SEPTEMBER 2020

PROVIDER QUALITY NEWSLETTER

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

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

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

Interpreta Tip – Multiple Year Data

Did you know that Interpreta provides access to data from 2018 and 2019? Just click on your name in the upper right had corner, choose "change plan" and choose the year you would like to see. From there, click on HEDIS and pull the Summary or Member Reports as needed.

For questions or to schedule a training, contact us at **qualitymeasures@medpointmanagement.com**, **(818) 702-0100, ext. 1353** or contact your HEDIS/Stars Specialist.

Spotlight on HEDIS

Two NEW HEDIS Measure Guides!

Please review and share the attached 1-page Guides with your providers and staff:

- **COA – Care for Older Adults**
- **W30 & WCV – Well Child Visits**

W30 and CIS10 go together!

When Providers see babies for their CIS-10 (Childhood Immunization Status) shots, it is important to make sure that the components of the W30 (Well Child Visits in the first 30 months) visit are also documented in the chart to receive credit for this often-missed measure. Every one of the 6 visits need to include complete documentation of the health history, physical and mental development, physical exam and health education/anticipatory guidance.

Also, please alert your Providers and staff that the WCV (Well Child Visit) measure now requires yearly visits for ages 3 to 21 years. Providers must submit encounters with the same codes as they did for W34 (Well Child age 3-6) and AWC (Adolescent Well Care) and use the correct age-specific CPT codes for ages 7-11. Please see our new Guide on the W30 and WCV measures!

Care for Older Adults (COA)

If you have members who are in a Special Needs Plan (SNP) or are Medi-Medi, the COA measure needs to be on your radar. This measure is for age 66 and older and requires CPT II coding for medication review, functional status assessment and pain assessment.

The measure can be completed at any in-person or telehealth visit and is most commonly done during the senior Annual Wellness Exam (AWE). Please ensure all services provided during an AWE are coded and submitted via an encounter and sent to MedPOINT for processing. The results will be updated in Interpreta and reflected in your HEDIS performance for measures covered during the AWE visit. The new Guide provides details regarding the COA measure

Priority Measures during COVID

Preventive and chronic care measures are the priority for 2020. This includes immunization measures (CIS and IMA) and the comprehensive diabetes care measures (CDC A1c, Eye Exam and Nephropathy). Multi-year measures such as, BCS and CCS are equally important as they impact future year performance

Supplemental Data Season is Here

Please review the attached **NEW Interpreta Supplemental Data Guide** and share it with your staff who will be working on supplemental data.

Encounters are always the best way to send HEDIS data; however, there are circumstances where only medical records or data extractions will make the members compliant. **There are two ways to submit supplemental data:**

1. **Interpreta Supplemental Data Portal** – upload medical records one by one.
2. **Excel Templates for Medical or Lab** – data extractions from your EHR in bulk, such as BMI or blood pressure.
   - **Type 1 – Standard Data** – EHR extract that require no corrections, additions of data or codes. No medical records are initially required to be sent.
   - **Type 2 – Non-Standard Data** – data has been manually altered. Medical records are required to be submitted with the file.

The most common data submitted as supplemental data include:

1. **BCS and CCS** - Exclusions for total hysterectomy and bilateral mastectomy or member reported screenings that are noted on medical records that include date (or year), where it was done and result.
2. **Child and Adolescent visits** (AWC, W34, W15 and WCC) - where age-specific CPT codes and codes for child BMI percentile, counseling for nutrition and physical activity were missed.
3. **CIS and IMA** – immunizations that are noncompliant in Interpreta.
4. **Point-of-Care Labs** – A1c, Microalbumin, FOBT, with results.
5. **COA** – where one component was coded, and others were not.
6. **Eye Exams** – Negative for retinopathy in 2019 (3072F).
7. **MRP** – medications were reconciled and not coded.
8. **Blood Pressure** – CPT II codes.
9. **Services completed at the clinic** under a different insurance coverage or program.

News Updates

1. **AWE Incentive** – LA Care has extended the $350 incentive payment for all submitted and coded AWEs if received by 12/31/20.
2. **DHCS** – Medi-Cal Telehealth & Well Child guidance letter (APL20-004-Revised) is available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-004-Revised.pdf.
3. **Molina** has provided 2 educational PowerPoint decks on the Managed Care Accountability Set (MCAS for Medi-Cal 2021-22: **(1)** Telehealth & HEDIS Update with codes (47 pages) and **(2)** Priority Measures with changes (22 pages). Please contact us if you would like them sent to you.
4. **Anthem** – Anthem is offering **free** pop-up **flu shot clinics** for anyone, not just Anthem members. See details here: https://blog-ca.anthem.com/low-income-health-care/no-cost-flu-shots.

Resources Attached

1. **LA Care** – Patient Satisfaction Training Series with SullivanLuallin – SIGN UP today!
2. **LA Care** – new HEDIS Telehealth Guide for 2020 MY
3. **Anthem** – Medi-Cal COVID-19 Telehealth Billing Guide
4. **CMS HHS** (Dept. of Health and Human Services) – Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs – updated 8/3/20
5. **Health Net** – Disaster Preparedness
6. **Health Net** – Sleep Apnea Screening

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

Creating a Positive Patient Experience

L.A. Care Health Plan
For All of L.A.

Online Training Series

SullivanLuallin Group

L.A. Care Health Plan is offering a customer service training program provided by SullivanLuallin Group as part of the Plan's commitment to improve member experience.

Training will include sessions for providers, managers, and staff to establish a culture of patient-centered care and exceptional service, motivating team members to go the "extra step." Effective techniques and toolkits will be shared in order to manage for the care experience.

For Providers	
CLEAR Strategies for a Great Care Experience (highly recommended overview course) October 6th 5:00 p.m. – 7:00 p.m. OR October 16th 11:30 a.m. – 1:30 p.m.	Win-Win Negotiation of Challenging Patient Expectations October 20th 5:00 p.m. – 6:00 p.m. OR October 30th 11:30 a.m. – 12:30 p.m.
Motivating Patients Towards Positive Health Behaviors November 5th 11:30 a.m. – 12:30 p.m.	Maximizing Video and Telephone Visit Effectiveness November 10th 5:00 p.m. – 6:00 p.m. OR November 19th 11:30 a.m. – 12:30 p.m.
Managing an Efficient and Effective Patient Encounter December 2nd 11:30 a.m. – 12:30 p.m.	How to Succeed with Challenging Situations with Patients December 11th 11:30 a.m. – 12:30 p.m. OR December 15th 5:00 p.m. – 6:00 p.m.

For some sessions, multiple timeslots will be available to accommodate different schedules.

For Managers and Staff
Managing for Telephone Service Excellence During COVID-19 October 21th 11:30 a.m. – 12:30 p.m. OR November 12th 11:30 a.m. – 12:30 p.m.
Handling Patient Complaints with HEART December 3rd 11:30 a.m. – 12:30 p.m. OR December 17th 11:30 a.m. – 12:30 p.m.

Register here or at www.lacare.org/QI-webinars

Questions? Email quality@lacare.org

Trainings Offered

Provider Topics:

1. CLEAR Strategies for a Great Care Experience – The foundational program that explains effective and efficient clinician patient communication using the CLEAR model: Connect, Listen, Empathize, Ask, Reconnect, a highly successful model for supporting clinicians in enhancing patient and clinician satisfaction. The concepts and strategies in this program make this our most popular single program to help improve the care experience. In addition, this program provides the foundation upon which our other programs are built.
2. Win-Win Negotiation of Challenging Patient Expectations – Clinicians are often presented with requests by patients for medication, referral, procedures, time off work, that are not aligned with standard medical practice. This program provides a successful approach to aligning patient expectations with clinician expectations, in aiming for a win-win encounter. At the same time, it teaches the role of saying "no" and setting boundaries that support clinician integrity.
3. Motivating Patients Towards Positive Health Behaviors – Clinicians are seldom taught how to motivate patients to change to healthy behavior, even though, it is an important aspect of every patient encounter. Based on the concepts of "Motivational Interviewing", this program provides proven steps to motivate patients using a "coaching" rather than "directing" style.
4. Maximizing Telephone and Video Visit Effectiveness – As a result of the COVID-19 pandemic, telephone and video visits are becoming a significant part of clinician practice. Although many of the care experience skills used during an in person visit still apply, telehealth visits require additional skills to result in positive outcomes. This program highlights those communication skills.

5. Managing an Efficient and Effective Patient Encounter – This program provides a framework for a medical encounter that facilitates an efficient and effective visit. It includes many time saving tips from preparing for the visit, through to the visit end, including skills that favorably impress the patient with the time the clinician spends with them.
6. How to Succeed with Challenging Situations with Patients – This program provides a "how to" to deal with challenging clinician-patient interpersonal situations that often disrupt the effectiveness of the clinician. Included in this program are many challenging situations such as patient anger, late patients, drug seeking patients, patients with a "laundry list" of complaints, patients who are disrespectful to staff and clinician. The program stresses an empathetic approach to the patient in these situations joined with cautious limit setting.

Manager and Staff Topics:

1. Managing for Telephone Service Excellence During COVID-19 – In this session managers will learn how to coach and motivate staff to understand the importance of proper telephone etiquette and how to use the CLEAR protocol for telephone communication. Basic tools to help manage and engage teams without overtaxing busy schedules will be provided.
2. Handling Patient Complains with HEART – Managers and staff members can expect to:
    - **ADOPT** powerful strategies that result in employees who are fully engaged, proud of the organization, and passionate about the work they do for patients.
    - **LEARN** how to manage for the C.L.E.A.R. and H.E.A.R.T. service "protocols "taught in the staff workshop to ensure consistent, outstanding service in every department.
    - **GAIN** proven techniques for rewarding top-performers and coaching low-performers.
    - **APPLY** useful, practical tools for monitoring staff member performance between surveys.
    - **CREATE** a useful Action Plan for reaching goals and ensuring team success.

FAQs

Who should attend these trainings?
Anyone with patient interaction will find relevant content in this series! The sessions are designed for specific audiences like providers and managers, but are open to all.

Some sessions have multiple dates – should I attend both?
Some sessions will be offered more than once to accommodate different schedules – you only need to attend one session per topic.

Do I have to attend each topic?
You are free to attend as many sessions that are interesting to you. There is no required attendance, however we strongly encourage providers to attend one of the "CLEAR Strategies for a Great Care Experience" sessions as an introduction to the series.

Why should I attend these sessions?
With an industry-wide shift toward clinical excellence and value-based payment, patient satisfaction is more important than ever. If you're wondering how to improve your patient survey results while empowering and motivating your patients, this training series is for you.

I can't make the scheduled sessions. Will more trainings be scheduled?
We hope to offer additional trainings in 2021, based upon the success of this series.

Meet the Consulting Team

Andrew Golden, M.D.

A leader in the field of physician-patient communication, Dr. Golden has dedicated much of his extensive career to educating physicians on how to make the most of their interactions with patients. Dr. Golden is a graduate of the University of Rochester School of Medicine where he completed his M.D. and a residency in family medicine. Dr. Golden joined Kaiser Permanente (KP) in 1978 where he worked until his retirement in 2015. During his time at KP, Dr. Golden served in many senior roles including Education Chairman, Chief of Family Practice and Director of Service Quality. Over the last 15 years, Dr. Golden has been responsible for developing curriculum and delivering communication skills training to thousands of KP physicians in southern California which has resulted in outstanding year-on-year communication performance scores.

Thomas P. Jeffrey

Tom currently serves as President of SLG and has been part of the organization for over a decade. Tom presently oversees all sales and marketing aspects of SLG's survey and assessment resources. These include patient, insider and referring physician satisfaction surveys, peer-to-peer surveys, client satisfaction surveys, and mystery patient shopping.

Prior to assuming the role of President, Tom served as Director of the Survey Division. In this role Tom also worked closely with the information technology division to design SLG's powerful data collection and reporting tools. During the past decade Tom has become a trusted advisor to many of SLG's largest clients through his successful implementation of patient measurement programs leading to operational transformation. Tom has an undergraduate degree in economics and a master's degree in public health. Tom honorably served four years in the United States Army, 101st Airborne Division.

Care for Older Adults – COA
2020-21 Coding and Documentation Guide

Eligible:

- The percentage of adults 66 years and older who had each of the following during the measurement year:
  - Functional status assessment.
  - Medication review.
  - Pain assessment.
- For members in a Medicare SNP (Special Needs Plan) and MMP (Medicare-Medicaid Plans).
- Components can be completed at any visit and telehealth can be used (see below).
- Annual Wellness Exam (AWE) visits are the most common and best way to complete this measure. Make sure the AWE forms are completed correctly and include the COA CPT II codes.
- Document all 3 components every year.
- Exclude services provided in an acute inpatient setting.

