Project 1.3 Target Population

* 1.3.5 - Request for Specialty Care Expertise Turnaround Time
* 1.3.6 - Specialty Care Touches: Specialty expertise requests managed via non-in-person specialty encounters

# 1.3.5 - Request for Specialty Care Expertise Turnaround Time

**Summary of Changes from DY14 Year End Reporting Manual**

* Metric Numerator changed “sent an individualized response within 5 calendar days” to “sent an individualized response within 5 full calendar days following the date of the request.”
* Numerator Codes, changed to None, as the prior language did not refer to codes, only re-stated the numerator
* To align with 1.3.6, Added *Denominator Note: Requests to PRIME Entity specialists during the measurement period should include the following information: 1) who made the request, 2) date request was made, 3) to which specialty the request was placed.*
* Denominator Exclusions, second bullet, added “…or diagnostic services” (change made to align 1.3.5 and 1.3.6)
* Definitions, “Individualized response within 5 calendar days”, changed to ““Individualized response within 5 full calendar days”

**Modification from Native Specification**

Specification Source: PRIME Innovative Metric Steward (Los Angeles County Department of Health Care Services; San Francisco Health Network; University of California, Davis)

Metric Steward: Los Angeles County Department of Health Care Services; San Francisco Health Network; University of California, Davis

* N/A

**Value Sets for this metric:**

* No external value sets required for this metric; all codes are listed within the metric specification.

**Metric Description**

Percentage of requests for specialty care expertise, regardless of patient age, for which an individualized response was sent to the referring provider and/or the referring provider’s care coordination team within 5 calendar days.

**Project 1.3, Metric 1.3.5 Target Population:**

Individuals for whom PRIME Entity Specialty Care Expertise has been requested at least once during the Measurement Period whether or not they meet the PRIME Eligible Population criteria*.*

**Metric Numerator**

Number of requests in denominator for whom the requester for specialty care expertise (and/or the requester’s care coordination team) was sent an individualized response within 5 full calendar days following the date of the request.

* Individualized response can include any of the following:
  + The initial reply from the specialist care reviewer with recommendations or clarifying questions/needing additional information (response may be electronic, by phone or by fax).
  + The decision documented by a specialist to schedule a face-to-face visit
  + For requests for specialty expertise not submitted by eConsult, a review and disposition by a specialist or Utilization Review Staff person with one of the following dispositions:
    - Referral denied with denial date.
    - Date of referral approval and note that specialty care appointment date is pending.
    - Date of referral approval and date of the scheduled specialty care appointment.

**Numerator Code/s (CPT, ICD10, other)**

None

**Metric Denominator**

Total number of requests received, during the measurement period, for PRIME Entity specialty expertise for ALL specialties that meet the following criteria:

1. The PRIME Entity must include in their denominator all specialties that use eReferral/eConsult
2. AND the PRIME entity must also include their top 10 highest volume non-eReferral/eConsult specialties in the denominator. The PRIME Entity has the option to include all other non-eReferral/eConsult specialties in the denominator in addition to those top 10.

Requests for specialty care expertise include both those submitted via eReferral/eConsult and those via traditional mechanisms, and include those originating from providers internal to the PRIME Entity as well as providers external to the PRIME Entity (thus measuring total PRIME Entity demand for specialty care expertise).

*Denominator Note: Requests to PRIME Entity specialists during the measurement period should include the following information: 1) who made the request, 2) date request was made, 3) to which specialty the request was placed.*

**Denominator Code/s (CPT, ICD10, other)**

For tracking of eReferral/eConsult, PRIME entity may choose use either locally developed codes or systems, or may choose to use the CPT codes[[1]](#footnote-2) listed for eReferral/eConsult in the California’s MediCal 2020 Special Terms and Conditions Attachment FF: Global Payment Program Valuation Protocol, Appendix 2: Categories of Service and Point Values, Non-Traditional:

* 99446-99449:Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations

OR

* 99241-5 with GT modifier

**Denominator Exclusion/s**

* This metric applies only to requests for specialty care expertise to specialists within the PRIME entity’s network/system. Requests to specialists external to the PRIME entity are excluded from this metric (whether it was initially external or started as an internal request and later became an external request/referral).
* Request for ancillary services that are “orders” for services (e.g, Audiology, Physical Therapy, Occupational Therapy and Speech Therapy, Radiology, Casting or Prosthetic services, or diagnostic services) for which the request triggers scheduling of the requested service without clinical review or opportunity for clinical dialogue between requester and specialist.
* Requests for inpatient specialty care expertise.

**Reporting Business Logic**

TBD

**Definitions as applicable**

**Request for Specialty Care Expertise**: A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient’s condition. For inclusion in the denominator, these requests must include the following information: 1) who made the referral, 2) date referral was made and 3) to which specialty the request was placed.

**Eligible Provider**: To be determined based on scope of practice and local rules.

**“Individualized response within 5 full calendar days”**

The number of calendar days between the submission date of the request for specialty care and the date of the individualized initial reply from the specialist or review and disposition by a Utilization Review Staff person.

**Request for Inpatient Specialty Care Expertise:** A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient’s condition that occur during an inpatient admission.

**Other Notes as applicable**

A higher rate indicates better quality.

