Health Net®

2018 Medi-Cal Encounter Data Toolkit

Business Process Improvement

Includes the following:

- HN Encounter Data Performance Standards & Best Practices
- HEDIS Provider Pocket Guide
- Incentive Programs
- Provider Incentive Programs
- PM160 Transition Guide
- PM160 Code Conversion Crosswalk
- PM160 – CMS-1500 Job Aide
- PM160 Webinar Calendar
- Prop 56 Infographic

Health Net Encounter Data

Performance Standards

Volume

PPGs must be at the 75th peer percentile for encounter volume as measured by number of services (CPT) rendered. This means that patients must have an average of 14 procedures (including lab) billed per year.

Timeliness

Practices must submit all encounters / claims within 20 days from the date of service

Best Practices

- Document all visits, procedures, and diagnosis codes on the CMS-1500 claim form
- Complete and submit encounters / claims on weekly basis
- Ensure patients receive all services for which they are eligible (HEDIS quality measures)
- Submit an encounter for every completed PM160 form (see PM160 Transition Guide)
- Document services eligible for Prop 56 Tobacco Tax (see Prop 56 infographic)

[Web Use Only]

Medi-Cal

HEDIS® 2018–2019

Provider Pocket Guide

Health Net®

Measure	*Immunizations for Adolescents (IMA) – Combo 2*	*Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	*Childhood Immunization Status (CIS) – Combo 3*	*Breast Cancer Screening (BCS)*	*Cervical Cancer Screening (CCS)*
Provider Action	• Administer 1 Tdap vaccine on or between the member's 10th and 13th birthdays. • Administer 1 meningococcal serogroups A, C, W, Y vaccine on or between the member's 11th and 13th birthdays. • Administer at least 2 human papillomavirus vaccines on or between the member's 9th and 13th birthdays. **Note:** There must be at least 146 days between the 1st and 2nd dose for the two-dose series. • Ask about vaccination status when patients come in for sick visits and sports physicals. • Document the name of the specific antigen and date of immunization.	Children ages 3, 4, 5, and 6 who had one or more well-child visits with a PCP during the measurement year. Well-child visits must include the following: • Make sure to document and submit both the correct CPT code and ICD-10 code to indicate the well-child visit was provided. • A PCP must perform the well-child visit but does not have to be the assigned PCP. • Documentation must include evidence of all the following: – a health history – a physical developmental history – a mental developmental history – a physical exam – health education/ anticipatory guidance This measure applies to patients who were ages 3–6 as of December 31 of the measurement year.	All vaccinations need to be on or before a child's second birthday: Combo 3 vaccines: DTaP (4), IPV (3), HiB (3), Hep B (3), MMR (1),* VZV (1),* PCV (4) *Vaccines need to be administered on or between the child's first and second birthdays. Medical record must include: • Member name • Date of birth • Date of service immunization was administered (not ordered) and one of the following: – a note indicating the name of the specific antigen or immunization – a certificate of immunization prepared by an authorized health care provider or agency, including types of immunizations administered – documented history of illness or a seropositive test result; there must be a note indicating the date of event, which must have occurred by the member's second birthday – notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" (applies to Hep B only) **Note:** Submit all immunizations to the immunization registry to ensure continuity of care. Makeup immunizations that occur after the member's second birthday will not count. Members who do not complete their 4th DTaP or 4th PCV due to being on a makeup schedule will also not count.	Women ages 50–74 who have had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 1 of the measurement year. 	Schedule and complete a cervical cancer screening when a member is due based on the following guidelines: • Ages 21–64: cervical cytology every 3 years. • Ages 30–64: cervical cytology and human papillomavirus co-testing every years. (Use 5-year time frame only if HPV co-testing was completed on the same day and includes results. Reflex testing will not count.) • Documentation should always include date of service, test name and results. • Record information in the medical record for services completed in the office or done elsewhere on an annual basis. • Document for history of total hysterectomy (TAH or TVH), or radical abdominal or vaginal hysterectomy and bill ICD-10 codes for any of the following: Acquired absence of: both cervix and uterus, cervix with remaining uterus, or agenesis and aplasia of cervix. **Note:** Documentationof a "hysterectomy" alone does not count.
Coding	**CPT codes/ICD-10-CM codes:** • **Meningococcal vaccine:** 90734 • **Tdap vaccine:** 90715 • **HPV vaccine:** 90649–90651 **Exclusions:** • **Anaphylactic reaction:** T80.52XA, T8052XD, T80.52XS	**CPT codes/ICD-10-CM codes:** • **Well-child visit:** 99382, 99383, 99392, 99393/Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1–Z02.6, Z02.71, Z02.79, Z02.81–Z02.83, Z02.89, Z02.9	All vaccines in the Combo 3 series need to be completed in order to count for HEDIS. Any services completed after the second birthday are noncompliant. • **DTap:** CPT 90698, 90700, 90721, 90723 • **IPV:** CPT 90698, 90713, 90723 • **Hib:** CPT 90644–90648, 90698, 90721, 90748 • **Hep B:** CPT 90723, 90740, 90744, 90747, 90748 • **MMR:** CPT 90707, 90710 or Measles/Rubella 90708, Measles 90705, Rubella 90706, Mumps 90704 • **VZV:** CPT 90710, 90716 • **PCV:** CPT 90669, 90670; HCPCS G0009 **Exclusions:** • **Anaphylactic reaction:** T80.52XA, T8052XD, T80.52XS Provide the appropriate diagnosis for disorders of the immune system, encephalopathy, malignant neoplasm of lymphatic tissue, intussusception, vaccine causing adverse effects, or HIV.	**CPT/ICD-10-PCS codes:** • **Mammography for 2018:** 77061–77063, 77065–77067 **Exclusions:** • **Bilateral mastectomy open approach:** OHTV0ZZ • **History of bilateral mastectomy:** Z90.13	**CPT codes:** **Codes for ordering labs:** • **Cervical cytology:** 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 • **HPV:** 87620–87622 **Surgical codes:** • **Absence of cervix:** 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550–58554, 58570–58573, 58951, 58953, 58954, 58956, 59135 • **ICD-10 codes:** Q5105, Z90.710, Z90.712 **Exclusion codes:** • **Abdominal hysterctomy:** 0UT90ZL, UT90ZZ, UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ • **Vaginal hysterectomy:** 0UT97ZL, 0UT98ZL, 0UT9FZL

