SAN FRANCISCO HEALTH PLAN
Here for you

July 1st, 2022

UPDATES INCLUDE:

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Updated Medical Necessity Criteria for Gender-Affirming Services

SFHP updated the medical necessity criteria for gender-affirming services. All previous criteria for gender-affirming services have been retired. The current criteria can be found on the SFHP website:

Either directly at this link, or,
Navigate to SFHP.org. Click the Provider section and navigate to the Authorizations section and the Medical Criteria page.
*SFHP uses this criteria to review the medical necessity of gender-affirming service authorization requests for both Medi-Cal and Healthy Worker SFHP members.

Gender-affirming chest and genital surgery criteria is based on the criteria provided by WPATH *Standards of Care, 7th edition*, per Department of Managed Health Care (DMHC) requirements. The criteria for all other surgical and non-surgical gender-affirming services are based on published Department of Health Care Services (DHCS) guidance, as well as state law for fertility preservation coverage for Healthy Workers.

The criteria includes lists of common services, but is not all-inclusive. Any service omission is unintentional and does not reflect benefit coverage nor influence authorization decisions. Please submit authorization requests for any medically appropriate service for your patients.

Please reach out to Provider Relations if you have any questions: 1(415) 547-7818 ext. 7084 or email provider.relations@sfhp.org. You can also call SFHP's Utilization Management department at 1(415) 615-7818 x7080 for authorization-specific help.

Medi-Cal Rx Benefit: Reinstatement of Reject Codes 80 and 88

Effective July 22, 2022, the Department of Healthcare Services (DHCS) is reinstating drug utilization review (DUR) and diagnosis requirements for select reject codes for Medi-Cal Rx claims. Specifically, requirements will be reinstated for National Council for Prescription Drug Programs (NCPDP) reject codes 80 ("Diagnosis Code Submitted Does Not Meet Drug Coverage Criteria") and 88 ("Drug Utilization Review Reject Error"). These edits were temporarily suspended in the initial period of Medi-Cal Rx implementation. These codes can be evaluated and navigated at the pharmacy, and in most cases should not require a prior authorization (PA); see details below.

- **Reject Code 80:** if a claim returns with code 80, the product submitted has Code 1 diagnosis restriction under the Contract Drugs List (CDL). Code 1 restrictions can be reviewed on the Covered Products Lists section of the Medi-Cal Rx Forms & Information page (https://www.medi-calrx.dhcs.ca.gov/provider/forms/). If the beneficiary's diagnosis matches the CDL restriction, the pharmacy may submit the appropriate ICD-10 and/or Submission Clarification Code (SCC) with the claim (no PA required). However, if the diagnosis does not match the CDL restriction, a PA is required.
- **Reject Code 88:** if a claim returns with code 88, the optimal therapy was not identified in the beneficiary's claim history. Code 88 may present as an informational message or as a claim rejection. If the claim rejects, the pharmacist should submit an override when an informed decision has been made based on clinical judgement. PA is not required for these rejections. For more details on the alerts that cause code 88 and the overrides accepted, review the reference guide linked below.

Additional information on these reject codes is available in the Medi-Cal Rx billing guidelines: NCPDP Reject Code 80 reference guide and NCPDP Reject Code 88 DUR Reference Guide posted on the Medi-Cal Rx Bulletins & News page (https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news). For claims or

Complete your ACE Training

Take the *Becoming ACEs Aware in California* training at

training.acesaware.org.

In January 2020, California's Medi-Cal program began paying eligible providers for conducting ACE screenings for Medi-Cal patients. Medi-Cal providers who **self-attest** to taking the certified training are able to receive payment for ACE screenings of their Medi-Cal patients.

Since the launch of the ACEs Aware initiative in December 2019, we have learned that non-clinicians who complete the training find it very useful in their work with children, adults, and families.

Have you taken the *Becoming ACEs Aware in California* training?
The *Becoming ACEs Aware in California* training is a free, online training that provides two Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits. The training educates clinical providers and non-clinicians about the importance of incorporating ACE screenings into their clinical practices, how to conduct ACE screenings, how to use clinical protocols to determine treatment plans, and best practices in providing trauma-informed care. The training is case-based, and offers cases related to pediatrics, internal medicine, family medicine, and women's health.

Billable Providers: Have you self-attested to finishing the training?
After taking the training, billable Medi-Cal providers must self-attest to having completed the training. Attestation is simple and only takes a few minutes. The **attestation form** also includes an option to be included in a **directory** of Medi-Cal providers who have completed a certified ACEs Aware training. Medi-Cal patients will be able to find "ACEs Aware" providers.

