CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Agenda

Quarterly Community Provider Network (CPN) Meeting

Contra Costa Health Plan

When: Time: 7:30 AM – 9:00 AM**
Date: January 23, 2017

Where: **Muir Parkway Office Center**
1340 Arnold Drive, Conference Room 112 ***(Please note new address)***
Martinez, CA. 94553

The agenda for the meeting is as follows:

I.	**CALL TO ORDER and INTRODUCTIONS**	
	• **Reminders: Initial Health Assessment (IHA) - USPSTF / SHA /H&P**	Christine Gordon, BSN, DHCS-MT
II.	**REVIEW and APPROVAL of Previous Meeting Minutes**	Jose Yasul, MD Assistant Medical Director, CCHP
III.	**NEW BUSINESS**	
	• **Behavioral Health/Medi-Cal Waiver** • **Lactation Program**	Fatima Matal Sol AOD Program Chief Catherine Harrell, MSW
IV.	**DISCUSSION ITEMS**	
	• **CCHP Updates** 1. **Referral Authorizations** 2. **Alcohol Misuse Screening & Counseling (AMSC)**	Jose Yasul, MD Assistant Medical Director, CCHP
V.	**CLAIMS Q&A**	Staff

Our next scheduled meeting is: April 24, 2018

**** CPN meeting reimbursement will be prorated based on length of time attendee is present in the meeting.**

CONTRA COSTA HEALTH PLAN

Central County

Quarterly Community Provider Network (CPN)

Meeting Minutes – January 23, 2018

Attending:

CCHP Staff: J. Yasul, MD; Christine Gordon, RN, BSN; Alycia Rubio, Business Services Manager; Kristine Miller, Support Staff Lead Clerk Specialist; Jonel Sangalang, Clerk; Delaina Gillaspy, Secretary

CPN Providers: S. Blair, CPNP; M. Chang, MD; D. Espinoza, CPNP; G. Graves, MD; E. Risgalla, MD; S. Sachdeva, MD; J. Sequiera, MD; S. Swenson, CPNP R. Tracy, MD; K. Warren, CPNP; L. Yang, MD

Discussion	Action	Accountable
Meeting called to order at 7:38 A.M.		Christine Gordon, BSN, DHCS-MT
I. Agenda was approved with no revisions.		Jose Yasul, MD
II. Reminders: 1. Initial Health Assessment (IHA) a. Must be completed within 120 days of enrollment into the health plan or documented within the 12 months prior to Plan enrollment. b. If member assigned to new PCP, IHA must be completed within 120 days of that assignment if no IHA documented within the past 12 months. c. IHA includes H&P and IHEBA 2. Staying Healthy Assessment (SHA) a. All SHA's must be signed and dated by PCP or cannot receive credit for SHA on (Medical Records Review) MRR. i. Assigned PCP's are responsible for SHA's b. SHA Handouts provided i. SHA must be completed for each specified age interval. c. United States Preventive Services Task Force (USPSTF) i. Handouts provided. ii. Recommendations for Practice: A and B 1. A: The USPSTF recommends the services. There is a high certainty that the net benefit is substantial. 2. B: The USPSTF recommends the service. There is a high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial. 3. Department of Health Care Services (DHCS) a. DHCS will be looking for IHA, SHA, USPSTF.		Christine Gordon, BSN, DHCS-MT
III. Review Care Matters Bulletin: • Alcohol Misuse Screening and Counseling (AMSC) ➢ Formerly called SBIRT ➢ AMSC is a requirement for all Medi-Cal members since January 1, 2014. ➢ Providers who meet requirements may be reimbursed using the following HCPCS codes and frequencies ▪ H0049 for alcohol screening ($24.00 for each qualifies member, once a year.) ▪ H0050 for brief intervention ($48.00 up to 3 times per year.)		Jose Yasul, MD

- AMSC provides a comprehensive, integrated delivery of early intervention and treatment services for persons with alcohol abuse disorders and those at risk of developing them.
- PCP's should offer the AMSC to members who answer "yes" to the alcohol question in the Staying Healthy Assessment (SHA) or at any time the PCP identifies a potential alcohol misuse problem.
- Providers should document in the medical record the offer of AMSC, and member refusal of SHA or AMSC.
- DHCS Recommends
  - Alcohol Use Disorder Identification (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (Audit-C) as a screening too.
- Online training is recommended, but not required.
  - Training is available at http://www/uclaisap.org/sbirt/
  - AMSC and SHA document are available at http://cchealth.org/healthplan/providers under **Forms and Resources**.