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Measure	*Prenatal and Postpartum Care (PPC) (Prenatal Care)*	*Prenatal and Postpartum Care (PPC) (Postpartum Care)*	*Annual Monitoring for Patients on Persistent Medications (MPM)*	*Asthma Medication Ratio (AMR)*	*Controlling Blood Pressure (CBP)*	*Comprehensive Diabetes Care (CDC)*
Provider Action	Schedule patients for their first prenatal visit in their first trimester or within 42 days of becoming a Health Net member. • **PCP:** Visits must include documentation of a diagnosis of pregnancy, the prenatal care visit date and evidence of one of the following: – evidence that a prenatal procedure was performed, such as a screening test/obstetric panel, TORCH antibody panel alone, rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or ultrasound/echography of a pregnant uterus – documentation of last menstrual period (LMP) or estimated date of delivery (EDD) in conjunction with either a prenatal risk assessment and counseling/education or a complete obstetrical history (gravida, para, abortions (GPA)) and a primary diagnosis of pregnancy • **OB/GYN:** Visit must be billed with one of the following: – a pregnancy diagnosis – TORCH panel – obstetrical panel (hematocrit, WBC count, platelet count, hepatitis B, surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) – prenatal ultrasound – rubella/Rh or rubella/ABO – a prenatal visit billed with all of the following completed on the same date of service: toxoplasma antibody, rubella, cytomegalovirus, and herpes simplex – in addition to fetal heart tone, pelvic exam with obstetrical observations and fundus height, documentation in medical record must include tests, outcomes and completed dates of service vs. ordered dates. **Note:** Members who switch health plans need to follow up with the provider within 42 days of switching, regardless of whether they have seen the same provider for care. The provider must document, at the very least, the LMP/EDD with obstetrical history (GPA) on the date of service with a primary diagnosis of pregnancy at the visit. The visit can be with a PCP or an OB/GYN.	Documentation of a postpartum care visit with an OB/GYN practitioner, midwife, family practitioner, or other PCP on or between 21–56 days after delivery. Documentation must include notation of postpartum visit, and assessment of breast, abdomen, blood pressure, and pelvic. **Note:** A Pap exam within 21–56 days after delivery also can be used. • Must also include the following: – Pelvic exam, or – Evaluation of weight, BP, breasts, and abdomen, or – Notation of "postpartum care," PP check, PP care, 6-week check, etc.	Members ages 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. • Monitor your patients on the following medications to ensure their safety: – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – diuretics – antihypertensive combination drugs • Annually order the appropriate lab tests (serum potassium and serum creatinine).	Patients ages 5–64 who have a medication ratio of 0.50 or greater of controller medications to total asthma medications during the measurement year. • Ensure members are accurately diagnosed with persistent asthma. • Ensure that asthma medication, especially controller medication, is being dispensed to the patient in accordance with the proper medication schedule or need. • Submit claims correctly and in a timely manner. Correct encounters/claims with erroneous diagnosis.	Patients ages 18–85 who had at least two diagnoses of hypertension in measurement year or prior and whose blood pressure was adequately controlled during the measurement year based on the following criteria: • Most recent blood pressure reading occurring on or after the second diagnosis of hypertension was <140/90mm Hg (139/89 or less). 	Schedule and complete services for members ages 18–75 with diagnosis of diabetes on an annual basis to assist with health maintenance of the disease processes. The following services are required: • Order at least 1 HbA1c screening annually. Repeat test if A1c is greater than 7.9%. • Collect A1c data completed during inpatient visits or elsewhere in order to evaluate if a repeat test is required. • Ensure retinal screenings are completed annually. • Review, document and bill CPT II codes for retinal screenings completed by an eye care professional. • Bill CPT II codes for negative screenings from prior year screenings within the measurement year. • Bill retinal screenings completed by the PCP and sent off site for review with a professional and technical component. Bill the professional component with ophthalmologist/optometrist National Provider Identifier (NPI) and technical component with PCP NPI. • Documentation of eye exams completed need to have date of service completed, outcome, name of service completed, and name of eye care provider who performed the service. • Kidney disease monitoring (any one of the following will count): – Urine protein tests (microalbumin/macroalbumin, random, spot, 24-hour, urine dipstick (protein)) – Dispensed ACE/ARB medication – Consultation with nephrologist (if appropriate) – Document all services in the medical record – Bill CPT II codes for dipsticks completed in office – Adequate control of blood pressure <140/90mm Hg (139/89 or less) is preferred. Measure accepts last BP of the measurement year.
Coding	**CPT codes/ICD-10-PCS codes:** • **Standalone prenatal visits:** 99500 and 0500F–0502F procedure codes meet the requirements when billed by an OB/GYN or a PCP (must include primary diagnosis of pregnancy). Global billing codes billed at time of delivery will not count. • **Prenatal visit during first trimester:** 99201–99205, 99211–99215 and 99241–99245 visits require a primary diagnosis of pregnancy along with the noted tests as referenced under best practices. PCPs can begin the orders for the appropriate tests noted above before referring to an OB/GYN: – **OB panel:** 80055 – **Prenatal ultrasound:** 76801, 76805, 76811, 76813, 76815–76821, 76825–76828/BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ – **Toxoplasma antibody:** 86777, 86778 – **Rubella antibody:** 86762 – **Cytomegalovirus antibody:** 86644 – **Herpes simplex antibody:** 86694–86696 – **ABO:** 86900 – **Rh:** 86901 **ICD-10-CM codes:** Please refer to the 2018 ICD-10-CM code book from The American Academy of Professional Coders for additional codes.	**CPT codes:** • **Postpartum visit:** 57170, 58300, 59430, 99501/0503F • **Cervical cytology:** 88141–88143, 88147, 88148, 88150–88154, 88164–88167, 88174, 88175 **ICD-10-CM codes:** • **Postpartum visit:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1–Z39.2	**CPT codes:** • **Lab panel:** 80047, 80048, 80050, 80053, 80069 or • **Serum creatinine:** 82565, 82575 • **Serum potassium:** 80051, 84132 	Prescription claims data is evaluated. **ICD-10-CM codes:** • **Asthma:** J45.20–J45.22, J45.30–J45.32, J45.40–J45.42, J45.50–J45.52, J45.901–J45.902, J45.909, J45.990–J45.991, J45.998 **Exclusions:** • **Emphysema:** J43.0, J43.1, J43.2, J43.8, J43.9 • **Other emphysema:** J98.2–J98.3 • **COPD:** J44.0, J44.1, J44.9 • **Chronic respiratory conditions due to fumes/vapors:** J68.4 • **Cystic fibrosis:** E84.0, E84.11, E84.19, E84.8–E84.9 • **Acute respiratory failure:** J96.00–J96.02, J96.20–J96.22	**CPT/CPT Cat. II codes:** • **Systolic:** 3074F, 3075F, 3077F • **Diastolic:** 3078F, 3079F, 3080F **ICD-10-CM codes:** • **Hypertension:** I10, I11.9, I12.9, I13.10	**CPT/CPT Cat. II codes:** • **HbA1c:** 83036 • **HbA1c fingerstick in office:** 83037 • **A1c value:** 3044F, 3045F, 3046F • **Eye exam (NPI of ophthalmologist/optometrist is required for the following codes to count):** 67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 67110–67113, 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 • **Include modifiers for technical and professional components when billing 92227 and 92228 for digital imaging systems and remote interpretation.** • **92250 should be billed with the ophthalmologist's NPI in order to count.** • **Eye care providers can bill the following as no evidence of retinopathy:** E10.9, E11.9, E13.9 • **PCP can bill the following eye exam codes when service is completed by an eye care professional:** 2022F, 2024F, 2026F • **Diabetic retinal screening negative in prior year (PCP):** 3072F • **Nephropathy screening (protein urine test):** 81000–81003, 81005, 82042–82044, 84156/3060F, 3061F, 3062F • **Nephropathy treatment:** 3066F, 4010F