Component	CPT II Coding	Medical Record

Functional Status Assessment	**1170F**
	Functional status assessed.
		• Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.
		• Notations for a complete functional status assessment must include **one** of the following:
		  ○ Notation that Activities of Daily Living (ADL) were assessed or at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
		  ○ Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
		  ○ Result of assessment using a standardized functional status assessment tool (see Tech Specs for compliant tools). Note that nurses and trained medical assistants can complete standardized assessment tools under the general supervision of the provider.
		• Telehealth: Functional status may be conducted over the phone by any care provider type including registered nurses and medical assistants.

Medication Review ***Tip:*** *If performing discharge reconciliation (1111F), also code for COA Med Review (1159F and 1160F).*	**1159F** Medication list documented in the medical record. **and** **1160F** Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record.	• Medical record must include both current medication list in 2020 and notation of medication review in 2020. • The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies. • Evidence of a medication review and the date when it was performed ***or*** notation that the member is not taking any medication in 2020 and the date when it was noted must be present. • Review can be conducted by prescribing practitioner or clinical pharmacist. • Telehealth: A registered nurse can collect the list of current medications from the member during a call, but there must be evidence that the prescribing clinician or clinical pharmacist reviewed the list. An electronic signature with credentials on the medication list is evidence the medications were reviewed.
Pain Assessment	**1125F** Pain Present. **or** **1126F** Pain not present.	• Progress notes – notation of a pain assessment (which may include positive or negative findings for pain) and date when it was performed. • Result of assessment using a standardized pain assessment tool . • Numeric rating scales (verbal or written) 0-10 is most common. • Telehealth: A pain assessment may be conducted over the phone by any care provider type including registered nurses and medical assistants.
Telehealth	Use POS (Place of Service) code **02** with modifier **95** (audiovisual visit).	• If a practitioner or other health plan staff contacts a member by phone to just gather information for HEDIS® data collection, a service isn't being rendered and will not meet criteria. • For common ICD-10 and CPT codes, see https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

2020-21 HEDIS Measures Review Guide

Well Child Visits in First 30 Months (W30)
Child and Adolescent Well-Care Visits (WCV)

Eligible:

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

Coding is Critical:

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

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

QualityMeasures@medpointmanagement.com / 818-702-0100, x1353

INTERPRETA SUPPLEMENTAL DATA PORTAL REFERENCE GUIDE 2020

MedPOINT MANAGEMENT
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Quality Management
qualitymeasures@medpointmanagement.com
818-702-0100, ext. 1353

Revised 08-26-2020

Introduction - Interpreta Supplemental Data Process

Supplemental data is important to capture medical records and data that cannot be submitted through the regular encounter process. This guide will help you navigate the **Interpreta Supplemental Data portal** at https://portal.interpreta.com.

The process to enter data one member at a time is easy and intuitive and medical records can be uploaded. This system will give you a running record of the data you have entered.

Once you hit submit, the record will be in pending status and then reviewed by our quality staff. It will then be approved or rejected. You can correct rejected records and submit them again. Rejected records will have comments stating why they were returned. Please be sure to **check for rejected records** so you can correct them and resubmit.

Before entering a record, please check that the measure is non-compliant. Do not enter data if Interpreta shows the measure is compliant. The supplemental data portal provides a list of due/overdue or compliant measures on the right side of the screen.

Please follow the steps in this guide and let us know if you have any questions.

Thank you for all the work you do to enter supplemental data to improve your HEDIS scores.

TRAINING
If you would like a **training**, please contact
qualitymeasures@medpointmanagement.com
or call 818-702-0100, x1353.

NEW USER
To request access for a **new user**, please fill out the Interpreta User Request Form located here: Interpreta - User Request Form (https://app.smartsheet.com/b/form/0adb2ae54f7147508030909fbedd1621).

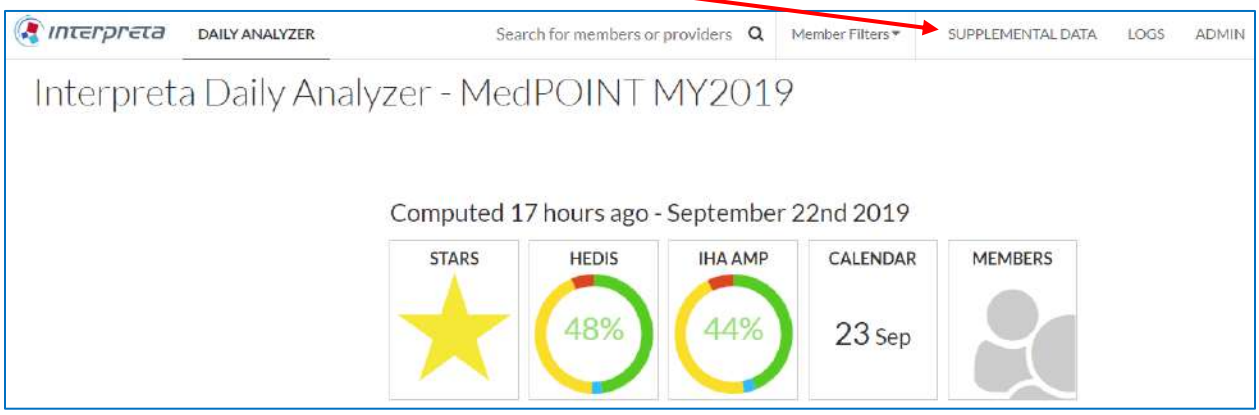
An email will be sent to the user by Interpreta and the password must be set up within 24 hours. If the email is not received, please check the spam folder.

Within this document you will find common codes used for specific measures.
Please refer to HEDIS 2020 & 2021 Volume 2 Technical specifications for Health Plans and NCQA's HEDIS 2020 Value Set Directory for a complete list of codes.

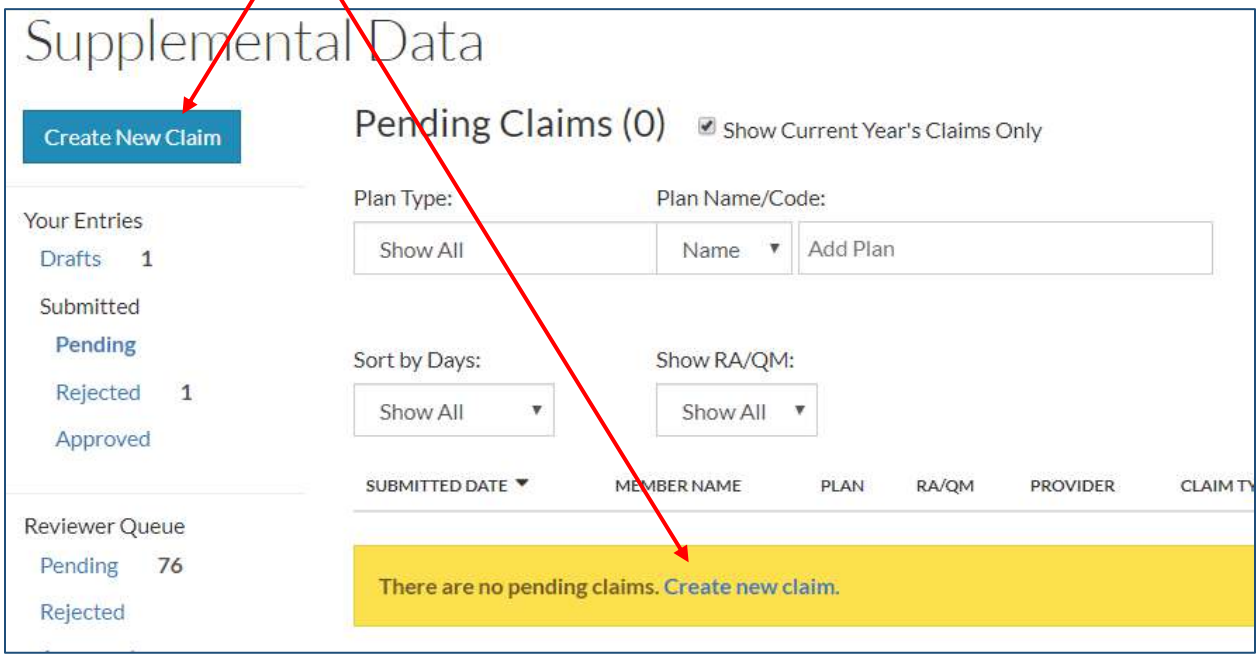
TABLE OF CONTENTS

1: Starting a Record

- Click “Supplemental Data.”



- Start a New Claim - There are two choices to start a new claim. Both will get you to the same screen.



2: Entering Member Information

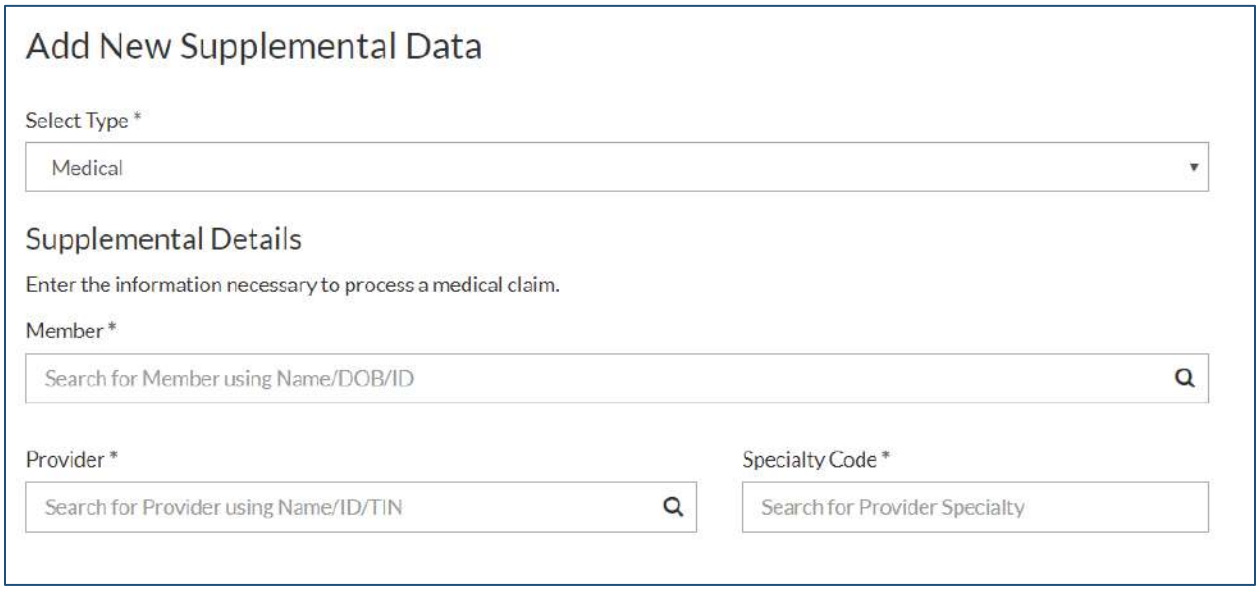
- Select Type – Select the type of record. Medical is for all medical records except lab records. Lab is for records from Quest or point-of-care services (cytology, HbA1c, nephropathy). Pharmacy/Rx is inactive so do not use this.

- Member - Type the member's first and last name or date of birth or ID number, pick the correct member and it will auto populate. The provider information will also auto populate.
  - It is recommended you have the Provider's NPI number and Specialty available to make this process more efficient.
  - Verify that the member you searched is the same as the member on the medical record.
  - If the member is due for HEDIS measures, **the open and closed gaps will appear in the right-hand side of the screen.**

- Provider – Provider will be auto populated as the default. Please **do not** change this field.

- Type the specialty, i.e. family practice, internal medicine, etc. The system will auto populate the specialty name, along with the code. Common Specialty Codes include:

01 - General Practice	43 - Certified Registered Nurse Practitioner
08 - Family Practice	42 - Certified Nurse Midwife
11 - Internal Medicine	41 - Optometry
37 - Pediatric Medicine	18 - Ophthalmology
30 - Diagnostic Radiology	69 - Clinical Laboratory
50 - Nurse Practitioner	10 - Gastroenterology



3: Date and Place of Service Information

1. **Quality Measures** - Under Provider name, you will see: "Use Supplemental Data details to close gaps related to." Click on the circle by "**Quality Measures**" or you will not be able to proceed to Service Line 1. (The "Risk Adjustment" choice is inactive.)

