MAY 2020

PROVIDER QUALITY NEWSLETTER

*Visit **MedPOINTManagement.com** for important information and resources in this newsletter.*

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

COVID-19 Updates

We continue to monitor frequent changes and promote the health, safety and well-being of our providers, members and staff. Many organizations are hosting webinars to explore solutions to the many challenges we face daily. We encourage you to take advantage of the information being shared by our industry leaders.

Some of the sources are highlighted below:

- **America's Physician Groups (APG)**
  www.apg.org
- **California Primary Care Association (CPCA)**
  cpca.connectedcommunity.org/home
- **Care Quality Commission (CQC)**
  www.calquality.org/resources/webinars.
  Webinars have included best practices for telehealth, staffing, caring for patients and physicians, and other valuable topics.

Interpreta - portal.interpreta.com

The Interpreta 2020 database will be available later this month. We know these are difficult times but please continue to focus on closing these gaps if you are able to do so. Please contact your HEDIS/Stars Specialist if you would like a training or refresh on Interpreta. Contact us at **qualitymeasures@medpointmanagement.com** or call **(818) 702-0100**, ext. **1353**.

Preventive Care Services Guide During COVID

MedPOINT has compiled a new Preventive Care Services Guide to help you navigate the preventive screenings in support of the federal, state and local recommendations during these unusual times. In support of maintaining a safe care delivery model, there are some approved uses of telehealth to allow continued efforts to offer much needed preventive care services and ensure provider and member safety. The guide includes some of this information and is current as 5/19/20.

Guidance on Resuming Preventive Care

The Department of Health Care Services (DHCS) posted an article on their website (updated 5/6/20) regarding "Well-Child Visits During COVID-19" that states that well-child visits should occur in person when possible (see **http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_44.asp**). Some recommendations for managing this request are included in the Guide mentioned above. Portions of the visit can be handled through telehealth efforts if a face-to-face physical compliments the findings by the end of the year.

The California Department of Public Health (CDPH) also released guidance on **"Resuming California's Deferred and Preventive Health Care"** that states, "This is to restart the care that has been postponed including preventive care such as well-child visits and vaccinations, adult clinical preventive services, and routine dental services." Please review this important information in the attachments or on their website.

Important Resources!

Please download the topical materials below that are included with this newsletter through the MedPOINT Quality Management website (see path below):

- AMA - Using Remote Technologies for Cardiovascular.pdf
- CDC - Immunizations and Milestones Tracker - Birth to 6.pdf
- CDPH - Resuming California's Deferred and Preventative Health Care.pdf
- CMS - Guidance for Infection Control.pdf
- CMS - Telehealth Services for Risk Adjustment Notice.pdf
- CPCA - Telehealth Physical Exam Chart.pdf
- DMHC - Telehealth Services Billing - All Plan Letter APL 20-013.pdf
- Health Net - Prop 56 Payments for Developmental Screenings.pdf
- Health Plan Key Contacts - Medi-Cal.pdf
- LA Care - Annual Wellness Exam (AWE) Telehealth Sample Form.pdf
- LA Care - Telehealth Guidance Letter.pdf
- MedPOINT - Provider Portal COVID-19 Form & Report FAQ.pdf
- MedPOINT - Interpreter Health Plan Contacts.pdf
- MedPOINT - Preventative Care Services Guide During COVID.pdf
- Molina - COVID-19 Prior Authorization End Dates Extended - Revision.pdf
- Molina - Smoking Cessation COVID-19 - IM IE OC SAC SD (not LA).pdf
- Quest - Telehealth partner - CompuGroup Medical (CGM) ELVI Flyer.pdf

MedPOINT Portal COVID Resources

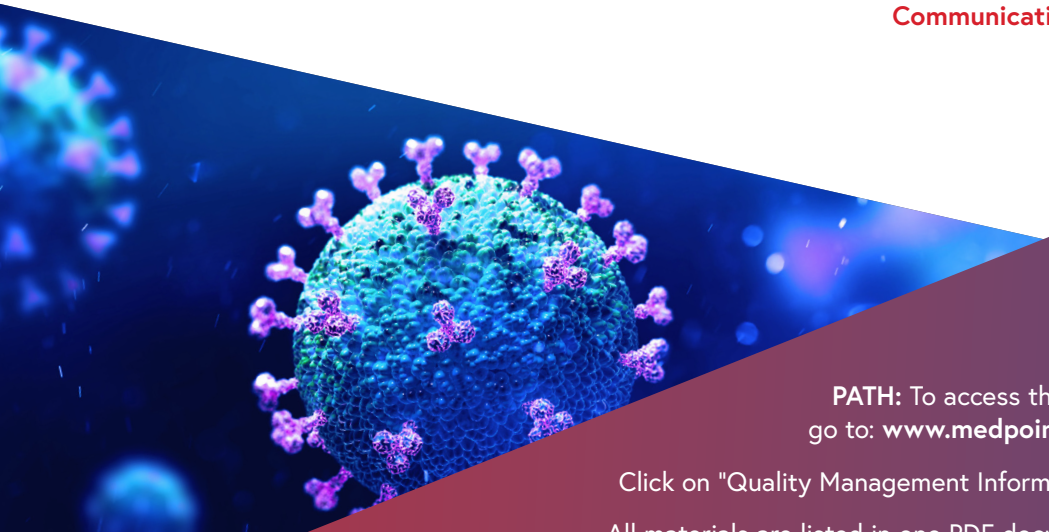
COVID-19 resources are available on the MedPOINT main website at **https://www.medpointmanagement.com/coronavirus/**. This includes important updates and information including DMHC laboratory testing guidelines and a Frequently Asked Questions (FAQ) sheet including billing information regarding Telehealth Services.

MedPOINT's Provider portal includes new COVID-19 information-sharing features. After login, there is an option at the top right for the following:

(1) COVID-19 Report Form – please use this online form to report a positive or presumptive positive COVID-19 result for tests not previously reported to MPM (test completed through a community drive through or other locations not processed through the IPA). This information is needed for data monitoring and member outreach purposes. The Center for Disease Control and Prevention (CDC) also mandates a form be filled out and this is an abbreviated version of that information.

(2) COVID-19 Member Report – this report displays a list of your assigned members who have tested positive for COVID-19 and includes a link to the Members Authorization and Claim History where this information was obtained, along with an indicator of the source of the positive test.

COVID resources are continually being updated on our website, so please check back often. For questions, please email **Communications@medpointmanagement.com**.



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

Click on "Quality Management Information" 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**."

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

American Heart Association.

Using Remote Patient Monitoring Technologies for Better Cardiovascular Disease Outcomes
Guidance

Position
Remote patient monitoring (RPM) can empower patients to better manage their health and participate in their health care.[1] When used by clinicians, RPM can provide a more holistic view of a patient's health over time, increase visibility into a patient's adherence to a treatment, and enable timely intervention before a costly care episode. Clinicians can strengthen their relationships with, and improve the experience of, their patients by using the data sent to them via RPM to develop a personalized care plan and to engage in joint decision-making to foster better outcomes.[2] The American Heart Association supports initiatives that increase access to and incentivize the appropriate design and use of evidence-based remote patient monitoring technologies.

The cost of healthcare has soared to untenable heights. In the United States, federal healthcare spending is rapidly approach 20% of GDP. Furthermore, chronic disease is highly prevalent, accounting for nearly 90% of all healthcare spending in the United States. Additionally, it costs 3.5 times more to treat chronic diseases than it does other conditions, and they account for 80% of all hospital admissions. Additionally, access to care is variable based on socioeconomic issues and environmental factors. In recent years, rapid advancements in healthcare delivery models and low-cost wireless communication have spurred optimism in finding cost-effective, value-enhancing solutions to these issues. Notably, the integration of mobile communications with wearable sensors has facilitated the shift of healthcare services from clinic-centric to patient-centric delivery models such as remote patient monitoring.

Background
RPM is a subset of telehealth that facilitates patient monitoring as well as the timely transfer of patient-generated data from patient to care team and back to the patient. To capture data, RPM can employ a host of wired or wireless peripheral measurement devices such as implantables, biosensors, blood pressure cuffs, glucometers, and pulse oximetry, as well as sensors that collect data passively (e.g., beacons in a home that can transmit data on movement and specific activity/inactivity) and they are most often used in a post-discharge setting or between routine office visits. Some RPM may also allow for real-time video interactions between the patient and provider.

Similarly, RPM can transmit user-entered data, store the data in secure records systems accessible to clinicians or care monitors, flag abnormal readings or responses, and alert clinicians/caregivers to abnormalities via e-mail or text messages. In response to these alerts, clinicians/others can log into the system, review data, follow up with patients, or take other appropriate actions. Some systems have the capacity to connect patients with additional resources such as patient health records (PHRs) or electronic medical records (EMRs), targeted educational materials, interactive self-care tools, medication optimization technologies, and health care providers.

RPM -> Patient-generated Health Data

Most RPM technologies allow for patients to generate their own data. Patient-generated health data (PGHD) are data created, recorded, or gathered by or from patients (or family members or other caregivers) to support their health. This data may include variables related to health history, biometric data, symptoms, and lifestyle information. The recent proliferation of RPM has increased the frequency, amount, and types of PGHD available. These advances in RPM have the potential to allow patients and their caregivers to independently and seamlessly capture and share their health data electronically with clinicians from any location.

Effect of RPM on Cardiovascular Disease

The potential for RPM to reduce the burden of CVD has led to a burgeoning volume of research aimed at evaluating its clinical and economic effectiveness.

Hypertension

Hypertension is a major risk factor for CVD. The age-adjusted prevalence of hypertension in US adults is nearly 35%, which equates to approximately 85 million.[3] By 2035, projections show that over 42% of US adults will be hypertensive, an additional 27 million from current projections.[3] Cost projections for hypertension are similarly daunting, with 2015 figures tallying nearly $70 billion and those for 2035 soaring to over $150 billion.[3] RPM may serve as a vital conduit for improving hypertension control and reducing the economic burden that stems from the costly hospital stays that result from acute events related to hypertension.

Research has shown RPM can reduce systolic blood pressure (SBP) and diastolic blood pressure (DBP) significantly compared to usual care and self-monitoring alone.[4-10] When compared directly to usual care, RPM on the average reduced SBP and DBP.[11-13] In three-way comparisons, though self-monitoring alone may have a positive impact on blood pressure control compared to usual care, the inclusion of RPM can have a more substantive impact on SBP and DBP than does self-monitoring.[6, 7] Additional studies have shown that RPM's positive impact on SBP can increase if the intervention is long-term,[4, 14] and if the intervention includes multiple behavior change techniques.[4, 8-14] However, the results of this research have been largely heterogenous, leading to inconclusive results on the degree to which RPM can positively impact blood pressure control.

Heart Failure

Heart failure (HF) is a chronic and life-threatening condition that places a substantial burden on health care systems worldwide with high rates of hospitalizations, readmissions, and outpatient visits. In the US, it is estimated that nearly 6 million adults currently have HF, a number that is expected to increase by 40% by 2035. Limited research has been published on the potential for RPM to improve clinical outcomes for heart failure patients, and the results have been mixed.

Although recent systematic reviews and meta analyses have shown a positive effect on HF-related admissions and mortality rates and all-cause mortality rates,[15, 16] the bulk of the literature consists of low-quality and inconsistent evidence about the beneficial effects of RPM. More specifically, though better evidence from randomized control trials has been unfavorable, it still stands in contrast to the favorable evidence gained from non-randomized trials. For example, while RPM has been shown to lower the risk of all-cause and HF mortality, and all-cause and HF hospital admissions in cohort analyses and non-randomized trials,[17-22] results from larger-scale, randomized control trials have been inconsistent with some showing no or negative effects, [23-30] and others showing decreases in HF-related admissions, emergency department visits, [31-33]

Future research should focus on understanding the process by which RPM works in terms of improving HF-related outcomes, identify optimal strategies and the duration of follow-up for which it confers benefits, and further investigate whether there is differential effectiveness between chronic HF patient groups and types of RPM technologies.

Atrial Fibrillation

An estimated 2.7 to 6.1 million in the United States have been diagnosed with atrial fibrillation (AF).[34] With the aging of the US population, this number is expected to increase to 7.1 million by 2035.[35] Approximately 2% of people younger than age 65 have AF, while about 9% of people aged 65 years or older have AF.[34] AF is associated with a reduced quality of life and an

increased number of adverse outcomes such as stroke, heart failure, increased number of hospitalizations, and mortality.[36-38] Therefore, an early diagnosis of this arrhythmia is crucial in order to adopt the most appropriate treatment strategy.

According to non-randomized trials, RPM has the potential to improve outcomes by enabling accurate and early detection and decreasing all-cause mortality rates and hospitalizations.[17, 18, 39, 40] Recent clinical guidelines strongly recommend the use of RPM for AF detection in both stroke and non-stroke patients.[41] However, RCTs have not conclusively shown such a reduction in hospitalization rates compared to in-office follow-up.[42] RCTs have also not convincingly shown any differences in cardiovascular mortality and all-cause mortality compared to traditional in-office follow-up.[42] However, the relative equivalence in overall clinical outcomes with guidelines-consistent office-based follow-up should provide reassurance to patients and providers in health systems and geographic regions where RPM may be the only option for AF follow-up.[42]

Guidelines for the Appropriate Design and Use of RPM

Usability and Access

The efficacy of RPM is highly dependent on its design and usability. The term usability refers to "the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency, and satisfaction in a specified context of use."[43] RPM often involves the interaction between multiple user groups through a digital system, or with GP at their office. Communication in these use scenarios is usually multimodal, which makes it crucial to know between whom, how and when the information transmission and personal communication occur.

In device development, a user-centered design approach involves end-users in all the stages and helps to understand users' needs and the context of use, which are key elements for the construction of a system framed within a clinical workflow.[44, 45] RPM that does not include a user-centered design can lead to low uptake and adherence rates.[46-48] Further, user errors can result from poor usability.[49, 50] Research has shown that a user-centered design appeals to a wide variance of ages and health and digital literacy levels, and increases patient satisfaction.[51-54] Thus, because ensuring adequate usability is of the essence for the individual patient, effective RPM requires a detailed analysis of end-users' needs to inform system designers.[55]

Guiding Principle: Remote Patient Monitoring technologies should reflect evidence-based, user-centered design principles, human factors science, and best practices.

Guiding Principle: Remote Patient Monitoring technologies should be rigorously evaluated in clinical trials to ensure patient efficacy.

Guiding Principle: Remote Patient Monitoring technologies should address the needs of all patients without disenfranchising financially disadvantaged populations or those with low literacy or low technologic literacy.

Guiding Principle: Remote Patient Monitoring technologies should not create an unnecessary burden on end users.

Guiding Principle: Remote Patient Monitoring technologies should be customizable to users' specific needs.

Guiding Principle: Training and support must be available for all users of Remote Patient Monitoring technologies with a duration of support dependent upon user capabilities.

Interoperability and Integration

Interoperability is defined as "health information technology that enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and does not constitute information blocking."[56] HIPAA currently allows for protected health information (PHI) (any health-related data that personally identifies a patient) to be shared as long as both the sender and receiver have a relationship with the patient, the information being shared pertains to the healthcare relationship, and the information being shared is necessary for the healthcare being provided.

This is highly dependent on what constitutes a patient's care team. As such, standards governing the flow of health data should allow for a flexible definition of a care team and standards should permit data to be shared across clinicians, lab, hospital, pharmacy and patient regardless of the application being used to share the data. In order to attain a truly interoperable system and to fully realize the benefits of RPM to healthcare systems, achieving the highest level of interoperability is essential.

A further dimension to interoperability is the integration of RPM with the existing clinical workflow. Many RPM technologies, rather than being stand alone, are designed to support delivery of existing clinical services that will already have an established workflow in place. The integration of RPM should be designed in such a way that it doesn't add burden to the clinical workflow. Rather, RPM should enhance the clinical workflow. Therefore, data from RPM must be integrated into healthcare systems, particularly those that use EHRs. This will provide easier and faster access to patient data, protect patient safety, allow for better diagnoses and a higher quality of treatment, and enhance consumer choice.

Guiding Principle: Remote Patient Monitoring technologies must allow the user the ability to access or request any of his/her health information collected, stored and/or transmitted by the device.

Guiding Principle: Data collected by Remote Patient Monitoring technologies should be fully integrated into patient EHRs.

Guiding Principle: Full interoperability must be established between Remote Patient Monitoring technologies and EHRs, which must include the exchange of data from providers to patients and from patients to providers.

Data Accuracy and Patient Safety

The quality of healthcare data impacts every decision made along the patient care lifecycle. Using RPM to make healthcare decisions necessitates the need for RPM technologies to produce accurate data and information integrity. According to WHO, accuracy is defined as the variable of health information quality that is intended to achieve desirable objectives using legitimate means.[57] Data accuracy helps in evaluating health, assess effectiveness of interventions, monitor trends, inform health policy and set priorities.[58] Lack of data accuracy and can cause serious harm to patients and limit the benefits of RPM. [59, 60]

Additionally, intentional and unintentional wrong data entry and the speed at which data is collected can be misleading. Misleading data results in misallocating resources or interventions when needed for the patients.[61] Inaccurate readings, insufficient amount of data, movement and physical activities also contribute to inaccurate data provided through the mHealth devices.[62] Concerns associated with data accuracy and integrity are persistent and can become a risk to patients' safety.[63]

Guiding Principle: Remote Patient Monitoring technologies should be rigorously evaluated in clinical trials to ensure that their usage does not compromise patient safety.

Guiding Principle: Documentation of appropriate patient informed consent for the use of Remote Patient Monitoring technologies must be obtained and maintained and should include provider and patient identification, provider credentials, full disclosure of how the technology will be used, liability and malpractice procedures, and details on data security measures and potential risks to patient privacy.

Guiding Principle: The prescription of Remote Patient Monitoring technologies must be consistent with state scope of practice laws.

Guiding Principle: The use of Remote Patient Monitoring technologies must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care, and positive health outcomes.

Guiding Principle: Remote Patient Monitoring must always deliver accurate data to ensure delivery of quality healthcare and patient safety.

Guiding Principle: To enable providers to make healthcare decisions based on meaningful and useful data, standards must be established to screen, select, and verify data communicated by Remote Patient Monitoring technologies.