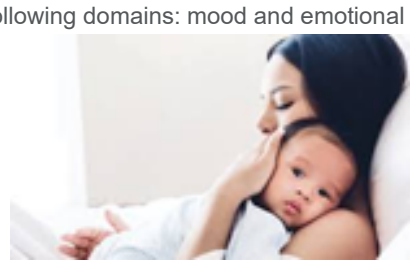
Non-billable providers do not need to attest; however, the training is appropriate for all who support ACE screening and response.

Are you screening Medi-Cal patients for ACEs?
Qualifying ACE screenings are eligible for payment in any clinical setting in which billing occurs through Medi-Cal fee-for-service or to a network provider of a Medi-Cal managed care plan. To learn more about qualifying ACE screenings and to see which enrolled Medi-Cal provider types are eligible to receive payment, visit **ACEs Aware Frequently Asked Operational Questions**.

Providers interested in ACEs and trauma-informed care, as well as patients who have questions, can find more information at **www.ACEsAware.org**.

FSR Provider Pearl: Medical Record Review Preventive Criteria Comprehensive Postpartum Care and Maternal Mental Health

The American College of Obstetricians and Gynecologists (ACOG) opines that the weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. Recommendations are that the comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.[1]



Maternal mental health condition means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. Women with postpartum depression have intense feelings of sadness, anxiety, or despair that prevent them from being able to do their daily tasks.

The California Department of Health Care Services (DHCS) Medical Record Review includes reviewing comprehensive postpartum visits for new moms as well as infants at the newborn, 1-, 2-, 4-, and 6-month visits. In addition, any opportunity a provider has through an encounter to follow mom or baby for up to one year after delivery, is an opportunity to assess for a maternal mental health condition using a validated tool as part of comprehensive care. The reviewer will be looking to see that the provider promoted healthy mom/baby social-emotional development through screening for postpartum depression during postpartum visits and well child checks.

Appropriate documentation by providers must include evidence that adequate systems are in place to ensure accurate diagnosis, effective treatment, and follow-up, which may include an additional evaluation, a suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up as indicated to address the member's severity of symptoms and functional status, including ability to care for and relate to the newborn. Additional self-care strategies, community resources, and crisis support should also be considered in the plan of care. Last, ensure documentation in medical records are clear and concise related to screening, interventions, counselling, and/or all appropriate care rendered to mother-baby dyad patient.

Information Slides for a short presentation about MDS screening and other resources to assist you in preparing your clinic for maternal depression screening and follow-up interventions.

In conclusion, maternal depression can take a substantial toll on the health and well-being of both mothers and children, and can increase related health costs, impede the development of the child, and create negative social consequences.[2] While these factors are understood, record reviews indicate that there are opportunities to close gaps that exist in the use of screening codes that keep in mind special populations, e.g. mothers and babies and maternal depression screening. It could be that most practices are screening for depression but not optimizing revenue potentials or may be screening but not noting the results or follow-up care or may not have workflows that support best practice screening processes. Whatever the reasons, screening codes for depression are underutilized. SFHP has prepared a basic Maternal Depression Screening (MDS) PCP Tip Sheet to initiate consideration for your practice's MDS screening processes. Key considerations for your billing and coding practices should include coding that captures the following services:

1. Validated Screening Tool
2. Accurate Diagnosis
3. Effective Treatment
4. Appropriate Follow-up
5. Coordination of Care

References:

1. American Academy of Pediatrics (AAP), Perinatal Depression

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Maternal-Depression.aspx

2. American College of Obstetricians and Gynecologists (ACOG), Postpartum Toolkit

https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/publications/2018-postpartum-toolkit.pdf

3. DHCS APL 20-006: Site Reviews: Facility Site Review and Medical Record Review.
4. ACOG, Optimizing Postpartum Care

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

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[1] Presidential Task Force on Redefining the Postpartum Visit, Number 736 (Replaces Committee Opinion Number 666, June 2016. Reaffirmed 2021), ACOG Committee Opinion Number 736_May 2018

[2] Maternal Depression Screening and Medicaid, CMS Informational Bulletin, December 5, 2016 https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf

"Provider Pearls" are monthly articles written to help you prepare for the California Department of Health Care Services (DHCS) FSR review processes.

For any questions about the Facility Site Review or Medical Record Review processes or tools, please use our fsr@sfhp.org email. A facility site review team member will respond and/or reach out to you to help you with your inquiry.