2. **Date of Service** - Use the calendar icon or type in the Date of Service (DOS).
   - The minimum to report is the Month and Year. If Month and Year are reported, the last day of the month will be used as the DOS.
   - Example with month/year - Patient reported procedure took place on 06/2020. The DOS on Supplemental Data would be 06/30/2020
   - Example with just year - If a patient reports they had a procedure done last year and does not remember when (pap smear, for example), use the last day of the year as the DOS for Supplemental Data, which would be 12/31/2019.

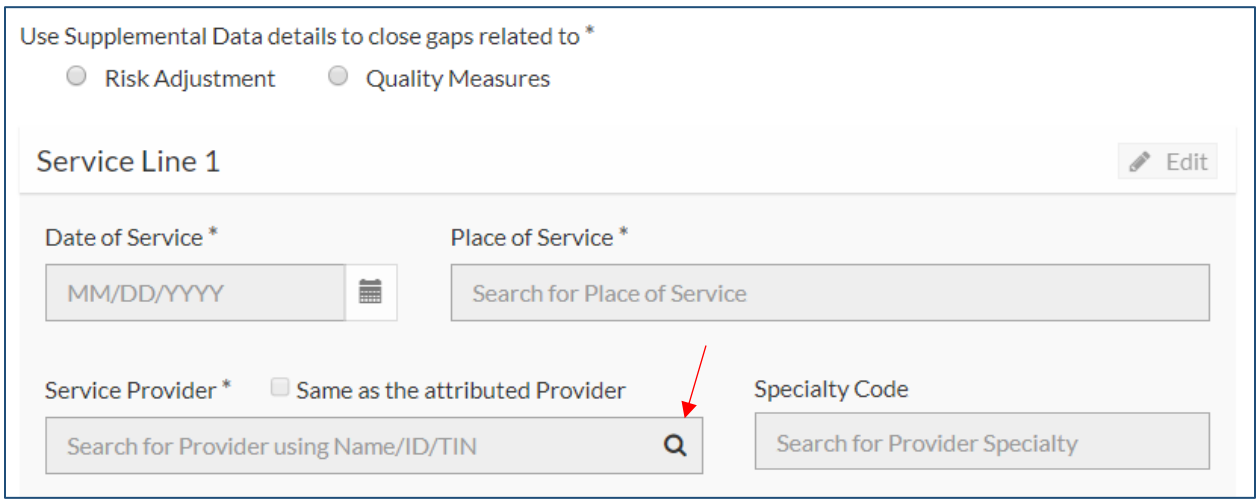
3. **Place of Service** – "Office" or "11" is used when the service was done at the office. Type "Lab" or "Optometrist," etc. for other locations. Type a word for the place of service and it will come up. Common codes include:

   02 – Telehealth
   11 - Office – used for most office visits including Radiology Center's visits
   81 - Independent Laboratory – for stand alone Labs such as Quest/LabCorp
   20 - Urgent Care Facility
   21 – Inpatient Hospital
   15 – Mobile Unit (mammogram)
   50 - Federally Qualified Health Center

4. **Service Provider** – If the provider is the same as the member's PCP, just click the little box that says, "**Same as the attributed Provider**" (located right above the Search box) and the Service Provider and Specialty Code information will auto populate.

   If the provider was other than the PCP, you can search by Provider NPI, Provider TIN or last name and first name with 'space' or a comma (for example: Cooper,Lee or Cooper Lee) and choose the correct provider. The specialty of the provider will come up automatically.

   NOTE: If the Service Provider name does not appear, click the magnifying glass icon to the right of the box. If it still does not appear, please call us for further instructions.



4: Coding for Other Measures - Summary

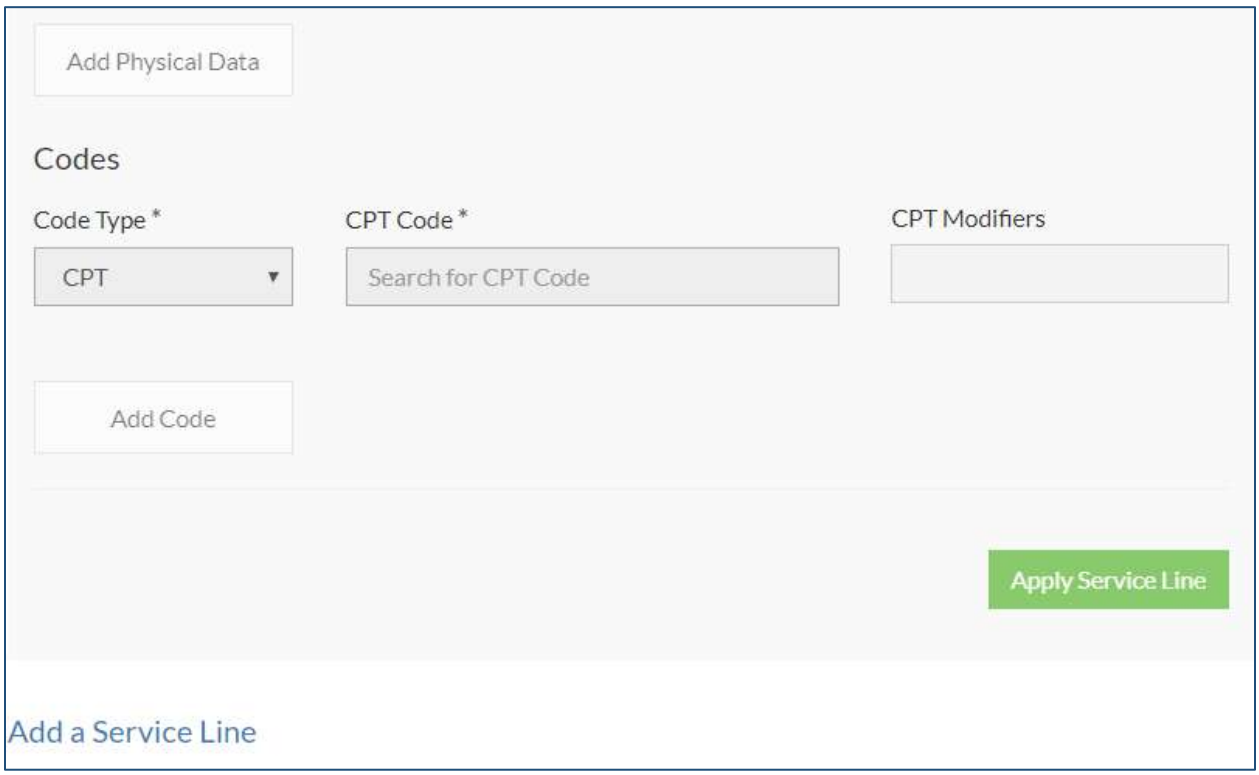
- Refer to "Coding for Other Measures" on page 12 for the most common codes.
- "Code Type" - Choose type of code you will enter first – CPT, HCPCS or ICD9/10.
- Enter code or name of test to see list of code options.
- Modifiers – Add modifiers if applicable.
- "Add Code" – Click this box if you would like to enter another HCPCS or ICD9/10 code. If you click it by accident and do not want to enter another code, click the X on the right side to get out of it.

  NOTE: Interpreta will only allow one CPT code per Service Line at this time. This means that if you have another CPT or CPT II code you want to add, you click "Add a Service Line," re-enter the date of service, place of service and provider information and then add the code. Example: HbA1c test is 83036, add a service line to add CPT II code 3045F.

  Please do not enter CPT or ICD-10 codes as a modifier. The record will be rejected.

  Once you click "Add a Service Line," you can make changes to what you just entered by clicking the "Edit" box on the upper right side.

- "Apply Service Line" – Click this box to apply the code(s) to your record. You will be moved down to the "Additional Supporting Documents" section.

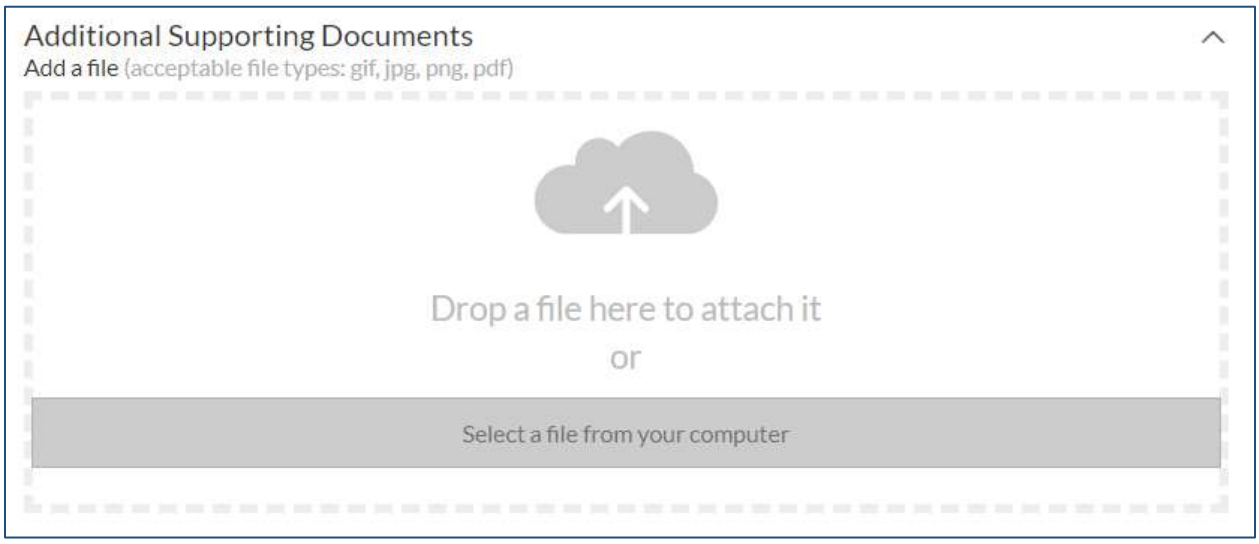


Add a Service Line

5: Uploading Records

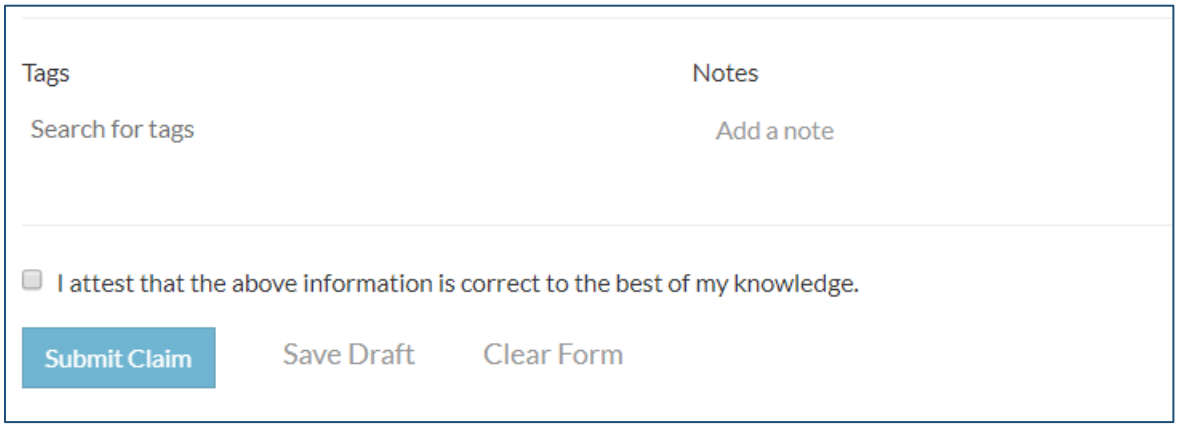
- Additional Supporting Documents – Click within the dotted line to bring up your file menu to attach the medical records. Files accepted include gif, jpg, png and pdf. This is a required field and every claim entered must have medical records supporting the data elements entered in to Interpreta.

  Please see guidance on page 9 of this Guide for details required for medical records.



8: Submitting Data

- Tags – This section is inactive.
- Notes – Add any notes you wish before submitting.
- Attest – Click the box that says, "I attest that the above information ins correct to the best of my knowledge." You cannot proceed without clicking this box.
- Submit – Click the blue "Submit Claim" box. You can also "Save Draft" or "Clear Form."



