

CalOptima Care Network (CCN)
Provider Lunch and Learn Meeting for CCN Contracted Providers
Tuesday, October 21, 2014
12:05 p.m. – 2:00 p.m.

Agenda

I.	Welcome and Introductions	Laura Grigoruk <i>Director, Network Management</i>	12:05 - 12:10
II.	Provider Relations Updates	Jackie Nguyen <i>Provider Relations Representative</i>	12:10 - 12:20
III.	Staying Healthy Assessment (SHA)	Novella Quesada <i>Manager Quality Improvement</i>	12:20 – 12:35
IV.	Seniors and Persons with Disabilities (SPD) Health Risk Assessment (HRA)	Terrie Stanley <i>Executive Director Clinical Operations</i>	12:35 – 12:50
V.	ICD – 10 Update	Marsha Buford <i>Director Coding Initiatives</i>	12:50 – 1:15
VI.	Avoiding Hospital Readmission Incentive	Dr. Roberto Madrid <i>Medical Director Medical Management</i>	1:15 – 1:30
VII.	Q & A and Closing Remarks	Laura Grigoruk <i>Director Network Management</i>	1:30 – 2:00



CalOptima Care Network (CCN)

**Lunch and Learn Meeting
October 21, 2014**



Welcome

Laura Grigoruk
Director, Network Management

Agenda

- Provider Relations Update
- SHA
- SPD HRA
- ICD-10
- Avoiding Hospital Readmission Incentive
- Q & A and Closing Remarks

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CCN Meeting Materials

- Meeting Agenda
- Notes page
- CCN Question Sheet
 - Complete if you would like for CalOptima staff to follow up with you after this meeting
- Today's meeting Evaluation
 - Please complete the yellow evaluation at the end of each presentation
- Additional meeting materials and presentations are available on CalOptima website at:
www.caloptima.org/en/Providers/ProviderEventsAndWorkshops.aspx

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Please place
your cell phones
on silent

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Provider Relations

Lunch and Learn
October 21, 2014

Jacqueline Nguyen
Provider Relations Representative

Provider Relations Updates

- ACA Primary Care Provider Payments
- Community Network
- HEDIS
- Pharyngitis Kit Distribution

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CalOptima
Better. Together.

SHA, SBIRT, Smoking Cessation Coding for PCP

October 21, 2014

Novella Quesada
Manager, Quality Improvement

Billing Codes

- Effective November 1, 2014
 - Smoking Cessation Intervention Coding – Non billable
 - 99406
- Effective January 1, 2015
 - SHA Coding – Non billable
 - 96150 (Initial)
 - 96151 (Subsequent visits)
- Effective January 1, 2015
 - SBIRT Coding – Billable
 - H0049
 - H0050

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A Public Agency

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Seniors and Persons With Disabilities (SPD) Health Risk Assessment (HRA)

CCN Lunch and Learn
October 21, 2014

Terrie M. Stanley
Executive Director Clinical Operations- Medical Affairs

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Topics

- BACKGROUND — CalOptima Contract SPD Requirements
- Board Action
- Model of Care for SPD
- PROPOSED Implementation Timeline
- Questions?

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DHCS Contract Requirements — SPD

- CalOptima Department of Healthcare Services Contractual Requirement and All Plan Letter
- Health Risk Assessment (HRA) for all newly enrolled SPD
- Completed in 45 days for HIGH risk and 105 days for LOW risk
- Annual process for existing members
- ICP's for members at the higher risk

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DHCS Contract Requirements-SPD

- ALL members must be provided :
 - Comprehensive medical case management that is person-centered
 - Discharge planning upon admission to hospital or institution and continuation into the post discharge period
 - Ensure necessary care, services and supports are in place in the community upon discharge from a hospital or institution
 - Schedule outpatient appointments
 - Conduct follow up with the member and/or caregiver

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Case Management — BASIC

- Provided by the PCP- Includes:
 - Initial Health Assessment (IHA)
 - Initial Health Education Behavioral Assessment (IHEBA)
 - Identification of appropriate providers and facilities (such as medical, rehabilitation and support services) to meet member care needs
 - Direct communication between the provider and member/family
 - Member and family education, including healthy lifestyle changes when warranted
 - Coordination of carved out and linked services, and referral to appropriate community resources and other agencies

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Case Management-COMPLEX

- Includes BASIC PLUS
 - Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
 - Intense coordination of resources to ensure member regains optimal health or improved functionality
 - Development of care plan (with member and PCP input) specific to individual needs and updating of these plans at least annually
 - Assessment of transitional needs of members into and out of complex case management services

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CalOptima Board Action

- Board Action Agenda Item VII B Passed August 7, 2014
 - Approved funding levels — Health Network supplemental capitation rate of \$8.94 pmpm for three years for PCC position
 - Authorized execution of required contract amendments
 - Authorized hiring of needed staff — staffing level of 1:600
 - Approved creation of required policies and procedures
 - Other requirements regarding sanctions and compliance deficiencies
 - CalOptima to develop
 - SPD quality initiative program
 - Performance monitoring

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Role of the PCC

- Serve as a liaison between members, the PMG, CalOptima, medical providers, behavioral health providers, Long-Term Support and Service (LTSS) providers, CCS and OCRC, when appropriate
- Ensure communication of HRA and Care Plan to all members of the care team
- Serve as the primary point of contact for the member, be an integral part of the member's interdisciplinary care team
- Provide support to members as they self-navigate the health care system

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Role of the PCC (Cont.)

- Coordinate activities required for the timely interdisciplinary care team meetings. This will include contacting and scheduling meetings (in person and telephonic) to include the member and/or the members authorized representatives and others required as per issues identified by responses to the HRA.
- Encourage member engagement in the process of team meetings and care planning.
- Identify and reduce barriers to members' care, assist the member in locating and accessing resources and educate the member on the importance of accessing care promptly.

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Role of the PCC (Cont.)

- Assist PCPs in the completion of the IHEBA, SHA and preventive services as, well as address “gaps in care” for SPD members.
- Facilitate/initiate referrals to both internal and external care management departments and other department/government/community agencies, including behavioral health.
- Work under the direct supervision of a licensed clinical professional to ensure optimal coordination of care for members.

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Implementation Timeline — DRAFT/PROPOSED

- August 2014
 - CalOptima begins mailing revised HRA for SPD.
 - COBAR passed by CalOptima Board of Directors.
- September 2014
 - Mail out contract amendments to health networks.
 - Establish performance-based funding.
- October 2014
 - Implement requirements for new SPD members only.
- January 2015
 - Implement requirements for members requiring annual HRA.
- April 2015
 - Begin data-driven iCP for non-responders; prioritize based on CML and those who have never responded

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Questions?

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ICD-10 Update

CCN Lunch and Learn
October 2014
Marsha Buford
Director of Coding Initiatives

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Topics to Discuss

- New Date
- Why Migrate to ICD-10?
- Differences Between ICD-9 and ICD-10
- Provider Impact
- Coding Concepts
- 5010 & 1500 Format Changes
- Implementation Steps
- Websites/Questions

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ICD-10 New Date

- On July 31, 2014, the U.S. Department of Health and Human Services (HHS) issued a rule ([CMS-0043-F](#)) finalizing October 1, 2015, as the new compliance date for health care providers and health plans to transition to ICD-10.
 - This is an opportunity to regroup and evaluate timelines.
 - Use this extra year to do more testing, training and improve clinical documentation.

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ICD-10 Code Implementation

Diagnoses are used for coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases.

- ICD-10-CM (Clinical Modification = diagnosis codes)
 - Used by all providers in every health care setting
 - Expansion to meet reporting needs
- ICD-10-PCS (Procedure Codes)
 - Replaces ICD-9-CM Procedures
 - Used only for inpatient institutional procedure coding
 - Not used on physician claims, even those for inpatient visits
- CPT/HCPCS will continue to be used for payment of physician claims

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ICD-10 Value

HHS mandates that all covered entities (including providers, clearinghouses, health plans,) must transition to this new code set.

