SAN FRANCISCO HEALTH PLAN
Here for you

February 1, 2022

UPDATES INCLUDE:

- Reminder About Continuous Glucose Monitor Benefit and Access
- Pharmacy Update: Quarterly Formulary and Prior Authorization (PA) Criteria Changes
- FSR Provider Pearl: Medical Record Review and Abdominal Aortic Aneurysm Screening
- State 30-day PPE Supply Offer

Reminder About Continuous Glucose Monitor Benefit and Access

Therapeutic Continuous Glucose Monitors (CGMs) are a Medi-Cal benefit as of 1/1/2022. Prior authorization is required. Medical necessity criteria differs for CGMs obtained through the pharmacy benefit and obtained through the medical benefit.

- Medi-Cal Rx, California's pharmacy benefit, covers therapeutic CGMs available through pharmacies. Visit the Medi-Cal Rx website at https://medi-calrx.dhcs.ca.gov/home/ to see the list of contracted devices and their medical necessity guidelines. Contact Medi-Cal Rx Customer Service at 1(800) 977-2273 for any questions about this pharmacy benefit.
- SFHP and its delegated medical groups cover CGMs available from Durable Medical Equipment (DME) providers under the medical benefit. SFHP uses MCG Care Guidelines to determine medical necessity of CGM requests. Contact SFHP Provider Relations at 1(415) 615-7818 x7084 for any questions about this medical benefit.

Pharmacy Update: Quarterly Formulary and Prior Authorization (PA) Criteria Changes

Changes to the SFHP formulary and PA criteria for Healthy Workers HMO have been approved by the SFHP Pharmacy and Therapeutics (P&T) Committee on January 19, 2022. The summary of formulary and prior authorization criteria changes is available on the SFHP website at (https://www.sfhp.org/about-us/committees/pharmacy-and-therapeutics-committee/). A complete list of approved formulary and prior authorization criteria are available on SFHP website at (https://www.sfhp.org/providers/pharmacy-services/sfhp-formulary/). All changes are effective February 20, 2022. For formulary or criteria information please visit our website or call SFHP pharmacy department at 1(415) 547-7818 ext. 7085, option 3.

FSR Provider Pearl: Medical Record Review and Abdominal Aortic Aneurysm Screening

An aneurysm is a pathological distension of a section of blood vessel, typically the aorta. Aortic aneurysms can occur anywhere in the aorta's length, but abdominal aortic aneurysms (AAAs) are associated with increased mortality if rupture occurs (around 50% in those who reach the hospital) because of catastrophic bleeding.[i] [ii] [iii] [iv]

subsequently rupture.[vii] Lifetime risk of AAA is approximately 1 in 17 in the general population and up to 1 in 9 for current smokers.[viii]

The California Department of Health Care Services (DHCS) Medical Record Review (MRR) Standards (APL 20-006) and the DHCS Medical Record Review 2022 Tool include screening for AAA in the Adult Preventive Criteria. Age-appropriate preventive screening services are provided for the purpose of promoting health and preventing illness or injury. The United States Preventive Services Task Force (USPSTF) found good evidence that screening for AAA and surgical repair of large AAAs (5.5 cm or more) in men aged 65 to 75 who have ever smoked (current and former smokers) leads to decreased AAA-specific mortality. The Standard for medical record review audits states, “Assess all individuals during well adult visits for past and current tobacco use. USPSTF recommends that medical providers should perform a one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked 100 or more cigarettes in their lifetime. Indirect evidence shows that smoking is the strongest predictor of Abdominal Aortic Aneurysm (AAA) prevalence, growth, and rupture rates. There is a dose-response relationship, as greater smoking exposure is associated with an increased risk for AAA”.[ix]

The opportunity for health screenings occurs during members’ well-care visits or any visits when the member is being seen. “The risk factors for AAA are based upon older age, male gender, Caucasian race, family history of the disorder, atherosclerotic disease and smoking[x],[xi], the latter being considered the primary modifiable risk factor[xii]. Other potential risk factors include diabetes mellitus (DM), which has been shown to be negatively associated with AAA[xiii], greater height[xiv], and low fruit and vegetable consumption[xv].”
The criterion standard is met when the following documentation elements are satisfied (applies to the specific ***USPSTF Grade B*** **AAA** recommendation):

1. Men aged 65 to 75 years who have ever smoked have risk factors assessed
2. Documentation of abdominal duplex ultrasonography in the medical record, including assessment of risk factors
3. Evidence of image from abdominal duplex ultrasonography in the medical record, or
4. Evidence of screening with positive result but test not given because of member refusal; must be documented