Pharmacy:

- Flu Season
  - Contra Costa Health Plan will pay for brand medications.
- Medications
  - Contra Costa Health Plan Preferred Drug List (PDL) can be found on http://cchealth.org/healthplan/pdf/pdl.pdf
- EPOCRATES
  - Free mobile and online formulary resource

Utilization Management:

- Prerequisites
  - Prerequisites must be done before referring a patient for service.
  - When there are no prerequisites it results in a denial for the member.

New Business:

IV. 1. Behavioral Health/Medi-Cal Waiver — Fatima Matal Sol, AOD Program Chief

a. New and enhanced benefits for all Medi-Cal members and undocumented patients. Treatment is provided all throughout Contra Costa County. Services are provided to all Contra Costa residents, they do not have to be a member of Contra Costa Health Plan to receive services.
b. Program was started July 1st, 2017 and has now expanded to 56 other counties.
c. There is NO waitlist list for patients to receive services.
d. Services can be provided within 10 days, and depending on level of care needed, treatment can be provided the next day.
e. This service offers different levels of care
   i. Outpatient treatment: 9 hours per week including counseling/other services
   ii. Intensive outpatient treatment: 9-19 hours per week including counseling/other services.
   iii. Inpatient treatment- residential: provides care to help patients progress to needing a lower level of care.
f. Withdraw Management/ Detoxification Services

	i. Telephone screening takes 10-12 minutes to complete. ii. A referral is not needed for detoxification services. g. Services offered for pregnant women with substance abuse problems. h. Medication assistant treatment i. Many new medications available with new benefit package.	
V.	2. Lactation Program a. New and enhanced benefit i. This service is provided for those who do not qualify for WIC ii. Covered by Contra Costa Health Plan b. Advice Nurse i. Can provide information about lactation program and contact Lactation Consultant. c. Lactation Consultant i. Lactation Consultant will try to make contact within 24 hours. ii. Lactation Consultant is available 7 days a week iii. Will provide 3-4 consultants in person/telephone iv. Initial consultation will be face-to-face	Christine Gordon, BSN, DHCS-MT
VI.	**Questions:** • Claims o A member from the claims department will be attending meetings to answer questions for providers. o Available for questions anytime by phone and email.	Alycia Rubio, Business Services Manager
	Adjournment: Meeting adjourned at 8:50 A.M.	

Next meeting April 24, 2018

Rationale: Pediatric preventive services are provided in accordance with current AAP periodicity, and include CHDP assessments. **RN/MD Review only**

Criteria	IV. Pediatric Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) IHA includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Well-Child Visit	
1. Well-child exam completed at age appropriate frequency	Health assessments containing CHDP age-appropriate content requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **Note**: Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, the AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.
2. Anthropometric measurements	Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months.
3. BMI Percentile	BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years. Note: The BMI percentile calculation is based on the CDC's BMI-for-age- growth charts, which indicates the relative position of the patient's BMI number among others of the same sex and age. Ref: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
4. Developmental screening	Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)
5. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member.
6. STI screening on all sexually active adolescents, incl. chlamydia for females	All sexually active adolescents should be screened for sexually transmitted infections (STIs), including chlamydia for females.
7. Pap smear on sexually active females	Pap smear within 3 years of onset of sexual intercourse.
D. Vision Screening	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations such as external eye inspection, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.

