Attachment FF: Global Payment Program Valuation Protocol

A. Valuation of Services

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points based on this protocol. Each service has an identical point value for every PHCS, but the assigned point values per service shall vary by GPP Program Year (GPP PY) as described in detail below.

1. Categories and tiers of service

Services associated with points in the GPP are shown in Table 1 below, grouped into both categories (1-4) and tiers within categories (A-D). These groupings can contain both traditional and non-traditional services. The groupings were intended to better display the full range of services that may be provided to the uninsured under the GPP, to help develop initial point values for non-traditional services (for which cost data is not available), and to clarify which service types it made sense to revalue up or down for GPP purposes over time.

Categories 1 through 4 are groupings of health care services that are organized according to their similar characteristics. For example, Category 1 contains outpatient services in traditional settings, mostly "traditional" services provided by licensed practitioners. Category 2 is made up of a range of outpatient services provided by non-provider care team members, both inside and outside of the clinic, including health education, health coaching, group and mobile visits, etc. Category 3 services are technologically-mediated services such as real-time video consultations or e-Consults between providers. Category 4 services are those involving facility stays, including inpatient and residential services.

Grouping of services into tiers was based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in-person, electronic, etc.). Generally speaking, within each category, tier D is the most intensive and/or costly, and often requires individuals with the most advanced training or certifications, resulting in higher initial point values on average, whereas tier A is on the other end of the spectrum in intensity and resource use. However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.

The services whose values would decline over time under the GPP (as described in section 4 below) are most service types in categories 1C (emergent outpatient) and 4B (inpatient medical/surgical and mental health), which are higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care.

Table 1: GPP Service Types by Category and Tier, with Point Values

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, and other non-emergent care (physicians or other licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis stabilization	T	250
	D	High-intensity outpatient services	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
	C	Community-based face-to-face encounters	Home nursing visit	NT	75
			Paramedic treat and release	NT	75
			Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-provider care team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C	Store and	Telehealth (patient - provider)	NT	50

		forward telehealth	- Store & Forward		
			Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store & Forward	NT	65
	D	Real-time telehealth	Telephone consultation with PCP	NT	75
			Telehealth (patient - provider) - real time	NT	90
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services, low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient, high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical community services	Trauma	T	863
			Transplant/burn	T	1,131

2. Valuation of traditional services

Services for which payment typically is made available upon provision of the service, referred to herein as "traditional" services, will receive initial point valuations based on their cost per unit of service in the historical year SFY2013-14. These traditional services are grouped into categories that reflect generally where care is being provided and intensity. Gross costs incurred for services provided to the uninsured by PHCS in SFY 2013-14, as determined under the applicable claiming methodologies, are summed across all PHCS by service type, using the most complete and reliable data when available, to obtain an average cost per unit for each traditional service. All traditional services are assigned point values based on their relative cost compared to an outpatient primary and specialty visit, which serves as the benchmark traditional service. These initial points are shown in table 1; the relative costs per unit of service are shown in Appendix 1.

3. Valuation, non-traditional services

Non-traditional services typically are not directly or separately reimbursed by Medicaid or other payors, and are often provided as substitutes for or complementary to traditional services. These services are assigned initial point values based on their estimated relative cost compared to the benchmark traditional service, and their value in enhancing the efficiency and effectiveness of traditional services.

The non-traditional services in the table 1 provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, by improving uninsured individuals' access to the right care, at the right time, in the right place. For example, instead of needing to go to the emergency department, an uninsured individual could have telephone access to his or her care team, which would both help address and treat the presenting condition, as well as help connect the patient back to the entire breadth of primary care services. Likewise, a PHCS deploying eReferral/eConsult services would be able to better prioritize which uninsured individuals need early access to face-to-face specialty care expertise, or which can benefit from receipt of specialty care expertise via electronic collaboration between their PCP and a specialist. This collaboration enhances the PCPs' capacity to provide high-quality, patient-centered care, and allows the individual receiving that care to avoid specialty care wait times and the challenges of travelling to an additional appointment to a specialist who may be located far from where they live. This increased ability to provide timely access to specialty expertise will result in earlier treatment of complex conditions and help uninsured individuals avoid the need to seek emergent or acute care for untreated or partially treated sub-acute and chronic conditions. More detail on non-traditional services, including codes where available and descriptions, is in Appendix 2.

