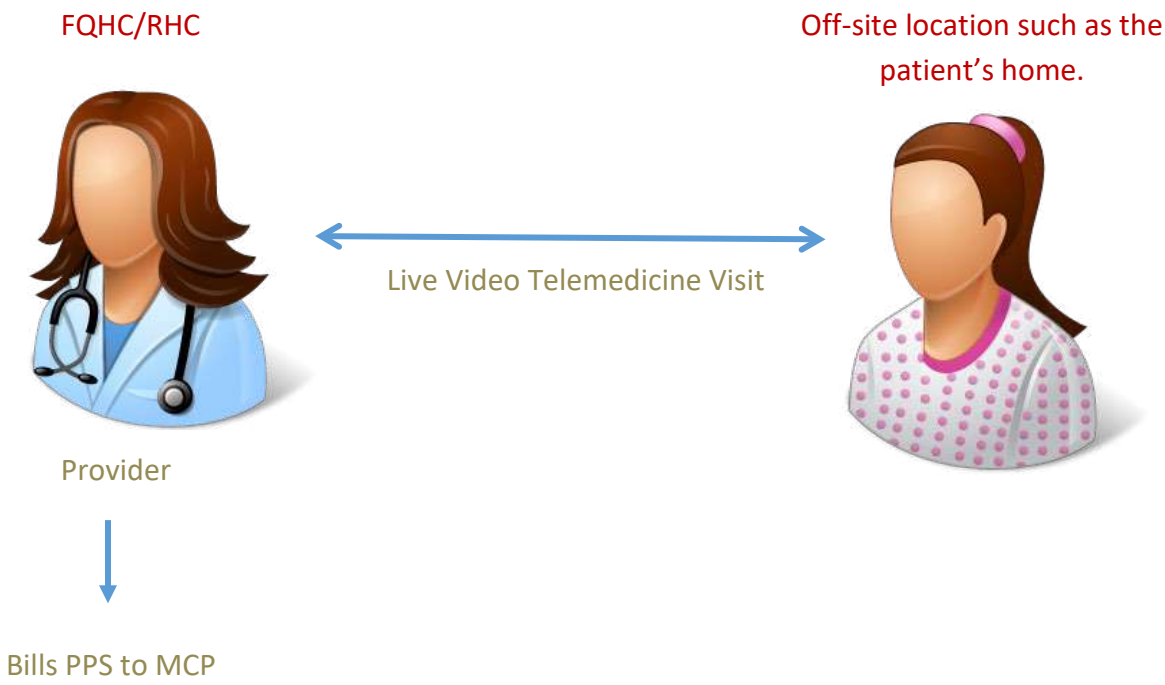
Medi-Cal Managed Care Plan (MCP)

Scenario 13 FQHC/RHC to Non-HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient but is NOT homebound, homeless, or a migratory or seasonal worker.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is not homebound, homeless, or a migratory or seasonal worker, therefor the code 18 wrap CANNOT be billed to the state.



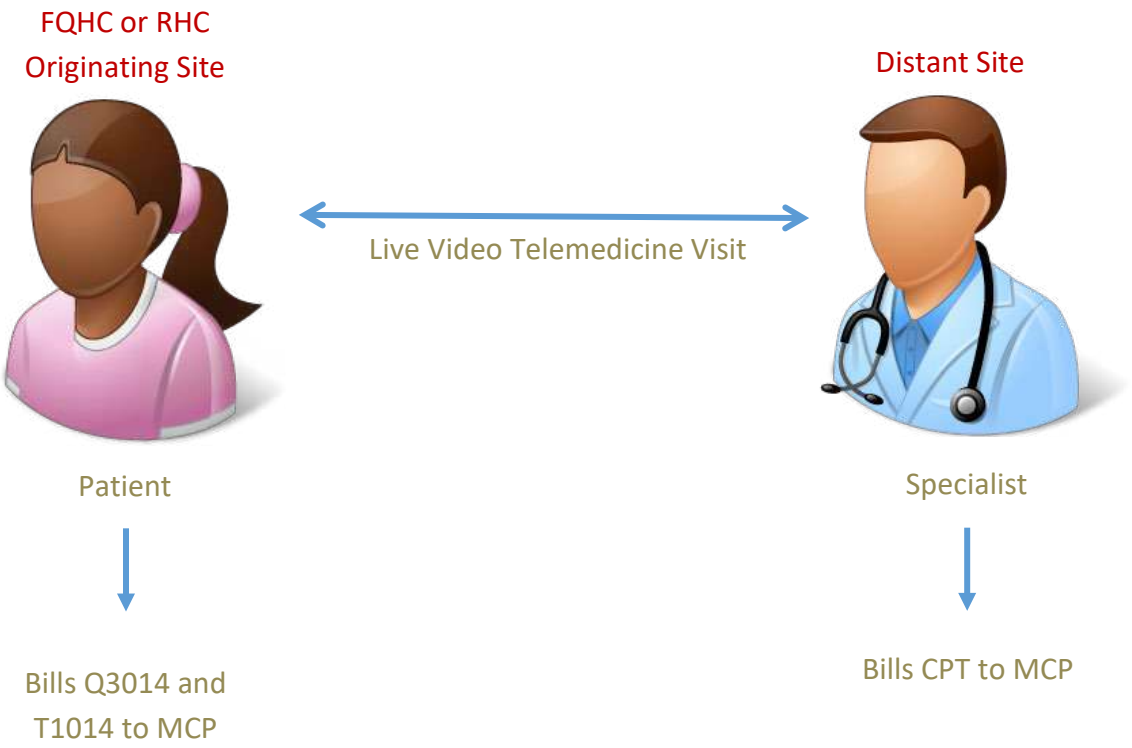
Medi-Cal Managed Care Plan (MCP)