Criteria	IV. Pediatric Preventive Reviewer Guidelines RN/MD Review only (continued from previous page)
E. Hearing Screening	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.
F. Nutrition Assessment	Screening includes: 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program for medical nutrition therapy or other in-depth nutritional assessment.
G. Dental Assessment	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist ***at any age*** if a dental problem is detected or suspected. Beginning at 3 years of age, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Blood Lead Screening Test	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1) at 12 month *and* 24 months of age, 2) between 12 months and 24 months of age *if* there is no documented evidence of BLL testing at 12 months or thereafter, *and* 3) between 24 months and 72 months of age *if* there is no documented evidence of BLL testing at 24 months or thereafter. Elevated BLL of 10 µg/dL or greater require additional BLL and follow-up in accordance with current DHCS policy or as follows: • 10-14 µg/dL: Confirm with venous sample within 3 months of original test; • 15-19 µg/dL: Confirm with venous sample within 2 months of original test, then retest 2 months following the confirmatory testing; • 20-44 µg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL; • 45-59 µg/dL: Retest with venous sample within 48 hour; • 60-69 µg/dL: Retest with venous sample within 24 hours; • ≥ 70 µg/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 µg/dL must be referred to CCS.
I. Tuberculosis Screening	All children are assessed for risk of exposure to tuberculosis (TB) at each health assessment. The Mantoux skin test, or other approved TB infection screening test,* is administered to children *identified at risk*, if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. *Per June 25, 2010 CDC MMWR, FDA approved IGRA serum TB tests, i.e., QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). The Mantoux is preferred over IGRA for children under 5 years of age. Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm
J. Childhood Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services. **RN/MD Review only**

Criteria	V. Adult Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) Includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Periodic Health Evaluation according to most recent USPSTF Guidelines.	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
D. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. USPSTF link for high blood pressure screening: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm
E. Obesity Screening	Includes weight and body mass index (BMI).
F. Lipid Disorders Screening	All men (ages 35 years and older) are screened. Women (ages 45 years and older) are screened if at increased risk for coronary heart disease. Screening includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Men under 35 years and women under 45 year may also be screened for lipid disorders if at increased risk for coronary artery disease. USPSTF link for lipid disorder screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services. **RN/MD Review only**

Criteria	V. Adult Preventive Reviewer Guidelines (continued from previous page)
G. Tuberculosis Screening	Adults are screened for tuberculosis (TB) risk factors upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test,* is administered to **all** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing.** The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and .treatment. * Per June 25, 2010 CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm ** Per CTCA/CDPH: www.ctca.org/guidelines/IIA2targetedskintesting.pdf
H. Breast Cancer Screening	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated. USPSTF link: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm
I. Cervical Cancer Screening	Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin within 3 years of onset of sexual activity or age 21 (whichever comes first) and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of invasive cancer, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal. USPSTF link for cervical cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm
J. Chlamydia Infection Screening	Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Practitioner may screen women older than 25 years of age if the practitioner determines that the patient is at risk for infection. Lab results are documented.
K. Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 50 years and continuing until age 75 years to include: 1. Annual screening with high-sensitivity fecal occult blood testing, **or** 2. Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years, **or** 3. Screening colonoscopy every 10 years. USPSTF link for colorectal cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm
L. Adult Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

Staying Healthy Assessment FAQs

What is the Staying Healthy Assessment (SHA)?

- The SHA is the Department of Health Care Services' (DHCS)

Individual Health Education Behavior Assessment (IHEBA). The form
is one page, front and back, and it is used to identify and document patients' health education needs
related to lifestyle, behavior, environment, and cultural and linguistic background.

- It is available in English, Spanish and Chinese, as well as many other languages.
- Primary Care Providers (PCPs) are required to use and administer the SHA to all Medi-Cal beneficiaries as part of the Initial Health Assessment (IHA) and re-administer it according to periodicity guidelines set forth by the Medi-Cal Managed Care Division (MMCD):
    - 0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years
    - Adult (18-55 years), Senior (55+ years)

- **SHA forms must be implemented in provider offices by April 1, 2014**.
- PCPs may use an alternative IHEBA with prior approval of the MMCD. Please contact SFHP (provider.relations@sfhp.org) if you are interested in utilizing an alternative form and we will seek approval from MMCD. MMCD required that all alternative forms already be submitted for approval to SFHP by February 28, 2014. If your office plans to use an alternative form and you did not already submit it for approval, please do so immediately. See below for details on submission.

How do I administer and document the SHA?