Individuals will be considered uninsured with respect to a non-traditional service if he or she has no source of third party coverage for a comparable traditional service. For example, an individual with coverage for outpatient visits would not be considered uninsured with regard to technology-based outpatient services, even if his or her insurance does not cover those services. DHCS shall, in consultation with the DPH systems, issue guidance letters addressing whether individuals shall be considered uninsured in specific factual circumstances, to ensure that the requirements are consistently applied.

4. Point revaluation over time

Point values for services will be modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value. The provision of general medical/surgical acute inpatient services and emergent services will receive fewer points over time,. The changing point structure will be designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible.

Point revaluation will be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if utilization and the mix of services provided remained constant. Specifically, for any PHCS, if its utilization and mix of services does not change from the baseline year of SFY 2014-15, it will not earn any more points in GPP PY 1 than it earned under the baseline year, and in subsequent GPP PYs shall earn fewer points.

As points for certain services are revalued over the course of the GPP, PHCS will be incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation will be phased in over time to enable PHCS to adapt to the change in incentives. In GPP PY 1, points will be identical to the initial cost-based point values. In GPP PY 2, 20% of the full change will be made to point values. In GPP PY 3, an additional 30% of the revaluation will be phased in, with the final 50% change occurring in GPP PY 4. This phase-in is illustrated in Table 2.

Point values will not vary from their initial cost-based amounts by more than 40% at any time during the GPP.

Table 2: Revaluations to categories of service, by year, compared to initial point value

Category of service	Initial point value (cost-based)	Point value (% change), GPP PY 1	Point value (% change), GPP PY 2	Point value (% change), GPP PY 3	Point value (% change), GPP PY 4	Point value (% change), GPP PY 5
OP ER	160	160 (0%)	158 (-1%)	156 (-2.5%)	152 (-5%)	152 (-5%)
Mental health ER / crisis stabilization	250	250 (0%)	248 (-1%)	244 (-2.5%)	238 (-5%)	238 (-5%)
IP med/surg	634	634 (0%)	630 (-0.6%)	624 (-1.5%)	615 (-3%)	615 (-3%)
IP mental health	341	341 (0%)	339 (-0.6%)	336 (-1.5%)	331 (-3%)	331 (-3%)

Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

B. PHCS-Specific Point Thresholds

DHCS established GPP PY 1 point thresholds for each PHCS by collecting utilization data for all traditional uninsured services (by each traditional table 1 category) provided in SFY 2014-15, and then multiplying those service counts by corresponding initial point values. The thresholds for PY1 are shown in Table 3.

For GPP PY 2 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 167, compared to the total GPP funds available in GPP PY 1, e.g. if total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%.

Table 3: GPP PY 1 PHCS Thresholds, Based on FY2014-15 Uninsured Services

Public Health Care System	**System Threshold, GPP PY1**
Los Angeles County Health System	101,573,445
Alameda Health System	19,151,753
Arrowhead Regional Medical Center	7,525,819
Contra Costa Regional Medical Center	5,674,651
Kern Medical Center	3,633,669
Natividad Medical Center	2,959,964

Riverside University Health System – Medical Center	8,066,127
San Francisco General Hospital	12,902,913
San Joaquin General Hospital	3,021,562
San Mateo County General Hospital	8,733,292
Santa Clara Valley Medical Center	19,465,293
Ventura County Medical Center	9,213,731