2018 Medi-Cal Incentive Programs

Update	HEDIS Quality Improvement Prog. (HQIP)	HEDIS Improvement Prog. (HIP)
Program Description	PPGs are awarded for improvement in encounter volume, timeliness and 10 select HEDIS measures.	PCPs are awarded for care gaps closed in 6 different HEDIS measures.
Max PMPM *What is the max PMPM potential assuming the provider meets all program requirements?*	Encounters $0.50 HEDIS $1.25 Max PMPM $1.75 PMPM	1. BCS $50 2. CCS $100 3. CDC-HbA1c $75 4. CIS3 $150 5. IMA2 $50 6. W34 $100
Payments	Final payment June 2019	Interim payment. Sept 2018 Final payment June 2019
HEDIS Measure	1. AMR 2. CBP 3. CCS 4. CIS3 5. IMA2 6. CDC –HbA1c 7. MPM Total 8. PPC –Pre 9. PPC-Post 10. W34	1. BCS 2. CCS 3. CDC –HbA1c 4. CIS3 5. IMA2 6. W34
Program Eligibility Requirements	• Member threshold = 1,000 • 85% open PCPs • Open to new Medi-Cal Mbrs • No incentive in contract	• Membership threshold = 50 (20 for IE) • Open to new Medi-Cal Mbrs • Less than 1% mbr loss