ICD-10 major objectives:

- Increased coding accuracy, standardization and expandability
- Better identification of members for care management
- Potential for deeper population-level analytics for public health
- Improved quality and outcomes data
- Improves communication between physicians

ICD-10 represents a major change in the medical coding system

- New code structure and coding rules
- New terminology to define medical procedure (no change to CPT/HCPCS)
- Much greater specificity in ICD-10
- Greatest impact is in cardiology, obstetrics and orthopedics

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ICD-10 Impact

- Physician
 - ICD-10-CM
 - CPT/HCPCS
- Hospital
 - Inpatient: Both ICD-10-CM and ICD-10-PCS
 - Outpatient: ICD-10-CM and CPT/HCPCS
- Behavioral Health
 - ICD-10-CM
 - CPT/HCPCS
 - DSM-IV

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ICD-10 Impact (Cont.)

- Laboratory
 - ICD-10-CM
 - CPT/HCPCS
- Long-Term Health Care
 - ICD-10-CM
 - CPT/HCPCS
- All Other
 - ICD-10-CM
 - CPT/HCPCS

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ICD-9-CM vs. ICD-10-CM: Coding

ICD-9-CM	ICD-10-CM
• 3–5 digits	• 3–7 digits
• Alpha “E” and “V” on first character	• 1st character = Alpha; 2nd = Numeric 3 rd – 7 th = Alpha or Numeric
• No place holder characters	• Include place holder character (X)
• Approximately 14,000 codes	• Approximately 69,000 codes
• Severity parameters limited	• Extensive severity parameters
• Does not include laterality	• Common definition of laterality
• Combination codes limited	• Combination codes are common
• Index and Tabular structure	• Index and Tabular section similar

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ICD-9 vs. ICD-10: Asthma Specificity

Asthma Codes in ICD-9-CM		Asthma Codes in ICD-10-CM
493.00	Extrinsic asthma, unspecified	J45.20 — Mild intermittent asthma, uncomplicated J45.30 — Mild persistent asthma, uncomplicated J45.40 — Moderate persistent asthma, uncomplicated J45.50 — Severe persistent asthma, uncomplicated
493.10	Intrinsic asthma, unspecified	
493.01	Extrinsic asthma with status asthmaticus	J45.22 — Mild intermittent asthma with status asthmaticus J45.32 — Mild persistent asthma with status asthmaticus J45.42 — Moderate persistent asthma with status asthmaticus J45.52 — Severe persistent asthma with status asthmaticus
493.11	Intrinsic asthma with status asthmaticus	

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ICD-9 vs. ICD-10: Diabetes Specificity

Diabetes Codes in ICD-9-CM		Diabetes Codes in ICD-10-CM
249.70	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled	E08.52 — Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
785.4	Diabetic gangrene	
443.81	Diabetic peripheral angiopathy	
250.31	Diabetes with other coma, type I, not stated as uncontrolled	E10.11 — Type 1 diabetes mellitus with ketoacidosis with coma
250.60	Diabetes with neurological manifestations, type II or unspecified, not stated as uncontrolled	E11.41 — Type 2 diabetes mellitus with diabetic mononeuropathy
355.9	Mononeuritis of unspecified site	

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ICD-10 CM Chapter 21 — Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Some codes are valid in both ICD-9 and ICD-10. The examples below show how significant the difference in the meaning can be...

ICD-9-CM Code and Description	ICD-10-CM Code and Description
V70.0: Routine general medical examination at a health care facility	V70.0: Driver of bus injured in collision with pedestrian or animal in non-traffic accident
V20.2: Routine infant or child health check	V20.2: Unspecified motorcycle rider injured in collision with pedestrian or animal in non-traffic accident
V76.2: Screening for malignant neoplasms of cervix	V76.2: Person on outside of bus injured in collision with other non-motor vehicle in non-traffic accident
V22.1: Supervision of other normal pregnancy	V22.1: Motorcycle passenger injured in collision with two or three wheeled motor vehicles in non-traffic accident

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Routine Child Health Exam

Routine Child Health Exam ICD-9-CM		Routine Child Health Exam ICD-10-CM
V202	Routine infant or child health check	<p>Z00.129 — Encounter for routine child health examination without abnormal findings</p> <p>Z00.121 — Encounter for routine child health examination with abnormal findings</p>

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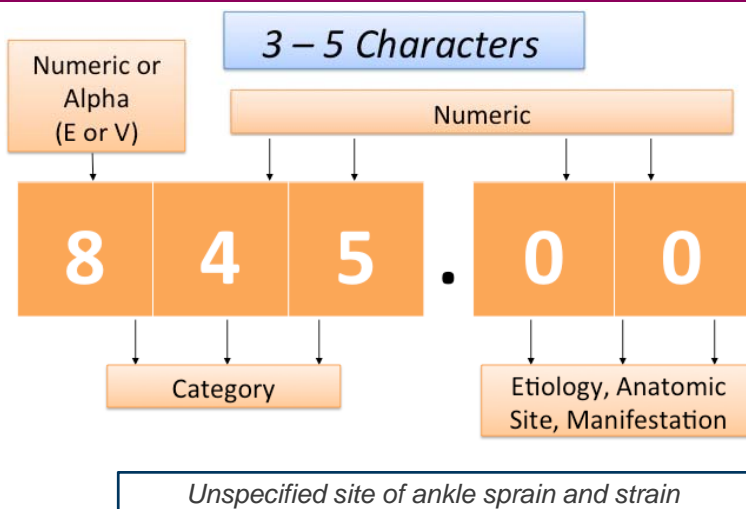
Varying Changes By Clinical Areas — Changes in the Number of Codes

Clinical Area	ICD-9 Codes	ICD-10 Codes
Fractures	747	17099
Poisoning and toxic effects	244	4662
Pregnancy related conditions	1104	2155
Brain injury	292	574
Diabetes	69	239
Migraine	40	44
Bleeding disorders	26	29
Mood related disorders	78	71
Hypertensive Disease	33	14
End stage renal disease	11	5
Chronic respiratory failure	7	4

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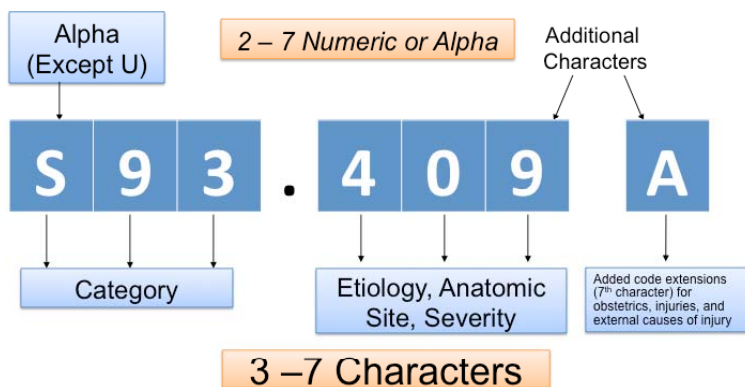


ICD-9 CM Code Layout



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ICD-10 CM Code Layout



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ICD-10 CM: New Features

Injury Codes

- Grouped first by specific site (head, arm, leg, etc.), then by type of injury (fracture, open wound, etc.)
- Fifth character defines type of injury
- Sixth character defines laterality
- Seventh character defines the encounter

Code	Injury and Laterality	Encounter
S00261A	Insect bite (nonvenomous) of right eyelid and periocular area	Initial Encounter
S00261D		Subsequent Encounter
S00261S		Sequela

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Procedure Terminology Changes

ICD-9 Procedure Term	ICD-10 Procedure Term
• Amputation	• Detachment
• Arthroscopy, Cystoscopy	• Inspection, Endoscopic Approach
• Aspiration	• Drainage
• Cesarean Section	• Extraction of Products of Conception
• Incision	• None
• Radical Mastectomy	• Resection (right, left or bilateral)
• Tracheostomy	• Bypass
• Colostomy	• Bypass (colon) to skin

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What Providers Need to Do

Determine the impact of ICD-10 to your practice.