Appendix 1

Table 4: Categories of Service and Point Values, Traditional

Category	Tier	Service Name	Cost/unit	Initial point value
1: Outpatient	B	OP Primary / Specialty (**benchmark, 100)**	587	**100**
	B	Dental	365	**62**
	B	MH Outpatient	225	**38**
	B	SU Outpatient	62	**11**
	B	SU Methadone	11	**2**
	B	Contracted Prim/Spec	110	**19**
	C	OP ER	942	**160**
	C	Contracted ER	411	**70**
	C	MH ER/Crisis Stabilization	1,470	**250**
	D	OP Surgery	4,554	**776**
4: Inpatient	A	SNF	829	**141**
	A	MH/SU Residential	138	**23**
	B	Med/surg	3,721	**634**
	B	MH Inpatient	2,000	**341**
	C	ICU/CCU	5,663	**964**
	D	Trauma	5,069	**863**
	D	Transplant/Burn	6,644	**1,131**

Table 5: Categories of Service and Point Values, Non-Traditional

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
Service Category 1: Outpatient				
A	RN Visit[1,2] (includes Wound Assessment visits)	**99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.		50
A	PharmD Visit[3]	**99605, 99606, 99607** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment, and intervention if provided;		75
A	Complex Care Manager[4]	**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, Comprehensive care plan established, implemented, revised, or monitored.		75
Service Category 2: Complementary Patient Support and Care Services				
A	Wellness[5,6]	G0438 Annual wellness visit; includes a		15

[1] CMS Source: https://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99211&RangeEnd=99215, Accessed 11/14/2015

[2] Understanding When to Use 99211, Family Practice Management, http://www.aafp.org/fpm/2004/0600/p32.html, Accessed 11/10/2015

[3] Pharmacist Services Technical Advisory Coalition, http://www.pstac.org/services/mtms-codes.html, accessed 11/15/2015

[4] CMS Medicare Learning Network, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf, Accessed 11/15/2015

[5] https://www.careimprovementplus.com/pdf/PROVIDER_COMMUNICATION_WELLNESS_AND_PHYSICAL_EXAMINATION_CODES.pdf

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		personalized prevention plan of service (PPPS), initial visit G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit **S5190** Wellness assessment, performed by non-physician **Z00.00, Z00.01x`**		
A	Patient Support Group	**Non-physician Health Care Professional CPT Code** **98961** Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/ Family) 2-4 Patients **98962** Education And Training as above; 5-8 Patients		15
A	Community Health Worker (CHW)		Encounters in which a Community Health Worker assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs[7]	15
A	Health Education		Services provided for the purpose of promoting health and preventing illness or injury. These include risk factor reduction interventions, preventive medicine counseling and behavior change interventions.	25

[6] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

[7] Bureau of Labor and Statistics, Standard Occupational Classification: 21-1094 Community Health Workers. http://www.bls.gov/soc/2010/soc211094.htm, Accessed 11/24/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Nutrition Education[8,9]	**97802** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient **97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient		25
A	Case management		Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.[10] **Case manager is assigned** to the patient and engages in direct care **OR** coordination of care **OR** manages patient's access to care **OR** initiates and/or supervises other health care services needed by the patient[11]	25
A	Health coach		Health and behavior intervention performed by non-provider member of the health care team to build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Includes motivational interviewing, self-management goal setting, patient education and activation and chronic disease support[12]	15

[8] National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1), https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=252&ncdver=1&NCAId=53&NcaName=Medical+Nutrition+Therapy+Benefit+for+Diabetes+%2526+ESRD&IsPopup=y&bc=AAAAAAAAIAAA&, Accessed 11/24/2015

[9] CMS, DHHS: Medical Nutrition Therapy (MNT) Services for Beneficiaries With Diabetes or Renal Disease - POLICY CHANGE, November 1, 2002. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A02115.pdf, Accessed 11/10/2015

[10] Case Management Society of America, http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx, Accessed 11/15/2015

[11] Oregon APM Patient Touches, direct communication with Oregon Health Authority

[12] Per 11/30/2015 communication with Dr. Nwando J. Olayiwola, Associate Professor, Department of Family and Community Medicine, and Director of the Center for Excellence in Primary Care (CEPC), University of California San Francisco. CEPC is a recognized national leader in Health Coach training.