Data Privacy

Traditionally, the medical information shared between provider and patient has remained within the confines of a healthcare facility. RPM changes the paradigm by gathering electronic data into a data repository that is remote from the health facility, yet readily accessed and shared with various health care providers involved in a patient's care or can be used for research or educational purposes. With accessibility, however, come challenges to maintaining the privacy of patient health information and potential issues related to liability and reimbursement for RPM-related services.

HIPAA places the burden of securing a patient's health information squarely on physicians and healthcare organizations. Most importantly, loss of patient control over confidential and sensitive health information threatens the confidential communication between doctors and patients. Confidentiality ensures that patients seek out care, and that they are open and honest with their providers. Ultimately impacting all stakeholders in the healthcare ecosystem, patients who fear a loss of control over their private medical information may lose faith in their provider--and in the health care system itself.

Guiding Principle: The use of Remote Patient Monitoring technologies should meet or exceed applicable federal and state legal requirements of medical information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security laws.

Guiding Principle: Patients and providers should be educated as to what data are collected through Remote Patient Monitoring technologies, how it will be used, and what other users and entities will have legitimate access to these data.

Guiding Principle: Remote Patient Monitoring technologies should contain patient controlled privacy settings to determine who has access to the data they collect, store, and transmit.

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Immunizations and Developmental Milestones for Your Child from Birth Through 6 Years Old

Child's Name _____ Birth Date _____

		Birth	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS
Recommended Immunizations	Hepatitis B	◯ **HepB**	◯ **HepB**[1]			◯ **HepB**
	Rotavirus			◯ **RV**	◯ **RV**	◯ **RV**[2]
	Diphtheria, Tetanus, Pertussis			◯ **DTaP**	◯ **DTaP**	◯ **DTaP**
	Haemophilus influenzae type b			◯ **Hib**	◯ **Hib**	◯ **Hib**
	Pneumococcal			◯ **PCV**	◯ **PCV**	◯ **PCV**
	Inactivated Poliovirus			◯ **IPV**	◯ **IPV**	◯ **IPV**
	Influenza (Flu)					◯ **Influenza**, first dose[3] ◯ second dose
Milestones*	Milestones should be achieved by the age indicated. Talk to your child s doctor about age-appropriate milestones if your child was born prematurely.	◯ Recognizes caregiver's voice ◯ Turns head toward breast or bottle ◯ Communicates through body language, fussing or crying, alert and engaged ◯ Startles to loud sounds	◯ Starts to smile ◯ Raises head when on tummy ◯ Calms down when rocked, cradled or sung to ◯ Pays attention to faces	◯ Begins to smile at people ◯ Coos, makes gurgling sounds ◯ Begins to follow things with eyes ◯ Can hold head up	◯ Babbles with expression ◯ Likes to play with people ◯ Reaches for toy with one hand ◯ Brings hands to mouth ◯ Responds to affection ◯ Holds head steady, unsupported	◯ Knows familiar faces ◯ Responds to own name ◯ Brings things to mouth ◯ Rolls over in both directions ◯ Strings vowels together when babbling ("ah', "eh", "oh")
Growth	At each well child visit, enter date, length, weight, and percentile information to keep track of your child s progress.	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE
	Shaded boxes indicate the vaccine can be given during shown age range.	**VISIT DATE**	**VISIT DATE**	**VISIT DATE**	**VISIT DATE**	**VISIT DATE**

continues on back page

[1] The second dose of HepB may be given either at the 1 month or 2 month visit.

[2] A third dose of rotavirus vaccine is only needed for RotaTeq.

[3] Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time and for some other children in this age group.

* Milestones adapted from Caring for your baby and young child: Birth to age 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and Bright Futures: Guidelines for health supervision of infants, children, and adolescents, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

This is not an exhaustive list of milestones from 0-6 years. See more at www.cdc.gov/milestones

If your child has any medical conditions that put him at risk for infections or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Last updated on April 2019 • CS300526-D

Immunizations and Developmental Milestones for Your Child from Birth Through 6 Years Old

Child's Name _____ Birth Date _____

		12 MONTHS	15 MONTHS	18 MONTHS	19 23 MONTHS	2–3 YEARS	4–6 YEARS
Recommended Immunizations	Hepatitis B	◯ **HepB** (Final dose administered between 6 and 18 months)					
	Diphtheria, Tetanus, Pertussis		◯ **DTaP**				◯ **DTaP**
	Haemophilus influenzae type b	◯ **Hib**					
	Pneumococcal	◯ **PCV**					
	Inactivated Poliovirus	◯ **IPV** (Third dose administered between 6 and 18 months)					◯ **IPV**
	Influenza (Flu)	◯ **Influenza,** first dose[2] ◯ second dose (if needed)				Age 2 3 ◯◯ **Influenza**, first dose[2] ◯◯ second dose (if needed)	Age 4 5 6 ◯◯◯ **Influenza**, first dose[2] ◯◯◯ second dose (if needed)
	Measles, Mumps, Rubella	◯ **MMR**					◯ **MMR**
	Varicella	◯ **Varicella**					◯ **Varicella**
	Hepatitis A	◯◯ **Hep A**[3]					
Milestones*	Milestones should be achieved by the age indicated. Talk to your child s doctor about age-appropriate milestones if your child was born prematurely.	◯ Cries when mom or dad leaves ◯ Says "mama" and "dada" ◯ Copies gestures (for example, waves "bye bye") ◯ May stand alone ◯ Looks at right picture or thing when named	◯ Imitates what you are doing ◯ Drinks from a cup ◯ Scribbles on his own ◯ Walks well ◯ Says a couple of words other than "mama" and "dada"	◯ Points to show others something interesting ◯ Says several single words ◯ Points to one body part ◯ May walk up steps and run	◯ Plays mainly beside other children ◯ Follows two-step commands ◯ Plays simple make-believe games ◯ Throws ball overhand	◯ Can name most familiar things ◯ Shows affection for friends without prompting ◯ Turns book pages one at a time ◯ Kicks a ball	◯ Speaks very clearly ◯ Tells stories ◯ Can print some letters or numbers ◯ Hops; may be able to skip ◯ Enjoys playing with other children
Growth	At each well child visit, enter date, length, weight, and percentile information to keep track of your child s progress.	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT / PERCENTILE LENGTH / PERCENTILE HEAD CIRCUMFERENCE	WEIGHT HEIGHT BMI	WEIGHT HEIGHT BMI
		VISIT DATE	VISIT DATE	VISIT DATE	VISIT DATE	VISIT DATE	VISIT DATE

Shaded boxes indicate the vaccine can be given during shown age range.

[2] Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time and for some other children in this age group.

[3] Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the first dose. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

* Milestones adapted from AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* Third Edition.

This is not an exhaustive list of milestones from 0-6 years. See more at www.cdc.gov/Milestones and download the Milestone Tracker App at www. cdc.gov/MilestoneTracker

If your child has any medical conditions that put him at risk for infections or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

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For more information, call toll free **1-800-CDC-INFO** (**1-800-232-4636**) or visit **www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html** (Immunization) or **www.cdc.gov/milestones** (Milestones)

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

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

GAVIN NEWSOM
Governor

April 27, 2020

TO:
SUBJECT: Resuming California's Deferred and Preventive Health Care

During the COVID-19 pandemic both State and Local governments have worked together to respond to the pandemic. Stay-at-Home orders are in place and have supported the flattening of the curve in California. During this time, non-urgent health care has been deferred to support the State's efforts and to further prevent the spread of COVID-19. This deferral of services was essential in response to the surge of COVID-19 patients, but creates its own public health impacts, which must be addressed as soon as practicable.

Even though current evidence shows progress in suppressing the virus, there is much to consider for the future of the State and to protect against a surge, once Stay-at-Home orders are modified. One important focus will be resuming our existing health care system for non-emergent and non-COVID-19 health care, which has been deferred during this time. These services will include resuming elective and non-urgent procedures at hospitals; outpatient care including primary care and specialty care in physician offices and health centers; behavioral health, long term care, ancillary, pharmacy, and dental services. This is to restart the care that has been postponed including preventive care such as well-child visits and vaccinations, adult clinical preventive services, and routine dental services. Whenever appropriate for patient and condition, visits should maximize the use of telehealth/telephonic modality.

This guidance is intended to set a plan for California while understanding there may be local or regional circumstances that require different timelines for resumption of services.

The sections below outline considerations and guidelines that should be reviewed and met prior to resuming services. It is expected that specific regions of California may resume services before the entire State is able to; therefore, regional delivery systems will need to consult local public health officers in neighboring counties as they begin to resume services to non-emergent and non-COVID-19 patients.

It is important to continue to monitor COVID-19, including case counts and hospitalizations and their impact on the health care delivery system. It is also important to monitor local health officer orders and Governor's orders in the event that a different health care delivery system response is necessary.

General considerations for resuming services will include the following:

1. When preparing to resume services, a variety of indicators, including but not limited to the following, should be considered for a service area:
    - COVID-19 infection rates [see consideration 3, below.]
    - COVID-19 hospitalizations
    - COVID-19 emergency room admissions

- COVID-19 Intensive Care Unit (ICU) utilization
- Skilled Nursing Facilities COVID-19 outbreaks
- Other COVID-19 factors that could increase the spread of COVID-19

2. Each facility, office, or any other place of health care services shall have an adequate stock of Personal Protective Equipment (PPE) in adequate supply for staff based on the type of care provided, risk level of patients, number of staff required to use PPE, and daily usage demand. PPE use should be consistent with Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) recommendations. In planning for PPE, consideration should be given for potential patient surges related to COVID-19 outbreaks.
3. Availability of testing with prompt results should be present for health care delivery situations when knowing the COVID-19 status of staff or patients served by the entity is important for clinical care and infection control.
4. Prior to resuming non-emergent and non-COVID-19 deferred services, offices and facilities should consult with local public health officers within counties served to determine if there are local COVID-19 patterns that could impact health care delivery.
5. Availability of qualified staff to safely perform procedures, provide care and needed follow up.
6. Each facility and office should have patient flow systems and infection control precautions in place to minimize exposure and spread while caring for both COVID positive and non-COVID patients.

Guidelines for Resuming Services:

Personal Protective Equipment

Personal Protective Equipment (PPE) is essential to protect health care workers and patients; therefore, the following is recommended when resuming services. Facilities should have a plan for circumstances when patients or visitors when allowed arrive without face coverings.

PPE Minimum Requirements for outpatient settings:

1. All healthcare providers and staff must wear appropriate PPE at all times, consistent with CDC universal source control recommendations [reference #4]
2. All healthcare providers and staff treating COVID-19 positive patients must have appropriate training on, and access to, appropriate PPE, including the use of specialized masks (i.e., N95), eye protection (face shield or goggles), gloves, and gowns when appropriate
3. Patients and visitors when allowed should wear masks (including when provided by facility staff) or cloth face coverings. Practices are encouraged to educate patients about proper face coverings, consistent with the CDC and CDPH recommendations, and reserving specialized masks (i.e., N95) for the health care employees who are at increased risk
4. COVID-19 PPE policies and procedures should also be in place for health care workers who are not in direct patient care roles (i.e. Front desk registration, schedulers, environmental cleaning, etc.)

PPE Minimum Requirements for Hospital settings:

Implement policies for PPE that account for:

1. Adequacy of available PPE as needed for level of care and COVID-19 status
2. Staff training on and proper use of PPE according to non-crisis level evidence-based standards of care
3. Policies for the conservation of PPE should be developed (e.g., intubation teams) as well as policies for any extended use or reuse of PPE per CDC and CDPH recommendations and FDA emergency use authorizations

PPE Minimum Requirements for Skilled Nursing Facilities (SNF) settings:

Implement policies for PPE that account for:

1. All healthcare providers and staff must wear appropriate PPE at all times consistent with CDC universal source control recommendations
2. All healthcare providers and staff treating COVID positive patients must have appropriate training on, and access to, appropriate PPE, including the use of specialized masks (i.e., N95), eye protection (face shield or goggles), gloves, and gowns
3. Patients, while not in their rooms, and visitors when allowed must wear masks or cloth face coverings. Practices are encouraged to educate patients and visitors about proper face coverings, consistent with the CDC and CDPH recommendations, and reserving specialized masks (i.e., N95) for health care employees who are at increased risk

Health Care Services

Providers and facilities are encouraged to gradually resume full scope of services when possible and safe to do so, based on these guidelines. It is encouraged that as many services as possible and appropriate be delivered by telehealth/telephonic even after loosening of the Stay-at-Home restrictions to protect patients and health care workers. The physical layout and flow of care delivery areas may change in terms of patient movement and waiting areas so that physical distancing is maintained; and there should be a process for determining the priority of types of services delivered initially as delineated below. Services should be available for both COVID-19 negative and COVID-19 positive assuming systems are in place to provide adequate testing, appropriate separation of the patients, and adequate PPE and training to protect health care workers.

Facility and Office Site Standards

Safeguards at facilities and offices will play an important role in continuing the fight against COVID-19. Therefore, facilities and offices resuming services should take additional steps to protect the workforce and patients being served.

Guidelines

General

- Facilities should comply with all State, Local, and CDC guidelines to protect against further spread of COVID-19.
- Facilities should institute rigorous screening of their health care staff for symptoms of COVID-19 and have policies in place for removal of symptomatic employees from the workplace
- Follow physical distancing requirements in work areas and common areas.
- Require face coverings for all patients, with the exceptions of SNF patients while in their room, patients receiving services that would not allow for the use of a mask, or residents of facilities with personal rooms while in their room.
- Limit the number of patients in waiting areas and limit space between patients to a minimum of 6ft.
- When possible, the use of Non-COVID Care zones should be utilized in facilities that serve both COVID-19 and non-COVID-19 patients.
    - All health care workers, staff, patients, and others. should be screened appropriately prior to entering a Non-COVID-19 Care zone as outlined in CMS guidance [reference #2]
    - Patients should be screened telephonically for possible COVID-related symptoms prior to office visits
    - Anyone demonstrating symptoms of COVID-19 during screening should be tested and quarantined
- Facilities shall have in place an established plan for cleaning and disinfecting prior to using facilities to serve non-COVID-19 patients and ongoing care.

- Facilities providing COVID-19 care should continue to be prepared for potential future surges. The plans for resumption of medically necessary care should include consideration of the impact on their ability to respond to future surges.
- Facilities should be prepared to modify resumption of clinical services in conjunction with surge status (as surge status increases, access to non-urgent care should decrease so as to not overwhelm the healthcare system). Staff can then be re-purposed to urgent care roles.

Health Care Staff

- Screen all workers and staff entering the facility for symptoms of COVID-19, prior to entering the facility.
- Health care staff should take measures to avoid rotating between care of COVID-19 positive/persons under investigation and non-COVID-19 patients as outlined in CMS guidance [reference #2]

Care Prioritization and Scheduling

Facilities and offices shall establish a prioritization policy for providing care and scheduling. Extended hours should be considered to limit the number of patients in an office at any given time. Facilities and offices should also consider scheduling special or reserved hours for elderly or immunocompromised patients, to minimize the risk of infection to vulnerable patients.

Clinical prioritization should consider clinical impacts of treatment delay and the current surge status of the health care infrastructure in a community. When considering community surge status, consideration should be given to capacity across the continuum of care. Consider additional guidance, including Joint Statement, California Medical Association and American Academy of Pediatrics guidance [reference #1,5,6] on care prioritization, scheduling, and outpatient guidelines.

Outpatient Visit Guidelines

Priority scheduling should consider**:

- Patients with acute illnesses that cannot be handled through telehealth
- Patients with chronic illness, including behavioral health conditions that have not been seen due to Stay-at-Home rules and need in person visit
- Preventive services including well child and vaccinations, as well as adult clinical preventive services
- List of previously cancelled or postponed patients
- Other patients needing in person visit to monitor status or assess illness, etc.

**Telehealth/telephonic modality should be used for all appropriate patients and conditions.

Dental Guidelines

With respect to dental services, the California Department of Public Health will update the current guidance regarding the prioritization and delivery of following non-urgent dental services:

- Previously cancelled or postponed patients
- Preventive services
- Dental Procedures
- Routine dental services

Hospital and Outpatient Surgery Guidelines

Priority scheduling should consider principles and considerations from the Joint Statement released by the American Hospital Association (AHA), American College of Surgeons (ACS), American Society of Anesthesiologists (ASA) and Association of periOperative Registered Nurses (AORN) providing key principles and considerations. All

facilities should consider opening in phases to allow for any necessary staff training or adjustments to new policies.

Prioritization scheduling should consider:

- Objective priority scoring (e.g., MeNTS instrument)
- List of previously cancelled and postponed cases with priority scoring
- Specialties' prioritization (cancer, organ transplants, cardiac, trauma)
- Strategy for allotting daytime "OR/procedural time" (e.g., block time, prioritization of case type [i.e., potential cancer, living related organ transplants, etc.])
- Identification of essential health care professionals and medical device representatives when necessary for procedures
- Plan for phased opening of operating rooms
    - Identify capacity goal prior to resuming
    - All operating rooms and post operating ICU beds simultaneously – will require more personnel and material
- Strategy for increasing "OR/procedural time" availability (e.g., extended hours before weekends)
- Issues associated with increased OR/procedural volume
    - Ensure primary personnel availability commensurate with increased volume and hours (e.g., surgery, anesthesia, nursing, housekeeping, engineering, sterile processing, etc.)
    - Ensure adjunct personnel availability (e.g., pathology, radiology, etc.)
    - Ensure supply availability for planned procedures (e.g., anesthesia drugs, procedure-related medications, sutures, disposable and non-disposable surgical instruments)
    - Ensure adequate availability of inpatient hospital beds and intensive care beds and ventilators for the expected postoperative care
    - New staff training

Skilled Nursing Facilities (SNF) Guidelines

Priority for SNF should focus on admission and protecting existing patients and new patients from the spread of COVID-19.

Scheduling should consider:

- Admission of confirmed non-COVID-19 patients in particular from acute facilities to maintain acute bed capacity
- Admission of confirmed COVID-19 positive patients only to facilities that have been designated or configured to manage these patients
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for 14 days, per the CDC universal source control recommendations [reference #4]
- Non-COVID-19 patients who become symptomatic must be isolated from the general resident population

Workforce Availability

The health care workforce and staff are essential to resuming the delivery of deferred and preventive health care services. All facilities and offices should be aware of the impact COVID-19 has had on many health care workers including fatigue and the impact of stress and should ensure they have an adequate workforce available prior to resuming services and that they provide needed resources to support health care workers.

Workforce considerations should take into account ancillary supports and downstream providers, such as potentially necessary referrals to SNFs.