2018 Provider Incentive Programs

Program	Perinatal Notification Incentive	PM 160 Incentive
Eligible Participants	PCPs & OBs	Child Health and Disability Prevention (CHDP) PCPs
Locations	All Health Net and CalViva Counties	LA County
Objective	Improve prenatal and postpartum HEDIS rates	Improve childhood HEDIS rates
Lines of Business	Medi-Cal	Medi-Cal
Form	Timely Prenatal Visit and Pregnancy Notification Form (TPV/PNF) and Postpartum Care Notification Form (PCNF)	Confidential Screening/Billing Report (PM 160)
Incentive	$50 per correctly completed form	$35 per form
Contact	Juli Coulthurst Sr. Quality Improvement Specialist Juli.b.coulthurst@healthnet.com	Terri Howell Director Provider Relations Terri.a.howell@healthnet.com

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PM160 Transition to CMS-1500

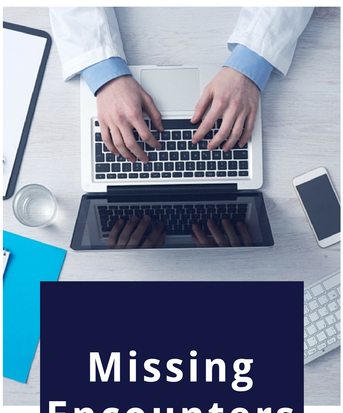
A Transition Guide for
Health Net CHDP Medi-Cal Providers

Effective January 1, 2018, DHCS discontinued the use of PM 160 - Information Only Forms. However, Health Net still requires CHDP Medi-Cal providers to submit PM 160 Forms, as a result of, provider feedback, impact on HEDIS, and incentives for services rendered in 2018. Beginning 2019, Health Net will only accept encounters.

Health Net Requires...

Unlike other plans

1. **CHDP PM160 Forms, and**
2. **Encounter CMS-1500 Forms**



Missing Encounters

Providers submitting PM160s are missing encounters 66% of the time

HEDIS

Immunization data has up to 20% impact on HEDIS scores

HQIP Incentives

Exceptional Care and Omnicare missed out on $200,000 due to low encounter volume and poor HEDIS scores

Helpful Resources

1. CHDP Code to National Code Crosswalk
2. Converting PM160 to CMS-1500 Job Aid
3. DHCS Medi-Cal CHDP FAQs

For more information:

Contact Provider Relations - HN_Provider_Relations@HealthNet.com

Health Net®
COMMUNITY SOLUTIONS

Child Health *and* Disability Prevention *(CHDP) Program Code Conversion*

Services previously reported on PM 160 forms must be captured on encounter and claim submissions. This guide will help your office identify the appropriate codes to submit.

For additional copies of this guide, contact Provider Relations. The guide is also available on the provider portal at provider.healthnet.com in the Provider Library *Provider Library > Operations Manuals > Public Programs > Child Health and Disability Prevention (CHDP) Program > PM 160 INF Form Information > Billing for CHDP Services.*

Health assessments

Local code	Description	National code
B1	Autism screening	96110
B3	Psychosocial/ behavioral assessment	96150
B4	Psychosocial/ behavioral reassessment	96151
01 History and physical exam	Initial, < 1 year	99381
	Age 1–4, 11 months	99382
	Age 5–11, 11 months	99383
	Age 12–17, 11 months	99384
	Age 18–20, 11 months	99385
01 History and physical exam	Periodic, < 1 year	99391
	Age 1-4, 11 months	99392
	Age 5-11, 11 months	99393
	Age 12-17, 11 months	99394
	Age1 8-20, 11 months	99395

Health assessments (continued)

Local code	Description	National code
02	Dental assessment	NA
03	Nutritional assessment	Z71.3
None	Physical activity assessment, sports participation	Z02.5
None	Physical activity assessment, exercise counseling	Z71.82
04	Anticipatory guidance health education	NA
05	Developmental assessment	NA
07	Hearing, screening test	92551
None	Hearing, audiometry threshold, air	92552

Labs and other

Local code	Description	National code
09	Urine dipstick	81000
12	TB, Mantoux test	86580
None	A1c POC testing	83037
None	Chlamydia screening via urine	87491
None	BMI percentile, pediatric <5%	Z68.51
None	BMI percentile, pediatric 5%-<85%	Z68.52
None	BMI percentile, pediatric 85%-<95%	Z68.53
None	BMI percentile, pediatric ≥ 95%	Z68.54

*NA – Not applicable.