6: Medical Record Documentation Requirements

- Medical record must be accurate and legible to pass audit as follows:
  - Member's name and date of birth is clearly identified on all pages of progress note.
  - Provider is clearly identified on the progress note and include name, signature and credentials.

- If any of the information received is not correct, missing, or illegible, the claim will be rejected.

- If you made a mistake such as the following, it will be rejected with a note and put in Pending for the submitter to correct and resubmit.
  - Incorrect date of services entered.
  - Member name does not match medical record received.
  - Date of birth does not match medical record received.
  - Medical record does not meet NQCA measure requirements.

- Patient reported results:
  When a patient has had a test in the past and a note is put in the medical record, the result must be present in order to be compliant for HEDIS. For example, if the patient says they had an eye exam, the result of normal or other outcome should be documented in the chart.

10: Coding for Specific Measures

Within this document, you will find the most common codes used for specific measures. Please refer to HEDIS 2020 Volume 2 Technical specifications for Health Plans and the NCQA's HEDIS 2020 Value Set Directory for a complete list of codes.

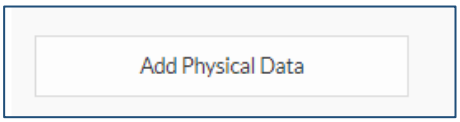
1. Blood Pressure (CBP and CDC BP Control)

Blood pressure data counts for for two HEDIS Measures:

1. Controlling Blood Pressure (CBP) - for members with hypertension.
2. Comprehensive Diabetes Care (CDC) - Blood Pressure Control <140/90 for diabetics.

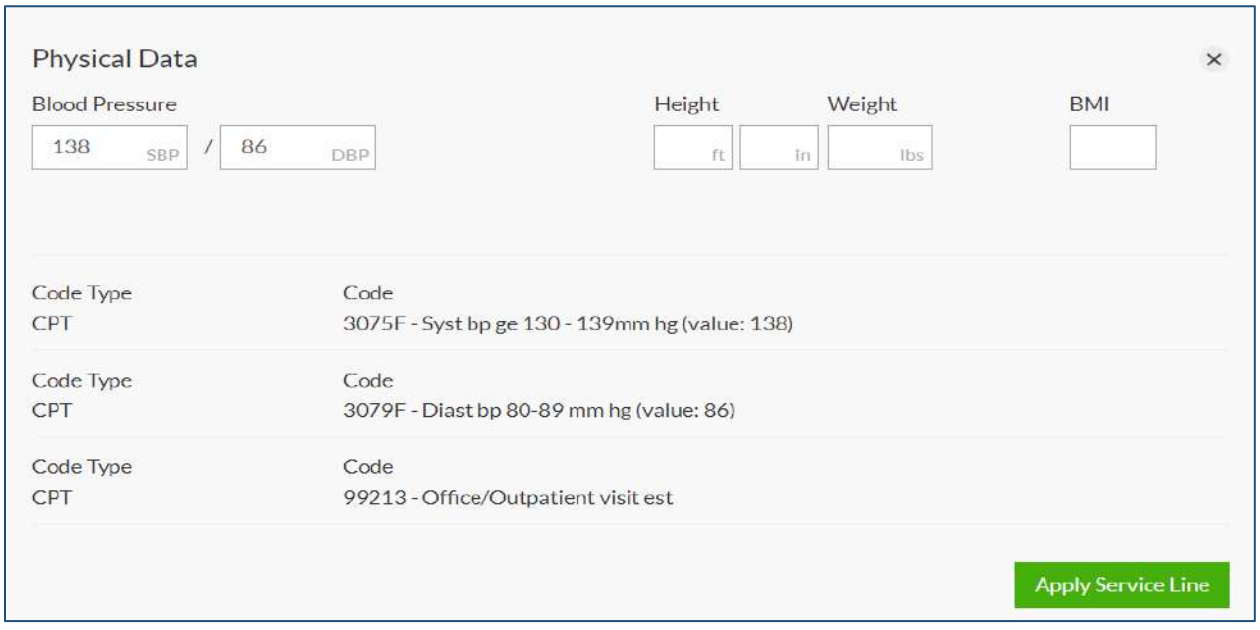
NOTE: Only enter compliant blood pressures <140/90.
All other noncompliant entries will be rejected.

Click "Add Physical Data"
For Blood Pressure and BMI data only.



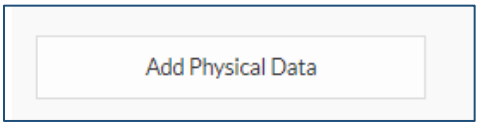
- Blood Pressure systolic and diastolic values must be added when uploading records for this service.
- Codes are automatically populated for the office visit and the CPT II blood pressure range codes as shown below.

- "Apply Service Line" – Click this box to apply the code(s) to your record.



2. BMI (ABA) - Adults

- Click “Add Physical Data”

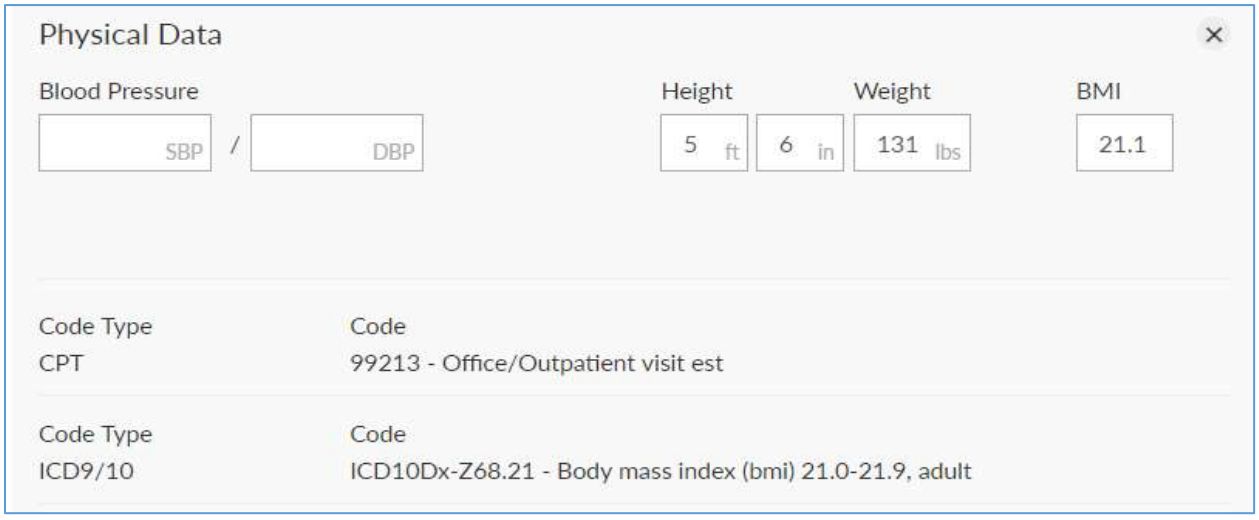


- Enter height in feet and inches, and the weight.
- Enter the BMI value noted in the record.
- The CPT code for the office visit and BMI ICD-10 Z code are applied automatically.
- “Apply Service Line” – Click this box to apply the codes to your record.

IMPORTANT:

- The height, weight and BMI value (or percentile) must be on the chart note before entering into Interpreta. If they are not in the chart, the record should not be submitted. Calculation of the BMI value is not allowed to be entered into Interpreta if it is not in the record.

Codes are automatically populated for the office visit and BMI as shown below.



3. BMI – Children (WCC)

- The age of the member will determine that the BMI percentile is needed for children up to age 19.
- Choose the correct BMI percentile that is noted in the medical record by clicking the down arrow in the "BMI Percentile" box.
- Make sure the BMI percentile is legibly shown on the medical record or the record will be rejected.
- The office CPT code and BMI percentile ICD-10 code are applied automatically.
- "Apply Service Line" – Click this box to apply the codes to your record.

4. Breast Cancer Screening (BCS) (Medical)

Codes:

- 77067 - Scr mammo bi incl cad
- 77066 - Dx mammo incl cad bi
- 77065 - Dx mammo incl cad uni
- 77062 - Breast tomosynthesis bi

Exclusions codes for Breast Cancer screening follows:

- ICD10Dx-Z90.11 - Acquired absence of right breast and nipple
- ICD10Dx-Z90.12 - Acquired absence of left breast and nipple
- ICD10Dx-Z90.13 - Acquired absence of bilateral breasts and nipples

5. Cervical Cancer Screening (CCS) (Lab)

- Use the Lab Layout.
- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.
- For "Ordering Provider," enter rendering provider, i.e. Quest, LabCorp, ABC Labs.
- For Point-of-Care lab, put facility name or FQHC name.
- IMPORTANT – The Date of Service on the Lab Layout should be the "Results date," "Reported date" or the latest date on the Lab Report.
- In the Service Line area, under "Place of Service," put 81 (Independent Laboratory).

Most Common Coding:

- If the record has PAP (cytology) results only, please code **88142** (good for 3 years).
- If both PAP and HPV have results for women who were age 30 and above on the date of service, please code **87624** (HPV high-risk types) with LOINC code **18500-9** (Thin Prep Cvx) (good for 5 years).

  Other codes that are compliant include:
  - 88141 - Cytopath c/v interpret - enter result for pap
  - 18500-9 - Thin Prep Cvx.
  - 87625 - HPV types 16 & 18 only.- enter result for HPV result
  - 21440-3 – HPV I/H Risk DNA CVX QI Probe.

EXCLUSION CODES:

- Z90.710 - Acquired absence of both cervix and uterus
- Q51.5 - Agenesis and aplasia of cervix

- Medical record must indicate any of the following to be excluded from the measure:
  - Total Abdominal Hysterectomy
  - "TAH"
  - Complete Hysterectomy
  - "NO Cervix"
  - Notation of just "Hysterectomy" does not meet criteria
  - For Date of Service, please see Date and Place of Service Information on page 7.

6. Colorectal Cancer screening (COL) (Lab)

- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.

- **82274** - Occult blood feces. "FOBT kit"
- 44388 - Colonoscopy
- **45378** - Diagnostic colonoscopy
- 45330 - Diagnostic sigmoidoscopy
- 74263 - CT Colonography
- G0464 - FIT-DNA

EXCLUSION: 44150 - Removal of colon

Note: "Place of Service" for point-of-care by a **FQHC** is **50** (Federally Qualified Health Center), then check "same as the attributed Provider" box.
For **outside lab**, enter **81** (Independent Laboratory) and name of lab.

7. Comprehensive Diabetes Care (CDC) - Eye Exam (Medical)

Medical records must be from an Ophthalmologist or Optometrist.
If record is from EyePACS or other vendor, please use date photos were taken.

For eye exams done in the **current year**, enter one of the following CPT II codes:

- 2022F - Dil retina exam interp rev – with retinopathy
- 2023F - Dil retina exam interp rev – without retinopathy
- 2024F - 7 field photo interp doc rev – with retinopathy
- 2025F - 7 field photo interp doc rev – without retinopathy
- 2026F - Eye image valid to dx rev (EyePACS) – with retinopathy
- 2033F - Eye image valid to dx rev (EyePACS) – without retinopathy
- S0625 - Digital screening retina

If reviewing results in the current year for dates of services done in the **previous year** and the note clearly state "No retinopathy" or "NDR" or "negative" or "w/o Retinopathy," you can enter the following CPT code:

- 3072F - Low risk for retinopathy in prior year

For clinics who have an Optometrist or Ophthalmologist **on staff**, use code 92250 and the specialist's NPI number should be used.

Do not submit record if result is "insufficient for any interpretation" or "unable to detect." We are waiting for guidance from NCQA regarding the correct code to use (1-16-20). Eye Exam Guide is available upon request.

8. Comprehensive Diabetes Care (CDC) – Nephropathy (Lab)

- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.

CPT codes:

- 82042 - Assay of urine albumin
- 81000 - Urinalysis nonauto w/scope

Result codes:

- 3061F - Negative microalbuminuria test result
- 3060F - Positive microalbuminuria test result

9. Comprehensive Diabetes Care (CDC) - Hba1c (Lab)

- Use the Lab template.
- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.
- To enter the HbA1c:
  1) Enter the result CPT II code.
     - 3044F - Hemoglobin A1c level < 7.0%.
     - 3051F - Hemoglobin A1c level 7.0 - <8.0%.
     - 3052F - Hemoglobin A1c level 8.0 - <9.0%.
     - 3046F - Hemoglobin A1c level > 9.0.