- Identify how ICD-10 will affect your practice.
- Implement an ICD-10 project management team.
- Develop and complete an impact assessment
 - Where is ICD-9 used today?
 - Will your current system accommodate ICD-10?
 - Plan for remediation of systems and changes to workflow.
 - Ask your EHR vendors, clearinghouses, billing services about ICD-10 readiness and time frames.
- Examine your superbill/encounter forms.
 - Identify your top diagnoses and map these codes to ICD-10.

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Roles in the Physician Office — Identify Impact of ICD-10

- Practice Manager
 - Manage Staff: Front Office
 - Verify benefits and coverage/co-pays
 - Submit referrals and authorization requests
 - Manage Systems/Vendors: Back Office
 - Room patients
 - Assist physician
 - Manage Accounts Receivable/Payable: Business Office
 - Code and bill claims
 - Manage denials and appeals

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Training

- Physicians
 - Documentation improvement
 - General ICD 10 education
- Front Office
 - General ICD-10 education
 - Targeted training based on duties; referrals and authorizations
- Back Office
 - General ICD-10 education
 - Medical record documentation support
- Business Office
 - Coder/biller training specific to practice (e.g., cardiology, urology)
 - Anatomy and physiology training

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Clinical/Business/Coding Relationships

- The role of the clinician is to document as accurately as possible the nature of the patient conditions and services done to maintain or improve those conditions.
- The role of the coding professional is to assure that coding is consistent with the documentation.
- The role of the practice manager is to assure that all billing is accurately coded and supported by the documented facts.

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ICD-10 Coding Concepts — Key Concepts Necessary for Successful Coding

- Follow coding conventions and guidelines.
- Use “unspecified” codes only when payer allows and it is warranted.
- Familiarize yourself with new concepts:
 - Laterality
 - Initial vs. subsequent encounter
 - Underdosing
- Open a dialogue with your physician.

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Summary

- Clinical documentation is not just about coding, and coding is not just about payment.
- Accurate coding is a requirement for good health care data.
- Good health care data is critical to improving the quality of care, effectiveness of care and assuring patient safety.
- Complete and accurate documentation of important clinical concepts of the patient condition is a **requirement for good patient care.**
- The requirements for documentation to support ICD-10 are consistent with documentation to support good patient care and improve health care data.

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5010 and CMS 1500 Form Impact

- EDI Format — 5010
 - Already includes qualifier to identify version of ICD codes reported
 - Qualifier in place for ICD-9 vs. ICD-10
- CMS 1500 Claim Form Changes
 - Expanding number of Diagnosis Codes from 4 to 12
 - Form accommodates a maximum of 7 characters in length
 - Indicator added to identify version of ICD codes reported
 - ICD-9 = 9 and ICD-10 = 0

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CalOptima Editing for Compliance

CalOptima will follow CMS guidelines that state that a Claim or Encounter, electronic or paper, cannot contain both ICD-9 and ICD-10 codes.

- CalOptima will reject non-compliant claims and encounters.
 - ICD-9 codes will no longer be accepted on claims with DOS or date of discharge **after** 9/30/15.
 - ICD-10 codes will not be accepted on claims with DOS or date of discharge **before** 10/1/15.
- CPT/HCPCS are still used for payment.

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10 Steps to Successful Implementation

1. Provide Organization with Awareness
2. Establish Interdisciplinary Steering Committee
3. Develop Strategy and Plan
4. Assess Functional Area Opportunities and Gaps
5. Initiate Interdisciplinary Project Management
6. Partner with Vendors
7. Integrate Internal and External Systems
8. Provide Detailed Training
9. Simulate and Manage Change
10. Launch Successful Implementation

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Hypertension in ICD-10 CM

- I10 = Essential (primary) hypertension

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ICD-10 Websites and Questions

- ICD-10 general information at the CMS website: www.cms.gov/ICD10
- CMS: <http://www.roadto10.org/>
- AHIMA resources: www.ahima.org/icd10
- AAPC: <http://www.aapc.com/ICD-10/training.aspx>
- Contexo Media: <http://www.contexomedia.com/icd-10/>
- HC Pro: <http://icd-10.hcpro.com/>
- World Health Organization ICD-10 Interactive Self-Learning Tool: apps.who.int/classifications/apps/icd/ICD10Training/
- WEDI website: www.wedi.org
- Questions: ICD10questions@caloptima.org
 - Let us know if you are interested in partner testing via Office Ally.

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Questions

ICD10questions@caloptima.org

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Initiative to Reduce 30-Day All Cause Avoidable Hospital Readmissions for Medi-Cal

Roberto Madrid, M.D.
October 21, 2014

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Avoidable Hospital Readmissions

- CalOptima's cost for hospital readmissions in 2012 was approximately \$32.6 million.
- Medical literature shows that reductions in readmission rates can be achieved through improved post-discharge care management services.
- Medicare added post-discharge care management services as benefits for their members in January 2013, but these services remain non-covered for Medi-Cal.



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Care Management Services

- On July 1, 2014, CalOptima implemented a two-year initiative aimed at lowering avoidable hospital readmissions for Medi-Cal members by extending payment for post-discharge care management services to PCPs.
- CalOptima and the health networks will reimburse PCPs on a fee-for-service basis at 100 percent of the current Medicare rate for codes 99495 and 99496 (30-day transitional care management).
- The health networks will be reimbursed by CalOptima based on paid encounter submissions (beginning October 2014)

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CPT Code 99495

- Communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge,
- Medical decision-making of moderate complexity during the service period, and
- A face-to-face visit within 14 calendar days of discharge

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CPT Code 99496

- Communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge,
- Medical decision-making of high complexity during the service period, and
- A face-to-face visit within 7 days of discharge

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Practitioner Responsibilities

- Ensure that the entire 30-day transitional care management (TCM) service was furnished.
- That the service began with a qualified discharge from a facility, and that the date of service on the claim is the final day of the period of TCM services (The 30-day period for the TCM service begins on the day of qualified Medicare discharge and continues for the next 29 calendar days.)
- The reported date of service should be the 30th day from discharge.

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FAQ

- What is the reimbursement amount?
 - Reimbursement will be at 100 percent of Medicare rates.
- What role do the health networks play?
 - Health networks will pay for the incentive and be reimbursed through the encounter process for paid claims.
 - Networks will create a process for notifying a member's PCP upon discharge from an inpatient hospital stay.
- Will the networks receive an incentive as well?
 - At the end of the reporting period, and depending on funds available, CalOptima will pay incentive to the health networks with:
 - The lowest readmission rate
 - The most improved readmission rate

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FAQ

- Are maternity-related admissions included?
 - No. Only relates to non-maternity-related hospitalizations

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CCN Lunch and Learn Q & A

- Yellow Evaluation Form: Please complete and leave behind.
- In your packet, there is a form for you to write any questions that we have not addressed today.
- What questions do you still have?