1. The SHA consists of seven age-specific pediatric questionnaires and two adult questionnaires

- 0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years
- Adult (18-55 years) and Senior (55+, at provider's discretion)

2. Filling out the SHA:

- Administer a new SHA at each new age interval; review and sign the existing form at annual visits
- Encourage patients ages 12 and older to self-complete the SHA
- SHA questions may be asked verbally and responses recorded directly in the patient's EMR
- Patients have the right to refuse, decline, or skip any or all parts of the SHA
- Encourage each patient to complete an age-appropriate SHA every subsequent year during a scheduled exam

3. Reviewing the completed SHA with the patient:

- Determine extent of risk factors on patient's health, and prioritize the risk factors with the patient
- Provide tailored health education counseling, intervention, referral, follow up, and risk reduction plan, if applicable
- Other clinic staff may assist with reviewing the SHA with the patient as long as medical issues are referred to PCP

4. Provider's documentation requirements:

- Sign and print provider's name and date
- Document specific behavioral risk topics and patient counseling, referrals, anticipatory guidance, and follow-up provided to the patient
- Document patient's refusal to complete the SHA
- Keep the signed SHA in the patient's medical record

5. SHA electronic format

- Providers may add SHA questions into an EMR template or scan the SHA into an EMR that includes the electronic provider signature (must include all current and unaltered SHA questions)
- SFHP must review the electronic format to ensure it meets all requirements at least two months prior to implementation (per the State regulation)

How do I use an alternative IHEBA?

1. Use of the SHA tool is strongly recommended (alternative IHEBAs require pre-approval by the Department of Health Care Services).

2. Any alternative assessments must be translated into Spanish and Chinese and meet all the same standards as the SHA.

3. The American Academy of Pediatrics' *Bright Futures* assessment has been pre-approved by DHCS as an alternative IHEBA. It can be used as long as it is the most current version.

4. Requests to use an alternative IHEBA must meet the following criteria:
a. Evidence that the alternative assessment includes the content and specific risk factors included in the most current version of the SHA.

b. The periodicity table and schedule for administration of the alternative IHEBA, which must be comparable to the requirements for the SHA.

c. A process or method for documenting and verifying that the administration, re-administration, and the annual review of the alternative assessment are similar to the SHA requirements.

How do I comply with the SHA regulation?

1. All SFHP-contracted PCPs will send attestation to provider.relations@sfhp.org by April 1, 2014, indicating the training slides were reviewed

2. SFHP Facility Site Review nurses will review if sites are in compliance once every three years

Where are the SHA forms located? All SHA forms and training slides are available for download and printing on the DHCS site:
www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

What if I have additional questions? Please contact provider.relations@sfhp.org or visit SFHP's website: http://www.sfhp.org/providers/download-forms/staying-healthy/

Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School?
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

USPSTF A and B Recommendations

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014*
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016*
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	October 2015*
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013*

Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016*
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	A	June 2016*
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014*
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016*
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016*
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015*
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012

Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	January 2017*
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014*
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013

Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017*
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	March 2008
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Preeclampsia: screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	B	April 2017
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014*
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012

Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.	B	November 2016*
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A	September 2015*
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A	September 2015*
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.	B	September 2016
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	June 2016*
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Vision screening: children	The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017*

†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1.

*Previous recommendation was an “A” or “B.”

Current as of: April 2017

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

National Medical Policy

Subject: **Septoplasty, Turbinoplasty and Rhinoplasty**

Policy Number: **NMP488**

Effective Date*: **March 2005**

Updated: **May 2016**

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

For Medicaid Plans: Please refer to the appropriate State's Medicaid manual(s), publication(s), citation(s), and documented guidance for coverage criteria and benefit guidelines prior to applying Health Net Medical Policies

The Centers for Medicare & Medicaid Services (CMS)
For Medicare Advantage members please refer to the following for coverage guidelines first:

Use	Source	Reference/Website Link
	National Coverage Determination (NCD)	
	National Coverage Manual Citation	
X	Local Coverage Determination (LCD)*	Cosmetic and Reconstructive Surgery: Plastic Surgery: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx
x	Article (Local)*	Cosmetic and Reconstructive Surgery: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx
	Other	
	None	Use Health Net Policy