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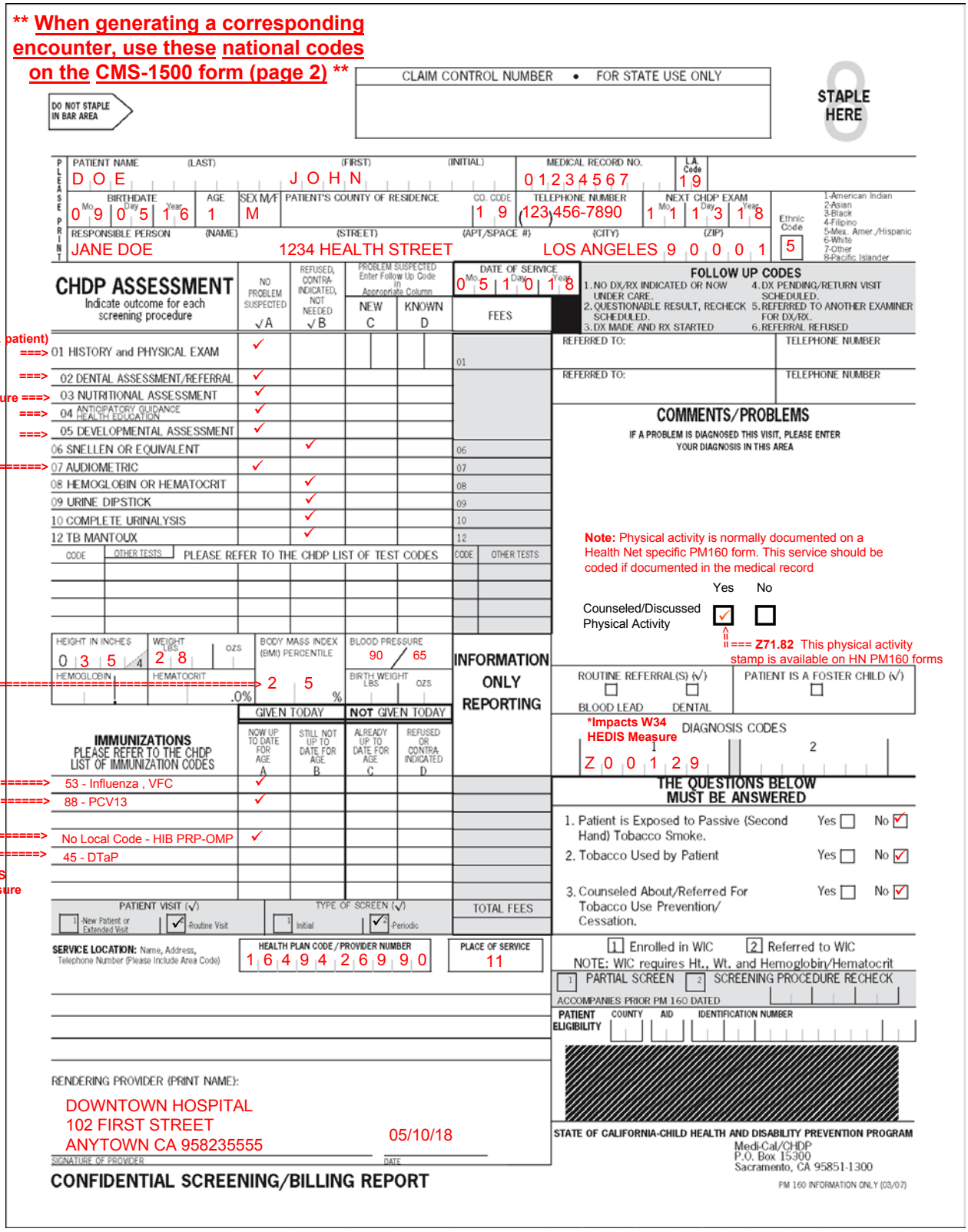
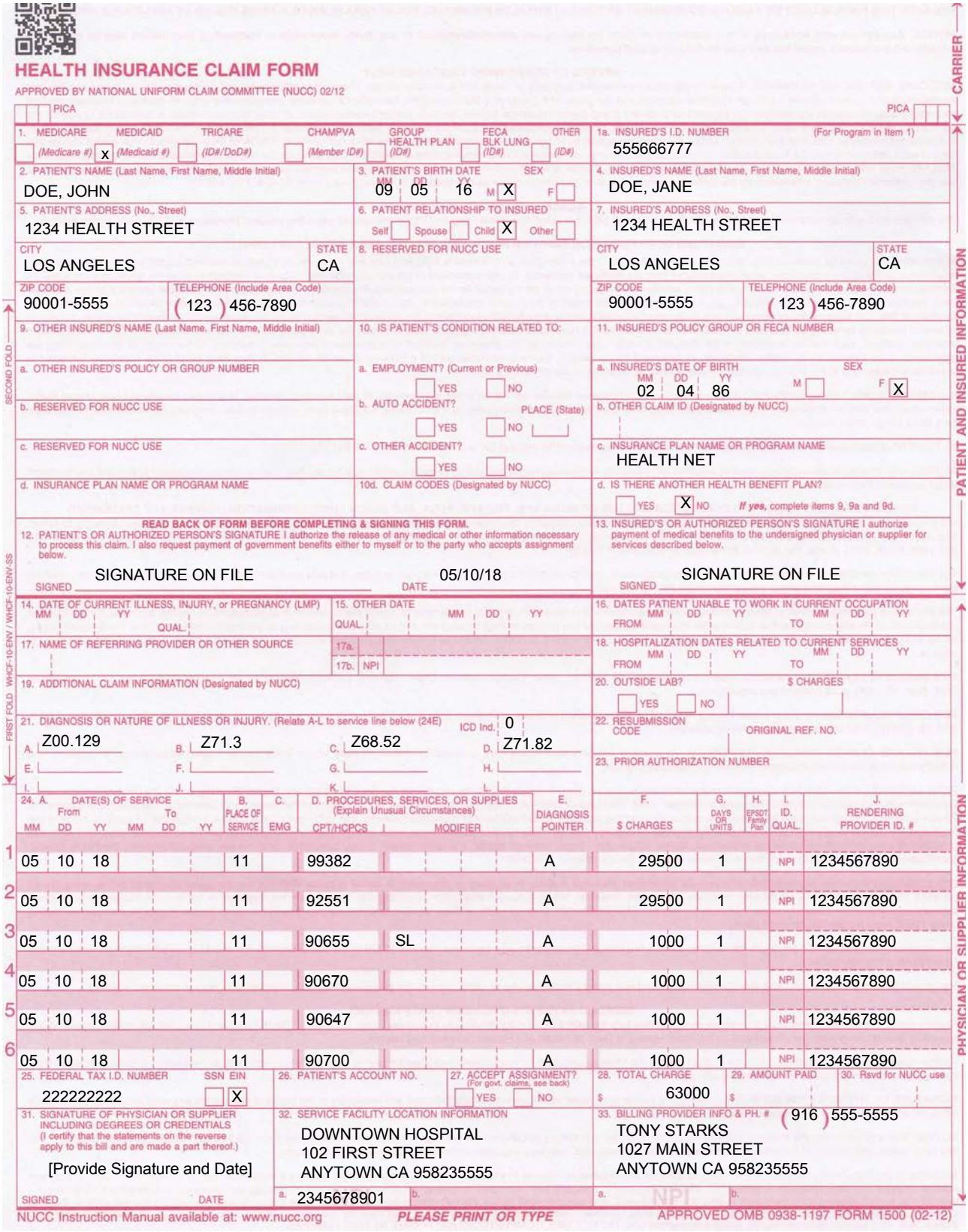
Vaccines – vaccines supplied by Vaccine for Children (VFC) program, add modifier SL and $0 charge		
Local code	**Description**	**National code**
M1, M2, M3	Bexsero® (MenB vaccine)	90620 + SL ($0.00 charge)
M4, M5, M6	Trumenba (MenB vaccin)	90621 + SL ($0.00 charge)
33	Measles, mumps and rubella (MMR)	90707 + SL ($0.00 charge)
39	Polio, inactivated	90713 + SL ($0.00 charge)
40	Hepatitis B, low-risk	90744 + SL ($0.00 charge)
41 and 57	Hepatitis B immune globulin (HBIG)	90371
42	Hepatitis B, high-risk, adult	90743 + SL ($0.00 charge)
45	DTaP	90700 + SL ($0.00 charge)
46	Varicella	90716 + SL ($0.00 charge)
48	MMR, adult	90707
51	Hepatitis B, high-risk, adult	90746
52	Varicella	90716
53	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, intramuscular	90655 + SL ($0.00 charge)
53	Influenza, trivalent (IIV3), split virus, intramuscular	90658 + SL ($0.00 charge)
53	Influenza, quadrivalent (ccIIV4), preservative and antibiotic free, intramuscular	90674 + SL ($0.00 charge)
53	Influenza, quadrivalent (IIV4), preservative free, intramuscular	90685 + SL ($0.00 charge)