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CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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Contact List

CalOptima Departments		
Department	Phone	Fax
Provider Resource Line	(714) 246 - 8600	
Care Coordination & Prior Authorization	(714) 246 - 8686 or (888) 587-7277	(714) 246-8579
Claims Department	(714) 246 - 8885	
Customer Service & Member Liason	(714) 246 - 8500 or (888) 587 - 8088	(714) 246 - 8580
OneCare Provider Inquiries	(714) 246 - 8600	
Pharmacy: PerformRX Help Desk	(888) 962 - 3100	(855) 452 - 9135
Provider Enrollment & Registration	(714) 246 - 8468	(714) 246 - 8448
Vision Service Plan	(800) 615 - 1883	(800) 884 - 1021

CalOptima Health Networks			
Health Network	24 Hour Line	Health Network	24 Hour Line
AltaMed Medical Group	(877) 861-6728	Kaiser Foundation Health Plan	(800) 464 - 4000
AMVI Care Health Network	(866) 796 – 4245	Monarch Family HealthCare	(888) 656 - 7523
Arta Western Health Network	(800) 780 - 8879	Noble Mid-Orange County	(888) 880 - 8811
CalOptima Direct	(888) 587 - 7277	Prospect Medical Group	(888) 747 - 2684
CHOC Health Alliance	(800) 424 - 2462	Talbert Medical Group	(800) 297 - 6249
Family Choice Health Network	(800) 611 - 0111	United Care Medical Group	(877) 225 - 6784

Other Agencies	
Medi-Cal Provider Support Line	(800) 541 - 5555
California Children's Services (CCS) Program	(714) 347 - 0300
Denti-Cal (Dental Services for Medi-Cal beneficiaries)	(800) 322 - 6384
Health Insurance Counseling & Advocacy Program (HICAP)	(714) 560 - 0424
Ombudsman Services	(888) 452 – 8609
Orange County Mental Health Inpatient Services (ETS)	(714) 834 - 6913
Orange Mental Health Plan	(800) 723 – 8641
Orange County Health Care Agency CHDP Program	(714) –567-6224
Regional Center of Orange County (RCOC)	(714) 796 – 5354
Social Services Agency	(714) 541 - 4895

Website: www.caloptima.org

HEDIS 2015 Hybrid Measures

Use of these codes should be appropriate to the service rendered and follow billing guidelines.
 Codes are from the NCQA HEDIS specifications and may not reflect Medi-Cal/Medicare billing guidelines and reimbursement.

HEDIS Measure and Description		Medical Record Documentation Needed	Codes
Well Child Visits (W15) Medi-Cal	The percentage of members who turned 15 months old during the measurement year and who had the 0-6 well-child visits with a PCP during their first 15 months of life:	Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following: <ul style="list-style-type: none"> • A health history (hx) (allergies, birth hx, family hx, status since last visit). • A physical developmental history (weight gain, teething, growth chart). • A mental developmental history (smiling, babbling). • A physical exam (vital signs & review of systems). • Health education/anticipatory guidance (car seat, ?). 	<u>CPT</u> : 99381, 99382, 99391, 99392, 99461 <u>HCPCS</u> : G0438, G0439 <u>ICD-9Dx</u> : V20.2, V20.31, V20.32,, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Well Child Visits (W34) Medi-Cal	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following: <ul style="list-style-type: none"> • A health history (allergies, birth hx, family hx, status since last visit). • A physical developmental history (diet, climbs stairs, rides tricycle, growth chart). • A mental developmental history (socialization, school readiness, vocabulary increasing). • A physical exam (vital signs & review of systems). • Health education/anticipatory guidance (completed Staying Healthy Assessment, car seat, seat belt use, diet, exercise, home safety, bike safety, helmet use). 	<u>CPT</u> : 99382, 99383, 99392, 99393 <u>HCPCS</u> : G0438, G0439 <u>ICD-9Dx</u> : V20.2, V20.31, V20.32,, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Adolescent Well Care Visit(AWC) Medi-Cal	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following: <ul style="list-style-type: none"> • A health history (allergies, birth hx, family hx, status since last visit). • A physical developmental history (diet, physical fitness, school activities, sexual activity/pelvic exam, growth chart.. • A mental developmental history (peer relationships, sexual activity, school grades, decision making). • A physical exam (vital signs & review of systems). • Health education/anticipatory guidance (completed Staying Healthy Assessment, seat belt use, diet, exercise, smoking, drug use, health habits, self care). 	<u>CPT</u> : 99383-99385, 99393-99395 <u>HCPCS</u> : G0438, G0439 <u>ICD-9Dx</u> : V20.2, V20.31, V20.32,, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

HEDIS 2015 Hybrid Measures

Use of these codes should be appropriate to the service rendered and follow billing guidelines.
 Codes are from the NCQA HEDIS specifications and may not reflect Medi-Cal/Medicare billing guidelines and reimbursement.

HEDIS Measure and Description		Medical Record Documentation Needed	Codes
Weight Assessment and Counseling for Nutrition and Physical activity for Children/Adolescents (WCC) Medi-Cal	Children 3 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following: <ul style="list-style-type: none"> BMI Percentile Counseling for nutrition Counseling for physical activity 	Documentation MUST include height, weight and BMI percentile during the measurement year and it must be from the same data source. <u>BMI:</u> <ul style="list-style-type: none"> BMI percentile BMI percentile plotted on age-growth chart. For adolescents 16-17 years on the DOS BMI value expressed as kg/m ² is acceptable. <u>Counseling for Nutrition:</u> <ul style="list-style-type: none"> Discussion of current behaviors (eating habits, dieting behaviors, etc.) Checklist indicating nutrition was addressed. Counseling or referral for nutrition education. Member received educational material on nutrition during face-to-face visit. Anticipatory guidance for nutrition. Weight or obesity counseling <u>Counseling for Physical Activity:</u> <ul style="list-style-type: none"> Discussion of current behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation). Checklist indicating physical activity was addressed. Counseling or referral for physical activity. Member received educational materials on physical activity during a face-to-face visit. Anticipatory guidance for physical activity. Weight or obesity counseling. 	BMI Percentile: <ul style="list-style-type: none"> ICD-9Dx: V85.51-V85.54 Counseling for Nutrition: <ul style="list-style-type: none"> CPT: 97802-97804 ICD-9Dx: V65.3 HCPCS: G0270, G0271, G0447, S9449, S9452, S9470 Counseling for Physical: <ul style="list-style-type: none"> ICD-9Dx: V65.41 HCPCS: G0447, S9451
Lead Screening in children (LSC) Medi-Cal	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday	Documentation in the medical record must include both of the following: <ul style="list-style-type: none"> A note indicating the date the test was performed. The result or finding. Blood lead levels (BLLs) are referenced in terms of mcg/dL. A common abbreviation is “Pb”, the chemical symbol for Lead.	CPT: 83655

HEDIS 2015 Hybrid Measures

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HEDIS Measure and Description		Medical Record Documentation Needed	Codes	
Childhood Immunizations (CIS) Medi-Cal	Children 2 years of age receiving the following immunizations by their 2 nd birthday: <ul style="list-style-type: none"> • Four diphtheria, tetanus and acellular pertussis (DTaP) • One measles, mumps and rubella (MMR) • Three Hepatitis B (HepB) • One Hepatitis A (HepA) • Two Influenza (flu) • Three IPV (polio) • Three haemophilus influenza type B (HiB) • One chicken pox (VZV) • Two (Rotarix) OR three (Rota Teq) rotavirus (RV) • Four Pneumococcal Conjugate (PCV) 	<p>For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:</p> <ul style="list-style-type: none"> • A note indicating the name of the specific antigen and the date or service, or • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. <p>For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.</p>	DTaP	<u>CPT</u> : 90698, 90700, 90721, 90723
			IPV	<u>CPT</u> : 90698, 90713, 90723
			MMR	<u>CPT</u> : 90707, 90710
			Measles and Rubella	<u>CPT</u> : 90708
			Measles	<u>CPT</u> : 90705
			Mumps	<u>CPT</u> : 90704
			Rubella	<u>CPT</u> : 90706
			HiB	<u>CPT</u> : 90645-90648, 90698, 90721, 90748
			Hepatitis B	<u>CPT</u> : 90723, 90740, 90744, 90747, 90748, <u>HCPCS</u> : G0010
			VZV	<u>CPT</u> : 90710, 90716
			Pneumo-coccal conjugate	<u>CPT</u> : 90669, 90670 <u>HCPCS</u> : G0009
			Hepatitis A	<u>CPT</u> : 90633
			Rotavirus (2-3 dose schedules)	<u>CPT</u> : 2-dose: 90681 <u>CPT</u> : 3-dose: 90680
			Influenza	<u>CPT</u> : 90655, 90657, 90661, 90662, 90673, 90685, <u>HCPCS</u> : G0008