Scenario 14 FQHC/RHC Originating Site to an MCP Contracted Distant Site

- Patient is physically present at the FQHC/RHC.
- Specialist is a MCP contracted provider not physically present at the FQHC/RHC.
- FQHC or RHC and specialist have an agreement to provide services, but the FQHC/RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- MCP contracted specialist is the Distant Site and can bill MCP.
- FQHC/RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face. However, the FQHC/RHC, *in most instances*, can bill an Originating Site fee and Transmission fee to the MCP.



Useful References

1. *State Telehealth Laws and Reimbursement Policies Report,* Center for Connected Health Policy – Fall 2018
   https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf

2. California Department of Health Services, Medi-Cal Program, Internet Version, Sacramento, California.
   http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx

3. Medicare Telehealth Program
   http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/

4. Medicare Telehealth Services Fact Sheet 2018
   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf

5. *Medicare Intermediary Manual* (CMS Publication 13-3), Baltimore, Maryland, Centers for Medicare and Medicaid Services.

6. *Medicare Benefit Policy* (CMS Publication 100-02), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.
   http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

7. *Medicare Claims Processing Manual* (CMS Publication 100-04), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.
   http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

8. *Medicare Benefit Policy Manual - Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*
   http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

9. *CMS Carriers Manual,* Part 3 Chapter XV Fee Schedule for Physicians' Service, Part 15516.

10. Anthem Blue Cross of California, *Anthem Blue Cross of California Telemedicine Program for Healthy Families and Medi-Cal Program – Telemedicine Billing Guidelines,*
    https://mediproviders.anthem.com/ca/pages/telehealth.aspx

11. *Partnership Health Plan Telehealth*
    http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Services.aspx

2020-21 HEDIS Measures Review Guide

Well Child Visits in First 15 Months (W30)
Child and Adolescent Well-Care Visits (WCV)

Eligible:

- Commercial and Medi-Cal members.
- The W30 and WCV measures are based on the American Academy of Pediatrics "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents" (published by the National Center for Education in Maternal and Child Health).
- Visit the Bright Futures website for more information about well-child visits at https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/.
- The well-care visit must occur with a PCP or an OB/GYN practitioner, but the rendering service practitioner does not have to be the practitioner assigned to the member.

Coding is Critical:

- Proper and timely coding W30 and WCV encounters is essential since NCQA has designated these measures as administrative rather than hybrid, meaning a chart sample will not be obtained to improve rates and use of supplemental data (EHR extracts or medical records) may be limited at health plan discretion.
- Keep this coding tip sheet handy and revisit your coding workflows for these measures to make sure they are coded properly.
- Make sure to use the age specific CPT codes below when billing for well child visits, in addition to the routine health exam ICD-10 code.
- Get started now by properly documenting and coding well child visits for 7-11 year olds.

Measure	Requirements	Coding
W30 Well Child Visits in the First 15 Months *Age 0-30 months (2.5 years)*	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. *Well-Child Visits in the First 15 Months*. **Six or more well-child visits** before the child turns 15 months old during the measurement year. 2. *Well-Child Visits for Age 15 Months–30 Months*. **Two or more well-child visits** between 15 months and before the child turns 30 months old during the measurement year.	**ICD-10** **Z00.121 / Z00.129** - Encounter for routine child health examination **with / without** abnormal findings (age 0-17). **CPT Preventive codes:** **99382** - age 1-4, new patient **99392** - age 1-4, established patient ***NOTE:*** *Visits must be at least 14 days apart.*
WCV Child and Adolescent Well-Care Visits *Age 3-21 years*	The percentage of members **3–21 years** of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. ○ Ages 7-11 years have been added. ○ Measure is reported in three age stratifications: 3-11 years, 12-17 years, 18-21 years. *NOTES: Be sure to also code for the Weight Assessment and Counseling for Nutrition and Physical Activity (**WCC**) measure during this visit for ages 3-17.* *Well care can be done at sick visits by adding the age CPT code and the ICD-10 routine code to the list of diagnosis.*	**ICD-10** – **Z00.121 / Z00.129** - Encounter for routine child health examination **with / without** abnormal findings (age 0-17). **Z00.00 or Z00.01** (age 18+). **Z02.5** - Sports Physical **CPT Preventive codes:** **99382** - age 1-4, new patient **99392** - age 1-4, established patient **99383** - age 5-11, new patient **99393** - age 5-11, established patient **99384** - age 12-17, new patient **99394** - age 12-17, established patient **99385** - age 18+, new patient **99395** - age 18+, established patient