Vaccines (continued)		
Local code	**Description**	**National code**
53	Influenza, quadrivalent (IIV4), preservative free, intramuscular	90686 + SL ($0.00 charge)
53	Influenza, quadrivalent (IIV4), intramuscular	90688 + SL ($0.00 charge)
54	Influenza, trivalent (IIV3), intramuscular	90658
55	Pneumococcal polysaccharide (23PS)	90732
58	Td, adult	90714 + SL ($0.00 charge)
59	DT, pediatric	90702
60	Td, adult PF	90714
64	Polio, inactivated	90713
65	Hepatitis A	90633 + SL ($0.00 charge)
66	Hepatitis A, adult	90632 + SL ($0.00 charge)
68	DTaP-HepB-IPV	90723 + SL ($0.00 charge)
69	Meningococcal conjugate (MCV4)	90734 + SL ($0.00 charge)
70, 73	MCV4	90734
71	FluMist®	90660 + SL ($0.00 charge)
72	Tdap booster	90715 + SL ($0.00 charge)
74	MMRV	90710 + SL ($0.00 charge)
75	Rotavirus, 3 doses, oral	90680 + SL ($0.00 charge)
76, 77, 78	Quadrivalent human papillomavirus (HPV)	90649 + SL ($0.00 charge)
79	Tdap	90715

Vaccines (continued)		
Local code	**Description**	**National code**
80	Influenza, inactivated, preservative-free	90655
81	Rotavirus, 2 doses, oral	90681 + SL ($0.00 charge)
82	DTaP-Hib-IPV	90698 + SL ($0.00 charge)
83	DTaP-IPV	90696
85, 86, 87	Bivalent human papillomavirus (HPV2)	90650 + SL ($0.00 charge)
88	Pneumococcal 13-valent conjugate (PCV13)	90670 + SL ($0.00 charge)
90	23PS	90732 + SL ($0.00 charge)
92	Meningococcal/Hib (MenHibrix®)	90644 + SL ($0.00 charge)
93, 94, 95	9-valent human papillomavirus (HPV9)	90651 + SL ($0.00 charge)
None	Influenza virus vaccine	90630 + SL ($0.00 charge)
None	Hepatitis A and hepatitis B	90636
None	Haemophilus influenza type b (Hib) PRP-OMB	90647 + SL ($0.00 charge)
None	Hib PRP-T	90648 + SL ($0.00 charge)
None	Influenza virus vaccine, trivalent (IIV3)	90656 + SL ($0.00 charge)
None	Influenza virus vaccine, trivalent (RIV3)	90673
None	Rabies vaccine, intramuscular	90675
None	Hepatitis B, intramuscular	90740