     Note: 3045F - Hemoglobin A1c level 7.0-9.0% - has been discontinued and is rejected effective 10/1/19.

  2) Enter the CPT A1c Test code.
     - 83036 - Glycosylated hemoglobin test. Use this code if A1c Test in Interpreta is noncompliant.
     - If only A1c Control measures are due and Test is compliant, enter the CPT II code only.
  3) Click on "Add Service Line" to enter second CPT II code and re-enter service information.

Note: If A1c was processed by an **outside laboratory** (i.e. Quest, etc.), enter 81 – Independent Laboratory for "Place of Service" in Service Line 1. Ordering Provider is the name of the lab (Quest, LabCorp, etc.).

If A1c was processed **in-house** by an FQHC, use 50 – Federally Qualified Health Center as the "Place of Service" and then check the "same as the attributed Provider" box.

10. Chlamydia Screening (CHL) (Lab)

- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.
  - 87110 - Chlamydia culture.
  - 87270 - Chlamydia trachomatis ag if.
  - 87490 - Chylmd trach dna dir probe.
  - 87491 - Chylmd trach dna amp probe.

11. Immunization for Adolescents (IMA) (Medical)

Meningococcal Vaccine:

- 90734 - Meningococcal vaccine im

TDAP / TD Vaccine

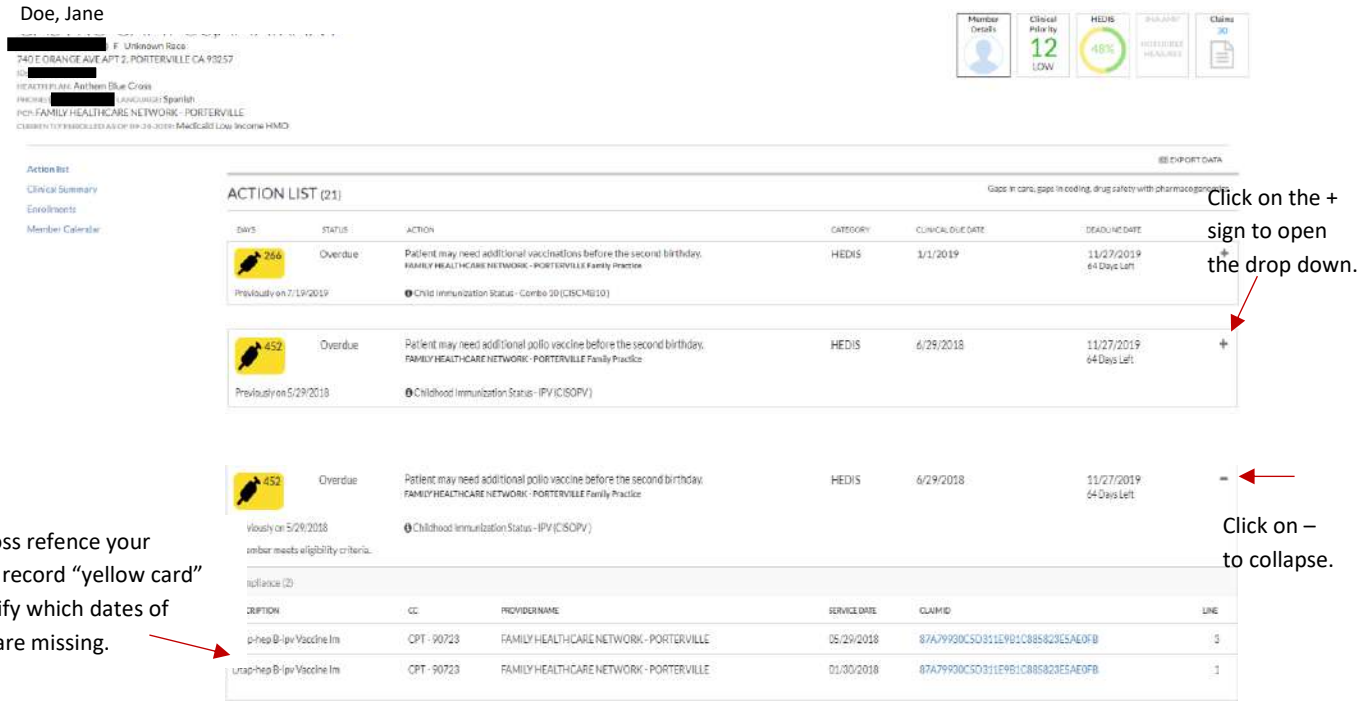
- 90715 - Tdap vaccine 7 yrs or older im

HPV Vaccine:

- 90651 - Human Papilloma Virus Nonavalent HPV 3 Dose IM
- 90650 - HPV vaccine 2 valent im
- 90649 - HPV vaccine 4 valent im

12. Childhood Immunization Status (CIS) - Combo 10 (Medical)

- Combo 10 includes all vaccines for children up to age 2.
- Before entering supplemental data into Interpreta, always first **check the member's dashboard** to identify which vaccines are missing as follows below.
- To be compliant for Combo 10, make sure all vaccines were completed before the child's 2nd birthday.
- Enter all vaccines even if the child missed a few shots and is not compliant.



Childhood Immunization Status (CIS) - continued

- After identifying missing vaccines, enter the supplemental data using the codes on the next page.
- Combo 10 includes the following vaccines:
  - four diphtheria, tetanus and acellular pertussis (DTaP)
  - three polio (IPV)
  - one measles, mumps and rubella (MMR)
  - three haemophilus influenza type B (HiB)
  - three hepatitis B (HepB)
  - one chicken pox (VZV)
  - four pneumococcal conjugate (PCV)
  - one hepatitis A (HepA)
  - two or three rotavirus (RV)
  - two influenza (flu) vaccines.

The most common codes for CIS 10 are as follows:

1) **DTaP:**
   90700 - DTaP vaccine < 7 yrs im (single vaccine)
   90698 - DTaP-ipv/HiB vaccine im (combo vaccine)
   90721 - DTaP/ HiB vaccine im (combo vaccine)

2) **IPV**:
   90713 – Polio virus IPV sc/im (single vaccine)
   90698 - DTaP-IPV/HiB vaccine im (combo vaccine)
   90723 - DTaP-HepB-IPV vaccine im (combo vaccine)

3) **MMR:**
   90707 - MMR vaccine sc live
   90710 - MMRV vaccine sc (combo code MMR and VZV)

4) **VZV:**
   90716 - Var vaccine live subq (VAR)

5) **Pneumococcal Conjugate (PCV):**
   90670 - PCV13 vaccine im
   90732 – PPSV23 pneumococcal polysaccharide vaccine, 23-valent

6) **ROTA:**
   90681 - Rv1 vacc 2 dose live oral – (Rotarix)
   90680 - Rv5 vacc 3 dose live oral – (Rota Teq)

7) **HEP A:**
   90633 - HepA vacc ped/adol 2 dose im

8) **Hep B:**
   90744 - HepB vacc 3 dose ped/adol im
   90723 - DTaP-HepB-IPV vaccine im
   90748 - HiB- HepB vaccine im

9) **HIB:**
   90647 - Hib PRP-OMP vacc 3 dose im
   90648 – Hib PRP-T vaccine 4 dose im
   90698 – DTaP-IPV/Hib vaccine im
   90721 - DTaP /Hib vaccine im
   90748 - HepB vaccine im

10) **INFLUENZA:**
   90655 - IIV3 vacc no prsv 6-35 mo im
   90657 - IIV3 vaccine 6-35 months im
   90661 - ccIIV3 vac im cult prsv free
   90662 - IIV no prsv increased ag im
   90673 - RIV3 vaccine no preserv im
   90685 - IIV4 vacc no prsv 6-35 m im

13. Well Child Visit age 3-6 (W34) (Medical)

Enter two codes – ICD-10 and CPT age specific code.

ICD-10 (age 0-17):

- Z00.121 – Encounter for routine child health examination with abnormal findings
- Z00.129 – Encounter for routine child health examination without abnormal findings

CPT age specific codes:

- 99382 - Init pm e/m **new** patient age 1-4
- 99392 - Prev visit **est** age 1-4 (established)
- 99383 - Prev visit **new** age 5-11
- 99393 - Prev visit **est** age 5-11 (established)

14. Adolescent Well Care (AWC) (Medical)

Enter two codes – ICD-10 and CPT age specific code. This measure is for age 12-21.

ICD-10:

- Z00.121 – Encounter for routine child health examination with abnormal findings (age 0-17)
- Z00.129 – Encounter for routine child health examination without abnormal findings (age 0-17)
- Z00.00 – Encounter for general adult medical examination without abnormal findings (18+)
- Z00.01 – Encounter for general adult medical examination with abnormal findings (18+)

CPT age specific codes:

- 99384 - Prev visit **new** age 12-17
- 99394 - Prev visit **est** age 12-17 (established)
- 99385 - Prev visit **new** age 18-39
- 99395 - Prev visit **est** age 18-39 (established)

15. Weight Assessment and Counseling for Nutriition and Physical Activity for Children/Adolescents (WCC) (Medical)

- This measure is for age 3-17.
- Multiple dates of services or a single date of service can make this measure complaint.
- If submitting multiples dates of service, please be sure to attach all medical records.

WCC - BMI (Body Mass Index)

- **See page 7** for details on entering the BMI for children.
- BMI percentile must be used (not value) for children under age 19.
- The following codes will auto populate based on the percentile chosen.

  - Z68.51 - BMI pediatric, less than 5th percentile for age
  - Z68.52 - BMI pediatric, 5th percentile to less than 85th percentile for age
  - Z68.53 - BMI pediatric, 85th percentile to less than 95th percentile for age
  - Z68.54 - BMI pediatric, greater than or equal to 95th percentile for age

For the following, only one ICD-10 code can be entered at a time.

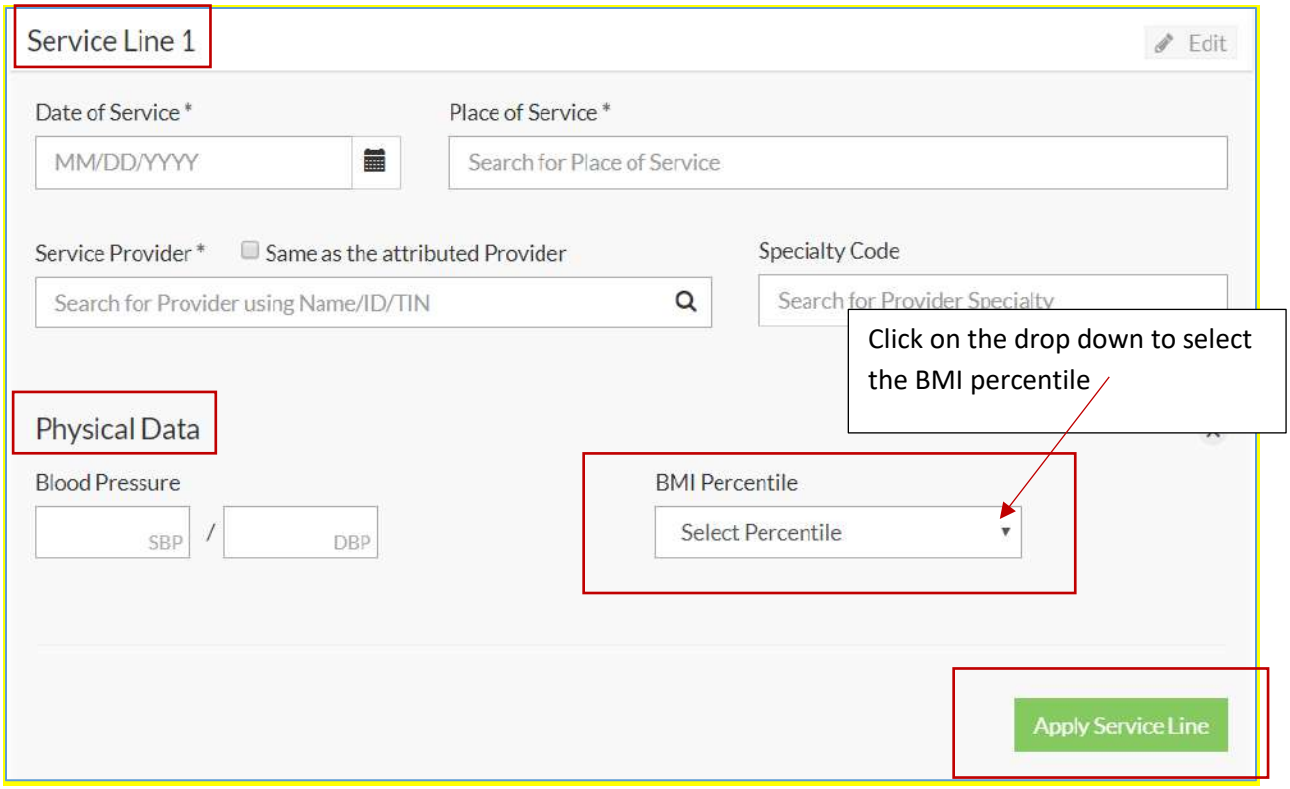
WCC - Nutrition

- Click “Add a Service Line.”.
- Re-enter date of service, place of service and click “Same as the attributed Provider.”
- Change “Code Type” to ICD9/10 and type in code below.
  - **Z71.3** - Dietary counseling and surveillance
- The code will be applied.
- NOTE: You cannot add the physical activity code in the Secondary Diagnosis Code box as it will not be applied correctly.
- Click “Apply Service Line” to apply the data.