Guidelines

- Facilities should ensure adequate staffing levels are in place to provide services, including staff to support additional safeguards at facilities
- Workforce considerations should not impact the ability to respond to surge needs in the future

Additional considerations for Hospitals

Hospitals are encouraged to consider the need to take additional precautions to protect against the spread of COVID-19.

Guidelines

- As possible, adopt Non-COVID Care zones to assist in the prevention of COVID-19, per CMS guidance [reference #2]
- Have appropriate levels of PPE, staffing, ventilators, and other critical resources in order to properly separate patient flow and care for both COVID-19 positive and non-COVID-19 related patients
- Prevent the rotation of health care workers, staff and patients between COVID-19 and non-COVID-19 zones
- Pre-op COVID-19 testing as indicated in the Joint Statement [reference #1]
- Policies on managing entry and exit points
- Physical distancing policies
- Screening requirements for staff and visitors
- Limit number of visitors per patient allowed
- Post-Acute care policies taking into account COVID-19 testing prior to placement in skilled nursing facilities
- Considerations for principles and considerations documentation from the Joint Statement released by the AHA, ACS, ASA and AORN providing key principles and considerations
- Discharge planning considerations, including considerations for Home Health, SNF placement and alternative care facilities.

Additional considerations for Skilled Nursing Facility care

Skilled Nursing Facilities (SNF) have had higher rates of COVID-19 cases and extra precautions will continue to be necessary when considering placement. Special considerations should be considered to protect high risk patients residing in SNFs.

Guidelines

- Continue to review all State, Local, and Federal guidelines, including the CDC guidelines
- Limit visiting but provide video communication between residents and their loved ones
- Screen **all** those entering the SNF
- Require facial coverings for visitors when allowed and staff
- Patients being admitted or re-admitted should be tested for COVID-19 prior to admission
- Ensure adequate infection control training for staff
- Particular focus on adequacy of staffing with contingency plans for staff illness, or resignations
- Limit group activities and communal dining to meet physical distancing guidelines

References and additional guidance to consider

Additional materials are provided here to support the health care systems in resuming deferred and preventive services during this time.

1. Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic (PDF)
2. CMS Guidance (PDF)
3. California Medical Association Guidance on Reopening the Health Care System (PDF)
4. CDC Universal Source Recommandations
5. AAP COVID-19 main page
6. AAP Pediatric Ambulatory Services

California Department of Public Health
PO Box, 997377, MS 0500, Sacramento, CA 95899-7377
Department Website (cdph.ca.gov)

Page Last Updated : April 29, 2020

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-22- ASC, CORF, CMHC, OPT, RHC/FQHCs

DATE: **March 30, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's healthcare facilities can respond to the threat of COVID-19.
- ***Coordination with the Centers for Disease Control and Prevention (CDC) and local public health departments*** - We encourage all healthcare facilities to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities).
- ***Guidance for Infection Control and Prevention of COVID-19 and Actions*** - CMS regulations and guidance support Ambulatory Surgical Centers (ASCs), Community Mental Health Centers (CMHCs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Outpatient Physical Therapy or Speech Pathology Services (OPTs), Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) taking appropriate action to address potential and confirmed COVID-19 cases. This guidance discusses recommendations to mitigate transmission including screening, restricting visitors, cleaning and disinfection, and possible closures. Supply scarcity guidance and FDA recommendations are also included within this memo.

Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring the health and safety of patients receiving care, treatment and services in healthcare facilities from the spread of infectious disease, including being committed to taking critical steps to ensure America's healthcare facilities can respond to the threat of COVID-19. This memorandum responds to questions we have received and provides important guidance for outpatient settings other than hospital outpatient departments, specifically ASCs, CMHCs, CORFs, OPTs, and RHCs/FQHCs (herein referred to as healthcare facilities) in addressing the COVID-19 outbreak and minimizing transmission to other individuals.

Guidance

Healthcare facilities should monitor CDC's website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) for up to date information and resources (additional resource links are below). They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Healthcare facilities should have plans for monitoring staff with exposure to patients with known or suspected COVID-19. Additional information about monitoring healthcare personnel is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

On March 18, 2020, CMS recommended that all elective surgeries, non-essential medical, surgical, and dental procedures be delayed during the COVID-19 outbreak. As increasing numbers healthcare providers are asked to assist with the COVID-19 response, it is critical that providers consider whether non-essential surgeries and procedures can be delayed to preserve personal protective equipment (PPE), beds, ventilators, and other critical resources as applicable. Facilities should maintain open lines of communication with patients, patient representatives and/or family and other care providers to respond to the individualized needs of each patient, as decisions are made whether to delay non-essential procedures. CMS also strongly encourages facilities with available PPE, bed capacity and ventilators to work closely with their local communities and their respective health departments to redistribute resources when possible. https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf

For purposes of this document we use the general term "patients," which includes clients in the CMHC setting as well. "Visitors" is also used generally and could include a wide variety of persons, dependent upon the outpatient setting.

Guidance for Limiting the Transmission of COVID-19, Recommendations, and Supply Shortages Guidance

Which patients are at risk for severe disease for COVID-19?

Based upon CDC data (https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html), older adults and people of any age with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes due to COVID-19. This information should be considered in the decision to conduct visits or provide services, surgical procedures or treatment to patients in the outpatient setting.

What actions should healthcare facilities implement to promote early recognition and management of patients, staff and visitors?

When possible, as recommended by CDC, facility staff should proactively communicate about COVID-19 with scheduled and potential patients. Healthcare facilities should provide patients with updates about changes to policies and procedures regarding appointments, the potential for coordinating non-urgent patient care by telephone, and any visitor restrictions. One consideration could be to use the facility's website or social media platforms to share updates. Healthcare facilities should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility.

Before or immediately upon arrival for appointments, healthcare facilities should ask about the following:

1. Fever or symptoms of a respiratory infection, such as a cough and sore throat;
2. International travel within the last 14 days to CDC Level 3 risk countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html;
3. Contact with someone with known or suspected COVID-19;
4. Residing in a community where community-based spread of COVID-19 is occurring.

Furthermore, to promptly identify and manage patients, staff or visitors with undiagnosed respiratory symptoms, the following actions should be implemented:

- At the time the appointment is scheduled, ask patients to call ahead to report fever or respiratory symptoms so the healthcare facility can be prepared for their arrival or triage them to a more appropriate setting (e.g., an acute care hospital). If capacity allows, call patients shortly before their appointment to ask if they have a fever or respiratory symptoms.
- Healthcare facilities should establish limited entry points for all patients and visitors and/or establish alternative sites for screening prior to entry.
- Healthcare facilities should identify those with fever or signs and symptoms of respiratory infections before they enter the waiting and treatment areas. Patients with fever or symptoms of a respiratory infection should put on a facemask (i.e., surgical mask) at check-in and keep it on until they leave the facility. The healthcare facility should provide the facemask if one is needed and available.
- Healthcare facilities should post signs at entrances with instructions (in appropriate languages) to patients with fever or symptoms of respiratory infection to alert staff who can implement appropriate precautions.
- Healthcare facilities should have the following supplies available to ensure adherence to hand and respiratory hygiene, and cough etiquette: tissues, no-touch receptacles for disposal of tissues, and hand hygiene supplies (e.g., alcohol-based hand sanitizer (ABHS))

How should healthcare facilities monitor or restrict their staff?

The same screening performed for patients and visitors should be performed for healthcare facility staff.

- Staff who have signs and symptoms of a respiratory infection should not report to work. Facilities should implement sick leave policies that are non-punitive, flexible and consistent with public health policies that allow ill staff members to stay home.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the facility's infection professional/preventionist (or leadership/administrator if no infection professional is available), and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).

- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Healthcare facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for healthcare professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html). Additional resources related to PPE and worker safety are located in the resources section of this memo.

What is the return to work criteria for health care staff?

Occupational health programs and public health officials making decisions about return to work for health care personnel (HCP) with confirmed COVID-19, or who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection, e.g., cough, sore throat, shortness of breath, fever, but did not get tested for COVID-19) should be made according to the CDC guidelines https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html.

Should healthcare facilities restrict patients from bringing visitors with them to appointments?

Healthcare facilities should set limitations on visitation. For example, limitations may include restricting the number of visitors per patient, or limiting visitors to those that provide assistance to the patient, participate in a joint treatment session (i.e. counseling session) or limiting visitors under a certain age. For additional guidance on visitation, visit CMS: https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0

Note: If a state implements actions pursuant to their authorities that exceed CMS requirements, (e.g., a ban on all visitation through a governor's executive order) a healthcare facility would not be out of compliance with CMS' requirements.

How should healthcare facilities ensure appropriate cleaning and disinfection of environmental surfaces, medical devices and equipment?

During environmental cleaning procedures, personnel should wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE such as gloves, gowns, masks, respirators, and eye protection). Environmental surfaces in patient care areas should be cleaned and disinfected, using an appropriate Environmental Protection Agency (EPA)-registered disinfectant on a regular basis (e.g., daily), when spills occur and when surfaces are visibly contaminated. Healthcare facilities should use disinfectants on List N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2 (the cause of COVID-19) or other national recommendations.

Additional guidance related to appropriate cleaning and disinfection is available at CDC's Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) for more information: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html.

Are Medicare-participating healthcare facilities, such as ASCs, CMHCs, CORFs, OPTs, and RHCs/FQHCs required to remain open during this outbreak?

The CMS health and safety requirements (i.e., the conditions of participation/conditions for coverage/certification) do not contain specific requirements for outpatient setting healthcare facilities to remain open during certain hours (e.g., Medicare-certified ASCs do not have the same statutory requirement of a hospital to provide 24 hour care). Therefore, if it is in the best interest of the facility's patients to cancel appointments and temporarily close the facility during an outbreak, that may be acceptable. Facilities should follow their emergency preparedness program policies and procedures to determine whether closure of the facility is appropriate and ensure patients receiving services are notified. Facilities should follow guidance of State and local health departments as conditions change in their state and area. CMS will not take administrative actions with respect to facilities who need to temporarily close during the outbreak, however, facilities are expected to resume operations or voluntarily terminate their Medicare enrollment within 30 days of the public health emergency being lifted.

If a Medicare-participating healthcare facility decides to voluntarily close temporarily or is asked to close by a state or federal recommendation, would that constitute a cessation of business/voluntary termination?

As a result of the ever evolving COVID-19 pandemic, CDC guidelines currently recommend delaying and rescheduling all elective and non-urgent visits/admissions to preserve staff, PPE, and patient care supplies (https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html). Additionally, CMS released a statement on March 18, 2020 recommending that all elective surgeries, non-essential medical, surgical and dental procedures be delayed during the COVID-19 outbreak.

If a healthcare facility temporarily closes because it only provides elective cases/non-emergency treatment or appointments consistent with CDC and CMS recommendations, CMS would not view this as a cessation of business; therefore, would not be deemed as a voluntary termination of the Medicare agreement under 42 C.F.R. §489.52 or §416.35(a)(3). Facilities needing to temporarily shut down or limit operations should post notices at their business as well as on public facing websites and social media platforms during this emergency.

Any healthcare facility that temporarily closes or limits operations are strongly encouraged to reach out to their local community and state health department for possible partnerships, as the conservation and sharing of critical resources such as ventilators and PPE is essential during a national emergency.

Will CMS issue waivers of certain health and safety requirements related to COVID-19?

The Secretary of the Department of Health and Human Services (HHS) is authorized to waive certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) program requirements and health and safety requirements pursuant to Section 1135 of the Social Security Act once the President declares an emergency through the Stafford Act or National Emergency Act, and the Secretary declares a Public Health Emergency (PHE). Under this authority, CMS has activated various blanket waivers, which will ease certain requirements for impacted providers. CMS will also temporarily modify certain requirements. For more information on such waivers and modifications that CMS has granted, visit: www.cms.gov/emergency.

We note there is no standardized waiver application form or template that is required for a state or individual provider to submit a request for a section 1135 waiver. We have assembled a national team to assist with monitoring, retrieving and responding to all 1135 waiver requests and-related questions as soon as possible. Therefore, we ask that any 1135 waiver questions or requests be submitted to the mailboxes provided below in the contact information of this memorandum. For more information on submitting a waiver, visit: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/How-We-Can-Help/How-We-Can-Help-page

Supply Scarcity Guidance

CMS is aware that there is a shortage of some medical supplies in certain areas of the country. State and Federal surveyors should not cite healthcare facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHS) if they are having difficulty obtaining these supplies for reasons outside of their control. However, CMS does expect healthcare facilities to take actions to mitigate any supplies shortages and show they are taking all steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHS we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortages, which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, and if needed, identify safe alternatives for patient care based on CDC guidelines (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html). If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Regional Office.

Additionally, facilities may review the Executive Order on preventing hoarding of health and medical resources issued by President Trump on March 23, 2020 https://www.whitehouse.gov/presidential-actions/executive-order-preventing-hoarding-health-medical-resources-respond-spread-covid-19/.

Expanded Respirator Guidance

The Food and Drug Administration (FDA) has approved CDC's request for an emergency use authorization (EUA) to allow HCP to use certain filtering facepiece respirators (FFRs) during the COVID-19 outbreak in health care settings by HCP. The FDA concluded that respirators authorized under this EUA may be effective in preventing HCP from airborne exposure during the COVID-19 outbreak. COVID-19 can cause serious or life-threatening disease, including severe respiratory illness.

Under this EUA, certain NIOSH-approved respirators are authorized for use in health care settings by HCP during the COVID-19 outbreak, thereby maximizing the number of respirators available to meet the needs of the U.S. health care system.

FFRs covered under this EUA are posted on the FDA's website:

- A list of NIOSH approved FFRs eligible for authorization can be found here: https://www.fda.gov/media/135764/download

- A list of FFRs authorized for use under this EUA, including ones that were NIOSH-approved but have since passed the manufacturers' recommended shelf-life, can be found here: https://www.fda.gov/media/135921/download

Therefore, any CMS guidance that explicitly, or by reference, indicates N-95 usage will automatically incorporate any FFRs authorized under this EUA. A second EUA concerning respirators was recently released and may be found here: https://www.fda.gov/media/136403/download

What other resources are available for facilities to help improve infection control and prevention?

Important CDC Resources:

- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID19) https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

CMS Resources:

CMS has issued additional guidance which may be beneficial to healthcare facilities surrounding the health and safety standards during emergencies. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Prioritization of Survey Activities, including guidance on visitation: QSO-20-20-All. https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

CMS COVID-19 FAQs: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

CMS Emergency Preparedness and Response Operations (EPRO): https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home including https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities

Contact:

Questions about this memorandum should be addressed to QSOG_EmergencyPrep@cms.hhs.gov. Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

Questions related to 1135 waivers, please contact the following CMS Branch Location mailboxes, or 1135waiver@cms.hhs.gov:

ROATLHSQ@cms.hhs.gov (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

RODALDSC@cms.hhs.gov (Dallas RO): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

ROPHIDSC@cms.hhs.gov (Northeast Division): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia, New York, New Jersey, Puerto Rico, Virgin Islands, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

ROCHISC@cms.hhs.gov (Chicago/Kansas City): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska.

ROSFOSO@cms.hhs.gov (Western Division): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, and the Pacific Territories.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately. This guidance will cease to be in effect when the Secretary of HHS determines there is no longer a Public Health Emergency due to COVID-19. At that time, CMS will publicly notify that this guidance has ceased to be effective via its website.

/s/
David R. Wright

cc: Survey and Operations Group Management

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: April 10, 2020

TO: All Medicare Advantage, Cost, PACE, and Demonstration Organizations

SUBJECT: Applicability of diagnoses from telehealth services for risk adjustment

The 2019 Coronavirus Disease (COVID-19) pandemic has resulted in an urgency to expand the use of virtual care to reduce the risk of spreading the virus; CMS is stating that Medicare Advantage (MA) organizations and other organizations that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter. This use of diagnoses from telehealth services applies both to submissions to the Risk Adjustment Processing System (RAPS), and those submitted to the Encounter Data System (EDS). Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication.

While MA organizations and other organizations that submit diagnoses for risk adjusted payment identify which diagnoses meet risk adjustment criteria for their submissions to RAPS, MA organizations (and other organizations as required) report all the services they provide to enrollees to the encounter data system and CMS identifies those diagnoses that meet risk adjustment filtering criteria. In order to report services to the EDS that have been provided via telehealth, use place of service code “02” for telehealth or use the CPT telehealth modifier “95” with any place of service.

Questions can be addressed to RiskAdjustment@cms.hhs.gov, please specify, “Applicability of telehealth services for risk adjustment” in the subject line.

CARAVANHEALTH

Telehealth Physical Exam

"Listen to your patient, he is telling you the diagnosis." — Sir William Osler

Performing a physical exam via telehealth can seem challenging, especially if the patient is in their home where assessment tools, such as a blood pressure cuff or digital stethoscope, may not be available. But with some thoughtfulness, cooperation of the patient, and adequate lighting and camera, providers are able to examine several organ systems. And, as Osler reminds us, let's not forget our most keen diagnostic tool: a thorough patient history.