HEDIS 2015 Hybrid Measures

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HEDIS Measure and Description		Medical Record Documentation Needed	Codes	
Immunizations for Adolescents (IMA) Medi-Cal	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.	For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following: <ul style="list-style-type: none"> A note indicating the name of the specific antigen and the date or service, or A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. Meningococcal conjugate or meningococcal polysaccharide vaccine on or between the 11th and 13th birthdays. Tdap or Td on or between the 10th and 13th birthdays.	Meningo-coccal	<u>CPT</u> : 90733, 90734
			Tdap	<u>CPT</u> : 90715
			TD	<u>CPT</u> : 90714, 90718
			Tetanus	<u>CPT</u> : 90703
			Diphtheria	<u>CPT</u> : 90719
Human Papillomavirus Vaccine for Female Adolescents (HPV) Medi-Cal	The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13 th birthday.	For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following: <ul style="list-style-type: none"> A note indicating the name of the specific antigen and the date or service, or A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. At least three HPV vaccinations, with different dates of service, on or between the member's 9th and 13th birthdays.	HPV	<u>CPT</u> : 90649, 90650
Prenatal Care (PPC) Frequency of Ongoing Prenatal Care (FPC) Medi-Cal	(PPC) The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. <ul style="list-style-type: none"> The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. (FPC) The percentage of expected prenatal visits	Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For a visit to a PCP, a diagnosis of pregnancy must be present. Documentation one of the following: <ul style="list-style-type: none"> A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetrics observations, or measurement of fundus height (standardized prenatal flow sheet may be used). OR Evidence that a prenatal care procedure was performed. OR Documentation of LMP or EDD in conjunction with either of the following <ul style="list-style-type: none"> Prenatal risk assessment and counseling/education Complete obstetrical history. 	<u>Prenatal Visits:</u> <u>CPT</u> : 99201-99205, 99211-99215, 99241-99245, 99500 <u>HCPCS</u> : G0463, H1000-H1004 <u>CPT II</u> : 0500F, 0501F, 0502F <u>Prenatal Ultrasound:</u> <u>CPT</u> : 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, <u>OB Panel:</u> <u>CPT</u> : 80055 <u>ABO/RH:</u> <u>CPT</u> : 86900, 86901 <u>TORCH:</u> <u>CPT</u> : 86644, 86694-86696, 86762, 86777	

HEDIS 2015 Hybrid Measures

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HEDIS Measure and Description		Medical Record Documentation Needed	Codes
Postpartum Care (PPC) Medi-Cal	<p>The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.</p> <ul style="list-style-type: none"> The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 	<p>Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery.</p> <p>Documentation one of the following:</p> <ul style="list-style-type: none"> Pelvic exam, OR Evaluation of weight, BP, breast and abdomen <ul style="list-style-type: none"> Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component. OR Notation of postpartum care, including, but not limited to: <ul style="list-style-type: none"> Notation of “postpartum Care”. “PPC care”, “PP check”, “6-week check”. A preprinted “postpartum Care” form in which information was documented during the visit. 	<p>Postpartum Visits: <u>CPT:</u> 57170, 58300, 59430, 99501 <u>CPT II:</u> 0503F <u>IDC-9-Dx:</u> V24.1, V24.2, V25.11, V25.12, V25.13, V72.31, V72.32, V76.2</p> <p>Cervical Cytology: <u>CPT:</u> 88141-88143, 88147, 88148, 88150, 88152-88154, 88164, 88165-88167, 88174, 88175 <u>HCPCS:</u> G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</p>
Cervical Cancer Screening (CCS) Medi-Cal	<p>The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:</p> <ul style="list-style-type: none"> Age 21-64 who had cervical cytology performed every 3 years Age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. 	<p>Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> A note indicating the date when the cervical cytology was performed. The result or the finding. <p>Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present” this is not considered appropriate screening.</p>	<p>Cervical Cytology: <u>CPT:</u> 88141-88143, 88147, 88148, 88150, 88152-88154, 88164, 88165-88167, 88174, 88175 <u>HCPCS:</u> G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091</p> <p>HPV Tests <u>CPT:</u> 87620, 87621, 87622</p>
Adult BMI Assessment (ABA) Medi-Cal & OneCare	<p>The percentage of members 18 – 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.</p>	<p>Documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI must be from the same data source. For members younger than 19 years on the date of service, the following documentation of BMI percentile also meets criteria:</p> <ul style="list-style-type: none"> BMI percentile documented as a value (e.g., 85th percentile) BMI percentile plotted on an age-growth chart. 	<p>BMI <u>ICD-9Dx:</u> V85.0-V85.45</p> <p>BMI Percentile Only for members younger than 19 years of age on the date of service <u>ICD-9Dx:</u> V85.51-V85.54</p>

HEDIS 2015 Hybrid Measures

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HEDIS Measure and Description		Medical Record Documentation Needed	Codes
Comprehensive Diabetes Care (CDC) Medi-Cal & OneCare	<p>The percentage of member 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:</p> <ul style="list-style-type: none"> Hemoglobin A1c (HbA1c) Testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). Eye exam (retinal) performed. Medical attention to nephropathy. BP control (<140/90 mm Hg). 	<p>Documentation of each:</p> <p><u>HbA1C:</u></p> <ul style="list-style-type: none"> Date of the HbA1c test was performed and the result would be numerator compliant for testing. Date of the HbA1c test was performed and the result <8.0% would be numerator compliant. <p><u>Eye Exam:</u></p> <ul style="list-style-type: none"> A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. A negative retinal or dilated exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. <p><u>Medical attention for nephropathy:</u></p> <ul style="list-style-type: none"> Date of the urine microalbumin test and the results of findings. A note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year. <p><u>BP Control:</u></p> <ul style="list-style-type: none"> Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. For numerator compliant <140/90 mm Hg. 	<p><u>Blood Pressure</u></p> <p><u>CPT II:</u> <u>Systolic:</u> 3074F, 3075F, 3077F <u>Diastolic:</u> 3078F, 3079F, 3080F</p> <p><u>Medical Attention for Nephropathy</u> <u>CPT:</u> 82042- 82044, 84156, 81000-81003, 81005, 36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512 <u>HCPCS:</u> G0257, S2065, S9339 <u>CPT II:</u> 3060F, 3061F, 3062F, 3066F, 4009F, 4010F <u>ICD-9Dx:</u> V42.0, V45.11, V45.12, 585.5, 585.6</p> <p><u>HBA1C Testing:</u> <u>CPT:</u> 83036, 83037 <u>CPT II:</u> 3044F, 3045F, 3046F</p> <p><u>Eye Exam (Retinal)</u> <u>CPT:</u> 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 <u>HCPCS:</u> S0620, S0621, S0625, S3000 <u>CPT II:</u> 2022F, 2024F, 2026F, 3072F</p>