Years of site review activities have demonstrated that key to establishing robust preventive care screening practices requires an all-staff approach. A best-practice approach to achieving compliance with preventive screenings is to embed specific workflow processes with staff to support the specific requirements for each screening type. Regular trainings, reminders, monitoring, and recalibrations of steps can foster an environment of learning for an energized focus on preventive services. Last, ensure that there is a clear understanding of reimbursement coding practices so that all primary care provider preventive services are reimbursed appropriately.
The **Abdominal Aortic Aneurysm Screening Coding Chart,** created by this writer, is provided as a general resource that you might find helpful as you adopt best practice screening processes. The AAA screening is one of the added criteria to the new Standards from APL 20-006 and therefore will be a part of every medical record review.

Abdominal Aortic Aneurysm Screening - USPSTF Rating Grade B (December 2019)

The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years (ends on 76th birthday) who have "ever" smoked. "Ever smoker" is commonly defined as smoking 100 or more cigarettes.

SERVICE	ICD-10 CODES		PROCEDURE DESCRIPTION	CPT/HCPCS CODE(S)	PROCEDURE DESCRIPTION
Ultrasound Screening Study for Abdominal Aortic Aneurysm	The F codes are from the Mental and Behavioral Disorder category. The F17 codes are used if the patient is dependent on tobacco.	**F17.210**	Nicotine dependence, cigarettes, uncomplicated	**76706**	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA) [From 2017, the CPT code 76706 should ONLY be used]
		F17.211	Nicotine dependence, cigarettes, in remission		
		F17.213	Nicotine dependence, cigarettes, with withdrawal		
		F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders		
		F17.219	Nicotine dependence, cigarettes, with unspecified nicotine induced disorders		
	The Z codes are used if there is NOT dependence on tobacco. The Z codes cannot be combined with an F17 code.	**Z13.6**	Encounter for screening for cardiovascular disorders		
		Z87.891	Personal history of nicotine dependence		

Notes:
USPSTF Source - US Preventive Services Task Force. Screening for abdominal aortic aneurysm: US Preventive Services Task Force recommendation statement [published December 10, 2019]. JAMA. doi:10.1001/jama.2019.18928
ICD-10 CODES - Code used to describe the condition or disease being treated, also known as the diagnosis code.
CPT/HCPCS CODE(S) - Code used to describe the treatment and diagnostic services provided for that diagnosis for billing purposes.
When billing for these services, payers may want to use modifier 33 to identify services that meet the criteria for the USPSTF grade A and B recommendations.
This is a general guidance chart and is not intended to replace any SFHP provider resources such as the Provider Manual, policies and procedures, guidelines, or claims submission requirements.

REFERENCES:

[i] Tang W, Yao L, Roetker NS, Alonso A, Lutsey PL, Steenson CC, Lederle FA, Hunter DW, Bengtson LG, Guan W, et al.. Lifetime risk and risk factors for abdominal aortic aneurysm in a 24-year prospective study: the ARIC Study (Atherosclerosis Risk in Communities).Arterioscler Thromb Vasc Biol. 2016; 36:2468–2477. doi:
[ii] Singh K, Bønaa KH, Jacobsen BK, Bjørk L, Solberg S. Prevalence of and risk factors for abdominal aortic aneurysms in a population-based study: the Tromsø Study.Am J Epidemiol. 2001; 154:236–244. doi: 10.1093/aje/154.3.236
[iii] Bath MF, Saratzis A, Saedon M, Sidloff D, Sayers R, Bown MJ; UKAGS Investigators. Patients with small abdominal aortic aneurysm are at significant risk of cardiovascular events and this risk is not addressed sufficiently. Eur J Vasc Endovasc Surg. 2017; 53:255–260. doi: 10.1016/j.ejvs.2016.10.013
[iv] Nordkvist S, Sonestedt E, Acosta S. Adherence to diet recommendations and risk of abdominal aortic aneurysm in the Malmö Diet and Cancer Study.Sci Rep. 2018; 8:1–8. doi: 10.1038/s41598-018-20415-z.
[v] Bahia SS, Vidal-Diez A, Seshasai SR, Shpitser I, Brownrigg JR, Patterson BO, Ray KK, Holt PJ, Thompson MM, Karthikesalingam A. Cardiovascular risk prevention and all-cause mortality in primary care patients with an abdominal aortic aneurysm.Br J Surg. 2016; 103:1626–1633. doi: 10.1002/bjs.10269
[vi] Gokani VJ, Sidloff D, Bath MF, Bown MJ, Sayers RD, Choke E. A retrospective study: factors associated with the risk of abdominal aortic aneurysm rupture.Vascul Pharmacol. 2015; 65-66:13–16. doi: 10.1016/j.vph.2014.11.006
[vii] Welsh, P., Welsh, C. E., Jhund, P. S., Woodward, M., Brown, R., Lewsey, J., ... & Sattar, N. (2021). Derivation and Validation of a 10-Year Risk Score for Symptomatic Abdominal Aortic Aneurysm: Cohort Study of Nearly 500 000 Individuals. Circulation, 144(8), 604-614.