EYES

- Appearance of conjunctiva and lids (lid droop, crusting/exudate, conjunctival injection)
- Appearance of pupils (equal, round, extraocular eye movements)
- Assessment of vision (seeing double)

EARS, NOSE, MOUTH, AND THROAT

- External appearance of the ears and nose (scars, lesions, masses)
- Assessment of hearing (able to hear, asks to repeat questions)
- Inspection of lips, mouth, teeth and gums (color, condition of mucosa)
- Gross inspection of throat (tonsillar enlargement, exudate)
- Appearance of face (symmetric, appropriate movement of mouth, no drooling or labial flattening, ability to raise eyebrow, frown/smile, close eyes, show upper lower teeth, puff out cheeks)
- Pain or tenderness when patient palpates sinuses or ears

NECK

- External appearance of the neck (overall appearance, symmetry, tracheal position, gross evidence of lymphadenopathy, jugular venous distention)
- Gross movement (degrees of flexion anterior, posterior and laterally)

RESPIRATORY

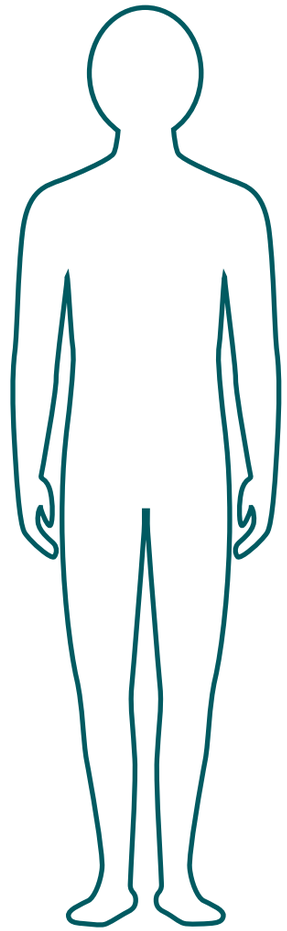
- Assessment of respiratory effort (intercostal retractions, use of accessory muscles, diaphragmatic movement, pursed lip breathing, speaking in full sentences or limited due to shortness of breath)
- Audible wheezing
- Presence and nature of cough (frequent, occasional, wet, dry, coarse)

CARDIOVASCULAR

- Presence and nature of edema in extremities (pitting, weeping)
- Capillary refill
- Temperature of extremities per patient/other measure

CONSTITUTIONAL

- Vital signs (heart rate and respiratory rate; if available, temperature, blood pressure, weight)
- General appearance (ill/well appearing, (un) comfortable, fatigued, attentive, distracted, disheveled/unkept)



CHEST

- Inspection of the breasts (symmetry, nipple discharge)
- Chest wall or costochondral tenderness with self-palpation

ABDOMEN

- Examination of the abdomen
- Tenderness on self-palpation

MUSCULOSKELETAL

- Examination of gait and station (stands with/without use of arms to push off chair; steady gait, broad/ narrowed based)
- Inspection of digits and nails (capillary refill, clubbing, cyanosis, inflammatory conditions, petechiae, pallor)
- Extremity exam may include:
  - Alignment, symmetry, defects, tenderness on self-palpation
  - Range of motion, pain, contracture
  - Muscle strength and tone (flaccid, cogwheel, spastic), atrophy, abnormal movements
  - Presence and nature of edema, temperature

SKIN

- Rashes, lesions, ulcers, cracking, fissures, mottling, petechiae
- Cyanosis, diaphoresis

NEUROLOGIC

- Dermatomal distribution of numbness or pain
- Examination of sensation (by touch or pin)

PSYCHIATRIC

- Orientation to time, place, and person
- Recent and remote memory
- Mood and affect
- Pressured speech
- Mood lability (crying, laughing)

Suggested Citation:

Showalter, G. (2020, March 30). Telehealth Physical Exam. Loengard, A., Findley, J. (Eds.). https://caravanhealth.com/

From: DMHC Licensing eFiling
Subject: APL 20-013 – Telehealth Services
Date: Tuesday, April 7, 2020 9:13:39 AM

Attachments: APL 20-13 - Telehealth Services (4.7.2020).pdf
Telehealth APL FAQ.pdf

Dear Health Plan Representative:

Please find the attached APL 20-013, regarding Delivery of Telehealth Services and Billing for Telehealth Services. This APL is meant to increase uniformity and efficiency with respect to provider billing during the COVID-19 State of Emergency to decrease administrative burdens on providers and plans.

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: April 7, 2020

TO: All Commercial Health Care Service Plans[1]

FROM: Sarah Ream**,** Acting General Counsel

SUBJECT: APL 20-013 - Billing for Telehealth Services; Telehealth for the Delivery of Services

On March 18, 2020, the Department of Managed Health Care (Department) issued an All Plan Letter (APL 20-009[2]) directing all health plans to:

1. Reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim.
2. For services provided via telehealth, not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in-person.
3. Provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee.

Following issuance of APL 20-009, providers and others asked the DMHC how providers should bill the services rendered via telehealth and whether APL 20-009 applies to all types of services, including Applied Behavior Analysis, physical therapy and speech therapy, among others.

Coding

This APL is meant to increase uniformity and efficiency with respect to provider billing during the COVID-19 State of Emergency to decrease administrative burdens on providers and plans. Accordingly, 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 codes for the particular services rendered.

[1] This APL does not apply to Medicare Advantage or Medi-Cal Managed Care products.
[2] APL 20-009 can be found by clicking on this link.

- Use Place of Service “02” to designate telehealth.
- Use modifier 95 for synchronous rendering of services or GQ for asynchronous.

Types of Services That Can Be Provided Via Telehealth

During the COVID-19 State of Emergency, a health plan may not exclude coverage for certain types of services or categories of services simply because the services are rendered via telehealth, if the enrollee’s provider, in his/her professional judgment, determines the services can be effectively delivered via telehealth. For example, a health plan may not categorically exclude coverage for Applied Behavioral Analysis services delivered via telehealth (video or telephone) during the State of Emergency.

Likewise, during the COVID-19 State of Emergency a health plan may not place limits on covered services simply because the services are provided via telehealth if such limits would not apply if the services were provided in-person. For example, if a health plan allows an enrollee to receive a particular covered service up to three times per week if the enrollee receives the service in-person, the health plan may not limit the service to only once per week if the service is delivered via telehealth.

Providers Who May Render Telehealth Services

The Department has heard from providers and enrollees that health plans are requiring their enrollees to access services through the plans’ contracted telehealth vendor (e.g., Teledoc) rather than covering telehealth services delivered by providers who have typically delivered services to the enrollees in person. During the COVID-19 State of Emergency, a health plan may not require enrollees to use the plan’s telehealth vendor, or a different provider from the one the enrollee typically sees, if the enrollee’s provider is willing to deliver services to the enrollee via telehealth and the enrollee consents to receiving services via telehealth.

Frequently Asked Questions

Attached to this All Plan Letter is a “Frequently Asked Questions” document which provides answers to common questions the Department has received regarding the provision of telehealth services during the State of Emergency.

If you have questions regarding this APL, please contact Sarah Ream, Acting General Counsel, at (916) 324-2522 or via email at sarah.ream@dmhc.ca.gov.

Delivery of Services via Telehealth During the COVID-19 State of Emergency
Frequently Asked Questions

During the COVID-19 State of Emergency, many health care providers need and want to continue to deliver services to their patients. Because social distancing is necessary to slow the spread of the coronavirus, many providers are using telehealth, when clinically appropriate, to deliver services they would typically deliver to patients in-person. This allows the patients to continue to receive care while limiting both the patients' and providers' exposure to the coronavirus.

On March 18, 2020, the Department of Managed Health Care (DMHC) issued All Plan Letter 02-009 (Letter), which requires the health plans the DMHC regulates to reimburse providers for services they would typically deliver to patients in-person but are now delivering via telehealth at the same rate as an in-person visit. The Letter applies to services delivered on or after March 19, 2020.

The DMHC has received numerous questions from providers about the Letter. This FAQ addresses those questions.

Question 1: Does the DMHC's Letter apply to all payers (e.g., health plans, health insurers, self-insured employers, Medicare, Medi-Cal)?

> **Answer:** The DMHC's Letter applies only to the health plans the DMHC regulates. DMHC-regulated plans cover the majority of people in commercial health care coverage in California. The DMHC also regulates most of the Medi-Cal managed care plans.
>
> However, there are types of health care coverage to which the Letter does not apply. These include:
>
> - Health insurers regulated by the California Department of Insurance. The Department of Insurance issued guidance regarding telehealth services.
> - Medi-Cal fee-for-service and Medi-Cal Managed Care. The Department of Health Care Services issued guidance regarding reimbursement for telehealth services.
> - Medicare. The Centers for Medicare and Medicaid Services issued guidance regarding the use of telehealth for Medicare patients.
> - Self-insured plans (also referred to as ERISA plans)
> - TRICARE

Question 2: How should a provider bill for services delivered via telehealth during the State of Emergency, when the provider would normally deliver the services in-person?

Answer: 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 the particular service(s) rendered.
- Use Place of Service "02" to designate telehealth.
- Use modifier 95 for synchronous rendering of services or GQ for asynchronous.

Question 3: Is the option to deliver services via telehealth available for all types of services?

Answer: Yes, so long as it is medically appropriate to render the services via telehealth.

During the COVID-19 State of Emergency, a health plan may not exclude coverage of certain types services or categories of services simply because those services are delivered via telehealth, if the enrollee's provider, in their professional judgment, determines the services can be effectively delivered via telehealth. For example, a health plan may not categorically exclude coverage for Applied Behavioral Analysis services provided via telehealth (video or telephone) during the State of Emergency.

Question 4: My patient's health plan says it covers telehealth only when the service is provided by the health plan's telehealth vendor. Does my patient need to change providers to receive covered services via telehealth?

Answer: No. If you believe, in your professional judgment, that it is medically appropriate for you to provide services to your patient via telehealth and you can effectively provide the services via telehealth, the health plan must cover the services as if you had provided them in-person.

Please note: As stated above in Answer to Question 1, the DMHC's APL and this FAQ does not apply if your patient receives his/her health care coverage from a self-insured plan, an insurer licensed by the California Department of Insurance, Medicare, Medi-Cal or TRICARE.

Question 5: Can the plan deny coverage for telehealth if the plan has not yet approved/credentialed the provider to deliver services via telehealth?

Answer: No, the plan cannot impose credentialing or approval requirements specific to telehealth if the provider is otherwise appropriate to render services to the enrollee and the health plan would cover the provider's services if the provider had rendered the services in-person. However, the plan may continue to have approval and/or credentialing requirements a provider must satisfy for inclusion in the health plans network.

Question 6: My patient's Evidence of Coverage says the plan covers telehealth only in certain circumstances. During the COVID-19 State of Emergency, does the plan have to cover services I provide to my patient via telehealth if I would normally deliver the services in-person?

Answer: Yes. Notwithstanding language to the contrary in an Evidence of Coverage, the health plan must cover services delivered via telehealth if:

1) the health plan would cover the services if they were delivered in-person by the provider;

2) the provider, in their professional judgment, determines it is appropriate to deliver the services via telehealth and the provider can effectively deliver the services via telehealth; and,

3) the enrollee consents to receiving the services via telehealth.

Question 7: Are there restrictions on the platforms or modalities providers can use to deliver services via telehealth?

Answer: During the COVID-19 State of Emergency, health plans may not require providers to use particular platforms or modalities to deliver services via telehealth as a condition for covering the services.

However, providers must keep in mind their obligations to protect the confidentiality of their patients. The federal Office of Civil Rights recently issued guidance relaxing enforcement of certain HIPPA requirements involving the use of telehealth. On April 3, 2020, California Governor Gavin Newsom issued an Executive Order to expand the use of telehealth to deliver care during the COVID-19 State of Emergency. The Order relaxes certain state privacy and security laws for medical providers, so they can provide telehealth services without the risk of being penalized. The Executive Order can be found at this link.

Question 8: Does the provider have to be physically present in their office when providing services via telehealth?

Answer: 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 health plan may not deny coverage of the services because the service was delivered outside the provider's usual place of business.

PROVIDER*Update*

Health Net®

REGULATORY | APRIL 30, 2020 | UPDATE 20-180 | 3 PAGES

Prop 56 Payments for Developmental Screenings

Start screenings at age 9 months, with follow-up at ages 18, and 24 or 30 months

This update gives information from the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-016, issued December 26, 2019. DHCS requires that the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits are followed. The periodicity schedule requires developmental surveillance during every well-child visit and is considered preventive care. Prior authorization is **not required**.

Developmental screenings beyond scoring and documentation occur when a problem is found during the developmental surveillance. A screening does not imply a diagnosis. It is a way to collect information on the patient.

Children enrolled in Medi-Cal can get developmental screenings as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Requirements to qualify

Supplemental payment applies to contracted providers who are eligible to offer and bill claims for each qualifying general developmental screening service as follows:

- Dates of service are on or after January 1, 2020.
- Adheres to the AAP/Bright Futures periodicity schedule.
- Adds CPT code 96110 (without modifier KX) to the claim or encounter.
  - Modifier KX is used for autism spectrum disorder (ASD) which **does not** qualify.
- Uses a standardized tool for the screening that meets the Centers for Medicare & Medicaid Services (CMS) criteria.[1]
  - Includes the domains for motor, language, cognitive, and social-emotional.
  - Scores about 0.70 or above for reliability, validity and sensitivity.
- Additional screenings qualify for supplemental payment when medically necessary due to identified risk.
- Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and Cost-based Reimbursement Clinics qualify for payments.
- Dually eligible members with Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D) **do not qualify** for payments.

[1] A list of standardized tools is found at www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

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

LINES OF BUSINESS:

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

PROVIDER SERVICES

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

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

Documentation requirements

Providers must document all of the following: tool used for the screening; that the completed screen was reviewed; results of the screen; interpretation of results; discussion with the member and/or family; and any appropriate actions taken. This documentation must be kept in the member's medical record and be available upon request.

Payments

Clean claims or accepted encounters must be received within one year from the date of service. Supplemental payments are made within 90 calendar days of receipt. The payments are in addition to:

- Base provider compensation under the *Provider Participation Agreement (PPA)*.
- Contracting rates with primary care physicians (PCPs) or participating physician groups (PPGs).

Prop 56 direct payment amount:

CPT code	Description	Amount
96110 – without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument	$59.90

Note: Supplemental payments for CPT code 96110 are paid for members under age 21.

Send in your W-9 form and contact information

To process supplemental payments, a current W-9 form must be on file. You can download the most current W-9 form from the Internal Revenue Service (IRS) website at www.irs.gov/pub/irs-pdf/fw9.pdf with complete instructions. The W-9 form **must include** the rendering physician's:

- Current address used to receive checks
- Individual taxpayer identification number (TIN)
- National Provider Identifier (NPI) – If two or more NPIs are used (individual and group), include both NPIs where space is available

Fill out the attached contact information sheet. Return the completed W-9 form and the contact information sheet by email or fax.

Email:	HNCA_W9_Submissions@Centene.com (Add the words "Prop 56 W9" in the subject line.)
Fax:	1-833-794-0423 (Include a cover sheet and clearly add the words "Prop 56 W9" and "PROTECTED HEALTH INFORMATION.")

How to file a grievance

Contact the Direct Pay team by email or fax with the provider's information.

Email:	HNCA_DirectPay@healthnet.com (Add the words "Prop 56 Grievance" in the subject line.)
Fax:	1-844-929-0402 (Include a cover sheet and clearly add the words "PROTECTED HEALTH INFORMATION.")

In your grievance correspondence, include the provider's:

- Last name
- First name
- Office address
- Email address
- TIN
- NPI

For additional information on these services, refer to the DHCS website at www.dhcs.ca.gov. If you have questions about the status of your W-9, Prop 56 payments or requesting a Remittance Advice (RA), contact the Health Net Medi-Cal Provider Services Center within 60 days at 1-800-675-6110.

Please return this page with your completed and signed W-9 form.

Email: HNCA_W9_Submissions@healthnet.com

(Please note this is a document procurement email only, and is not monitored by an individual.)

Fax: 1-833-794-0423

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Providers with same TIN and their individual NPI information can be listed here.
(or can be added as a separate page, sent with the W9)

Date: _____

PCP name (print): _____

PCP individual (Type 1) NPI: _____

PCP name (print): _____

PCP individual (Type 1) NPI: _____

PCP name (print): _____

PCP individual (Type 1) NPI: _____

PCP name (print): _____

PCP individual (Type 1) NPI: _____

PCP name (print): _____

PCP individual (Type 1) NPI: _____

TITLE: Medi-Cal Health Plan Member Resources

SUMMARY: In order to support providers and key partners, Los Angeles County's Medi-Cal health plans have collaborated to compile and share key contact information for each respective plan. This document should be used as a guide to assist with identifying key health plan contact information for members you may be working with who need assistance connecting with their corresponding health plan.

This document is intended for health & social service provider use in L.A. County; it is not designed for member / client / patient use.

Key Contact Information Included:

- Health Plan Website
- Member Services/Call Center Information
- Telehealth Services
- Nurse Advice Line
- Pharmacy Mail Service
- Transportation Services
- Community Resource Platform (as available)

Additional Background: People enrolled in Medi-Cal have the opportunity to choose their Medi-Cal health plan up to once per month. In L.A. County, there are two primary plans that work with different health plan partners. The plans are L.A. Care Health Plan (with Plan Partners: Anthem Blue Cross, Blue Shield of California Promise Health Plan, and Kaiser), and Health Net (with Plan Partner Molina).

Special Note: This is the first version of this document and additional resources may be added as needed
Version 1: Updated as of 3/26/20
Compiled by: L.A. Care Health Plan

Medi-Cal Health Plan Member Resources

Description: This document should be used as a guide to assist with identifying key health plan contact information for members you may be working with who need assistance connecting with their corresponding health plan.

This document is intended for health & social service provider use in L.A. County; it is not designed for member / client / patient use.