** When generating a corresponding encounter, use these national codes on the CMS-1500 form (page 2) **
CLAIM CONTROL NUMBER • FOR STATE USE ONLY
DO NOT STAPLE IN BAR AREA
STAPLE HERE
PLEASE PRINT
PATIENT NAME (LAST) DOE (FIRST) JOHN (INITIAL)
MEDICAL RECORD NO. 01234567
LA. Code 19
BIRTHDATE 09 05 16
AGE 1
SEX M/F M
PATIENT'S COUNTY OF RESIDENCE
CO. CODE 19
TELEPHONE NUMBER (123)456-7890
NEXT CHDP EXAM 11 13 18
Ethnic Code 5
1-American Indian 2-Asian 3-Black 4-Filipino 5-Mex. Amer./Hispanic 6-White 7-Other 8-Pacific Islander
RESPONSIBLE PERSON (NAME) JANE DOE (STREET) 1234 HEALTH STREET (APT/SPACE #) (CITY) LOS ANGELES (ZIP) 90001
CHDP ASSESSMENT
Indicate outcome for each screening procedure
NO PROBLEM SUSPECTED √A
REFUSED, CONTRA-INDICATED, NOT NEEDED √B
PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column
NEW C
KNOWN D
FEES
DATE OF SERVICE 05 10 18
FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED
01 HISTORY and PHYSICAL EXAM ✓
02 DENTAL ASSESSMENT/REFERRAL ✓
03 NUTRITIONAL ASSESSMENT ✓
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION ✓
05 DEVELOPMENTAL ASSESSMENT ✓
06 SNELLEN OR EQUIVALENT ✓
07 AUDIOMETRIC ✓
08 HEMOGLOBIN OR HEMATOCRIT ✓
09 URINE DIPSTICK ✓
10 COMPLETE URINALYSIS ✓
12 TB MANTOUX ✓
CODE OTHER TESTS PLEASE REFER TO THE CHDP LIST OF TEST CODES CODE OTHER TESTS
REFERRED TO: TELEPHONE NUMBER
REFERRED TO: TELEPHONE NUMBER
COMMENTS/PROBLEMS
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA
Note: Physical activity is normally documented on a Health Net specific PM160 form. This service should be coded if documented in the medical record
Yes No
Counseled/Discussed Physical Activity ✓
=== Z71.82 This physical activity stamp is available on HN PM160 forms
HEIGHT IN INCHES 035 1/4
WEIGHT LBS. 28 OZS
BODY MASS INDEX (BMI) PERCENTILE 25 %
BLOOD PRESSURE 90 / 65
HEMOGLOBIN .0%
HEMATOCRIT
BIRTH WEIGHT LBS. OZS
INFORMATION ONLY REPORTING
ROUTINE REFERRAL(S) (√) BLOOD LEAD DENTAL
PATIENT IS A FOSTER CHILD (√)
*Impacts W34 HEDIS Measure
DIAGNOSIS CODES
1 Z00.129 2
IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES
GIVEN TODAY
NOW UP TO DATE FOR AGE A
STILL NOT UP TO DATE FOR AGE B
NOT GIVEN TODAY
ALREADY UP TO DATE FOR AGE C
REFUSED OR CONTRA-INDICATED D
53 - Influenza , VFC ✓
88 - PCV13 ✓
No Local Code - HIB PRP-OMP ✓
45 - DTaP
THE QUESTIONS BELOW MUST BE ANSWERED
1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☑
2. Tobacco Used by Patient Yes ☐ No ☑
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☑
PATIENT VISIT (√) 1 New Patient or Extended Visit ☑ Routine Visit
TYPE OF SCREEN (√) 1 Initial ☑ Periodic
TOTAL FEES
SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)
HEALTH PLAN CODE / PROVIDER NUMBER 1649426990
PLACE OF SERVICE 11
1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit
1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED
PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER
RENDERING PROVIDER (PRINT NAME):
DOWNTOWN HOSPITAL
102 FIRST STREET
ANYTOWN CA 958235555
SIGNATURE OF PROVIDER
05/10/18
DATE
STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300
CONFIDENTIAL SCREENING/BILLING REPORT
PM 160 INFORMATION ONLY (03/07)
99382 (new patient) or 99392 (est. patient) *Impacts W34 HEDIS Measure ===> 01 HISTORY and PHYSICAL EXAM
No National Codes ===> 02 DENTAL ASSESSMENT/REFERRAL
Z71.3 *Impacts WCC HEDIS Measure ===> 03 NUTRITIONAL ASSESSMENT
No National Codes ===> 04 ANTICIPATORY GUIDANCE HEALTH EDUCATION
No National Codes ===> 05 DEVELOPMENTAL ASSESSMENT
92551 ======> 07 AUDIOMETRIC
Note: In order to code 99382 or 99392, History and physical, anticipatory guidance health education, developmental assessment and vitals need to be completed -- this needs to be documented in the medical record: health history, physical developmental history, mental developmental history, a physical exam, and health education, and anticipatory guidance
BMI Percentile Z68.52 ======> 25 %
90655 + SL ======> 53 - Influenza , VFC
90670 ======> 88 - PCV13
90647 ======> No Local Code - HIB PRP-OMP
90700 ======> 45 - DTaP
*Impacts CIS HEDIS Measure
Note: Coding may change based on immunization used. Note that SL modifiers are for state funded immunizations