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Panel management		Document in patient's medical record when staff proactively reach out to a patient and speak with them regarding preventive services, chronic illness management, their care plan, problem list, health goals, and/or treatment options[13]	15
A	Oral Hygiene Encounters		Adult and Pediatric oral health services including dental varnishing, oral health education and other prevention services provided by dental hygienists	30
B	Group medical visits	**99411-99412** Preventive medicine counseling and/or risk factor reduction provided to individuals in a group setting **99078** Physician educational services rendered to patients in a group setting (eg, obesity or diabetic instructions)		50
B	Integrative medical therapies	**97810-97811:** Acupuncture, one or more needles, without electrical stimulation, personal one-on-one contact with the patient		50
B	Palliative Care	**0690-0699 Pre-hospice/Palliative Care Services**: Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration. Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists. Unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters.	Encounters with non-provider care team members that focus on preventing and relieving suffering, and improveing the quality of life of patients and their families facing serious illness. Palliative care is provided by an interdisciplinary team which works with primary and specialty care providers to identify and treat pain and other distressing symptoms, provide psychosocial and spiritual support, and assist in complex decision-making and advance care planning.	50
B	Pain management		Encounter provided by a non-provider caregiver or care team focused on enhancing self-management of chronic pain, implementing behavioral strategies for managing pain, discussing medication effectiveness and side effects, assessing treatment	50

[13] Oregon APM Patient Touches

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
			effectiveness, and adjusting treatment plan and goals. Chronic pain visits may also include assessment for signs of substance use or mental health disorder as well as motivational interviewing or other treatment strategies for these disorders	
C	Physician Home Visits[14]	**99341 - 99347** Home visit, new patient; **99347 - 99350** Home visit, established patient		125
C	Home nursing visits	**G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	Visits by RNs to patients at home for acute or chronic disease management. May include history taking, physical exam, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level, or medications.	75
C	Mobile Clinic Visits	**CPT Physician Code** **99050** Service(s) provided in office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service **99051** Service(s) provided in the office during regularly scheduled evening, weekend or holiday hours, in addition to basic service **99056** Services typically provided in the office, provided out of the office at request of patient, in addition to basic service Use POS code 15 with the above codes to signify a services provided in a mobile setting[15]		90
C	Paramedic treat and release		Paramedic assessment, treatment if appropriate, and discharge of a patient without ambulance transport[16]	75
Service Category 3: Technology-Based Outpatient[17]				

[14] CMS Billing and Coding Guidelines - L31613 PHYS-081 - Home and Domiciliary Visits: https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31613_1/L31613_PHYS081_CBG_050111.pdf, Accessed 11/10/2015

[15] https://www.supercoder.com/my-ask-an-expert/topic/mobile-clinic

[16] Millin, M. et al. EMS provider determinations of necessity for transport and reimbursement for ems response, medical care, and transport: Combined resource document for the national association of EMS physicians position statements, http://www.naemsp.org/Documents/Position%20Papers/POSITION%20Determinationoftransport-Resource%20Doc-PEC_2011.pdf, Accessed 11/24/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Texting		Texting services provided by the care team to an established patient, parent, or guardian to support care management. Cannot focus on administrative tasks such as scheduling appointments. Must not originate from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	1
A	Video Observed Therapy		Observation of patients taking their tuberculosis medication in their homes. Observation is done using a live video telephone on both the patient and provider ends[18]	10
A	Nurse advice line[19,20]	**98966, 98967, 98968** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment		10
A	RN e-Visit[21]	**98969** Online evaluation and management service provided by a qualified non-physician		10