Versioin 1: Updated as of 3/26/20

Resource Type	Description	L.A. Care	Anthem	Blue Shield of California Promise	Kaiser	Health Net	Molina
Health Plan Website	General link to obtain health plan information.	http://www.lacare.org/	https://www.anthem.com/	https://www.blueshieldca.com/promise/medical	www.KP.org	www.healthnet.com	www.molinahealthcare.com
Member Services/Call Center	Member Services contacts provide general assistance for members regarding your health plan benefits and resources.	**Medi-Cal:** 1-888-839-9909 (TTY 711) **Cal MediConnect:** 1-888-522-1298 (TTY 711) **L.A. Care Covered:** 1-855-270-2327 (TTY 711) **PASC-SEIU Plan:** 1-844-854-7272 Available 24 hours a day, 7 days a week, (including holidays).	**L.A County:** 1-888-285-7801 (TTY 711) Monday through Friday from 7am to 7pm	**Medi-Cal**: 855-699-5557 **Medicare**: 800-544-0088	**Call:** 1-800-464-4000 (toll free for English and more than 150 languages using interpreter services) 1-800-788-0616 (toll free for Spanish) 1-800-757-7585 (toll free for Chinese dialects) 711 (TTY for the deaf/hard of hearing/speech impaired)	**Health Net Medi-Cal** 1-800-675-6110 TTY (hearing and speech impaired) 711	**Call:** 1-800-675-6110 **TTY**: 1-800-431-0964 or 711
Telehealth	Telehealth offers access to doctors by phone or video 24 hours a day, seven days a week.	**Download App:** https://www.teladoc.com/mobile/ **Website:** https://member.teladoc.com/lacare **Call Teladoc** at 1.800.TELADOC (1.800.835.2362)	LiveHealth Online https://livehealthonline.com/	Medi-Cal providers may bill Blue Shield for telehealth services	**Call 24/7** at 1-833-574-2273 (TTY 711) e-visits - online care from a Kaiser Permanente provider, including some prescriptions and 24/7 self-care advice — without a trip to your doctor's office. Start an e-visit on www.KP.org member portal	**Contact Member Services** 1-800-675-6110	Medi-Cal providers may bill Molina for telehealth services
Nurse Advice Line	You can call the Nurse Advice Line 24 hours a day, 7 days per week for any health related question.	**L.A. Care Health Plan Nurse Advice Line:** 1-800-249-3619 (TTY 711). **LA Care Connect**: https://members.lacare.org LA Care member can now chat live with a nurse from your L.A. Care Connect online member account	**24/7 NurseLine** 1-800-224-0336 (TTY 711)	**Call:** 1-800-609-4166	**Call 24/7:** 1-833-574-2273 (TTY 711)	**Call:** 1-800-893-5597 TTY: 711	**Molina Healthcare of California Members may call the Nurse Advice Line with health questions.** • English: (888) 275-8750 • Spanish: (866) 648-3537 • Deaf and Hard of Hearing: 7-1-1 or (866) 735-2929
Pharmacy Mail Service	Members can receive mail order services through mail order pharmacy.	**Website:** http://www.lacare.org/members/getting-care/pharmacy-services **Call** 1-888-839-9909 for questions about your pharmacy benefits	**L.A County IngenioRX** 1-833-232-1712	N/A	**KP.org member portal** or 866-206-2983	**HomeScripts Pharmacy Mail Order** 1-888-239-7690	**Call:** 855-322-4075 options 1,2,2
Transportation Services	Medi-Cal members are eligible for both emergency and non-emergency transportation benefits. Depending on your plan and the service needed, prior authorization may be required.	Call to learn more about your transportation options and how to schedule a ride **Medi-Cal:** 1-888-839-9909 (TTY 711) **L.A. Care Covered™ and** **L.A. Care Covered Direct:** 1-855-270-2327 (TTY 711) **PASC-SEIU Plan** 1-844-854-7272 (TTY 711) **Cal MediConnect** 1-888-522-1298 (TTY 711) .	**Call:** 1-877-931-4755	**Call:** 1-877-433-2178	**NMT**: 1-844-299-6230	**Logisticare** To reserve a ride, call 1-855-253-6863. Hearing-impaired members, call TTY: 1-866-288-3133.	**Call:** 1-800-675-6110 **TTY:** 1-800-431-0964 or 711
Community Resources	Community Resource Directories provide information for members, providers, and the community on essential resources.	L.A. Care offers a free online Community Resource Directory to all members, powered by Aunt Bertha. **Website:** https://lacare.auntbertha.com/	https://anthembc.auntbertha.com/search results	N/A	N/A	https://healthnet.auntbertha.com/	**Molina Health Education Material** https://www.molinahealthcare.com/providers/ca/medicaid/forms/Pages/fuf.aspx

Member: _____ CIN #: _____ DOB: _____ Age: _____

Date of Service: _____ (mm/dd/yyyy) PCP Eff Date: _____ AWE ID: _____

ANNUAL WELLNESS EXAM FORM

Fax No: (213) 438-4874

1. **VITAL SIGNS:** Blood Pressure: _____ Pulse: _____ Temperature: _____

Respiratory: _____ Height: _____ Weight: _____ BMI: _____

2. **ALLERGIES:** (List all types): _____

3. **MEDICAL HISTORY:** Check all that apply if member has or has had history of any of the item listed below.)

- ☐ Amputation; site: Date: _____
- ☐ Asthma: Controller Medication Prescription Start Date: _____
- ☐ Cancer; Type: _____ On active Treatment? Yes ☐ No ☐
- ☐ COPD/Chronic Bronchitis: Spirometry Testing? Yes ☐ No ☐ Date: _____
- ☐ Congestive Heart Failure
- ☐ Diabetes (Link manifestation if any): Manifestation? Yes ☐ No ☐ Prescribed Statin Medication Date: _____
- ☐ GI Problems
- ☐ Glaucoma/Other Eye Problems: Specify: _____
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Liver Disease or Hepatitis
- ☐ Myocardial Infarction
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Past Fracture: ☐ Vertebral ☐ Hip ☐ Wrist ☐ Other Specify: _____
- ☐ Kidney Disease: Hemodialysis Yes ☐ No ☐
- ☐ Rheumatoid Arthritis
- ☐ Seizures or Convulsions
- ☐ Skin Condition(s): (Ulcers/decubitus) Specify: _____
- ☐ Stroke: Late Effects? Yes ☐ No ☐
- ☐ Surgery; Type: _____ Date: _____
- ☐ Thyroid Problem
- ☐ Transplant; Type: _____ Date: _____
- ☐ Transfusion; Date: _____
- ☐ Vascular Disease: ☐ Aortic ☐ Peripheral (Claudication) Prescribed Statin Medication Date: _____
- ☐ Other: Specify: _____

Visit conducted via Telehealth (Audio/Visual) and HIPPA Compliant _____Physician Initials

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

V01.2020

4. **SOCIAL BEHAVIORAL HISTORY:** (Check all that apply)

☐ Alcohol Abuse/Dependence: Enrolled in an alcohol dependent treatment? Yes ☐ No ☐ Date: _____

☐ Bipolar Disorder

☐ Generalized Anxiety Disorder

☐ Dementia

☐ Depression

☐ Drug Abuse/Dependence: Enrolled in a drug dependent treatment? Yes ☐ No ☐ Date: _____

☐ Schizophrenia

☐ Smoking: ☐ Past ☐ Current; # packs: _____ # of years: _____

5. **FAMILY HISTORY:** (Indicate if any blood relatives have or have had any of the conditions listed below. List all that apply.)

Condition	Relationship	Condition	Relationship
Alcoholism		Diabetes	
Asthma		Glaucoma	
Cancer; Type		High Cholesterol	
Coronary Artery Disease		Hypertension	
Depression/Suicide		Stroke	

6. **LIST OF CURRENT MEDICATIONS:** (List all prescriptions/non-prescription medications with DOSAGE/FREQUENCY.)

☐ **No Current Medications** ☐ Provider has reviewed all medications ☐ See Attachment

7. **ADVANCED DIRECTIVE ON FILE?**

☐ Yes if YES, Date: _____

☐ No if NO, Discussed with Member? Yes ☐ No ☐

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

Member: _____ CIN #: _____ DOB: _____ Age: _____

Date of Service: _____ (mm/dd/yyyy) PCP Eff Date: _____ AWE ID: _____

8. **REVIEW OF SYSTEMS:** (Review with member and indicate Y or N for each item listed below.)

ALLERGY					
☐ Yes	☐ No	Anaphylaxis	☐ Yes	☐ No	Nasal Congestion
☐ Yes	☐ No	Food Intolerance	☐ Yes	☐ No	Rash
☐ Yes	☐ No	Itching			
BLOOD					
☐ Yes	☐ No	Bleeding/bruising tendency			
CONSTITUTIONAL					
☐ Yes	☐ No	Chills	☐ Yes	☐ No	Fever
☐ Yes	☐ No	Daytime drowsiness	☐ Yes	☐ No	Night sweats
☐ Yes	☐ No	Fatigue			
EAR/NOSE/THROAT					
☐ Yes	☐ No	Hearing difficulty/loss	☐ Yes	☐ No	Frequent sneezing
☐ Yes	☐ No	Ringing in ears (tinnitus)	☐ Yes	☐ No	Frequent sore throat
☐ Yes	☐ No	Frequent each aches	☐ Yes	☐ No	Snoring
☐ Yes	☐ No	Ear discharge	☐ Yes	☐ No	Recent change in voice
☐ Yes	☐ No	Attacks of vertigo	☐ Yes	☐ No	Sleep apnea
☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No	Difficulty in swallowing
☐ Yes	☐ No	Nasal blockage	☐ Yes	☐ No	Nose bleeds
ENDOCRINE/METABOLISM					
☐ Yes	☐ No	Unusual hair loss/growth			
EYES					
☐ Yes	☐ No	Wears glasses/contacts	☐ Yes	☐ No	Problems with vision
☐ Yes	☐ No	Cataracts			
HEART/CIRCULATION					
☐ Yes	☐ No	Chest discomfort (angina)	☐ Yes	☐ No	Swelling of legs
☐ Yes	☐ No	Shortness of breath w/activity	☐ Yes	☐ No	Heart surgery
☐ Yes	☐ No	Blood clot in artery/vein	☐ Yes	☐ No	Black out spells
☐ Yes	☐ No	Aneurysm of blood vessel	☐ Yes	☐ No	Heart murmur
☐ Yes	☐ No	Palpitations, racing/pounding heart			
KIDNEYS/URINARY TRACT					
☐ Yes	☐ No	Bladder infections in past year	☐ Yes	☐ No	Frequent night urination
☐ Yes	☐ No	Pain/burning w/urination	☐ Yes	☐ No	Kidney stones/infection
☐ Yes	☐ No	Trouble starting urinary stream	☐ Yes	☐ No	Blood in urine in past year
MEN					
☐ Yes	☐ No	Testicular Swelling	☐ Yes	☐ No	Frequent urination
☐ Yes	☐ No	Prostate problems			
MUSCLES/BONES/JOINTS					
☐ Yes	☐ No	Arthritis/other joint disease	☐ Yes	☐ No	Chronic back trouble
NERVOUS SYSTEM					
☐ Yes	☐ No	Headache/migraine			
PSYCHOLOGICAL					
☐ Yes	☐ No	Loss/change in appetite	☐ Yes	☐ No	Insomnia
☐ Yes	☐ No	Behavioral change	☐ Yes	☐ No	Memory loss
☐ Yes	☐ No	Confusion	☐ Yes	☐ No	Mood change
RESPIRATORY					
☐ Yes	☐ No	Cough	☐ Yes	☐ No	Coughing up blood
☐ Yes	☐ No	Shortness of breath			
SKIN					
☐ Yes	☐ No	Rash/psoriasis/dermatitis	☐ Yes	☐ No	New skin growth or mole
STOMACH/INTESTINES					
☐ Yes	☐ No	Ulcer	☐ Yes	☐ No	Poor appetite
☐ Yes	☐ No	Hiatal hernia	☐ Yes	☐ No	Frequent diarrhea
☐ Yes	☐ No	Frequent heartburn/indigestion	☐ Yes	☐ No	Abnormal stool
☐ Yes	☐ No	Blood from bowels/rectum	☐ Yes	☐ No	Acid reflux
☐ Yes	☐ No	Gall bladder attacks/gallstones			
WOMEN					
☐ Yes	☐ No	Painful periods	☐ Yes	☐ No	Vaginal burning
☐ Yes	☐ No	Excessive flow	☐ Yes	☐ No	Irregular cycles
☐ Yes	☐ No	Hot flash/menopause symptoms	☐ Yes	☐ No	Currently pregnant

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

9. PHYSICAL EXAM:

Area	NL	ABN	Describe Findings if Abnormal	Area	NL	ABN	Describe Findings if Abnormal
General				Pelvic			
Skin				Musculoskeletal			
HEENT				Neurological			
Neck / Thyroid				Vascular			
Heart				Lymphatic			
Lungs				Extremities			
Breast				Prostate			
Abdomen				Rectal			

10. PAIN ASSESSMENT:

1. Do you have any pain or hurting anywhere now? Yes ☐ No ☐
2. Have you had any pain or hurting in the last 5 days? Yes ☐ No ☐
3. If YES to 1 or 2: When you have pain, where is it? Check all that apply, note specific site if requested.)

☐ Back: _____ ☐ Neck ☐ Other joint: _____
☐ Bone: _____ ☐ Stomach ☐ Muscle: _____
☐ Chest (w/usual activities) ☐ Hip ☐ Other: _____
☐ Head: _____ ☐ Incisional

4. Tell me what the pain feels like. (Check all that apply. Circle R for RADIATING or L for LOCALIZED.)

☐ Aching	R or L	☐ Pressure	R or L	☐ Tingling	R or L
☐ Burning	R or L	☐ Prickling	R or L	☐ Tender	R or L
☐ Crushing	R or L	☐ Sharp	R or L	☐ Uncomfortable	R or L
☐ Dull	R or L	☐ Sore	R or L	☐ Other: _____	
☐ Gnawing	R or L	☐ Stabbing	R or L		
☐ Numbing	R or L	☐ Throbbing	R or L		

5. How would you rate the intensity for your pain now or during the last 5 days on a scale of 1 (mild) to 5 (severe)?

_____

6. How does your pain affect your everyday life? (Check all that apply.)

☐ Ability to bathe/groom/dress self ☐ Daily Activities ☐ Self-care activities
☐ Appetite ☐ Interactions with people ☐ Sleep
☐ Concentration ☐ Nausea ☐ Other: _____

7. What medications have relieved your pain in the past? _____

_____

_____

PRINT /STAMP PROVIDER NAME: _____
Provider Signature: _____ Date Signed: _____
Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

11. FUNCTIONAL STATUS ASSESSMENT / ADLS / IADLS: (Check all that apply)

Ability to take medication by self: ☐ Yes ☐ No
Ability to prepare food: ☐ Yes ☐ No
Ability to feed self: ☐ Yes ☐ No
Ambulation (Check all that apply.):
☐ Walk without assistance
☐ Bedridden ☐ Walker ☐ Cane ☐ Wheelchair
☐ Partial w/c dependent ☐ Complete w/c dependent
Bladder incontinence: ☐ Yes ☐ No
If YES, discussed w/member OR pt on Tx during the last 6 months? ☐ Yes ☐ No
Exercising: ☐ Yes ☐ No
If YES, Type/frequency: _____
If NO, did you discuss an exercise program with the member? ☐ Yes ☐ No
Grooming (Includes dressing and bathing): ☐ Yes ☐ No
Have caregiver: ☐ Yes ☐ No
If YES, type: ☐ IHHS ☐ Other: _____
Homelessness: ☐ Yes ☐ No
If YES, where does the patient stay at night? ☐ Shelter ☐ Street ☐ Other: _____
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower
Physical accessibility requirements at doctor's office:
☐ Adjustable exam table ☐ Wheelchair accessible scale ☐ Transfer assistance or Hoyer lift
Preferred language: _____ ☐ TTY ☐ Interpreter Services ☐ ASL
Risk of admission to hospital: ☐ Yes ☐ No
If yes, list the reason(s) _____
Risk of placement to SNF: ☐ Yes ☐ No
If yes, list the reason(s) _____
Risk for falls: ☐ Yes ☐ No
If YES, discussed w/member in last 12 months? ☐ Yes ☐ No
Transportation (check all that apply):
☐ Drive self ☐ Driven by others ☐ Bus/taxi ☐ Public transportation: Type: _____
☐ Logisticare ☐ None
Toileting: ☐ Yes ☐ No

PRINT /STAMP PROVIDER NAME: _____
Provider Signature: _____ Date Signed: _____
Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

Member: _____ CIN #: _____ DOB: _____ Age: _____

Date of Service: _____ (mm/dd/yyyy) PCP Eff Date: _____ AWE ID: _____

12. COGNITIVE FUNCTIONING:

Oriented: Yes ☐ No ☐	Memory Deficit: Yes ☐ No ☐
Immediate Recall: Yes ☐ No ☐	Inappropriate Behavior: Yes ☐ No ☐
Delay Recall: Yes ☐ No ☐	Confused: ☐ Mostly ☐ At Times ☐ Not at all
If abnormal in 1 or more, administer Mini-Cog; Results: Clock Drawing _____ Memory: _____	

13. NUTRITION/WEIGHT ASSESSMENT:

Check one: ☐ BMI normal range ☐ BMI above normal range; plan discussed ☐ BMI below normal range; plan discussed

Recent weight change: ..... Yes ☐ No ☐

☐ Increase amount _____ ☐ Decrease amount _____ Time period _____ months

If weight loss of > 10% in 6 months or > 5% in 3 months or > 2% in 1 month, consider clinically significant for malnutrition:

☐ Mild protein-calorie malnutrition ☐ Moderate protein-calorie malnutrition

Dietary counseling for weight loss/gain or any nutritional issues? ..... Yes ☐ No ☐

14. ANNUAL PREVENTATIVE SERVICES AND TESTS FOR DIABETICS:

☐ A1c Test* Date: _____ Result: _____ ☐ Most recent A1c <8.0 * Should be performed at least twice a year.	☐ Hypertension: Date of Diagnosis: _____ Most recent BP <140/90 Date: _____ Most recent BP: Systolic: _____ mm Hg Diastolic: _____ mm Hg
☐ Foot exam with monofilament test Date: _____ Result: ☐ Normal ☐ Neuropathy ☐ LL skin ulcer ☐ Absence of foot pulse (PAD)	☐ Retinal or dilated eye exam by optometrist ophthalmologist Date: _____ Result: ☐ Normal ☐ Abnormal ☐ Non-proliferative retinopathy ☐ Proliferative retinopathy ☐ Vitreous hemorrhage
☐ Microalbumin/creatinine ratio or Urinalysis Date: _____ Result: _____ Coding Chronic Kidney Disease Stages 1-2 ☐ Stage 1: At least 2 m/c ratio tests >30 at least 3 months apart + eGFR>90 ☐ Stage 2: >+2 m/c >30 3 months apart + eGFR 60-89	☐ GFR, estimated (Serum creatinine) Date: _____ Result: _____ Coding Chronic Kidney Disease Stages 3-5 ☐ Stage 3: 2 eGFR 30-59 at least 3 months apart ☐ Stage 4: 2 eGFR 15-29 at least 3 months apart ☐ Stage 5/Renal Failure: eGFR <15 / dialysis
☐ Dialysis: Yes ☐ No ☐	

PRINT / STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

Member: _____ CIN #: _____ DOB: _____ Age: _____

Date of Service: _____ (mm/dd/yyyy) PCP Eff Date: _____ AWE ID: _____

15. OTHER PREVENTATIVE SERVICES/TESTS: (Check all other tests completed and include date(s) performed. SPECIFY IF THE PATIENT DENIED, REFUSED, DECLINE OR IF TESTS WERE NOT ADDRESSED DURING THE VISIT. Do not leave blank.)

