2021 Care-Based Incentives (CBI) Spring Refresher Webinar

Frequently Asked Questions (FAQ)

1) **How is the TB Risk Assessment tracked? We have a risk assessment built into preventive exams but the assessment is not reported to the Alliance. Is there a CPT code we should be adding or is the diagnosis Z11.1 enough for you to capture this?**
   The TB Risk Assessment measure will be tracked using the ICD-10 diagnosis code Z11.1 attached to an office visit claim.

2) **We have used the purified protein derivative (PPD) skin test in the past. Should we use PPD or QuantiFERON (QFT), and how will you count the PPD reading?**
   The Tuberculosis (TB) Risk Assessment measure will be only be looking for members 12 months to 21 years who have been screened for latent tuberculosis infection (LTBI) risk factors by staff at the PCP office during the measurement year using the **ICD-10 Code Z11.1**, encounter for screening for respiratory tuberculosis. If a member is screened positive using the risk assessment tool, the clinic can decide which testing methodology to use in compliance with current clinical guidelines.

3) **How much is the dental fluoride varnish per unit?**
   The application of fluoride varnish is reimbursable at $18 per application up to 3 times in a 12-month period for children ages 6 months to 5 years (up to before the member's 6th birthday). Application of topical fluoride varnish by a physician or other qualified health care professional **CPT code is 99188**. The topical application of fluoride varnish **CDT code is D1206**. Please outreach to your local CHDP office to order fluoride varnish kits.

4) **Can you clarify what 'remote monitoring for BP' means? i.e. if I have a phone visit with a member and they self-report a BP using a home BP device, does that "count towards compliance" if we enter that information into our EHR?**
   Some of the remote monitoring services are covered under Medi-Cal, and others are not. The Alliance includes all benefit codes covered under Medi-Cal. In October, a Provider news update was distributed with education on remote visits with blood pressure readings which can be accepted using either a telemedicine specific HCPCS code or an E&M visit code with a telehealth modifier and telehealth POS code. The visit must also include the relevant CPT II codes for the systolic and diastolic ranges in order to evaluate whether the BP is in control: https://www.ccah-alliance.org/providerspdfs/Provider_Memos/2020/10142020_CBPFax.pdf

Type of Visit	HCPCS
Telephone & Virtual Video Visits	Use synchronous telehealth modifier and POS code as applicable with PCP office codes (table below)
Telemedicine Specific Codes	**G2010** Remote Evaluation of Recorded Video and/or Images Submitted by An Established Patient (E.G., Store and Forward), Including Interpretation with Follow-Up with the Patient within 24 Business Hours, Not Originating from a Related E/M Service Provided **G2012** Brief Communication Technology-Based Service, E.G. Virtual Check-in, By A Physician or Other Qualified Health Care Professional Who Can Report Evaluation and Management Services, Provided to An Established Patient, Not Originating from A Related E/M **Must bill either G code with telehealth modifiers 95 or GT**

Previous telehealth guidelines available through the Provider News: https://www.ccahalliance.org/providerspdfs/Provider_Memos/2020/03252020_Guidance_on_Telehealth_Services.pdf

5) What is the calculation used to convert CBI scores into money? How much is each point worth, and is there a way to speed up utilization reporting?

At the end of the CBI program year, the Board of Commissioners approves the overall pool of money available for the CBI program. That pool then gets dispersed into the three comparison groups for Family Practice, Pediatrics and Internal Medicine. The overall calculation the CBI payment is a factor of the Member Months associated to the practice, risk stratification score, and CBI points which gets weighed across the peer groups. These calculations are discussed in more detail in the CBI addendum.

For the CBI reports, the delay in the report release is based on additional validation steps placed to verify accuracy of the CBI data. Each quarter we work through 33 steps involving multiple staff across different departments to generate, review and ensure data accuracy for what data has been received by the end of the quarter as well as for the extended data submission timeline for Q4 data (i.e. claims must be submitted by the end of January, supplemental data must be received by the end of February). In the beginning of the year there is some overlap between Q4 and Q1 validation processes, where the validation process for Q1 is started after the end of the first quarter.

6) How has the formula for awarding incentive amounts changed?

The formula for awarding incentive amounts changed in the 2020 program year from using a weighting factor of the linked provider's Senior and Person's with Disability (SPD) population to the risk stratification

score. The score is derived based on member demographic information (ex. age and gender) as well as diagnosis submitted through claims.

7) Will you be updating the Quality Reports to reflect the new well-child measure?

Yes, we have submitted a ticket to our programmers to update the report. There have been a number of regulatory projects that have competed with the time needed to update a number of the Quality Reports, but we hope to provide an updated Child and Adolescent Quality Report before the end of the year.

8) Are CBI staff available to do DST only trainings with providers?

Yes. The CBI Team is available to provide DST only trainings with staff.

9) Is there a deadline each month to submit supplemental data through the DST for it to be incorporated in the following month's reports?

In order for you to see your data submissions uploaded into the Provider Portal Quality Reports, it is recommended that you submit data through the DST prior to the 24th of the month. If data submission takes place after this date, you can expect to see the changes in the following month.

> Example: If a provider uploads data through the DST anytime between May 1st and May 24th, a provider should see these changes to the quality report(s) for June. If the DST upload takes place between May 25th and May 31st, the provider should expect to see these changes in the July reports. In rare circumstances we run the data ahead of the 25th due to competing projects.

10) When will the CBI Spring Refresher Webinar be posted?

The webinar will be available when the new website is released on July 1st. We will send a Provider news announcement when the video and FAQ has been posted.

14) What are the ICD-10 codes used in the program?

Hyperlinked within the technical specifications are the codes applicable for each measure. This could include codes that bring a person in to the measure, bring them out of the measure, or make them compliant. For smaller code sets, there are some codes listed in the CBI Tip Sheets.

15) How is the data for the CBI extracted? How do smaller practices with less members compete in the CBI?

Data is extracted in a number of ways. We compile information gathered from laboratories that we have active data exchange processes as well as claims, DHCS encounter data, lead information from DHCS, immunization registries (registries utilize a name matching processes that happen monthly), as well as through the Data Submission Tool for information that could not be conveyed in a claim. We're happy to meet with all providers, and for smaller practices we have met to train on submission of data gaps through the DST, as well as walked through more of the nuances to the CBI program in one-on-one meetings and CBI Forensics visits.