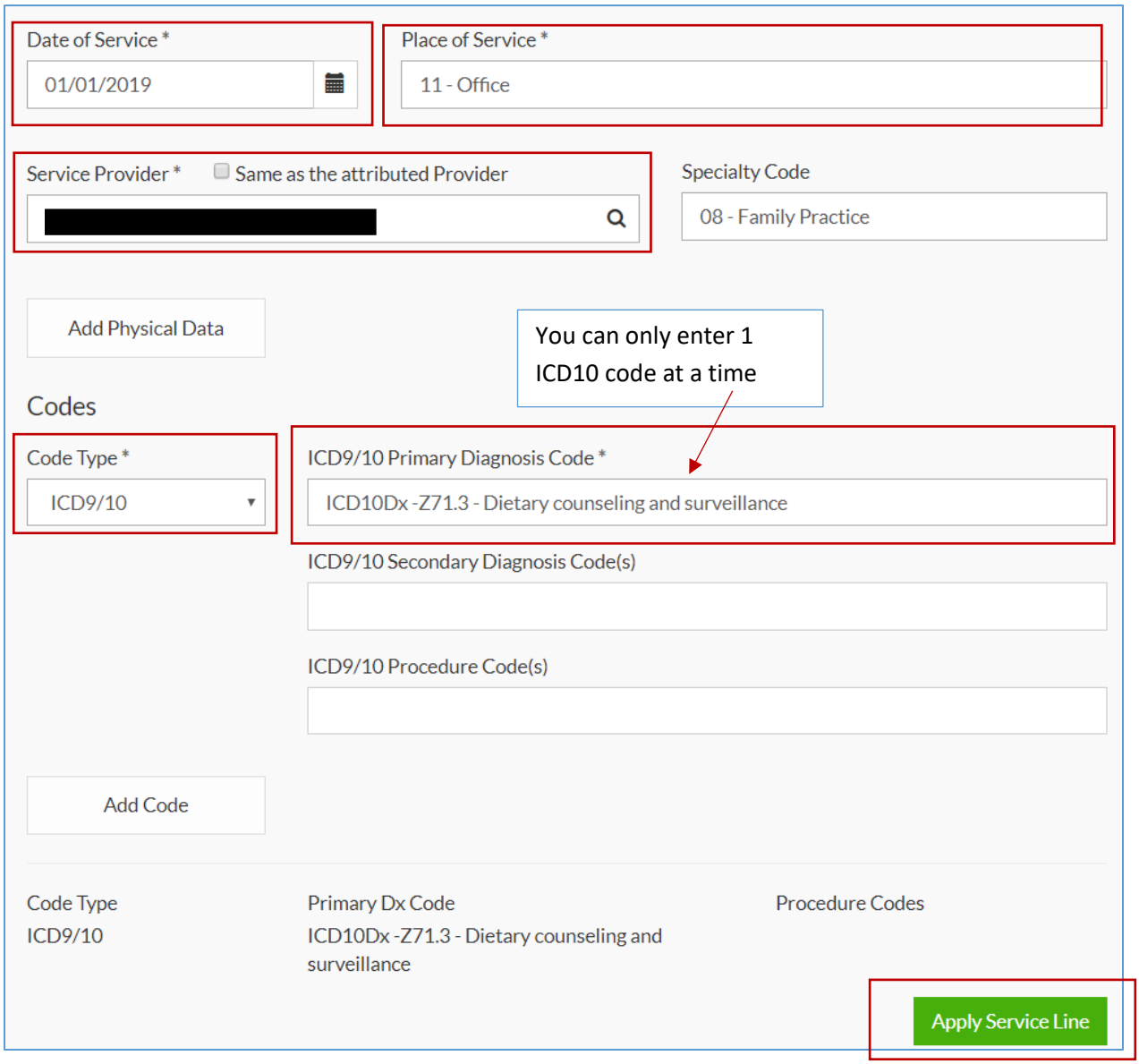
WCC - Physical Activity

- For the final time, click “Add a Service Line.”.
- Re-enter date of service, place of service and click “Same as the attributed Provider.”
- Change “Code Type” to ICD9/10 and type in code that applies below.
  - **Z71.82** - Exercise counseling
  - Z02.5 – Sports Physical
- The code will be applied.
- Click “Apply Service Line” to apply the data.

(15) **WCC - BMI** – Interpreta Sample Record



(15) **WCC – Nutrition and Physical Activity** – Interpreta Sample Record



(15) **WCC – All 3 components** – Interpreta Sample Record

Service Line 1

Date of Service	Place of Service	Provider
01/01/2019	11	BAEZ,ALFONSO M 08 - Family Practice

Code Type	Code
CPT	99213 - Office/Outpatient visit est

Code Type	Code
ICD9/10	ICD10Dx-Z68.52 - Body mass index (bmi) pediatric, 5th percentile to less than 85th percentile for age

Service Line 2 Edit ×

Date of Service	Place of Service	Provider
01/01/2019	11	BAEZ,ALFONSO M 08 - Family Practice

Code Type	Primary Dx Code	Procedure Codes
ICD9/10	ICD10Dx -Z71.3 - Dietary counseling and surveillance	

Service Line 3 Edit ×

Date of Service	Place of Service	Provider
01/01/2018	11	BAEZ,ALFONSO M 08 - Family Practice

Code Type	Primary Dx Code	Procedure Codes
ICD9/10	ICD10Dx -Z71.82 - Exercise counseling	

16. Osteoporosis Management in Women who had a fracture (OMW) (Medical)

- Enter the code that meets the medical records review requirement.
- Radiology Department is the most common Service Provider to use.
- 30-Diagnostic Radiology is the most common Specialty Code to use.
    - 77080 - Dxa bone density axial
    - 76977 - Us bone density measure

17. Medication Reconciliation Post Discharge (MRP) (Medical)

- **1111F** – Discharge medications reconciled with the current medication list in outpatient medical record.

18. Care for Older Adults (COA) (Medical)

- This measure is for age 66 and older.
- Multiple dates of services or a single date of service can make this measure complaint.
- If submitting multiples dates of service, please be sure to attach all medical records.
- This measure requires 5 CPT II codes.
- Each code must be entered separately by clicking "Add a Service Line."

Advanced Care Planning – 1 code required

- 1157F - Advnc care plan in rcrd
- 1158F - Advnc care plan tlk docd
- 99497 - Advncd care plan 30 min

Fuctional Status assessment – 1 code required

- 1170F - Fxnl status assessed

Medication Review – BOTH CODES must be entered and reflected in the record

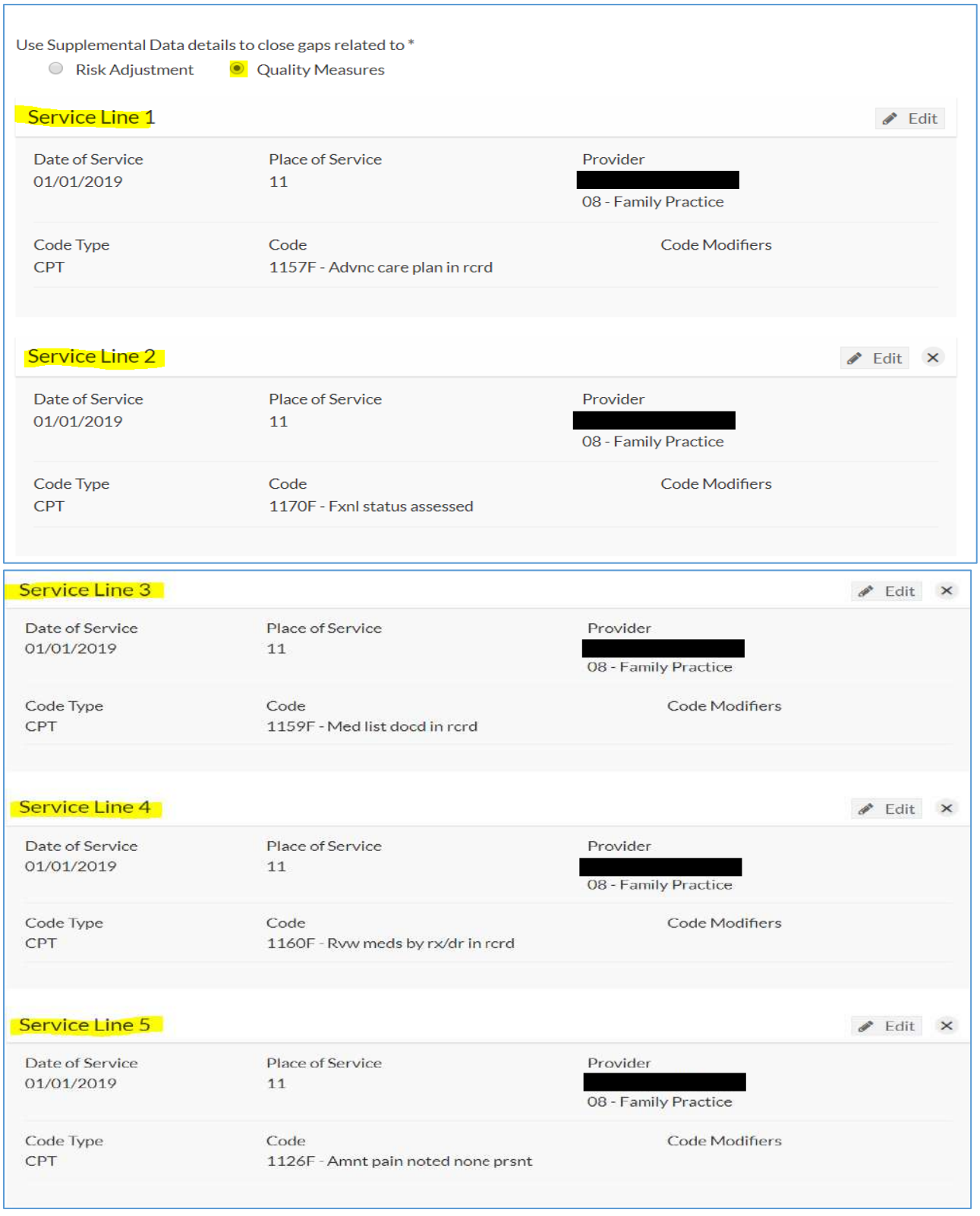
- 1159F - Med list docd in rcrd
- 1160F - Rvw meds by rx/dr in rcrd

Pain assesment – 1 code required

- 1125F - Amnt pain noted pain prsnt
- 1126F - Amnt pain noted none prsnt

(18) **Care for Older Adults** – Interpreta Sample Record

The sample below is what the multiple coding would look like before uploading the medical records.



If you have any questions, please refer to page 1 for our contact information.

19. Well-Child Visits in the First 15 Months of Life (W15) (Medical)

- This measure calls for a minimum of 6 well-child visits that include documentation of the following components:
  1) Health history
  2) Physical developmental history
  3) Mental developmental history
  4) Physical exam
  5) Health education/anticipatory guidance

- Enter each visit in one submission by adding Service Lines for each date of service and attaching all 6 records.

- Enter two codes for each service date – (1) ICD-10 and (2) CPT age specific code.

  ICD-10 (age 0-17):

  Z00.121 – Encounter for routine child health examination with abnormal findings
  Z00.129 – Encounter for routine child health examination without abnormal findings

  CPT age specific codes:

  99381 – age younger than 1 year
  99382 – age 1-4 new patient
  99392 – age 1-4 established patient

Telehealth Guide for

HEDIS® 2020 MY

L.A. Care HEALTH PLAN®

For All of L.A.