- ☐ Flu vaccine in current season (All members) Date: _____
- ☐ Pneumonia vaccine (One time at 65 years of age) Date: _____
- ☐ Biennial mammogram (Women aged 50-74) Date: _____
- ☐ Bilateral Mastectomy Date: _____
- ☐ Two unilateral mastectomies Date (1): _____ Date (2): _____
- ☐ Colorectal cancer screening (Age 50-75)
  - ☐ FoBT/FIT (Annual) Date: _____
  - ☐ Colonoscopy (Every 10 years) Date: _____
  - ☐ FoBT/FIT (Annual) CT Colonography (Every 5 years) Date: _____
  - ☐ FIT DNA (Every 3 years) Date: _____
  - ☐ Flexible Sigmoidoscopy (Every 5 years) Date: _____
  - ☐ Other Tests: _____ Date: _____
- ☐ Colorectal cancer Diagnosis Date: _____
- ☐ Total colectomy Date: _____
- ☐ Patient with rheumatoid arthritis currently on DMARD Last Rx date: _____
- ☐ Diagnosis of Pregnancy Date: _____
- ☐ Diagnosis of HIV Date: _____
- ☐ Patient with cardiovascular condition:
  - ☐ LDL-C Test Date: _____ Result: _____
  - ☐ Most current LDL-C value is <100MG/dL
- ☐ Patient diagnosis of hypertension:
  - ☐ Most recent BP is <140/90
  - ☐ Diagnosis of ESRD Date: _____
  - ☐ Kidney transplant Date: _____
- ☐ Women 65 years+ had bone density test in last 24 months Date: _____
- ☐ Women with bone fx in last 12 months had bone density test OR Date: _____
  Rx to treat/prevent osteoporosis (Test date/last RX date)

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

16. PREVIOUSLY DOCUMENTED CONDITIONS:

(Any previous chronic conditions and new conditions need to be completely re-assessed on Diagnostic Assessment and Care Plan on Page 9 and/or Page 10.)

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

17. DIAGNOSTIC ASSESSMENT AND CARE PLAN:

Detailed Diagnosis Description	Status	Care Plan
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	

17. DIAGNOSTIC ASSESSMENT AND CARE PLAN: (CONTINUED)

Detailed Diagnosis Description	Status	Care Plan
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	
	[ ] Resolved [ ] Does not have Dx [ ] Stable [ ] New Onset: [ ] Improved [ ] Worsened	

Note on Diabetes Complication: Please provide a diagnosis, assessment and plan for both the condition AND for the diabetes complication; for example:

Diagnosis Description	Assessment	Plan
CKD stage 4	Stable; last GFR = 25	Continue med to control blood pressure
Diabetes with Nephropathy	Improving diabetes control	Continue ACE inhibitor

PRINT /STAMP PROVIDER NAME: ______________________
Provider Signature: ______________________ Date Signed: __________
Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

18. PHQ-9 (English)

PATIENT HEALTH QUESTIONNAIRE-9
P H Q - 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use " O " to indicate your answer)	**Not at all**	**Several days**	**More than half the day**	**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**
	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
☐	☐	☐	☐

PRINT /STAMP PROVIDER NAME: _____
Provider Signature: _____ Date Signed: _____
Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

18. PHQ-9 (English)

CUESTIONARIO SOBRELA SALUD DEL PACIENTE - 9
P H Q - 9

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? (Marque con un "O" para indicar su respuesta)	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	**0**	**1**	**2**	**3**
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	**0**	**1**	**2**	**3**
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiadoh	**0**	**1**	**2**	**3**
4. Se ha sentido cansado(a) o con poca energía	**0**	**1**	**2**	**3**
5. Sin apetito o ha comido en exceso	**0**	**1**	**2**	**3**
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	**0**	**1**	**2**	**3**
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	**0**	**1**	**2**	**3**
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	**0**	**1**	**2**	**3**
9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	**0**	**1**	**2**	**3**
	0 +	+	+	
			= Total Score:	_____

Si marcó cualquiera de los problemas, ¿qué tanta dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

No ha sido difícil	Un poco difícil	Muy difícil	Extremadamente difícil
☐	☐	☐	☐

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

19. PHQ – 9 SCORING

PHQ-9 Depression Severity – This is calculated by assigning scores of 0, 1, 2 and 3, to the response categories of not at all, several days, more than half the days, and nearly every day, respectively. PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately sever and severe depression, respectively. Sensitivity to change has also been confirmed. *From Kroenke K, Spitzer RL, Psychiatric Annals 2002; 32:509-521.

PHQ – 9 Score	Provisional Diagnosis	Proposed Treatment Actions / Recommendation
0 - 4	None – minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counsel, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and /or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Excerpted from: http://phqscreeners.com/instructions/instructions.pdf
There are numerous translations of the PHQ as well as the PHQ-9 and GAD-7 available in many languages, which are freely downloadable on the PHQ website (www.phqscreeners.com).

19a. Does the patient have Major Depressive Disorder? Yes ☐ No ☐ If Yes, complete 19b

A score of 10> is often associated with Major Depressive Disorder. If patient's score is 10 or higher, please select the Severity and Episode of the Diagnosis:

Severity: ☐ Mild ☐ Moderate ☐ Severe

Episode: ☐ Single ☐ Recurrent ☐ Partial Remission ☐ Remission

19b. Diagnosis Assessment and Care Plan (Do not leave blank):

Status	Care Plan
[ ] Resolved [ ] Stable [ ] Improved [ ] Worsened [ ] Does not have Dx [ ] New Onset:	

PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

20. Mini-Cog Test Instructions

Administration:

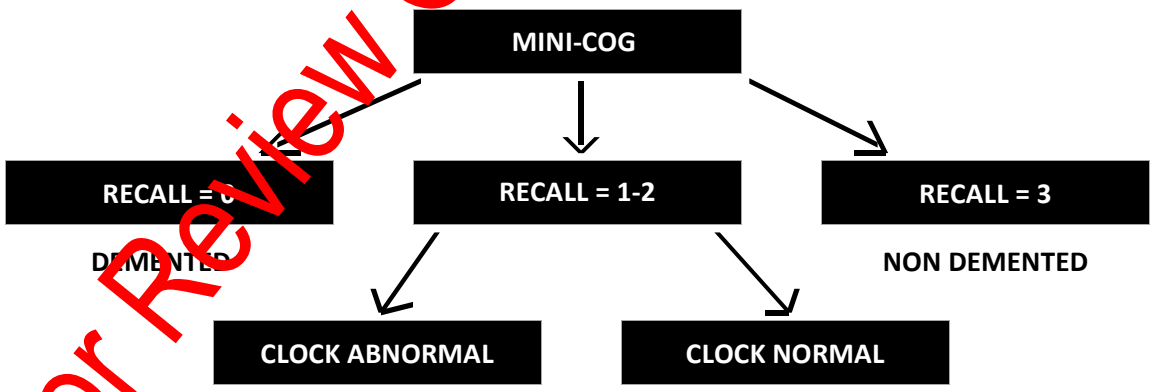
The Mini-Cog test is a 3-minuite instrument to screen for cognitive impairment in older adults in the primary care setting. The Mini-Cog uses a three-item recall test for memory and a simply scored clock-drawing test (CDT). The latter serves as a n "informative distractor", helping to clarify scores when the memory recall score is intermediate. The Mini-Cog was as effective as, or better than, established screening tests in both an epidemiologic survey in a mainstream sample and a multi-ethnic, multilingual population comprising many individuals of low socioeconomic status and education level. In comparative tests, the Mini-Cog is less affected by subject ethnicity, language, and education, and can detect a variety of different dementias. Moreover, the Mini-Cog detects many people with mild cognitive impairment (cognitive impairment too mild to meet diagnostic criteria for dementia).

Scoring: (See Figure 1): 1 point for each recalled word

0	Positive for cognitive impairment
1-2	**Abnormal** CDT them positive for cognitive impairment
1-2	**Normal** CDT then negative for cognitive impairment
3	Negative screen for dementia (no need to score CDT)

Score clock drawing as **Normal** (the patient places the correct time and the clock appears grossly normal) or **Abnormal**

Figure 1: The Mini-Cog scoring algorithm. The Mini-Cog uses a three-item recall test for memory and the intuitive clock-drawing test. The latter serves as an "informative distractor", helping to clarify scores when the memory recall score is intermediate.



PRINT /STAMP PROVIDER NAME: _____

Provider Signature: _____ Date Signed: _____

Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

21. The MINI COG Test

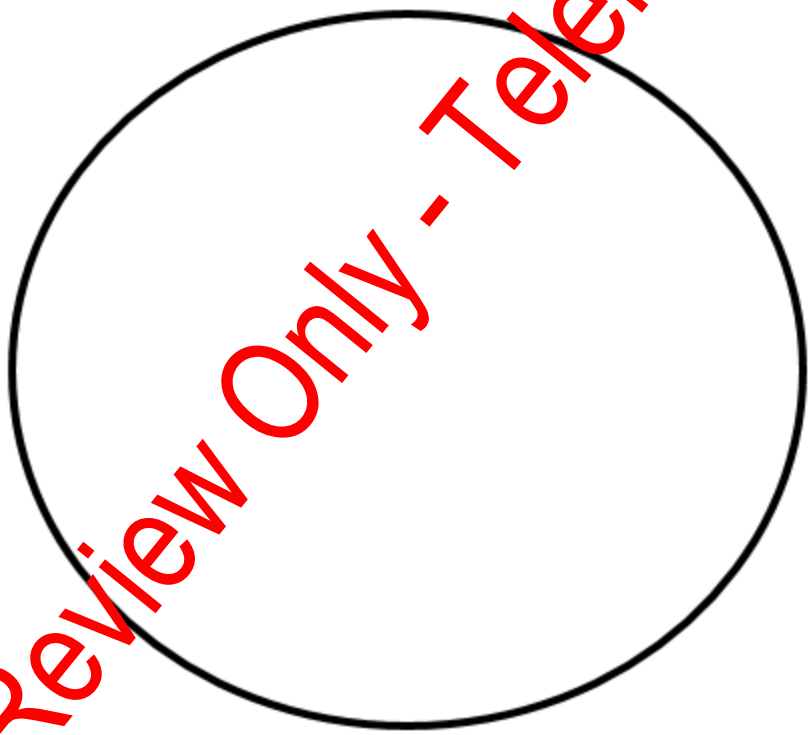
1. Instruct the patient to listen carefully and repeat the following:

APPLE	WATCH	PENNY
MANZANA	RELOJ	PESETA

2. Administer the Clock Drawing Test:

Clock Drawing Instructions

Inside the circle, draw the hours of a clock as if a child would draw them. Place the hands of the clock to represent the time "forty five minutes past ten o'clock".
Dentro del círculo dibuje las horas del reloj como si lo haria un nino. Ponga las manos del reloj para representar el tiempo "cuarenta y cinco minutos despues de las diez".



3. Ask the patient to repeat the three words given previously:

1. _____ 2. _____ 3. _____

PRINT /STAMP PROVIDER NAME: _____
Provider Signature: _____ Date Signed: _____
Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

22. Orders for Medicare Star Screening Tests:

Breast Cancer:

☐ Referral to Mammography

Cardiovascular Disease – MI, CABG.:

☐ Percutaneous coronary interventions (PCI)
☐ Ischemic vascular disease (IVD)
☐ Lipid profile (LDL)

Colorectal Cancer:

☐ gFOBT
☐ iFOBT
☐ Referral for colonoscopy

Diabetes:

☐ A1C
☐ Urine micro albumin/creatinine ratio
☐ Urinalysis

Eyes:

☐ Retinal or dilated eye exam

Vaccines:

☐ Influenza
☐ Pneumococcal (Pneumovax)

(Optional: detach and give to staff to order tests or referrals, or use your own order forms as desired)

PRINT /STAMP PROVIDER NAME: _____
Provider Signature: _____ Date Signed: _____
Provider Credentials: (Please select one) ☐ MD ☐ DO ☐ NP ☐ FNP ☐ PA

L.A. Care Internal Member ID Number: **MEM00000000000**

Member Information Profile Form

HEDIS Data Captured For Measurement Year 2019

Data Processed Through July 2019

Member Demographics:

Member Name:	**Jon Snow**	**Member Date of Birth:**	**1/1/1940**	**Member Age:**	**79**
Member Address:	**1st Street, Los Angeles, California 99999**	**Member Phone Number:**	**999 999 9999**	**Member Gender:**	**M**

Selected HEDIS Effectiveness of Care Measures:

This member qualifies for each of the measures below. If marked compliant, we have a record that the service(s) have been provided. If marked non-compliant, please make sure the services are performed as soon as possible. If services have already been performed, indicate the date(s) of service in the appropriate section of the AWE form.
Possible Measures for Screening and Chronic Conditions: AMM, BCS, CBP, CDC, COA, COL, COU, DAE, MRP, SPC, SPD

Measure	Sub Measure Description	Measurement Year 2019	Measurement Year 2018
Controlling High Blood Pressure (CBP)	Controlling High Blood Pressure	Non-Compliant	Non-Compliant
Comprehensive Diabetes Care (CDC)	Eye exam (retinal) performed-Medicare Disability only	Non-Compliant	**Compliant**
Comprehensive Diabetes Care (CDC)	HbA1c control (<8.0%)	Non-Compliant	**Compliant**
Comprehensive Diabetes Care (CDC)	Medical attention for nephropathy	**Compliant**	**Compliant**
Comprehensive Diabetes Care (CDC)	BP control (<140/90 mm Hg)	Non-Compliant	Non-Compliant
Colorectal Cancer Screening (COL)	Colorectal Cancer Screening-Medicare Disability only	Non-Compliant	Non-Compliant
Statin Therapy for Patients With Diabetes(SPD)	Statin Therapy for Patients	**Compliant**	Non-Compliant
Statin Therapy for Patients With Diabetes(SPD)	Statin Therapy for Patients with adherence 80%	Non-Compliant	Non-Compliant

Unique Medication Prescribed in 2019:

Drugs for: Asthma, COPD, Blood Pressure, Diabetes, Antidepressants, High Risk Medications, Opioids
Non-Exhaustive List of Medications

Medication Categories	Brand Name	Generic Drug Name
ACE Inhibitor/ARB Medications	Lisinopril	lisinopril 40 mg oral tablet
Diabetes Medications	GlipiZIDE	glipiZIDE 5 mg oral tablet

Latest Service/Test Date on File for Selected Categories:

Below are the latest dates we have in our records for the services below. If services were performed later than these dates, please indicate in the appropriate section of the AWE form.
Type of Services: HbA1C, Colonoscopy, Inpatient Stay, Emergency Room Visit, Blood Pressure, Mammogram

Service Grouping	Latest Date
hba1c	April 13, 2018
Emergency Room Visit	March 29, 2019

Distribution Confirmation

Provider Communication(s) re: COVID-19

Est. 03.2020

L.A. Care HEALTH PLAN

For All of L.A.

Subject: COVID-19 General Preparation Recommendation and Telehealth Guidance (P)

Distribution Date: March 31, 2020

Time: 5:53 PM

Sent By: ProviderCommunications@lacare.org

Provider Type(s):

PPGs

Line(s) of Business:

All LOBs

This document was sent via:

☐ Certified Mail

☒ Email Blast

☐ Fax Blast

☐ US Mail

☐ Other – Please specify:

Additional Comments:
N/A

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

March 31, 2020

RE: L.A. Care Health Plan – COVID-19 Related Communication: General Outpatient Network Provider Recommendations and Telehealth Guidance

Dear Colleagues:

With L.A. County urgently trying to reduce and manage the spread of COVID-19 to "flatten the curve" and reduce the peak of the outbreak, we know that you are busy supporting the public health measures and are managing many requests and concerns from patients, staff, and downstream providers. L.A. Care Health Plan (L.A. Care) is here for you in this unprecedented time. In order to streamline communications in this rapidly changing environment, we want to provide you with the below information so that you can provide care and treatment to L.A. Care members, and provide timely information and communications to your downstream contracted providers.

As a reminder, please look to the local L.A. County public health departments for local resources, guidance, and updates for community-specific clinical and public health instructions. Please look to the California Department of Public Health (DPH) and Centers for Disease Control and Prevention (CDC) for state and federal level guidance and resources, respectively. Please also refer to DHCS website or DMHC website for guidance and resources for services rendered to our members.

Should you have questions regarding your contract with L.A. Care, please contact your L.A. Care account manager.

In an effort to ensure that there is an adequate network and appropriate access to care, please timely communicate with your contracted providers (primary care, specialists, and service providers/vendors (such as DME, home health, etc.)) that:

- They should understand how to and when to order COVID-19 testing.
- COVID-19 testing is available for members and reimbursed by the contracted provider (PPG or health plan).
- They should promptly contact you if their office, clinics, or services have been disrupted or if they are no longer operating.
    - You, in turn, should inform your L.A. Care account manager should any provider's offices or services close, in whole or in part.
- They should be aware of general rules and guidance around telephone or tele-video visits during this emergency period, and coding/billing for such services including the following:
    - Telephone visits can substitute for face-to-face visits with appropriate clinical documentation and submission of encounter and billing codes.
    - The Centers for Medicare and Medicaid Services' (CMS) "Summary of Medicare Telemedicine Services" as provided in the chart below:

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	PATIENT RELATIONSHIP WITH PROVIDER
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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

- They (primary care providers and specialists) are encouraged by the Health and Human Services Office for Civil Rights to utilize one of the below televideo platforms that are free or low cost:
    1. Zoom Healthcare - https://www.zoom.us/healthcare
    2. Doxy.me - https://doxy.me/
    3. Updox - https://www.updox.com/
    4. Google G Suite Hangout Meet - https://gsuite.google.com/products/meet/
    5. Cisco Webex Meetings - https://www.webex.com/video-conferencing
    6. Amazon Chime - https://aws.amazon.com/chime/
    7. Go to Meeting - https://www.gotomeeting.com/

Please also refer to the American Medical Association (AMA) quick guide to telemedicine in practice which provides general practice guides, tools, and resources, including rules and regulatory guidance, for providers.

Again, L.A. Care is here for you and your L.A. Care patients. We wish you the very best. By working together, we will get through this pandemic. Be safe and well.

Sincerely,

Richard Seidman, MD, MPH
Chief Medical Officer
L.A. Care Health Plan

Alexander Li, MD
Deputy Chief Medical Officer
L.A. Care Health Plan

MedPOINT Management (MPM) COVID-19

Frequently Asked Questions

This FAQ guide is intended to assist our providers with an assortment of topics related to COVID-19.

COVID-19 Testing

If any of your patients test positive for COVID-19, how and where should I report this information?