HEDIS 2015 Hybrid Measures

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HEDIS Measure and Description		Medical Record Documentation Needed	Codes
Care for Older Adults (COA) SNP	<p>The percentage of adults 66 years and older who had each of the following during the measurement year.</p> <ul style="list-style-type: none"> • Advance Care Planning • Medication review • Functional status assessment • Pain screening 	<p><u>Advanced care planning</u></p> <ul style="list-style-type: none"> • The presence of an advance care plan in the medical record. • Documentation of an advance care planning discussion with the provider and the date when it was discussed. The documentation of discussion must be noted during the measurement year. • Notation that the member previously executed an advance care plan. <p><u>Medication Review</u> Documentation must come from the same medical record and must include the following:</p> <ul style="list-style-type: none"> • A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed. • Notation that the member is not taking any medication and the date when it was noted. <p><u>Functional Status Assessment</u></p> <ul style="list-style-type: none"> • Activities of Daily Living (ADL) were assessed of that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilets, walking. • 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, meal preparation, housework, home repair, laundry, taking medication, handling finances. • At least three of the following four components were assessed: <ul style="list-style-type: none"> –Cognitive status –Ambulation status –Hearing, vision, and speech (i.e., sensory ability) –Other functional independence (e.g., exercise, ability to perform job). <p><u>Pain Assessment</u></p> <ul style="list-style-type: none"> • Patient was assessed for pain (which may include positive or negative findings for Pain) 	<p><u>Advance care planning</u> CPT II: 1157F, 1158F HCPCS: S0257</p> <p><u>Functional Status:</u> CPT II: 1170F</p> <p><u>Pain Assessment:</u> HCPCS: 1125F, 1126F</p> <p>Medication List and Medication Review (MUST have <u>both</u> on the <u>same</u> DOS):</p> <p><u>Medication List:</u> HCPCS: G8427 CPT II: 1159F</p> <p><u>Medication Review:</u> CPT: 90863, 99605, 99606 CPT II: 1160F</p>

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HEDIS Measure and Description		Medical Record Documentation Needed	Codes
Controlling High Blood Pressure (CBP) Medi-Cal & OneCare	<p>The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:</p> <ul style="list-style-type: none"> Members 18-59 years of age whose BP was <140/90 mm Hg. Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90. 	<p>Documentation of the most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). Confirmation of HTN diagnosis prior to June 30th of the measurement year.</p> <p>Do not include BP readings:</p> <ul style="list-style-type: none"> Taken during an acute inpatient stay or an ED visit Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy). Reported by or taken by the member. <p>If multiple readings on the same day use the lowest systolic and lowest diastolic BP on that date as the representative BP.</p>	<p><u>Code to identify hypertension:</u></p> <p><u>ICD-9Dx:</u> 401.0, 401.1, 401.9</p>
Colorectal Cancer Screening (COL) OneCare & SNP	<p>The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.</p>	<p>Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the 'medical history' section of the record. If it's not clear the results or finding must also be present to ensure that the test was performed and not merely ordered.</p> <ul style="list-style-type: none"> Fecal occult blood test (FOBT, iFOBT) during 2014 Flexible sigmoidoscopy between 2010-2014 Colonoscopy between 2005-2014 	<p><u>FOBT:</u> <u>CPT:</u> 82270, 82274 <u>HCPSC:</u> G0328</p> <p><u>FLEXIBLE SIGMOIDOSCOPY</u> <u>CPT:</u> 45330-45335, 45337-45342, 45345 <u>HCPSC:</u> G0104 <u>ICD-9PCS:</u> 45.24</p> <p><u>COLONOSCOPY</u> <u>CPT:</u> 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 <u>HCPSC:</u> G0105, G0121 <u>ICD-9PCS:</u> 45.22, 45.23, 45.25, 45.42, 45.43</p>
Medication Reconciliation Post-Discharge (MRP)	<p>The percentage of discharges from January 1-December 1 of the measurement year for member 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.</p>	<p>Progress notes of the following:</p> <ul style="list-style-type: none"> Medication List Hospital discharge summary in 2014 Documentation in the medical record must include evidence of medication reconciliation with discharge medications, and the date on which it was performed. 	<p><u>CPT:</u> 99495; 99496 <u>CPT II:</u> 1111F</p>

ANGIE x8636	ANNIE x6196	ARELY x8738	JACKIE x8476	JORGE x5751	JUDY x8616	LETICIA x8577	SYLVIA x8482
Aliso Viejo	Huntington Beach	Buena Park	Fountain Valley	Anaheim	St. Joseph Heritage Healthcare	Santa Ana	Orange
Costa Mesa	Los Alamitos	Cypress	Garden Grove	Family Planning	UCI Specialists	Out of County Providers	Hospitals
Dana Point	Westminster	Fullerton	Tustin		Gerinet	Audiology	DME
Foothill Ranch	Home Health Agencies	La Habra	CVS Minute Clinics		Long Term Care		Ambulatory Surgical Centers
Irvine	Hospice	La Palma	Dialysis Centers		MOMS		
Laguna Beach		Placentia			Transportation		
Laguna Hills		Yorba Linda			Brea		
Lake Forest		Community Clinics					
Mission Viejo		FQHCs					
Newport Beach		CBAS Centers					
San Clemente		CHOC PSF					
San Juan Capistrano							
Orthotics & Prosthetics							

PROVIDER UPDATE

September 2014 Issue

PROVIDER RESOURCE LINE

714-246-8600

providerservices@caloptima.org

PROVIDER RELATIONS REPRESENTATIVES

Arely Servin: 714-246-8738

Jacqueline Nguyen: 714-246-8476

Annie Pruitt: 714-468-1039

Judy Roberts: 714-246-8616

Angie Saucedo: 714-246-8636

Leticia Simpson: 714-246-8577

Sylvia Mora: 714-246-2482

PROVIDER OUTREACH AND EDUCATION EMAIL:

bsaccoman@caloptima.org

WHAT'S INSIDE. . .

- Medi-Cal Primary Care Providers Receive Post-Discharge Service Reimbursements
- Quality Improvement Program Accomplishments and Progress Toward Goals
- Do You Know Medi-Cal's Coverage Conditions for Sterilizations Reimbursement?
- Provider Code Updates

CalOptima Ranked Top Medi-Cal Plan In California

CalOptima is California's top-ranked Medi-Cal health plan, according to NCQA's Medicaid Health Insurance Plan Rankings 2014–2015. The National Committee for Quality Assurance (NCQA) recognized the overall quality of care CalOptima and our provider partners deliver to more than 600,000 Orange County residents. CalOptima is 1st in the state and 29th nationwide among the 136 Medicaid plans that were ranked. The NCQA rankings are based on standardized, third-party-audited data regarding health care quality and customer satisfaction, as well as NCQA accreditation scores.

"This ranking is possible because of the collaborative effort between CalOptima and our provider partners across Orange County. We share this honor with thousands of devoted health care professionals who our members look to each day for quality health care services," said Richard Helmer, M.D., CalOptima Chief Medical Officer. "Together, we are helping Orange County's most vulnerable residents live better and healthier lives."

The 2014–2015 NCQA rankings of Medicaid plans come at an important time of expanded access to such plans for low-income people across the nation. In Orange County through CalOptima, nearly 200,000 people have gained health coverage since January 2014. "Our new members can rely on CalOptima and feel confident that the care they receive is among the best in the state," said CalOptima CEO Michael Schrader. "CalOptima is a mission-driven organization focused on providing all members with access to quality health care delivered in a cost-effective and compassionate manner. The NCQA ranking affirms that we are truly living our mission."

CalOptima's provider partners are the foundation of our high performance, and the Board of Directors and executive leadership decided last year to collect and share the full set of NCQA measures so nationwide comparison would be possible in 2014. Releasing the comprehensive data helps to showcase the quality care that Orange County providers deliver to our members. Thank you!



California's **Top-Ranked**
Medi-Cal Plan

—NCQA's Medicaid Health Insurance Plan Rankings 2014–2015

PROVIDER UPDATE

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Medi-Cal Primary Care Providers Receive Post-Discharge Service Reimbursements

Incentives for Reducing Hospital Readmissions

In an effort to help reduce network and hospital readmissions, CalOptima will reimburse contracted primary care providers (PCPs) for care management services provided to Medi-Cal members upon discharge from an inpatient facility.