LA2972 08/20

Telehealth Guide for **HEDIS® 2020 MY**

Per NCQA, providers can use telehealth services for providing care and services to their members. Telehealth services can be done by: Telephone only visit, e-visits (via email), or virtual check-ins (interactive audio and video).

Providers should use the same codes as the in-person visits and to include the appropriate telehealth codes.

Provider does not need to specify the type of telehealth used in the medical record but should submit correct code for the method used.

HEDIS MEASURES THAT INCLUDE TELEHEALTH SERVICES:

- Follow-up Care for Children Prescribed ADHD Medication (ADD, ADD-E)
- Acute Hospital Utilization (AHU))
- Antidepressant Medication Management (AMM)
- Asthma Medication Ratio (AMR)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Breast Cancer Screening (BCS, BCS-E)
- Care for Older Adults (COA)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)
- Colorectal Cancer Screening (COL)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Emergency Department Utilization (EDU)
- Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
- Follow-up After Hospitalization for Mental Illness (FUH)
- Follow-up After Emergency Department Visit for Mental Illness (FUM)
- Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)
- Hospitalization for Potentially Preventable Complications (HPC)
- Mental Health Utilization (MPT)
- Osteoporosis Management in Women Who Had a Fracture (OMW)
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

- Plan All-Cause Readmissions (PCR)
- Postpartum Depression Screening and Follow-up (PDS-E)
- Prenatal Depression Screening and Follow-up (PND-E)
- Prenatal and Postpartum Care (PPC)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Therapy for Patients with Diabetes (SPD)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)
- Transitions of Care (TRC)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

NEW MEASURES:

- Cardiac Rehabilitation (CRE)
- Kidney Health Evaluation for Patients with Diabetes (KED)
- Osteoporosis Screening in Older Women (OSW)
- Well-Child Visits in the First 30 Months of Life (W30)
- Child and Adolescent Well-Care Visits (WCV)

NOTE Attached are Telehealth Codes for your reference.
You can also visit our **HEDIS Resources webpage** for additional code references at:
http://www.lacare.org/sites/default/files/la2498_hedis_2020_hybrid_measure_guide_201912.pdf/

Telehealth Codes

TELEPHONIC | **Codes that refer to phone conversations with your doctor are billed in time increments from five minutes to a half an hour**	**CPT**
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	99443

TELEPHONIC | **Codes for phone consultations with physician extenders, who are usually nurses, NPs, or PAs, usually correspond with a bill that is less than the bill for phone conversations with your doctor.**	**CPT**
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	98967
Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	99443

Telehealth Codes

Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	98968
Email or some other online service to discuss a medical problem with a physician.	99444

TELEHEALTH - ESTABLISHED PATIENTS | **Add the Modifiers to specify the type of face-to-face visit.**	**CPT**
Requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	99212
Requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	99213
Requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	99214
Requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	99215

Telehealth Codes

Modifiers	CPT
Synchronous telemedicine service rendered via a **real-time interactive audio and video** telecommunications system. Append this modifier to an appropriate CPT code (listed in Appendix P in the 4/13/2020 CPT manual) for a real time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider. The totality of the communication of information exchanged between the reporting provider and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Codes must be listed in Appendix P or have the symbol «next to the code.	95
Via **interactive audio and video telecommunication systems**. Use only when directed by your payer in lieu of modifie **NOTE** *Medicare stopped the use of modifier GT in 2017 when the place of service code 02 (telehealth) was introduced. If your payers reject a telemedicine claim and the 95 modifier is not appropriate, ask about modifier GT.*	GT (Telehealth)
The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)	02 (Telehealth)

Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Provider Bulletin
August 2020

COVID-19 and Telehealth Billing Guide for Medi-Cal Managed Care

Anthem Blue Cross (Anthem) is closely monitoring COVID-19 developments and what it means for our customers and health care provider partners. Anthem will continue to follow policies from the Department of Health Care Services (DHCS).

To help address care providers' questions, Anthem has developed the following temporary billing guidelines for Medi-Cal Managed Care (Medi-Cal) providers in the Anthem network during this state of emergency.

Diagnosis codes

Please follow the below CDC guidance for diagnosis coding for COVID-19 claims. For patients showing any COVID-19 signs/symptoms (such as cough, fever, etc.) and where a definitive diagnosis has not been established, assign codes for the Signs & Symptoms (S&S). For example:

- R05 — Cough
- R06.02 — Shortness of breath
- R50.9 — Fever, unspecified

Diagnosis	Dates of service prior to April 1, 2020	Dates of service after April 1, 2020
Pneumonia caused by confirmed COVID-19	J12.89 — Other viral pneumonia **and** B97.29 — Other coronavirus as the cause of diseases classified elsewhere	J12.89 — Other viral pneumonia **and** U07.1 – COVID-19
Acute bronchitis caused by confirmed COVID-19	J20.8 — Acute bronchitis due to other specified organisms **and** B97.29 — Other coronavirus as the cause of diseases classified elsewhere	J20.8 — Acute bronchitis due to other specified organisms **and** U07.1 — COVID-19
Bronchitis not otherwise specific (NOS) caused by confirmed COVID-19	J40 — Bronchitis, not specified as acute or chronic **and** B97.29 — Other coronavirus as the cause of diseases classified elsewhere	J40 — Bronchitis, not specified as acute or chronic **and** U07.1 — COVID-19
Lower respiratory infection NOS or acute respiratory infection NOS caused by confirmed COVID-19	J22 — Unspecified acute lower respiratory infection **and** B97.29 — Other coronavirus as the cause of diseases classified elsewhere	J22 — Unspecified acute lower respiratory infection **and** U07.1 — COVID-19
Respiratory infection NOS caused by confirmed COVID-19	J98.8 — Other specified respiratory disorders **and**	J98.8 — Other specified respiratory disorders **and**

ACAPEC-2491-20 August 2020

Diagnosis	Dates of service prior to April 1, 2020	Dates of service after April 1, 2020
	B97.29 — Other coronavirus as the cause of diseases classified elsewhere	U07.1 — COVID-19
Acute respiratory distress syndrome (ARDS) caused by confirmed COVID-19	J80 — Acute respiratory distress syndrome **and** B97.29 — Other coronavirus as the cause of diseases classified elsewhere	J80 — Acute respiratory distress syndrome **and** U07.1 — COVID-19
Possible exposure to COVID-19 but ruled out	Z03.818 — Encounter for observation for suspected exposure to other biological agents ruled out	Z03.818 — Encounter for observation for suspected exposure to other biological agents ruled out
Confirmed exposure to COVID-19	Z20.828 — Contact with and (suspected) exposure to other viral communicable diseases	Z20.828 — Contact with and (suspected) exposure to other viral communicable diseases

Note: Diagnosis code B34.2 is not appropriate for COVID-19 cases.

Source: **https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf**

COVID-19 lab tests

Per DHCS guidance, Anthem is covering the below codes for COVID-19 testing. **Please note that IPAs/PMGs that are at risk for labs will be responsible for all COVID-19 tests.**

HCPCS/CPT	Description	DHCS rate
U0001	CDC 2019 novel coronavirus test	$35.91
U0002	Non-CDC 2019 novel coronavirus test	$51.31
87635	Infectious agent detection by nucleic acid (DNA or RNA); Severe Acute Respiratory Syndrome Coronavirus 2	$51.31
G2023	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2(sars-cov-2/Covid-19)any specimen source	$23.46
G2024	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2(sars-cov-2/Covid-19)from individual skilled nursing	$25.46
86318	Immunoassay for chemical constituent	$14.10
86328	Immunoassay for infectious agent antibody(ies) qualitative semiquantitative, single step method(eg, reagent strip)	$45.23
86769	Antibody; Severe Acute Respiratory Syndrome Coronavirus 2 (sars-cov-2) (Coronavirus disease-Covid-19)	$42.13
86602	Antibody; actinomyces	$10.05
86635	Coccidioides (For severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}]	$10.24
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.	$100
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.	$100

HCPCS/CPT	Description	DHCS rate
C9803	Hospital outpatient clinic visit specimen collection for Severe Acute Respiratory Syndrome(sars-cov-2)(Covid-19)any spec	$22.99
87426	Infectious agent antigen detection by immunoassay technique (eg,enzyme immunoassay(eia)enzyme-linked immunosorbent	$35.33

Telehealth for professional providers

Please follow the DHCS guidelines for billing virtual and telephonic visits including specific documentation in the medical records that satisfies the requirements of the CPT or HCPCS code utilized.

Place of service **02** should be billed for all telehealth visits with the exception of clinic visits and visits billed on a CMS1450/UB04.

Type of service	Code(s)	Description	Modifiers
Virtual communication	G2010 G2012 G0071	Remote evaluation and brief communication	95 or GQ
Evaluation and management	99201-99205 99211-99215 99381-99385 99391-99395	Evaluation and management sick and well visits	95 or GQ
Behavioral health	90791-90792 90832-90838 90853 90863	• Psychiatric evaluations • Psychotherapy • Group psychotherapy • Pharmacologic management	95 or GQ
Behavioral health for autism and related disorders	H2012 H2014 H2019 H0031 H0032	Family guidance, treatment and assessment	95 or GQ
E-consults	99451	Inter-professional e-consult	GQ
Originating site	Q3014	Telehealth originating site facility fee	95 or GQ
Transmission	T1014	Telehealth transmission per minute	95 or GQ
FQHC*/RHC** clinic visit	T1015	Telehealth clinic visit	SE
IHC† clinic visit	T1015	Telehealth IHC visit	SE

* Federally Qualified Health Center
** Rural Health Clinic
† Indian Health Clinic

Sources: March 18, 2020, "Supplement to All Plan Letter 19-009" **https://www.dhcs.ca.gov/Documents/COVID-19/APL19-009-Supplement-Telehealth-031820.pdf**

Medi-Cal payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19) **https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth_Other_Virtual_Telephonic_Communications_V3.0.pdf**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs
April 27, 2020
(Updated on August 3, 2020)

Question: In light of the COVID-19 pandemic, can CMS clarify which telehealth services are valid for data submissions for the HHS-operated risk adjustment program?

Response: Any service provided through telehealth that is reimbursable under applicable state law[1] and otherwise meets applicable risk adjustment data submission standards[2] may be submitted to issuers' External Data Gathering Environment (EDGE) servers for purposes of the Department of Health and Human Services (HHS)-operated risk adjustment program.[3] If a code submitted to an issuer's EDGE server is descriptive of a face-to-face service furnished by a qualified healthcare professional and is an acceptable source of new diagnoses, it will be included in the risk adjustment filtering.[4] Telehealth visits are considered equivalent to face-to-face interactions, but they are still subject to the same requirements regarding provider type and diagnostic value.

Some codes for services that are eligible for inclusion in risk adjustment explicitly mention telehealth, such as the emergency department or initial inpatient telehealth consultation Healthcare Common Procedure Coding System (HCPCS) codes (G0425, G0426 and G0427). Other examples of such codes include those for follow-up telehealth consultations furnished in hospitals or skilled nursing facilities (G0406, G0407, G0408, G0459, G0508, and G0509). Furthermore, many additional services can be furnished in the telehealth setting, and this can be reflected in the data submissions with the addition of a modifier code (95/ GQ/ GT) and/or with a place of service code "02." Changing the modifier or place of service for an otherwise acceptable

[1] Applicable state law refers to the laws of the state, in which the issuer is licensed, for services that are rendered by a health care professional licensed in the state in which he or she practices and if required, in the state in which the enrollee resides.
[2] EDGE Server Business Rules are posted to REGTAP at (login required): https://www.regtap.info/reg_library_openfile.php?id=37&type=k.
[3] Beginning with the 2017 benefit year, HHS has operated the risk adjustment program under section 1343 of the Patient Protection and Affordable Care Act on behalf of all states and the District of Columbia.
[4] For more information on risk adjustment filtering, see discussion in prior years' "Do It Yourself (DIY)" Software Documentation; the 2019 Benefit Year Risk Adjustment Updated HHS-Developed Risk Adjustment Model Algorithm DIY is available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CY2019-DIY-instructions.04.15.2020.pdf.

face-to-face service to telehealth or telephone-only has no impact on the inclusion of specific services for purposes of the risk adjustment program because, as mentioned above, these settings are considered equivalent to the face-to-face setting for purposes of the HHS-operated risk adjustment program.