Instructions

- Medicare NCDs and National Coverage Manuals apply to ALL Medicare members in ALL regions.
- Medicare LCDs and Articles apply to members in specific regions. To access your specific region, select the link provided under "Reference/Website" and follow the search instructions. Enter the topic and your specific state to find the coverage determinations for your region. *Note: Health Net must follow local coverage determinations (LCDs) of Medicare Administration Contractors (MACs) located

outside their service area when those MACs have exclusive coverage of an item or service. (CMS Manual Chapter 4 Section 90.2)

- If more than one source is checked, you need to access all sources as, on occasion, an LCD or article contains additional coverage information than contained in the NCD or National Coverage Manual.
- If there is no NCD, National Coverage Manual or region specific LCD/Article, follow the Health Net Hierarchy of Medical Resources for guidance.

Current Policy Statement

Septoplasty

Health Net, Inc. considers septoplasty (submucous resection), and associated middle and inferior turbinate surgery with obstructive symptoms medically necessary to correct internal deformities of the nose when any of the following are met:

1. To correct a deviated septum that produces chronic nasal obstruction and results in significant medical disabilities from recurrent purulent sinusitis (more than 3 episodes per year), and both of the following:

    a. Must have evidence by CT scan of unremitting chronic or recurrent sinusitis (e.g., clouding of sinuses, opacification of a sinus, air-fluid levels or mucosal thickening with significant narrowing or obstruction of the osteomeatal complexes); and

    b. Conservative therapy for a period of at least 3 months has failed to alleviate or prevent episodes of sinusitis, including any of the following:

        - Appropriate antibiotics; OR
        - Nasal sprays, decongestants, antihistamines and/or topical intranasal steroids; OR
        - Specific documented attempts to discontinue nasal irritants, including smoking, occupational exposure, drugs, and inadequate humidification.

2. Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty not responding to 4 or more weeks of appropriate medical therapy; or

3. Recurrent epistaxis related to a septal deformity (4 or more significant episodes per year) when conservative treatment measures have failed, such as avoidance of medications affecting coagulation, adding humidity to the environment, and cauterization; or

4. Nasal septum trauma/perforation that resulted in new and significant functional abnormalities; or

5. Need for reconstruction after the removal of a benign or malignant tumor, or surgical removal of part of a structurally significant part of the nasal septum; or

6. When done in association with congenital malformations (e.g., cleft lip and/or palate or any craniofacial deformity associated with severe, documented functional impairment); or

7. Deviation is causing difficulty tolerating nasal continuous positive airway pressure (CPAP) used to treat documented obstructive sleep apnea, and is refractory to medical management; or

8. Treatment of atypical, unilateral facial pain (Sluder's Syndrome) caused by septal contact points diagnosed by spray anesthesia of the nasal mucosa

Note: Health Net, Inc. considers laser-assisted septoplasty and radiofrequency volumetric tissue reduction (RFVTR, Somnoplasty) of nasal turbinates (turbinate coblation) medically necessary as the turbinate mucosa can be measurably and reproducibly corrected using these tools instead of a knife.

Contraindications to performing septoplasty include, but are not limited to:

1. Large septal perforation;
2. Cocaine abuse;
3. Wegener granulomatosis;
4. Malignant lymphomas or monoclonal T- or B-cell proliferations.

Rhinoplasty
Rhinoplasty is considered not medically necessary when performed solely as a cosmetic surgical procedure to shape the external contour of the nose (e.g., to correct the appearance of a bulbous tip, an obvious bump or hook, or flared nostrils, etc.) However, reconstructive rhinoplasty may be considered medically necessary to correct deformities for functional improvement in any of the following explicit situations:

1. Birth defects, e.g., congenital cleft lip and/or palate, and any other congenital craniofacial deformity, when associated with severe functional impairment

2. Significant, documented nasal trauma with distortion within the 3 months prior to surgery that significantly compromises the nasal airway and can only be corrected by combined septo-rhinoplasty as opposed to delayed open reduction of nasal and septal fracture, (CPT 21335).

3. Choanal atresia

4. Cancer

5. Septal infection with saddle deformity

6. When there is documentation that obstructed nasal breathing due to septal deformity is not amenable alone to septoplasty due to significant loss of structural integrity of the septum by external nasal traumatic deformity.