To be eligible for this two-year program, Transitional Care Management (TCM) services must begin on the day of discharge and continue until day 30. In addition, the reporting date of service must be exactly 30 days post discharge. Providers must ensure that all components of the following TCM services are received by the member.

To receive reimbursement, providers should bill using CPT Code 99495 when:

- Communication (direct contact, telephone, or electronic) with the patient and/or caregiver is within two business days of discharge,
- Medical decision-making of moderate complexity is during the service period, and
- A face-to-face visit is within 14 calendar days of discharge.

Or use CPT Code 99496 when:

- Communication (direct contact, telephone, or electronic) with the patient and/or caregiver is within two business days of discharge,
- Medical decision-making of high complexity is during the service period, and
- A face-to-face visit is within seven days of discharge.

At the end of the reporting period, based on available funds and ability to meet performance standards, CalOptima contracted hospitals and health networks may also be eligible to receive a reimbursement. For more information, call the Provider Relations department at 714-246-8600.

2014 CalOptima Circle of Care Awards

Established in 2000, the Circle of Care Award has been given to more than 250 distinguished health care professionals, medical groups and allied health providers whose dedication has made a lasting impact on Orange County's vulnerable populations. In particular, CalOptima recognizes those who reach out to the underserved to improve access to care with culturally appropriate services and a focus on quality improvement.

2014
CIRCLE OF CARE
AWARDS

This year's award ceremony took place on September 12 at the Doubletree Hotel in Orange, recognizing a total of 20 recipients. Each honoree was nominated by physicians or health care and community leaders for the pivotal role they play in providing care to underserved populations.

The 2014 Circle of Care Award categories and honorees include:

Physicians: Margaret M. De Sa, M.D.; Haresh S. Jhangiani, M.D.; John P. Kelly, M.D.; Bichlien Nguyen, M.D.; David Núñez, M.D.; Alexandra A. Roche, M.D.; Joseph M. Ruggio, M.D.; Daphne L. Wong, M.D.; **Behavioral/Mental Health:** Alzheimer's Family Services Center; **Nurse/Nurse Practitioners:** Jocelyn Escobar; B.S.W.; Susan Cabral, R.N.; **Medical Group and Clinics:** Planned Parenthood of Orange & San Bernardino Counties; Serve the People Community Health Center; Share Our Selves Health Center; **Pharmacy:** James H. Roache, Pharm.D.; **Other:** Bahram Bahremand, Friends of Family Health Center; West Coast Radiology Breast Centers; Carlos Green, O.D.; Linda Smith, Family Support Network and **Special Recognition:** John (Jack) Silberstein, RPh.

PROVIDER UPDATE

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Reserve Your Seat

CME Workshop

CalOptima is hosting a no-cost CME workshop dinner entitled “Update on Pharyngitis, Sinusitis and Otitis Media” on Wednesday, September 24, from 6:30–8:30p.m., at the Doubletree Hotel located at 100 The City Drive in Orange.

The featured presenter, Dr. Jasjit Singh, specializes in pediatric infectious disease, international health issues and vaccines for children. The timing of this workshop provides essential information for the fast-approaching cold and flu season. Physicians and licensed health care professionals are invited to attend and learn more about the various issues surrounding pharyngitis and upper respiratory infections including:

- Epidemiology and clinical features of Group A strep (GAS) pharyngitis
- Guidelines regarding diagnosis and treatment of GAS pharyngitis
- Clinical features and complications of acute bacterial sinusitis
- Identification of recent guidelines regarding diagnosis and treatment of acute bacterial sinusitis
- Explanation of the epidemiology, etiology and treatment of otitis media in children

Registration is required; please RSVP before September 19, 2014. Contact Byron Naté at CalOptima at bnate@caloptima.org or 714-349-3203. In addition, rapid strep A test kits will be distributed at no cost to all CalOptima providers attending this CME event. Supplies are limited.

September is National Childhood Obesity Awareness Month

One in three children in the United States is overweight or obese. Childhood obesity puts kids at risk for health problems that were once seen only in adults, like type 2 diabetes, high blood pressure, and heart disease.

The good news is that childhood obesity can be prevented. In honor of National Childhood Obesity Awareness Month, CalOptima encourages our providers to inform their patients and families how to make healthy changes together by:

- Getting active outside: Walk around the neighborhood, go on a bike ride, or play basketball at the park.
- Limiting screen time: Keep screen time (time spent on the computer, watching TV, or playing video games) to 2 hours or less a day.
- Making healthy meals: Buy and serve more vegetables, fruits, and whole-grain foods.

Taking small steps as a family can help your child stay at a healthy weight. For more information, contact the CalOptima Health Education department by fax at 714-338-3127 or by email at healthpromotions@caloptima.org.

**STOP
CHILDHOOD
OBESITY**

PROVIDER UPDATE

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CalOptima Regional Extension Center

Your Trusted Advisor in Health IT

CALOPTIMA
FOUNDATION
COREC



Privacy & Security, ICD-10 and California Telehealth Network

Come and Learn about

Privacy and Security in the World of EHR and Health Information Technology

- Your patients trust you. Trust is clinically important and a key business asset.
- How your practice handles patient information is an important aspect of this trust.
- To help cultivate patients' trust in you

Prepare for ICD-10 - When it Happens

- Now is a great time to brush up on ICD-10 basics as you get ready for the transition.

California Telehealth Network Benefits

- California Telehealth Network (CTN) is California's leading agency focusing on increasing access to health care through the innovative use of technology .

Tuesday, September 30, 2014

5:30 p.m. – 8 p.m.

**Hors d'oeuvres and refreshments will be provided*

LOCATION:

**CalOptima Office
505 City Parkway West, #109
Orange, CA 92868**

Please RSVP to <http://privacy-security.eventbrite.com>

For more information, please contact COREC at: info@corecoc.org

PROVIDER UPDATE

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Quality Improvement Program Accomplishments and Progress Toward Goals

CalOptima strives to provide access to quality health care services. Every year, we inform members, providers and community partners about the goals, activities, achievements and projects within our Quality Improvement (QI) program.

These projects and processes ensure that CalOptima provides access to quality health care services that offers education and tools to prevent disease, and manage chronic health conditions.

You can find a complete list of our 2013–2014 QI programs and progress in meeting goals on the CalOptima website at www.caloptima.org.

**Quality
Improvement**

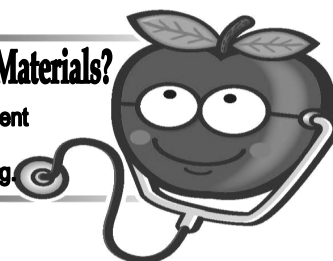
We want to hear from you. . .

Our goal is to make sure that our monthly fax-blast newsletter provides information that fits your needs and interests. Are there topics you would like us to cover? How do you like the *Provider Update*? We hope you'll take a moment to provide us with your input, and send your feedback to:

mdowner@caloptima.org

Looking for Health Education Materials?