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [x] (Medicaid #) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 555666777

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE: 09 05 16 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

5. PATIENT'S ADDRESS (No., Street): 1234 HEALTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1234 HEALTH STREET

CITY: LOS ANGELES STATE: CA

8. RESERVED FOR NUCC USE

CITY: LOS ANGELES STATE: CA

ZIP CODE: 90001-5555 TELEPHONE (Include Area Code): (123) 456-7890

ZIP CODE: 90001-5555 TELEPHONE (Include Area Code): (123) 456-7890

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: 02 04 86 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: HEALTH NET

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 05/10/18

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E)) ICD Ind. 0

A. Z00.129 B. Z71.3 C. Z68.52 D. Z71.82

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	10	18			11		99382		A	29500	1		NPI	1234567890
2	05	10	18			11		92551		A	29500	1		NPI	1234567890
3	05	10	18			11		90655	SL	A	1000	1		NPI	1234567890
4	05	10	18			11		90670		A	1000	1		NPI	1234567890
5	05	10	18			11		90647		A	1000	1		NPI	1234567890
6	05	10	18			11		90700		A	1000	1		NPI	1234567890

25. FEDERAL TAX I.D. NUMBER: 222222222 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 63000

29. AMOUNT PAID: $

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

[Provide Signature and Date]

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

DOWNTOWN HOSPITAL
102 FIRST STREET
ANYTOWN CA 958235555

a. 2345678901 b.

33. BILLING PROVIDER INFO & PH. # (916) 555-5555

TONY STARKS
1027 MAIN STREET
ANYTOWN CA 958235555

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB 0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

Note: Document the NPI of the provider (PCP) who is rendering services

Janice E. Carter,
Health Net
We're invested in supporting provider practices.

Health Net®

PM 160 Webinars

Health Net's Providers Are Invited to Attend Upcoming PM 160 Webinars

Why Should I Attend?

- As of 2019, PM 160 forms will no longer be accepted
- Ensure that you submit your encounters coded properly
- Update your superbills with the Z codes for counseling
- Update your EMR to ensure all CPT codes and Z codes are updated

Details About the Webinars

Several communications have been distributed to inform providers about the PM 160 transition to the CMS 1500 Claims. In an effort to provider further support to providers regarding the changes, Health Net's Provider Relations team has scheduled educational provider webinars.

During the webinars, we will be covering the following key topics:

1. How to Code the Encounter
2. Crosswalk of Codes That Health Net Has Created

Health Net recommends that coders, billers, attend the webinars.

How to Register for the Webinar

You must pre-register for the webinar(s), and, to do so, please see the link below. All sessions are 45 minutes long and start at 12:15 p.m. Providers can attend the webinars using the link below. At the end of the registration process, you will be given the option to add the webinar to your calendar.

The webinar has a call-in number, or you may listen to the audio broadcast through your computer. Attendees may type questions as necessary. A copy of the presentation material and a recording of the webinar will be distributed following the webinar.

After registering, you will receive a confirmation email containing information about joining the webinar.

Dates	Webinar Links
September 27, 2018	https://centene.zoom.us/recording/share/EO0VSUEV5XKzML73wF2IoX56X328PV7rw_F8RNwhMzawIumekTziMw
October 3, 2018	https://centene.zoom.us/recording/share/EUM6-0OzZYNJtVfvPz93H63TfOAvz4wac1OPy7M0R2KwIumekTziMw
October 4, 2018	https://centene.zoom.us/recording/share/qTZVol5QArFLH6SmHAyJYB2XB5fSLeOF5_aIZ7t-M4OwIumekTziMw
October 11, 2018	https://centene.zoom.us/recording/share/dlOePPolghp3GBIWCwcCUUzlk9XxwwJnLumKpVlhzMewIumekTziMw

Questions

If you have questions, contact the Health Net Provider Relations team at HN_Provider_Relations@healthnet.com

Health Net®

Tobacco Tax
Proposition 56

CLAIMS & ENCOUNTERS

JULY 1 2017 - JUNE 30, 2018

Dates of Service

Payment	New Patient - Office or Other Outpatient Visit	Established Patient - Office or Other Outpatient Visit	Psychiatric Diagnostic Procedures or Services
$10	**99201** 10 min	**99211** 5 min	
$15	**99202** 20 min	**99212** 10 min **99213** 15 min	**90863** Pharmacologic management, incl. rx and review of meds, when performed w/ psychotherapy services
$25	**99203** 30 min **99204** 45 min	**99214** 25 min **99215** 40 min	
$35			**90791** Psychiatric diagnostic evaluation **90792** Psychiatric diagnostic evaluation w/ medical services
$50	**99205** 60 min		

Payment CPT codes w/ Physician Service Descriptions

Prop 56

increases excise tax on all cigarettes and tobacco-related product purchases

AB 120

allows DCHS to use funds from Prop 56 to provide supplemental payments for physician services

More Info...

HN_Provider_Relations@HealthNet.com
Provider Relations
1-800-675-6110
Health Net Medi-Cal Provider Services
Provider.HealthNet.com
General Information