7. To correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves and/or nasal bone distortion significantly compromising the nasal airways) due to trauma, disease, or congenital defect, when all of the following are met:

Frequency Restriction

Cardiac implantable devices and stents have a frequency restriction of once a year for the same recipient by the same provider. Medical justification documented in the *Remarks* field (Box 80) is required for any surgical implantable device claims billed more than once in a year

Surgical Treatment of Varicose Veins

Varicose veins may be surgically treated when conservative treatment has been unsuccessful in resolving symptoms.

Definition

Symptomatic varicose veins are defined as one of more of the following:

- Documented persistent or recurrent symptoms attributable to venous insufficiency such as pruritis, burning or edema that interfere with daily activity, or pain requiring analgesics. Submitted documentation should summarize the diagnostic evaluation and describe the nature of the functional limitation. These individuals must have failed a three-month trial of conservative management, including analgesics and prescription gradient support stockings providing at least 20 mm Hg of compression at the ankle.
- Hemorrhage from venous varicosity.
- Venous stasis ulceration.

TAR Requirements

An approved *Treatment Authorization Request* (TAR) is required for all reimbursements for stab phlebectomy, ligation and division with or without vein stripping, and radiofrequency ablation (RFA) or endovenous laser ablation (EVLA) of incompetent veins.

The following data must be clearly reported and accompany all TARs for surgery:

- Duplex ultrasound demonstrating clinically significant venous reflux of the great saphenous, small saphenous or perforating veins defined as greater than or equal to 0.5 seconds retrograde flow in the vein to be treated.
- Vein diameter must be 4.5 mm or greater in diameter, not severely tortuous, and vein diameter no greater than 12 mm for RFA or 20 mm for EVLA.
- Adequate patency of the deep veins of the leg documented by ultrasound.

Limitations

Additional limitations for surgical treatment of varicose veins:

- Duplex ultrasound when performed during a procedure or to monitor postoperative progress is not separately reimbursable.
- Stab phlebectomy may only be performed concurrently or shortly after RFA or EVLA if varicosities remain following successful RFA or EVLA. Duplex ultrasound must demonstrate no residual reflux and patency of the deep veins of the leg.
- No TARs will be approved for multiple treatment sessions of the same procedure on the same extremity. Repeat procedures are only indicated if clinical and anatomic failure unresponsive to conservative treatment is demonstrated after the 90-day post-operative period.

Contraindications

Contraindications for surgical treatment of varicose veins include but are not limited to:

- Pregnancy and three months following delivery
- Acute febrile illness or infection
- Recent deep vein thrombosis
- Acute superficial thrombophlebitis
- Severe peripheral artery disease (ankle-brachial index of 0.4 or less)
- Obliteration of deep venous system

Ventricular Assist Devices and Accessories

Ventricular Assist Devices that are FDA-approved are a benefit for FDA-approved indications. Claims for HCPCS codes Q0478 – Q0504 and Q0506 – Q0509 (ventricular assist devices and accessories) are reimbursed at invoice cost. Q0478 (power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type) is reimbursable as a rental only, using modifier RR. Q0479 (power module for use with electric or electric/pneumatic ventricular assist device, replacement only) is reimbursable as a replacement only, using modifier RB. Q0478 and Q0479 are non-taxable. Q0506 (Battery, lithium-ion, for use with electric or electric/pneumatic, ventricular assist device, replacement only) must be billed with modifier NU.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER CONTRA COSTA COUNTY FAQ

What is the Waiver?

The Drug Medi-Cal Organized Delivery System "Bridge to Reform" Demonstration Waiver ("DMC Waiver") is a pilot program that expands benefits to treat substance use disorders (SUDs). The DMC Waiver will test new models of delivering services to Medi-Cal eligible county residents with SUD.

California counties opting into the DMC Waiver are allowed Medi-Cal reimbursement for additional SUD treatment modalities and new benefits for Medi-Cal beneficiaries.

How does the DMC Waiver improve SUD treatment?

- Increase and improve the quality and availability of SUD services
- Expand the types of services available
- Support coordination and integration of physical and behavioral healthcare systems
- Reduce emergency room and hospital inpatient visits
- Ensure faster access to SUD services while also increasing program oversight and integrity at the county and state level

How does the DMC Waiver change current SUD treatment services?