In response to the COVID-19 pandemic and the increased need to expand the use of telehealth and virtual care, HHS will be designating nine e-visit codes, new for calendar year 2020, as valid for 2020 benefit year HHS-operated risk adjustment data submissions, subject to applicable state law requirements. This newly released group of Current Procedural Technology (CPT) codes (98970-98972,[5] 99421-99423) and HCPCS codes (G2061-G2063), which were effective January 1, 2020, are generally for short online assessments where qualified healthcare professionals review patient input and determine whether an office visit is warranted. These e-visit codes allow for online evaluation and management (E&M) or professional assessment conducted via a patient portal, including subsequent communication with the patient through online, telephone, email, or other digitally-supported communication. The e-visit CPT set is for use by physicians and non-physician qualified health professionals who may independently bill for E&M visits. The e-visit HCPCS code set is for use by non-physician qualified health professionals who may not be able to bill independently for E&M visits (e.g., clinical psychologists). Due to the expansion and encouragement of telehealth and virtual services during the COVID-19 pandemic, these e-visit codes will be valid for diagnosis filtering purposes in risk adjustment data submissions for the 2020 benefit year.[6] Risk adjustment eligible diagnosis codes provided via allowable telehealth and virtual services will be validated in HHS risk adjustment data validation in the same manner as risk adjustment diagnosis codes provided via in-person services are validated. HHS also intends to reconsider these codes' inclusion for future benefit years, as may be appropriate (e.g., if the COVID-19 public health emergency continues into the 2021 benefit year).

<u>Question:</u> In light of the COVID-19 pandemic, can HHS clarify which telephone service codes are valid for data submissions for the HHS-operated risk adjustment program?

<u>Response:</u> Recognizing the continuing increased need for providing telephone and virtual services during the COVID-19 public health emergency, HHS has given additional consideration to the treatment of telephone-only services in the HHS-operated risk adjustment program and is announcing additional codes that will be valid for 2020 benefit year data submissions for the HHS-operated risk adjustment program. HHS will designate diagnosis codes from telephone-only service CPT codes (98966-98968, 99441-99443) as valid for risk adjustment diagnosis filtering purposes in risk adjustment data submissions for the 2020 benefit year,[7] subject to applicable state law requirements.

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[5] This list of codes is updated from the April 27, 2020 FAQ to include 3 additional e-visit codes (98970-98972). All 9 e-visit codes (98970-98972, 99421-99423, G2061-G2063) will be designated as valid for the 2020 benefit year HHS-operated risk adjustment data submissions, subject to applicable state law requirements.

[6] These e-visit codes will be incorporated in the 2020 DIY software final version. We release interim versions of DIY software, ahead of the final version, and these codes should appear in the next initial 2020 software updates.

[7] Ibid.

Like telehealth visits, telephone-only services are subject to the same requirements regarding provider type and diagnostic value and must be reimbursable under applicable state law. We recognize that many conditions cannot be diagnosed telephonically but will defer to applicable coding and diagnosis guidelines setting groups (e.g., American Medical Association) on what a permissible diagnosis telephonically may be.[8] Risk adjustment eligible diagnosis codes provided via allowable telehealth and telephone-only services will be validated in HHS' risk adjustment data validation in the same manner as risk adjustment diagnosis codes provided via in-person services are validated. We also intend to reconsider these codes' inclusion for future benefit years, as may be appropriate (e.g., if the COVID-19 public health emergency continues into the 2021 benefit year).

Questions about these FAQs can be addressed to RARIPaymentOperations@cms.hhs.gov, please specify, "HHS-RA COVID-19 Question" in the subject line.

[8] For example, the American Medical Association has provided several resources specific to use and coding of communication technology based services (including telephonic service) during the COVID-19 pandemic: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice or https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance

PROVIDER*Update*

Health Net®

REGULATORY | SEPTEMBER 10, 2020 | UPDATE 20-670 | 3 PAGES

Have a Plan Ready When Disaster Strikes

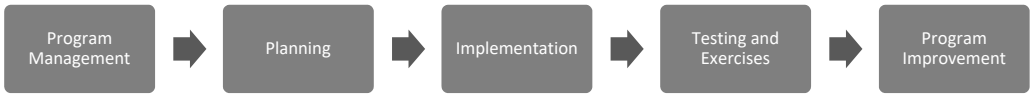
Protect members' health, manage stress and know your resources

Continue giving high quality care with a disaster preparedness plan when the unexpected happens. It reduces risks to your practice and identifies the resources you need for different types of disasters:

- Outbreak of communicable diseases, such as COVID-19
- Natural disasters like floods and earthquakes
- Economic downturns
- Human-caused hazards such as accidents, acts of violence or fire

Tailor your plan to fit your practice

The steps below outline what to cover in your plan, how to train staff and where to make improvements. Details about preparing a disaster preparedness plan are available at Ready.gov and CalOES.ca.gov. For more information, refer to *online resources* at the end of this update.



Program management

- Organize, develop and administer your program
- Identify regulations that establish minimum requirements

Planning

- Gather information about hazards and assess risks
- Conduct a business impact analysis
- Examine ways to prevent hazards and reduce risks

Implementation – Write a plan that includes:

- Resource management
- Emergency response
- Crisis communications

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

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

LINES OF BUSINESS:

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

PROVIDER SERVICES
provider_services@healthnet.com
1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com

- Business continuity
- Information technology

Testing and exercises

- Test and evaluate your plan
- Define different types of exercises
- Learn how to conduct exercises
- Use exercise results to evaluate how well the plan works

Program improvement

- Identify when the plan needs to be reviewed
- Find ways to evaluate the plan
- Use the review to make changes

Excessive stress and effects on health

Disasters cause stress which can lead to short and long-term physical and mental health impacts, such as cardiovascular, metabolic, immunologic, and neuropsychiatric risk. To help regulate the stress response, adapt disaster-responsive and trauma-informed principles as part of your usual practice. Common signs of distress can include:

- Feelings of fear, anger, sadness, worry, numbness, or frustration
- Changes in appetite, energy, and activity levels
- Difficulty concentrating and making decisions
- Difficulty sleeping or nightmares
- Physical reactions, such as headaches, body pains, stomach problems, and skin rashes
- Worsening of chronic health problems
- Increased use of alcohol, tobacco, or other drug

Resources for members

In active crisis**:**

- CalHOPE – Delivers crisis support for communities impacted by a national disaster.

  (833) 317-HOPE (4673)

  https://calhope.dhcs.ca.gov/

- SAMHSA'S Disaster Distress Helpline – Provides 24/7, 365 days of crisis counseling and support for emotional distress related to natural or human-caused disasters.

  1-800-985-5990 or text TalkWithUS to 66746

  www.samhsa.gov/find-help/disaster-distress-helpline

Impacted by disaster or excessive stress:

- MHN – Refer members who are ready for a mental health evaluation and treatment.

  1-800-327-4103

  www.mhn.com/providers.html

- Case Management – For help or to learn more, refer members to Health Net Behavioral Health Case Management.

  1-866-801-6294

- Health Net Community Connect – Use this tool to search online for free or reduced cost local resources like medical care, food, job training, and more based on a ZIP code. Go to https://healthnet.auntbertha.com. Enter a ZIP code and click on *Search*.

- Telehealth – Cost-effective and user-friendly when in-person contact is not required.

- myStrength – Offers online self-care resources that cover a range of topics (i.e., stress, anxiety, chronic pain, and more). Note: If a member needs emergent or routine treatment services, call MHN at 1-800-327-4103.

  Members can download the myStrength app at Google Play or the Apple Store.

  To join online, go to https://bh.myStrength.com/hnmedical. Click *Sign Up*. Complete the myStrength sign-up process with a brief wellness assessment and personal profile.

Online resources

Title	URL
Home page includes multiple topics about disasters	www.ready.gov/
Five steps to develop your business preparedness plan	www.caloes.ca.gov/businesses-organizations
Healthcare Preparedness	www.cdc.gov/cpr/readiness/healthcare/planning.htm
Train Your Crisis Counseling Assistance and Training Program (CCP) Staff	www.samhsa.gov/dtac/ccp-toolkit/train-your-ccp-staff
All Plan Letter (APL) 20-008, Mitigating health impacts of secondary stress due to COVID-19 Emergency	www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-008.pdf
A disaster preparedness plan for pediatricians	www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/children-and-disasters/Documents/DisasterPrepPlanforPeds.pdf?
Disaster Responder Stress Management	www.samhsa.gov/dtac/dbhis-collections/disaster-response-template-toolkit/disaster-responder-stress-management
Taking Care of Your Emotional Health	https://emergency.cdc.gov/coping/selfcare.asp

Additional information

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

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

PROVIDERUpdate

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NEWS & ANNOUNCEMENTS | AUGUST 14, 2020 | UPDATE 20-613 | 2 PAGES

Sleep Apnea as a Risk Factor for Your Patients

You can screen and treat sleep disorders to improve health outcomes

Untreated sleep apnea may lead to serious health consequences. Associated health conditions, such as high blood pressure (HBP), heart failure, diabetes, and stroke, can increase your patients' risk for adverse health outcomes. The major factor for obstructive sleep apnea (OSA) is excess body weight. Providers are the first line of defense to screen and evaluate patients for OSA.

OSA disorders

OSA is characterized by repeated episodes of partial or complete closure of the upper airway that disturbs breathing during sleep. Patients who report snoring, witnessed apneas or daytime sleepiness should be screened for sleep apnea.

OSA risk factors

The American Academy of Sleep Medicine (AASM) recommends[1] providers, during routine health exams, use questions that can evaluate patients with the OSA risk factors below.

- Arrhythmia
- HBP and pulmonary hypertension
- Coronary artery disease, heart failure and/or stroke
- Type 2 diabetes mellitus
- Obesity
- Refractory hypertension

Positive findings should prompt a comprehensive sleep evaluation.

Evaluate your patients with screening tools

Some available screening tools include:

- STOP-Bang questionnaire, go to www.stopbang.ca/osa/screening.php to find the form and more information.
- Berlin Questionnaire (BQ), go to www.sleepapnea.org to use this form.
- The sleep apnea clinical score (SACS) is based on snoring, witnessed apneas, neck circumference, and systemic hypertension. It can calculate the suspected presence of OSA. Those who obtain scores greater than or equal to 15 points have a high probability of OSA. [2]

[1]Buman D Sleep Disorder. FP Essent. 2017, 460 1:48

[2]Flemons WW, Whitelaw WA, Brant R, Remmers JE. Likelihood ratios for a sleep apnea clinical prediction rule. Am J Respir Crit Care Med. 1994;150(5):1279–1285.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
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LINES OF BUSINESS:

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- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ○ Riverside
  - ● Sacramento
  - ○ San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES
provider_services@healthnet.com

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

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provider.communications@
healthnet.com

Diagnosis

Having patients attend an in-laboratory sleep study (diagnostic polysomnography) is considered the best diagnosis of OSA. A portable home sleep test may also be used for diagnostic criteria for OSA.

PAP therapy and treatment

The most common form of treatment for OSA is the use of positive airway pressure (PAP). Numerous studies have shown that PAP therapy can decrease the apnea-hypopnea index (AHI) to less than 5 to 10 events/hour in the majority of patients.

Most patients are treated with continuous positive airway pressure (CPAP) therapy.

61% of patients with heart failure have either central or OSA. Sleep apnea:

- Is associated with poor health related quality of life (HRQOL).
- Increases levels of natriuretic peptides.

Treatment may improve cardiac function and decrease pulmonary hypertension for patients. It may also improve blood oxygen levels with a better quality of rest.

Additional information

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

If you have questions regarding the information contained in this update, contact the applicable Health Net* Provider Services Center within 60 days at:

Line of Business	Telephone Number	Provider Portal	Email Address
EnhancedCare PPO (IFP)	1-844-463-8188	provider.healthnetcalifornia.com	provider_services@healthnet.com
EnhancedCare PPO (SBG)	1-844-463-8188	provider.healthnet.com	
Health Net Employer Group HMO, POS, HSP, PPO, & EPO	1-800-641-7761	provider.healthnet.com	
IFP (CommunityCare HMO, PPO, PureCare HSP, PureCare One EPO)	1-888-926-2164	provider.healthnetcalifornia.com	
Medicare (individual)	1-800-929-9224	provider.healthnetcalifornia.com	
Medicare (employer group)	1-800-929-9224	provider.healthnet.com	
Medi-Cal	1-800-675-6110	provider.healthnet.com	N/A