[17] General resource for this section is the American Telemedicine Association Letter to CMS on Telehealth Services, December 31, 2013. http://www.americantelemed.org/docs/default-source/policy/medicare-code-request-for-2015.pdf?sfvrsn=4, Accessed 10/28/2015

[18] California Department of Public Health Tuberculosis Control Branch - Guidance for Developing a Video Observed Therapy (VOT) - Policy and Procedures. https://www.cdph.ca.gov/programs/tb/Documents/TBCB-SPM-Cert-Guidance-VOT-Policy-And-Procedures.doc, Accessed 11/24/15

[19] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

[20] American Academy of Pediatrics, Charging for Nurse Telephone Triage. https://www.aap.org/en-us/professional-resources/practice-support/Telephone-Care/pages/Charging-for-Nurse-Telephone-Triage.aspx, Accessed 10/20/2015

[21] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		health care professional to an established patient, guardian or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network		
B	Email consultation with PCP[22]	**99444** Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network		30
C	Telehealth (patient - provider) - Store & Forward[23,24]	Digital Retinal Screening **92250** (global) Fundus photography with interpretation and report		50
C	Telehealth – Store & Forward	+GQ modifier for distant site: **99241-99243** Office consultation, new or established patient **99251-99253** Initial inpatient consultation **99211-99214** Office or other outpatient visit **99231-99233** Subsequent hospital care OR **99446-99449**: Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations	Store and Forward services that include images, such as Teleophthalmology and Teledermatology	65
C	Telehealth (provider - provider) – eConsult/ eReferral[25]	**99446-99449**, the new "Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations OR **99241-5** with GT modifer for distant site		50

[22] *Ibid*

[23] July 2015, Medi-Cal Ophthalmology Updatehttps://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/0B578FE9-ED37-42F6-BCDF-B7C157751889/ophthal.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO' Accessed 10/15/2015

[24] communication with Jorge Cuadros, OD, PhD, Director of Clinical Informatics Research, UC Berkeley School of Optometry, CEO of EyePacs

[25] RTR- ECONSULT CPT CODES, UC Davis. https://static1.squarespace.com/static/52d9c6c5e4b021f2d93416db/t/534c2d9fe4b0d8fffdf288f5/1397501343957/CPT+Codes.pdf, plus communication 10/27/2015 with Timi Leslie, BluePath Health and Rachel Wick, Blue Shield of CA Foundation in reference to BSCF eConsult grant program.

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
D	Telephone consultation with PCP[26]	**CPT Physician Code** **99441** through 99443. Telephone E&M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	ALTERNATIVE DESCRIPTION: PCP speaks via telephone with patient about medical/dental/MH/substance use condition or medications AND discusses or creates care plan OR discusses treatment options	75
D	Telehealth (patient - provider) - real time[27,28]	**99201-99215** with modifier **GT** "Office or other outpatient visits" Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems"		90
D	Telehealth (provider - provider) - real time[29]		Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems	90
Service Category 4: Inpatient				
A	Sobering Center[30]		Nurse assessment and monitoring, to determine and ensure safety for individuals found intoxicated in public[31]	50
A	Recuperative/Respite Care[32]		Provision of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Services may include recuperative care, completion of therapy	85

[26] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

[27] CMS Medicare Learning Network: Telehealth Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, Accessed 10/28/2015

[28] Medi-Cal Provider Manual: Telehealth, December 2013. http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc, Accessed 10/28/2015

[29] *Ibid*

[30] San Francisco Department of Public Health, Housing and Urban Health, Medical Respite and Sobering Center. https://www.sfdph.org/dph/comupg/oprograms/HUH/medrespite.asp, Accessed 11/25/2015

[31] 12/23/2015 communication with Dr. Hali Hammer, Medical Director for Ambulatory Services, San Francisco Health Network.

[32] National Health Care *for the* Homeless Council, definition of Recuperative Care https://www.nhchc.org/ accessed 11/24/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
			(e.g, antibiotics, wound care), temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults[33]	

[33] Ibid 12/23/2015 communication with Dr. Hammer.