It expands reimbursable services under Drug Medi-Cal (DMC). DMC will fund outpatient, intensive outpatient, residential and opioid (methadone) treatment programs. The Waiver allows DMC to fund a more comprehensive system of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD services.

Who is eligible for the SUD benefits?

All Medi-Cal beneficiaries who live in Contra Costa County or another participating county have access to the new services. This includes previously eligible Medi-Cal beneficiaries (such as children in households with income up to 250% of the federal poverty level) and the Medi-Cal expansion population (single adults without children with incomes up to 138% of the federal poverty level). A qualified physician or Licensed Professional of the Healing Arts (LPHA) MUST determine the services to be medically necessary.

When will the DMC Waiver be available in Contra Costa County?

The new services are already available. The DMC Waiver contract was approved by the federal Centers for Medicare & Medicaid Services and by the county Board of Supervisors as of June 2017.

What does medical necessity mean?

"Medically necessary" means the patient is diagnosed with at least one disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except tobacco-related disorders and non-substance-related disorders, or is younger than 21 and assessed to be at risk for developing a SUD. Patients must meet ASAM criteria for medical necessity or, if applicable, the ASAM adolescent treatment criteria.

How can residents access services under the DMC Waiver?

Contra Costa residents may access services by calling the toll-free Behavioral Health Access Line at 1-800-846-1652. to obtain ASAM placement and be referred to a Drug Medi-Cal certified provider.

CONTRA COSTA
ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

What is Medication Assisted Treatment (MAT)?

Medications can be used in combination with behavioral therapies to treat alcohol or opiate abuse. Methadone treatment is already available through DMC. Several more pharmacotherapies are available through the DMC Waiver.

For example, **Acamprosate** reduces alcohol withdrawal symptoms and can help patients to achieve abstinence or maintain longer sobriety periods.

Naltrexone, a medication used to block the effects of opioids, can also reduce craving in those with alcohol use disorders.

Disulfiram changes the way the body metabolizes alcohol, resulting in unpleasant reactions such as flushing and nausea if a patient consumes alcohol after taking it.

Buprenorphine is a safe and effective medication to help people reduce or quit their use of heroin or other opiates.

Summary of Benefits and Coverage				
Services you May Need	**ASAM Level**	**Youth (13-18)**	**Adult**	**Limitations and Exceptions**
Preventive Care: Screening and Brief Intervention (SBIRT)	.5	✓	✓	Once per year with your medical provider or managed care plan benefits
Outpatient care from DMC-certified providers	1	✓	✓	Up to nine hours of weekly treatment for adults and six for youth
Intensive Outpatient care from DMC-certified providers	2.1	✓	✓	Nine to 19 hours of weekly treatment for adults and six to 19 hours for youth
Short-term & long-term residential treatment (Social Model DMC-certified providers)	3.1	✓	✓	Two non-continuous, 90-day stays for adults per year. Requires prior authorization. One 30-day extension may be authorized, subject to utilization review.
				Two non-continuous stays of up to 35 days for youth per year. Requires prior Authorization. One 30-day extension may be authorized, subject to utilization review.
Non-medical withdrawal management 24-hour detoxification and moderate withdrawal support in a Social Model setting	3.2	N/A	✓	Immediate admission with authorization required.
MEDICATION ASSISTED TREATMENT (MAT) PHARMACOTHERAPY				
Opioid Treatment				
Methadone – NTP licensed facilities Behavioral counseling of up to 200 minutes per month, in 10- to 20-minute sessions.		N/A	✓	Additional counseling with medical justification for individual and group behavioral therapy
Suboxone Services available through specialty "Choosing Change" clinics within Contra Costa Health Services and waivered doctors		N/A	✓	Behavioral Health individual and group counseling through behaviorists in the clinics
Case Management		✓	✓	Supports transition across levels of care.
Recovery Support		✓	✓	Prevents relapses, sustains sobriety and builds self-management skills. Benefit may be available after completion of treatment.

ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)

Alcohol Misuse Screening and Counseling (AMSC), formerly called SBIRT, has been a requirement for adult Medi-Cal members since January 1, 2014. AMSC provides comprehensive, integrated delivery of early intervention and treatment services for persons with alcohol abuse disorders and those who are at risk of developing them. Based on the United States Preventive Services Task Force (USPSTF), it is recommended that Primary Care Providers (PCPs) provide screening and brief interventions when a member aged 18 or older misuses alcohol.

PCPs should offer the AMSC to members who answer "yes" to the alcohol question in the Staying Healthy Assessment (SHA) **or at any time the PCP identifies a potential alcohol misuse problem.** Providers should document in the medical record the offer of the AMSC and any member refusal of the SHA or AMSC.

The Department of Health Care Services (DHCS) recommends using the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (Audit-C) as screening tools which are available on our website (Go to www.cchealth.org, then click on Health Plan, For Providers, and see Forms and Resources). If indicated, a **screening** should be done at least one time and may be done up to three times per year, per member. Persons engaged in risky or hazardous drinking should then be given **brief behavioral counseling interventions** to reduce alcohol misuse. **Brief Interventions** consist of a provider interaction with a member that is intended to encourage a positive change in a health-related behavior. Brief Interventions may include an initial intervention, a follow-up intervention, and/or referral to Mental Health. **Follow-up Intervention** consists of reassessment of the member's status, progress, and the promotion to sustain a reduction in alcohol use and/or to assess a member's need for additional services.

Behavioral counseling intervention(s) typically include one to three 15-minute sessions. Providers may combine these sessions in one or two visits or administer the sessions as three separate visits. Additional behavioral counseling interventions can be provided if medically necessary. If a member meets criteria for alcohol use disorder, or the diagnosis is uncertain, then he or she should be referred to the Contra Costa County Mental Health Services at 1-888-678-7277. The member may also be referred by using the forms available on our website at the following link: http://cchealth.org/healthplan/providers/ then go to Forms and Resources under which clickable Mental Health referral forms are listed.

AMSC services may be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider, including, but not limited to a:

- Licensed Physician
- Physician Assistant
- Nurse Practitioner

- Psychologist

It is recommended that at least one supervising licensed provider per clinic or practice take four hours of AMSC training after initiating AMSC services. The training is not required for reimbursement. However, it is recommended. Training is available at: http://www/uclaisap.org/sbirt/ and AMSC and SHA documents are located on our website at http://cchealth.org/healthplan/providers/ **under Forms and Resources**.

Reimbursement

Providers who meet the requirements above to screen and provide brief intervention for alcohol misuse/abuse may be reimbursed using the following HCPCS codes and frequencies:

- **H0049 for alcohol screening ($24.00 for each qualifying member, once a year).**
- **H0050 for brief interventions ($48.00 up to 3 times per year).**

If you have any questions, please contact the CCHP Provider Relations Nurses Line at (925) 313-9527 or by email at Christine.Gordon@hsd.cccounty.us, Minawar.Tuman@hsd.cccounty.us and/or Alejandro.Fuentes@hsd.cccounty.us

Updated STOP-Bang Questionnaire

Yes ○ No ○ **S**noring?
Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Yes ○ No ○ **T**ired?
Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Yes ○ No ○ **O**bserved?
Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes ○ No ○ **P**ressure?
Do you have or are being treated for **High Blood Pressure**?

Yes ○ No ○ **B**ody Mass Index more than 35 kg/m^2?

Yes ○ No ○ **A**ge older than 50 year old?

Yes ○ No ○ **N**eck size large? (Measured around Adams apple)
For male, is your shirt collar 17 inches/43 cm or larger?
For female, is your shirt collar 16 inches/41 cm or larger?

Yes ○ No ○ **G**ender = Male?

Scoring Criteria:

For general population

Low risk of OSA: Yes to 0-2 questions
Intermediate risk of OSA: Yes to 3-4 questions
High risk of OSA: Yes to 5-8 questions

or Yes to 2 or more of 4 STOP questions + male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m^2
or Yes to 2 or more of 4 STOP questions + neck circumference

(17”/43cm in male, 16”/41cm in female)

Modified from: Chung F et al. Anesthesiology 2008; 108:812-21; Chung F et al. Br J Anaesth 2012, 108:768–75; Chung F et al. J Clin Sleep Med 2014;10:951-8.