10.1161/ATVBAHA.116.308147LinkGoogle Scholar
2.Singh K, Bønaa KH, Jacobsen BK, Bjørk L, Solberg S. Prevalence
[ix] U.S. Preventive Services Task Force; Owens DK, Davidson KW, Krist AH , et al. Screening for abdominal aortic aneurysm: US Preventive Services Task Force recommendation statement. JAMA. 2019;322(22):2211-2218.
[x] Lederle FA, Johnson GR, Wilson SE, et al. The aneurysm detection and management study screening program validation cohort and final results. Arch Intern Med. 2000;160(10):1425–30. https://doi.org/10.1001/archinte.160.10.1425.
[xi] Aune D, Schlesinger S, Norat T, Riboli E. Tobacco smoking and the risk of abdominal aortic aneurysm: a systematic review and meta-analysis of prospective studies. Sci Rep. 2018;8(1):14786. https://doi.org/10.1038/s41598-018-32100-2.
[xii] Ullery BW, Hallett RL, Fleischmann D. Epidemiology and contemporary management of abdominal aortic aneurysms. Abdom Radiol. 2018;43:1032. https://doi.org/10.1007/s00261-017-1450-7.
[xiii] Aune D, Schlesinger S, Norat T, Riboli E. Diabetes mellitus and the risk of abdominal aortic aneurysm: a systematic review and meta-analysis of prospective studies. J Diabetes Complicat. 2018;32(12):1169–1174. https://doi.org/10.1016/j.jdiacomp.2018.09.009.
[xiv] Collaboration Emerging Risk Factors. Adult height and the risk of cause-specific death and vascular morbidity in 1 million people: individual participant meta-analysis. Int J Epidemiol. 2012;41(5):1419–33. https://doi.org/10.1093/ije/dys086.
[xv] Stackelberg O, Björck M, Larsson SC, Orsini N, Wolk A. Fruit and vegetable consumption with risk of abdominal aortic aneurysm. Circulation. 2013;128(8):795–802.

“Provider Pearls” are monthly articles written to help you prepare for the California Department of Health Care Services (DHCS) FSR review processes. If a clinic manager, office manager, nurse manager, or operations person, can take the time to independently self-monitor clinic practices with the aid of SFHP checklists and DHCS standards at least annually, we can all work together to strive toward improved quality standards in office practice operations. For any questions about the Facility Site Review or Medical Record Review processes or tools, please contact Jackie at jhagg@sfhp.org or by her direct line at 1(415) 615-5637. You may also go to**:** SFHP Website MRR Resources

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State 30-day PPE Supply Offer

The Statewide Logistics Taskforce is offering public health and medical stakeholders a one-time opportunity to request for a 30-day sustainment supply of PPE. This 30-day supply may be used to stock disaster caches or used in daily operations. The select PPE items that are available from the State is listed below. Specificities of each item was not provided, so requestors should be willing to accept any product brand and type.

- Procedural masks
- BYD N95 masks
- Face Shields
- Hand sanitizer (16.9 ounce per bottle size only)
- Goggles
- Gowns
- Nitrile gloves (Medium, Large and XL only)
- Disinfecting wipes (400 count and 80 count)

How to make a request

Please complete the form in this link before February 25, 2022 to request for the supplies: https://forms.office.com/g/k7iQmUeb86 . The SF MHOAC will review your request and submit it to the State. You will be notified once your request is submitted to that State. From this point, the State will communicate with your facility's point of contact regarding approval and delivery. The following information is required in the form.

- Main Point of Contact - full name, title, organization name, email address, and phone number
- Delivery Information - recipient full name, title, email address, phone number, delivery address, and delivery notes
- PPE items being requested and quantity of each item. Calculate 30-day amounts based on burn rate.

If you have a question, please email it to sfprephcc@sfdph.org.