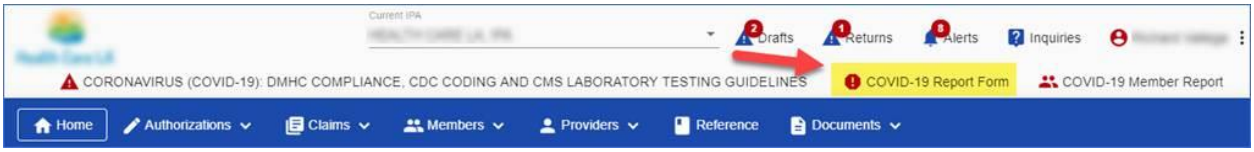
You are required to report all positive test results to your local health department and the CDC. Additionally, your contracted IPA/Medical Group is also requesting that you submit this information via the MedPOINT Management (MPM) Web Portal. Please follow the below link and instructions which includes a quick guide to steps for submission via the web portal.

Please use this link for more information on reporting to the CDC: https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html

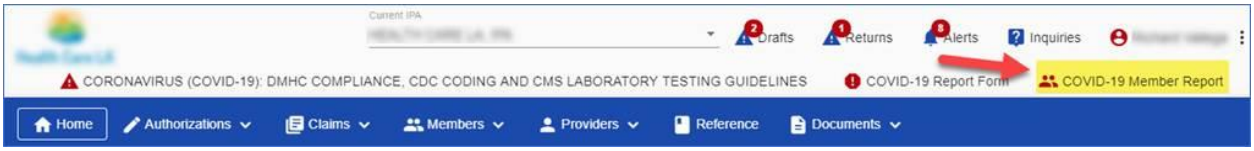
A listing of local public health websites can be found here: https://www.naccho.org/membership/lhd-directory?searchType=standard&lhd-search=&lhd-state=CA

Where can I find a list of my COVID-19 positive members?
The MPM Web Portal has published a new report that allows you to view a list of your patients who have tested positive for COVID. To access the report, please follow the below links and steps:

- Login to the MedPOINT Provider Web Portal here: https://portal.medpointmanagement.com
- To submit a case please click the link highlighted below:



- To view your COVID19 members please click the link highlighted below



What is the IPA doing for my members who tested positive?

Your contracted IPA is conducting outreach and case management services for members who tested positive for COVID-19. We conduct a COVID-19 assessment telephonically, and provide members with resources regarding social services, food delivery, appointment scheduling and establishing medication home delivery. For patients who tested positive in the outpatient setting, our member outreach team is contacting these members to assess their needs. If the member needs an appointment with their PCP, we will contact your office to help schedule the appointment and resolve any immediate issues. For high risk patients or patients recently discharged from the hospital, these members are followed by the Case Management team. To speak directly with the Case Manager assigned to your member who was recently discharged from the hospital, please call 818-702-0100 ext. 1834.

Where should I send a member for COVID-19 testing?

LA County is offering free testing for anyone who meets the current criteria. You can instruct your members who need a COVID-19 test to follow the below link and instructions. Appointment availability opens for slots the next day.

For LA County residents, please direct patients to this link: https://lacovidprod.service-now.com/rrs

Riverside County https://www.rivco-familycarecenters.org/ you have to call to make an appointment 1-800-945-6171

Long Beach residents with symptoms of COVID should follow this link to get information on testing sites: http://www.longbeach.gov/health/diseases-and-condition/information-on/coronavirus/covid-19-testing/

San Diego COVID-19 testing is being considered for people who have a fever and a cough and are part of high-risk group only – Call your provider to determine if testing is required.

Is Quest offering COVID-19 antibody testing?

Effective 4/21/20, Quest will begin offering SARS-CoV-2 Serology (COVID-19) Antibody (IgG), Immunoassay. The CPT code for this immunoassay is 86769 and the test code is 39504.

Is LabCorp offering COVID-19 antibody testing?

Effective 4/27/20, LabCorp will begin offering SARS-CoV-2 Serology (COVID-19) Antibody (IgG), Immunoassay. The CPT Code for this immunoassay is 86769 and the test code is 164055.

COVID-19 Billing, Encounters, Authorization, and Claims

Per regulatory guidance, no co-pays, deductibles, or co-insurance are to be collected from members for COVID-19 testing and screening. Which types of services does this apply to?

The DMHC directs all full-service commercial and Medi-Cal plans to immediately reduce cost-sharing including but not limited to co-pays, deductibles, or co-insurance to zero for all medically necessary screening and testing for COVID-19, including hospital (emergency department), urgent care visits, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19. If there are treatments, exams, procedures, or other services that cannot be adequately provided via telehealth, those services are not eligible to be provided using this method.

Do I need to submit an authorization for COVID testing and screening?

You do not need to submit an authorization for COVID testing or screening. Your IPA has also automatically extended all authorizations by an additional 180 days in order to facilitate your member's access to care.

Do I need to obtain authorization for telehealth services?

For services that generally require an authorization, the standard pre-authorization requirements apply regardless of whether the services are being provided via telehealth or in-person. Your current authorizations are valid, and you do not need to do anything further to change these authorizations. You do not need to request a new authorization with a POS 02. Please follow your normal authorization processes with your contracted IPAs and contact them directly with any questions or concerns about telehealth. When submitting claims for authorized services, medical records must be attached via the MPM web-portal to the approved authorization. For assistance, please contact Provider Network Operations (providerservices@medpointmanagement.com) or the IT Help Desk (ITSupport@medpointmanagement.com).

If I am seeing a member via a telehealth visit, how should these visits be billed?

Telephone visits can substitute for face-to-face visits with appropriate clinical documentation and submission of encounter and billing codes. This service does vary depending on the line of business and a distinction should be made between telephonic (phone only) and telemedicine visits which include a video component. When billing telehealth services use **POS 02 (telehealth)** and **modifier 95**. Refer to CMS billing guidelines at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

The Centers for Medicare and Medicaid Services' (CMS) "Summary of Medicare Telemedicine Services" as provided in the chart below:

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	PATIENT RELATIONSHIP WITH PROVIDER
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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

What is the distinction between E&M office visits done via telehealth and telephone visits?

The definition of telehealth technically excludes audio-only telephone visits. Medicare currently only allows E&M office visits 99201-99215 to be coded if there is video capability. If there is no video capability Medicare only allows a telephone visit to be coded. CMS has posted a list of exceptions which include G0438 and G0439 Annual Wellness Visits. During the public health emergency (PHE) Medi-Cal and Commercial allow E&M office visits to be done by telephone or telehealth. It's important to document patient consent.

What are the Medicare risk adjustment rules?

Medicare E&M office visits done by telehealth do risk adjust. This includes AWV codes G0438 and G0439 but not G0402, so providers should not use the latter code until CMS clarifies. Telephone visits currently do not risk adjust (although this is being appealed).

How should audio-only telephone encounters be coded?

Telephone visits are usually coded with either CPT 99441-99443 or G0071. The latter code is for FQHCs/RHCs. It's important to document the length. Phone calls are not telehealth visits, so no modifiers are required. For Medi-Cal and Commercial, it is recommended that providers code phone visits as E&M office visits by telehealth in order to ensure credit for HEDIS and Star measures, and because there is a rule about coding telephone visits 7 days after or 24 hours before another visit. DHCS has clarified that when there is a supplemental payment for well child visits, such as CHDP, and the purpose of an in-person visit is only to complete items that could not be completed during a preceding telephone or telehealth visit, it is not appropriate to receive payment for both visits.

What is the purpose of the MedPOINT coding telehealth coding guidance?

MedPOINT has asked that providers use both the place of service (POS) 02 and modifier 95 when submitting telehealth encounters. This is to ensure that these visits are accurately tracked and because different health plans have different requirements. When submitting encounters directly to the plans, to DHCS or to CMS, follow the guidance of the recipient.

How to properly document a telehealth visit?

All documentation must comply with standard State and Federal requirements. MPM recommends that the documentation in the Member's medical record should include the following: Notation that patient consented to the consult held via telephone/online, Names of all people present during a telemedicine consultation and their role, Chief complaint or reason for telephone/online visit, Relevant history, background, and/or results, Assessment, Plan and next steps and Total time spent on medical discussion. Additional information regarding the recommendation may be found at: https://www.careinnovations.org/wp-content/uploads/1.-Telephone-Visits-Definitions-Coding-Documentation_CP3-Toolkit.pdf

How should I bill for COVID-19 tests that were done in my office or facility?

If the specimen is collected as a component of the in-person office visit, the collection is included and should not be billed separately. If the specimen is collected on a separate day, bill using **99211** or **99000**, if code requirements are met. The following codes are reserved for clinical laboratories and other providers who have the capability to analyze specimens on site: **CPT Codes – 86328, 87635, 86769**, and **HCPCS Codes – U0002, U0003, U0004**.

What diagnosis codes should I use for COVID-19 positive or suspected COVID-19 visits?

Effective with services on and after April 1, 2020, a confirmed diagnosis of COVID-19 (2019 novel coronavirus disease) should be reported with diagnosis code **U07.1**, COVID-19. Assignment of this code is applicable to positive COVID-19 test results and presumptive positive COVID-19 test results.

While this list is not comprehensive, here are some additional ICD-10-CM codes that may be helpful for reporting encounters related to possible COVID-19 exposure as described in the ICD-10-CM Official Coding and Reporting Guidelines at:

- Z03.818: (Encounter for observation for suspected exposure to other biological agents ruled out)
- Z20.828: (Contact with and (suspected) exposure to other viral communicable diseases)
- Z11.59 (Encounter for screening for other viral diseases)

For more information on COVID 19 Coding, please refer to CDC coding guidelines:
https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Please Note: The above guideline is directed to coders; the clinician's judgement that the patient has COVID-19 is sufficient to code U07.1.

COVID-19 Telehealth and Practice Impact

Which platforms can I use to provide telehealth services to my members?

Primary Care Providers and Specialists are encouraged by the Health and Human Services Office for Civil Rights to utilize one of the below televideo platforms that are free or low cost:

1. Zoom Healthcare - https://www.zoom.us/healthcare
2. Doxy.me - https://doxy.me/
3. Updox - https://www.updox.com/
4. Google G Suite Hangout Meet - https://gsuite.google.com/products/meet/
5. Cisco Webex Meetings - https://www.webex.com/video-conferencing
6. Amazon Chime - https://aws.amazon.com/chime/
7. Go to Meeting - https://www.gotomeeting.com/

Please also refer to the American Medical Association (AMA) quick guide to telemedicine in practice, which provides general practice guides, tools, and resources, including rules and regulatory guidance, for providers.

Due to COVID, my office is temporarily closed, has limited hours, or is only seeing members via telehealth. How should I let the IPA know?

If any Primary Care, Specialty Care, or Ancillary Provider is unable to provide services to Members due to temporary office closure, submit a notification to MPM via email to ProviderServices@medpointmanagement.com. Please also notify us of any changes to your office hours or if you are providing services via telehealth. Please also ensure that you have adequate messaging on your office recording so that members are aware of your closure and any alternative arrangements.

How will I receive my capitation check?

Due to the Public Health Emergency (PHE), providers will not be able to pick up their capitation check from MedPOINT Management's headquarters. The process for capitation check retrieval as a result of the PHE is regular mail or FedEx (if requested). If check is sent via FedEx, the cost of the charge will be deducted from the following capitation check.

My office or facility is running low on PPE. How can I obtain PPE?

The California Department of Public Health issued an All Facilities Letter discussing how to extend PPE supplies: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-39.aspx
Facilities facing a critical shortage of PPE should contact the Medical Health Operational Area Coordinator for their County (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-39.aspx).
The Community Clinic Association of LA County (CCALAC) is helping to coordinate group acquisition of PPE for its members: https://ccalac.org/resource-library/covid-19-resources/

Will HEDIS and/or Risk Adjustment scores and schedule be put on hold due to COVID?

Health plans will adjust their P4P programs as CMS, NCQA and DHCS clarify their expectations of the plans. CMS has given health plans flexibility to use Measurement Year 2018 Star ratings in place of MY2019 ratings. Star cut-points for MY2020 will be adjusted and other disaster-related "hold harmless" provisions will apply. CMS will allow diagnoses from telehealth visits to count for risk adjustment. Additional risk adjustment program changes and deadline extensions are under consideration. NCQA and DHCS have not yet announced program modifications but are encouraging telehealth when clinically appropriate.

Have there been any changes to the process for elective surgeries?

As of April 22, 2020, Governor Newsome has announced that certain surgeries, such as cancer-related procedures, cardiac procedures, etc. can resume. Providers are given a 6-month window to schedule instead of 3 months. Members need to verify with their surgeon regarding scheduling.

Where can I find a list of all COVID resources?

MedPOINT Management has updated the landing page of their website (www.medpointmanagement.com) to include pertinent COVID-19 related resources. The informational materials will continue to be available under the Provider Resources section on the website as well. Check frequently for updates as the information is revised frequently from the various regulatory agencies, health plans, and social service agencies.

In addition to MPM's website, please look to the local County public health departments for local resources, guidance, and updates for community-specific clinical and public health instructions. Please look to the California Department of Public Health (DPH) and Centers for Disease Control and Prevention (CDC) for state and federal level guidance and resources, respectively. Please also refer to the DHCS website or DMHC website for guidance and resources for services rendered to our members.

You may also find useful resources on the health plan websites. See below for a directory of COVID Information posted to the health plan websites.

Health Plan	Website
Aetna	https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Aetna Better Health of CA	https://www.aetnabetterhealth.com/california/wellness/coronavirus
Alignment	https://www.alignmenthealthplan.com/members/coronavirus-covid-19
Anthem	https://www.anthem.com/ca/coronavirus/
Blue Shield	https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/COVID-19-network-providers-info/
Blue Shield Promise	https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/COVID-19-network-providers-info/
Brand New Day	https://bndhmo.com/coronavirus
California Health & Wellness	https://www.cahealthwellness.com/providers/important-updates.html
Central Health Plan	https://www.centralhealthplan.com/Home/Covid19
Cigna	https://www.cigna.com/coronavirus/
Community Health Group	https://www.chgsd.com/providers/alerts
Health Net	https://www.healthnet.com/portal/provider/content/iwc/provider/unprotected/working_with_HN/content/important_updates.action
Humana	https://www.humana.com/provider/coronavirus
IEHP	https://iehp.org/en/providers/plan-updates?target=coronavirus-advisory
Imperial Health Plan of CA	https://www.imperialhealthplan.com/california/providers/
LA Care	https://www.lacare.org/providers/provider-central/news/health-advisories

Molina	https://www.molinahealthcare.com/members/wa/en-US/mem/Pages/Coronavirus.aspx
Scan	https://www.scanhealthplan.com/members/coronavirus-information
United Healthcare	https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html
WellCare	https://www.wellcare.com/California/COVID-19/Medicare-Provider
CDC	https://www.cdc.gov/coronavirus/2019-ncov/index.html
CDPH	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx

Interpreter Service Contact Information for Health Plans Affiliated with MedPOINT Management

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Aetna	Over 200 languages - using LauguageLine	**Medi-Cal/Medi-Care/Commercial** LauguageLine Interpreter Services: (855) 380-5345 Client ID# **737610** 4 digit pin code:**1020** **Face to Face appointment:** **4 days notice** for onsite interpretation service **Additional Resource:** www.aetna.com
Alignment Health Plan	All Threshold Languages - using Voiance Language Services	**Medicare:** **Voiance Language Services:** (866) 998-0338 **Account Number:** 30488 **4 digit pin code:** 1099 **Face to Face:** Not Available **Additional Resource:** http://interpret.voiance.com/about/
Anthem Blue Cross	All Threshold languages	Services are arranged through Anthem Blue Cross Health Plan's Member Services department. Face to face visit require advanced notification. **Medi-Cal** (888) 285-7801 (inside Los Angeles County) (800) 407-4627 (outside Los Angeles County) **After business Hours:** call the 24/7 Nurse Line at (800) 224-0336 **Commercial and Medicare Advantage** Providers can call the Anthem's Provider Services Department at (800)677-6669 to receive assistance with translation and interpretation services. Members can contact the number on the back of their ID card for assistance. **Additional Resource:** https://mediproviders.anthem.com/ca/pages/free-interpreting-services.aspx
Blue Shield of California	All languages - over 200 languages	Blue Shield of California's Provider Services can direct calls to their vendor for interpreter Services. **Provider Services:** (800)541-6652 **Or** call the number on the back of the member's ID card. A Blue Shield Representative will connect the call to LanguageLine (a third party vendor) for assistance with interpreting, translations and face to face visits **Additional Resource:** https://www.blueshieldca.com/provider/guidelines-resources/patient-care/language-assistance.sp
Blue Shield of California, Promise Health Plan (formally Care1st)	Oral translations in all languages, print translations Spanish & Traditional Chinese	Face to Face and telephonic interpreting services are arranged bye Blue Shield of California, Promise Health Plan. Face to face visits need to schedule 4 days in advance. **Medi-Cal** (800) 605-2556 **Medicare** (800) 544-0088 **CalMedi Connec**t (855) 905-3825 **After Business Hours:** Call Pacific Interpreters: (877) 904-8195 **ACCESS CODE:** 828201
Brand New Day	Spanish, Vietnamese, Mandarin Chinese, Cantonese Chinese, Cambodian, Tagalog. Pacific Interpreter (third party vendor) provides interpreter services for languages not available through Brand New Day.	Face to Face Interpreter services is only provided for members who require assistance with Sign Language. Telephonic services are available by appointment only. All services require a 3-5 business day notice and must be arranged through Brand New Day's Member Services department. Member Services Department: (866) 255-4795

Interpreter Service Contact Information for Health Plans Affiliated with MedPOINT Management