Contact the Health Education Department
by fax 714-338-3127 or
email healthpromotions@caloptima.org



Provider Code Updates

Based on recent Operating Instruction Letters (OILs) received from the Department of Health Care Services, CalOptima has updated the procedure codes for the subjects listed below:

- Rate Update to HCPCS Code J7300 (Intrauterine Copper Contraceptive)
- Surgery Reimbursement Policy Update
- Clarification for Coexisting or Additional Diagnoses on Hospice Claims
- New Benefit for Treatment of Ulcerative Colitis and Crohn's Disease
- Unit Limit Increases for Tissue Culture Codes
- National Correct Coding Initiative Quarterly Update for July 2014
- CHDP Program Adds State-Provided Tdap Vaccine

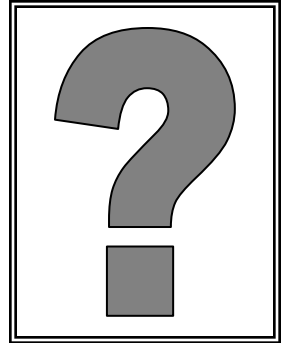
UPDATE

For CalOptima's prior authorization required list, please refer to the CalOptima website: www.caloptima.org. For detailed information regarding these changes, please refer to the August 2014 General Medicine Bulletin on the Medi-Cal website at [Medi-Cal: Medi-Cal Update - General Medicine | August 2014 | Bulletin 482](#) or the CHDP Bulletin [Medi-Cal: Medi-Cal Update - CHDP | August 2014 | Bulletin 118](#).

PROVIDER UPDATE

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Do You Know Medi-Cal's Coverage Conditions for Sterilizations Reimbursement?



Human reproductive sterilization is defined by the regulations as any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations which are performed because pregnancy would threaten the life of the mother (referred to as “therapeutic” sterilizations) are included in this definition. The term sterilization, as used in Medi-Cal regulations, means only human reproductive sterilization, as defined above.

The conditions for which sterilization procedures, both inpatient and outpatient services, are reimbursable by Medi-Cal are consistent with federal regulations (California Code of Regulations, Title 22, Section 51305.4).

A sterilization will be covered by Medi-Cal only if the following conditions are met:

- The individual is at least 21 years old at the time written consent for sterilization is obtained.
- The individual is not mentally incompetent.
- The individual is able to understand the content and nature of the informed consent process.
- The individual is not institutionalized.
- The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section.
- At least 30 days, but not more than 180 days, have passed between the date of the written and signed informed consent and the date of the sterilization.

Exceptions can be made in the following situations:

- Sterilization may be performed at the time of emergency abdominal surgery if:
The patient consented to the sterilization at least 30 days before the intended date of sterilization, and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.
- Sterilization may be performed at the time of premature delivery if the following requirements are met:
the written informed consent was given at least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.

Remember: A completed consent form must accompany all claims for sterilization services. In addition, the only sterilization form accepted by Medi-Cal is the DHS Consent Form (PM330). Claims submitted with a computer generated form or any other pre-printed version of the PM330 will not be reimbursed. Sterilization Consent forms (in English and Spanish) can be downloaded from the forms page of the Medi-Cal website located at www.medi-cal.ca.gov or by calling the Telephone Service Center (TSC) at **800-541-5555**. Providers must supply their NPI number when ordering the form(s).

Providers must maintain the completed and signed Sterilization Consent Form (PM 330) in the client's chart as a permanent part of the medical record.

PROVIDER UPDATE

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Important Meetings

CalOptima Board of Directors Meeting:

October 2, 2 p.m.

CalOptima Provider Advisory Committee Meeting:

October 9, 8 a.m.

CalOptima Care Network Lunch N Learn Meeting:

October 21, 12 p.m.

CalOptima Investment Advisory Committee Meeting:

October 27, 2:30 p.m.

Visit the Provider Events and Workshops section of the CalOptima website to view the provider activities calendar and download registration forms. CalOptima's office is located at: 505 City Parkway West, Orange, CA 92868.

Unless otherwise specified, meetings are held at CalOptima.

Visit the CalOptima Website

Please visit the CalOptima website at www.caloptima.org to view the provider manuals and information on topics that include:

- Member Rights and Responsibilities
- QI Program and Goals
- Privacy and Confidentiality
- Pharmaceutical Management Procedures
- Cultural and Linguistic Services
- Changes to the Approved Drug List (Formulary)
- Clinical Practice Guidelines
- Complex Case Management
- Disease Management Services
- Utilization Management

www.CalOptima.org

Request hard copies by calling **714-246-8600**.



Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data as of August 31, 2014

Total CalOptima
Membership
638,565

Program

Medi-Cal

OneCare (HMO SNP)*

Multipurpose Senior Services Program*

Program of All-Inclusive Care for the Elderly (PACE)*

Members

638,565

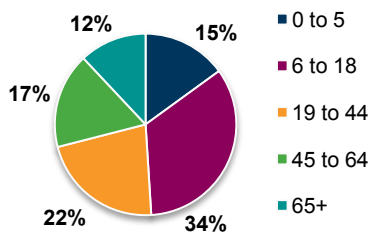
14,714

440

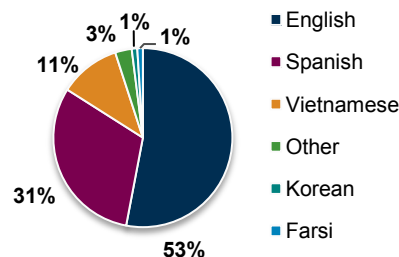
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*Membership already accounted for in total Medi-Cal membership

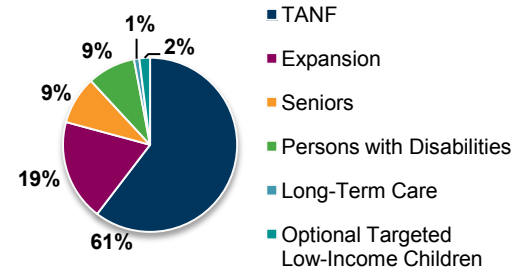
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



Financial Information FY 2014–15 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	\$2,649,895,043	87.57%
OneCare	\$220,826,124	7.30%
Cal MediConnect	\$142,204,222	4.70%
PACE	\$5,147,296	0.17%
MSSP	\$1,949,675	0.06%
All Other Lines	\$6,128,392	0.20%

Total Budgeted Annual Revenue

\$3 billion

Current Reserves = \$430.5 million
(as of August 31, 2014)

CalOptima spends more than 95 cents of every dollar on member care.

Our administrative cost ratio is the fourth lowest (4.74%) out of 15 public plans in California and second lowest among all county organized health systems.



Community Focus

CalOptima is viewed as a trusted source in the community to provide updated and accurate information about the local impact of the Affordable Care Act (ACA) and Medi-Cal. CalOptima supports local community stakeholders through:

45 community activities including:

- Health Fairs
- Town Halls
- Workshops
- Speaking Engagements
- Community Health Care Coalition Meetings
- Health Care Committee Meetings
- Community, Stakeholder and Public Events

Program Quality

CalOptima is the **top ranked** Medi-Cal plan in California according to the **National Committee for Quality Assurance's** Medicaid Health Insurance Plan Rankings 2014–2015:

- 1st in California
- 29th in the United States

CalOptima Medi-Cal received **accreditation with commendable status** from the **National Committee for Quality Assurance**.



Member Satisfaction

2,628 — Average number of customer service calls per day in August 2014

83 percent of CalOptima members surveyed reported **satisfaction** with physician interaction and communication.

96 percent of attendees rate the CalOptima new member orientation as good or excellent.

Provider Network

CalOptima has a strong provider network contracted to serve our members.

1,824 primary care providers

5,386 specialists

30 acute and rehab hospitals

32 community health centers

508 pharmacies

107 long-term care facilities

Sources

1. Administrative Cost Ratio: Department of Managed Health Care, full-service plans 2013 annual data for local initiatives and county organized health systems in California. 2013 is the last full year of reported data as of May 2014.
2. Membership Data: Based on unaudited financials.
3. Community Focus: CalOptima Public Affairs data.
4. Program Quality: NCQA's Medicaid Health Insurance Plan Rankings 2014–2015.
5. Member Satisfaction: CalOptima Customer Service data as of August 2014; annual Provider Relations and Customer Service data.
6. Provider Network: CalOptima contracting data.