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Central Health Plan	All languages	**Face to Face** Interpreter services is only provided for members who require assistance with Sign Language. **Services require a 3-5 business day notice**. All services must be arranged through Central Health Plan's Member Services department. **Member Services Department:** (866) 314-2427 **Additional Resource:** https://www.centralhealthplan.com/Materials/MultiLanguage
CIGNA	Interpretation - any language Translation of documents -Spanish, Traditional Chinese	Interpretation is available in any language Call (800) 806-2059 **or** call the number on the back of member's Cigna ID card. You will need the member's CIGNA ID number, date of birth and your TAX ID number (or NCPDP for pharmacies) to confirm eligibility and access interpretation services. Advanced arrangements are not necessary. **Face to Face interaction:** (800) 997-1654 **Additional Resource:** https://www.cigna.com/health-care-providers/resources/topic-cultural-competency-health-equity
Health Net of California, Inc.	Interpretation available in all languages	Services are arranged through Health Net. Telephonic and Face to Face services available. Service available 24 hours a day, 7 days a week. Medi-Cal: (800) 675-6110 Cal Medi-Connect – Los Angeles: (855) 464-3571 Cal Medi-Connect – San Diego (855) 464-3572 Commercial: (800) 520-0088 After Hours, weekends and holidays: (800) 546-4570 Medicare Advantage: (800) 929-9224 (M-F 8AM – 5PM) TTY: 711 **Additional Resource:** www.healthnet.com (Click 'Language' tab on the top part of the website)
IEHP	All languages	Member Services: (800) 440-4347 or (800) 718-4347 for TTY users, at least 5 days before appointment. IEHP tries to accommodate same day requests as well, but prefers to schedule in advance when possible. **To cancel your request**, call at least 2 days before appointment. **Additional Resources:** https://ww3.iehp.org/en/providers/provider-resources (Scroll All the way down)
LA Care Health Plan	All languages	**All Lines of Business;** (855) 322.4034 Provide the member's LA Care Member ID and the Physician's NPI number. **Face to Face and Telephonic services** **Medi-Cal:** (888) 839-9909 **Cal Medi-Connect:** (888) 522-1298 **L.A. Care Covered:** (855) 270-2327 **PASC-SEIU:** (844) 854-7272 Face to face visits require advanced notification: **Additional Resource:** http://www.lacare.org/nondiscrimination-notice

Interpreter Service Contact Information for Health Plans Affiliated with MedPOINT Management

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Molina Healthcare of California	All languages through Globo, third party vendor	**Globo:** (844) 311-9777 **Location Code:** 1011 (California) **Product Line:** 1 - Medi-Cal 2 - Marketplace 3 - CalMedi Connect (Duals) 4 - Medicare **Department Code:** 088 (Provider Office) or **Medi-Cal:** (888) 665-4621 Mon-Fri, 7am-7pm **Marketplace:** (888) 858-2150 Mon-Fri, 8am-6pm **Medicare:** (800) 665-0898 Mon-Fri, 8am-8pm **Cal MediConnect (Duals):** (855) 665-4627 Mon-Fri, 8am-8pm **After Hours and Weekends,** call Molina's Nurse Advice Line to arrange for service: **English:** (888) 275-8750 **Spanish:** (866) 648-3537 **Face to Face** services must be arranged in advance through Molina's Member Services department. **Additional Resource:** http://www.molinahealthcare.com/providers/ca/medicaid/resource/Pages/ask_cultural.aspx
United Healthcare of California	Spanish, Chinese (Traditional Chinese Characters), Vietnamese, Tagalog, Armenian, Russian, Japanese	**Medi-Cal and Medicare Dual Plans** Member Services (866) 270-5785 **Medicare Advantage:** (888) 866-8297 **Commercial:** (866) 633-2446 **Provider Services:** (877) 842-3210 **Additional Resource:** https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices
SCAN	All languages - through CQ Interpreter Services	**CQ Interpreter Services:** (888) 338- 5514 **Provider code:** TPSCAN **or** contact SCAN's Member Services department: Phone Number: (800) 559-3500 Press # 4 for Provider Press # 6 for Interpreta services **Additional Resource:** http://www.molinahealthcare.com/providers/ca/medicaid/resource/Pages/ask_cultural.aspx
WellCare/Easy Choice Health Plan	Vietnamese, Cantonese Chinese, Mandarin Chinese, Spanish and Korean. All other languages available through third party vendor.	All services must be arranged through WellCare/Easy Choice Health Plan's Member Services department. **Member Services:** (866) 999-3945 (5 major languages listed) Press #1 for English Press #2 for provider Member Services will connect the call to an Interpreter. **Face to Face:** Member has to request interpretation services 1 week in advance - onsite service (based on the member's benefit coverage). If denied by the plan, the IPA's delegate will provide service.

Preventive Care Services Guidelines During COVID-19

with Helpful Links

The following HEDIS preventive measure guidance has been compiled in support of federal, state, and local recommendations to reduce potential exposure to COVID-19 during this unprecedented time.

Please adhere to the latest CDC guidelines for patient care at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html. Please also refer to the MedPOINT 2020 HEDIS/Stars Provider Reference Guide for coding assistance at https://www.medpointmanagement.com/provider-resources/ (under Quality Management Information, HEDIS Documents). **Please note** that telehealth visits are billed using Place of Service code 02 and Modifier 95. Please do not use this coding for telephone visits.

The guidance in the following table does not replace the Provider's responsibility in clinical decision-making for an individual patient. The decision regarding whether a telehealth visit is clinically appropriate and safe in place of an in-office visit is ultimately at the Provider's discretion and must be based on the clinical judgement of the Provider. This includes assessing the clinical need for a physical examination or the assessment of vital signs.

Adult Measure	COVID-19 Recommendation
Breast Cancer Screening (BCS)	• Delay non-urgent/routine testing at this time and schedule for a later date. • Providers can document member-reported history of a completed mammogram during telehealth visits.
Care for Older Adults (COA)	• For senior patients over age 66 in a SNP or MMP program, information for the four components of the measure can be completed through telehealth.
Cervical Cancer Screening (CCS)	• Delay non-urgent/routine testing at this time and schedule for a later date. • Providers can document member-reported history of a completed mammogram during telehealth visits.
Chlamydia Screening in Women (CHL)	• Delay non-urgent/routine testing at this time and schedule for a later date.
Colorectal Cancer Screening (COL)	• Delay screening colonoscopies. • FIT kits can be mailed to members to complete, along with CDC educational material (https://www.cdc.gov/cancer/colorectal/pdf/sfl_inserts_screening.pdf). • Follow up to confirm kit was mailed to the laboratory. • Providers can document member-reported history of a completed colonoscopy during telehealth visits.
Comprehensive Diabetes Care - HbA1c Control <8 (CDC)	• Delay non-urgent/routine testing at this time. • Telephonic disease management can be provided for uncontrolled diabetics.

Adult Measure	COVID-19 Recommendation
Comprehensive Diabetes Care – Eye Exam, Nephropathy (CDC)	• It is recommended to use provider discretion for high risk patients to determine if testing is needed. • Delay non-urgent/routine testing at this time and schedule for a later date. • Providers can document member-reported history of a completed eye exam during telehealth visits.
Controlling Blood Pressure (CBP)	• Remote patient monitoring is appropriate. Remote patient monitoring is the collection of physiologic data (for example, blood pressure) digitally stored and transmitted by the patient or caregiver or both. • Use CPT code 99091 *(collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and transmitted by the patient and/or caregiver to the physician or other qualified health care professional).* • In addition, also code the results using the blood pressure CPT II codes noted in the MedPOINT 2020 HEDIS/Stars Provider Reference Guide. • Restrictions on member reported values are subject to change. • Telephonic disease management can be provided for hypertensive members.
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheaumatoid Arthritis (ART)	• Review patient past/current medical records to confirm diagnosis of Rheumatoid Arthritis (RA). • If the patient is diagnosed with RA, reach out to confirm the member is filling their DMARD prescriptions timely. • For patients with a diagnosis of Osteoarthritis the was miscoded as RA, please submit a corrected encounter to the plan to have the RA diagnosis retracted. • Contact your MedPOINT Quality Improvement Specialist if you need assistance with this process.
Medication Reconciliation Post-Discharge (MRP)	• Telehealth visits may be used to meet this measure of reconciling medications for members discharged from the hospital within 30 days, if clinically appropriate. • This can also be completed by Pharmacist or Registered Nurse. • See the MedPOINT 2020 HEDIS/Stars Guide for further details and code.
Osteoporosis Screening and Management after Fracture (OMW)	• Monitor women with a fracture date between 7/1/2019 - 6/30/2020 to insure they receive a bone mineral density (BMD) test or are dispensed a prescription to treat osteoporosis within the six months (180 days) after the fracture. • If BMD is not available, consider starting medication until MD can be completed.
Pharmacy Measures	• Complete Antidepressant Medication Management (AMM) and Asthma Medication Ratio (AMR) measures via telehealth. • Encourage members to refill medication and get a 90-day supply to minimize visits to the pharmacy and to take advantage of mail delivery.
Postpartum Care, Timeliness of (PPC-Post)	• Follow latest ACOG recommendations: https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetric. • Telehealth visits may be used for postpartum visits (between 7-84 days after delivery).
Prenatal Care, Timeliness of (PPC-Pre)	• Follow latest ACOG recommendations: https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics. • Patient–physician discussion regarding a plan for alternate prenatal care in the setting of the COVID-19 pandemic should be documented in the medical record. • Patient-level determinations should be made.

Under 21 Measure	COVID-19 Recommendation
Adolescent Well-Care Visits (AWC) Well-Child Visits age 3-6 (W34)	• Telehealth visits may be used for obtaining history information and discussing health education/anticipatory guidance. • Completion of the in-person components can be deferred until a later date. • Keep a list of rescheduled appointments to facilitate patient recall later. • Visual Physical Exam • Health History • Mental Development History • Physical Development History • Health Education/Anticipatory Guidance • BMI Assessment • Nutrition Counseling • Exercise Counseling • Age-appropriate SHA/IHEBA • ACE Trauma Screening • Offer **Physical Exams** via face-to-face visit later in the year before December 31, 2020. • Note the plan for a **follow-up physical exam** in the patient's medical record as part of the telehealth visit. • Consider changing office layout to include separate waiting area and exam rooms for well patient care.
Childhood Immunizations - Combo 10 (CIS 10)	• **Prioritized this measure.** • The Routine Childhood Immunizations during COVID-19 Pandemic memo from DHCS provides recommendations for office practices/protocols to keep 0-24-month-old children up to date on immunization schedule. • See California Vaccines for Children (VFC) program latest recommendations here: https://eziz.org/assets/docs/VFC_Letters/VFCletter_PediatricIZGuidelinesduringCOVID19Pandemic_03_27_20.pdf**.**
Immunizations for Adolescents - Combo 2 (IMA 2)	• Telehealth visits may NOT be used to meet this measure. • Access at the patient level and offer face-to-face visit.

Initial Health Assessment (IHA)	• Telehealth visits may be used for IHAs if determined by the Provider to be clinically appropriate.
	• Please note that the physical exam portion of the IHA will not be required for IHA visits conducted during this time where social contact is being restricted.
	• The IHA must still include all of the following components:
	  ○ Complete mental health exam
	  ○ Comprehensive medical history including a complete social history
	  ○ Individual Health Education Behavior Assessment (IHEBA)
	  ○ A plan for provision of appropriate preventive services must be documented in the medical record
	  ○ A plan for a follow-up comprehensive physical exam at a later time must be documented in the medical record

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – all sub measures (WCC)	• Telehealth visits may be used to meet this measure if determined by the Provider to be clinically appropriate specifically for nutrition and physical activity. • Ask he patient for height and weight and calculate the BMI until the patient can be seen in person.
Well-Child Visits in First 15 Months of Life (W15)	• Align well care visits with immunizations. • Document all 5 components of well-child visit in medical record.

COVID19 Helpful Links

Source	Website
California COVID Toolkit	• https://toolkit.covid19.ca.gov/
CDC - Centers for Disease Control FAQ for Members	• CDC FAQs (Frequently Asked Questions): https://www.cdc.gov/coronavirus/2019-ncov/faq.html • CDC Video – Handwashing: https://www.cdc.gov/handwashing/videos.html
CDPH – California Dept. of Public Health	• COVID-19 Alerts, Stats, Updates, Programs, Reporting: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/nCOV2019.aspx • Tool Kit – California DPH: https://toolkit.covid19.ca.gov/ • One Stop Site for Donating Supplies: https://www.gov.ca.gov/2020/04/04/governor-newsom-launches-one-stop-website-for-donations-sales-of-essential-medical-supplies-in-fight-against-covid-19/
CMS - Medicare Coverage and Payment of Virtual Services	• Video – MLN Medicare Learning Network https://www.youtube.com/watch?v=bdb9NKtybzo&feature=youtu.be
CMS FAQs	• Telehealth Visits and Billing Information 2020.0317 • https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet • Telehealth Frequently Asked Questions (FAQs) Frequently Asked Questions: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf 2020.0317
CMS Updates – General COVID	• Up-to-date on CMS materials on COVID-19: Virtual Toolkit • Task Force work in response to COVID-19: Coronavirus.gov • Specific to CMS: Current Emergencies Website • Recent CMS Actions: https://www.cms.gov/newsroom/press-releases/cms-news-alert-march-26-2020 • News specific to CMS: https://www.cms.gov/newsroom
COVID Tracker Statistics	• **John Hopkins University** Desktop Version: https://coronavirus.jhu.edu/map.html Mobile Version link is located directly below the bottom of the map.
LA County - SNFs, ALFs, Shelters, etc. with COVID Positive Patient	• **LA County Department of Public Health** running log of all the SNF, ALF, and shelters that have a positive COVID member: http://publichealth.lacounty.gov/media/Coronavirus/locations.htm
WHO - When and How to Use Masks	• World Health Organization – mask protocol: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks

For questions, please contact qualitymeasures@medpointmanagement.com or 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
X121599

San Diego County
X121735

Imperial County
X125682

****REVISION****

COVID-19 PRIOR AUTHORIZATION END DATES EXTENDED

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding Prior Authorization end dates extended as to the COVID-19 Pandemic.

As part of MHC's effort to stay in front of COVID-19, MHC has made changes to its utilization management process to extend the end date/expiration date for all previously authorized services. This will maximize access to care and remove barriers for timely access to care. These changes are consistent with additional regulatory requirements most recently released to extend prior authorization end dates.

These changes **include** the following:

- Urgent or Elective services previously authorized by MHC with an expiration date between 3/1/20 - 8/31/20 will be extended to 9/1/20.
- Urgent or Elective services newly approved by MHC will now expire no earlier than 9/1/20.

The changes **exclude** the following referral types and the utilization management process will remain the same for:

- Retrospective Reviews
- Inpatient Admissions/Concurrent Reviews
- Nursing/Residential Facilities

For **Telehealth Services**:
Do Telehealth Services require prior authorization?

- For services that normally require authorization, the standard prior authorization requirements apply regardless of whether the services are being provided via telehealth or in-person. Your current authorizations are valid, and you do not need to do anything to change these authorizations.

Please follow your normal authorization processes as required by your participating IPA/medical group. For Molina Direct Network, please refer to our prior authorization list located on our website at:

- www.Molinahealtcare.com
- I'm a Healthcare Professional
- Select State (CA) and line of business
- Forms
- Frequently Used Forms
- Q2 2020 PA Code Matrix

Services provided in an urgent care or emergency department setting do not require authorization.

How do telehealth services apply to behavioral health treatment (BHT) for children with autism or other related conditions?

- "Telehealth" means a mode of delivering healthcare services via information and communication technologies. Telehealth includes both audio-video and simple telephonic communication.
- Providers must use interactive audio, video or data telecommunications systems that permit real-time communication between them and the member. In addition, the equipment must be of quality or resolution to adequately complete all necessary components for the CPT code or HCPCS code billed.
- Molina permits Telehealth for all BHT services for which telehealth is appropriate: supervision (H0046), caregiver training (S5111), social skills groups (H2014), some elements of a functional and diagnostic assessment (H0031 and H0032) and in some instances direct services(H2019).
- Any current Molina provider type can provide telehealth services he/she is approved to render when billed and supervised by a currently appropriate provider. For example, each 15-minute unit of parental training given via telephone without video by a BCBA would be billed as place of service 02; procedure code S5111-HO (no 95 modifier).
- Face-to-face is almost always needed for direct service. In certain instances, audio-video may substitute for direct face-to-face service (e.g. high-functioning members with caregivers present in person). Telephonic contact alone may be indicated for limited 'touch base' contacts, but rarely for long term, intensive direct ABA treatment (H2019). When direct service (H2019) is rendered via telehealth, the billing/supervising provider attests that the service provided is appropriate.
- Any currently authorized direct service billed as telehealth will be paid with the understanding that the billing/supervising provider has reviewed such service and determined that the service has been rendered and that the intensity and mode of service is appropriate. Future requests for telehealth must highlight the site of service, the provider type rendering service, and the clinical rationale for both as medically appropriate, all of which will be considered in the authorization review.
- Providers do not need to submit anything additional to Molina in order to conduct **currently authorized services** via telehealth. Future requests for services must highlight the site of service, the provider type rendering service, and the clinical rationale for both as medically appropriate.

MHC will continue to communicate any changes to process as these changes become available.

QUESTIONS

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

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Smoking Cessation COVID-19

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding Smoking Cessation Services during the COVID-19 pandemic.

Since smoking increases respiratory infections, members who smoke or vape may be especially vulnerable at this time because the virus that causes COVID-19 attacks the lungs making it a particularly serious threat to their health.

It is more important than ever that we encourage our members (adults, youth and young adults) that smoke, use tobacco products, including e-cigarettes to quit, to protect their health and the health of others who may be exposed to the second-hand smoke.

Molina Healthcare collaborates with the California Smoker's Helpline to offer smoking cessation services in multiple languages (Spanish, Korean, Vietnamese, Cantonese and Mandarin). Providers can refer members directly:

- **Helpline (1-800-NO-BUTTS)**
- **Vaping (1-844-8-NO-VAPE)**
- **OR** via the Web based referral system

You can register for the Helpline's web based referral system at http://www.nobutts.org/referral/register. You will receive immediate confirmation that your referral has been received.

Nicotine Replacement Therapy is covered for all Molina Healthcare members.

To access smoking and vaping cessation resources and education materials please visit the following websites:
CYANOBLINE: www.cyanonline.org/quit-tobacco
No BUTTS: www.nobutts.org
CA QUITS: www.caquits.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.

CONNECT WITH PATIENTS ANYTIME, ANYWHERE

Try CGM Telemedicine Free of Charge for Two Months

HR 6071 (emergency spending bill) passed by Congress in March which includes $500 million for telemedicine services and waives Medicare's geographical restrictions on reimbursement for telehealth during a public health crisis. The Robert Koch Institute recommends minimal contact with individuals to avoid potential contact with those infected.

Telemedicine video consultation allows you to see your patients while protecting yourself and your team.

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- Avoid unnecessary journeys for vulnerable patients
- Reduce workload of doctors and staff

CONTACT OUR TELEMEDICINE EXPERTS:

quest.elvi.us@cgm.com 866.590.8895

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