# 1.3.6 - Specialty Care Touches: Specialty expertise requests managed solely via non-in-person specialty encounters

**Summary of Changes from DY14 Year End Reporting Manual**

* Title and throughout specification, changed “in-person face to face” to “non-in-person”, and changed “6 months” to “6 calendar months”
* Added Numerator Note, starting with language previously under Numerator Codes
  + First paragraph, changed “email” to “Store and Forward telehealth (e.g., secure email messaging, eConsult, teledermatology)”.
  + First paragraph, as “non-face to face” has been changed to “non-in-person”, removed language clarifying that synchronous video is both face to face and non-in-person, as this is no longer relevant.
  + Second paragraph, changed
    - From “…and no documentation of a clinic appointment.”
    - To “…and no documentation of a clinic appointment in the 6 calendar months following the request for specialty care.”
  + Third paragraph, starting with “For specialties without eConsult/eReferral,…” added to end of sentence “…and no documentation of a clinic appointment in the 6 calendar months following the request for specialty care.”
* Moved all language previously in Numerator Codes into Numerator Note.
* Replaced previous Numerator Codes language to “None”
* Removed “Numerator Exclusions”
* Metric Denominator changed
  + From: “Total number of requests received,…”
  + To “Total number of outpatient requests received (includes requests originating from Urgent Care),…”
  + Updated time frame for DY15
  + Limited the denominator requests for specialty requests using the following language
    - “…from the following medical sub-specialties:
      * Allergy
      * Cardiology
      * Dermatology
      * Endocrinology
      * Hepatology
      * Hematology
      * Infectious Disease
      * Nephrology
      * Pulmonology
      * Rheumatology”
* Denominator Codes changed to “None”. Previous language moved to Denominator Note.
* Denominator Exclusions,
  + Added “Requests for specialty care expertise originating from the Emergency Department“
  + second bullet, added “…or diagnostic services” (change made to align 1.3.5 and 1.3.6)
  + Removed third bullet “Requests for ancillary services…” as due to the revised denominator this exclusion would no longer apply.
* Added Rationale and Reference sections

**Modification from Native Specification**

Specification Source: PRIME Innovative Metric Steward (Los Angeles County Department of Health Care Services; San Francisco Health Network; University of California, Davis)

Metric Steward: Los Angeles County Department of Health Care Services; San Francisco Health Network; University of California, Davis

* N/A

**Value Sets for this metric:**

* N/A. No value sets or codes included in this metric.

**Metric Description**

Total number of outpatient specialty care requests that were managed solely via non-in-person encounters.

**Project 1.3, Metric 1.3.6 Target Population:**

Individuals for whom PRIME Entity Specialty Care Expertise has been requested at least once during the Measurement Period (Note: The target population for this metric does not need to meet PRIME Eligible Population inclusion criteria described above).

**Metric Numerator**

Number of denominator requests for specialty care expertise that are managed by, arranged by and/or contracted by the PRIME Entity solely via non-in-person specialty encounters within 6 months of the date of the request for specialty care expertise.

* The numerator measurement period extends from 6 calendar months prior to the start of the measurement period through to the end of the measurement period, thus allowing up to 6 calendar months after the last specialty request was received for the non-in-person specialty encounter(s) to occur. For DY13 YE the numerator would include non-in-person specialty encounters occurring between: 1/1/17 – 6/30/18.
* For a given patient, non-in-person specialty care encounter(s) must have occurred within 6 calendar months of the associated request for specialty care expertise.
* Management of non-in-person specialty care encounters can be performed only by a NP, PA, DO, MD, or clinical pharmacist working under physician protocol. Non-in-person specialty care encounters may include electronic correspondence between referrer and reviewer (e.g., eReferral/eConsult, email), phone conversations or telemedicine platforms.

**Numerator Notes:**

Telephone, Store and Forward telehealth (e.g., secure email messaging, eConsult, teledermatology) and synchronous video telemedicine visits can be considered non-in-person specialty encounters (aka “touches”).

For specialties employing eConsult/eReferral, count the total number of denominator requests for which no in-person specialty care encounter was recommended in the specialty care response and no documentation of a clinic appointment in the 6 calendar months following the request for specialty care.

For specialties without eConsult/eReferral, count the total number of denominator requests with documentation of specialty care expertise provided by an NP, PA, DO or MD via a non-in-person modality and no documentation of a clinic appointment in the 6 calendar months following the request for specialty care.

The following does not count towards the numerator:

* Communication from the requested specialty care service back to the referring provider for administrative purposes only does not count towards the numerator. Communication from the requested specialty care service back to the referring provider for administrative purposes only (e.g., appointment scheduling, registration) or for UM Approval/Denial of request for authorization based on utilization review.

PRIME Entity request for specialty care via telehealth services, without concomitant provision of a specialty care telehealth service that is managed by, arranged by and/or contracted by the PRIME Entity.

**Numerator Code/s (CPT, ICD10, other)**

* None

**Metric Denominator**

Total number of outpatient requests received (includes requests originating from Urgent Care), during the 6 calendar months prior to the measurement period and the first 6 calendar months of the measurement period, for PRIME Entity outpatient specialty care expertise (for DY15 YE: 1/1/19 – 12/31/19) from the following medical sub-specialties:

* Allergy
* Cardiology
* Dermatology
* Endocrinology
* Hepatology
* Hematology
* Infectious Disease
* Nephrology
* Pulmonology
* Rheumatology

*Denominator Note:*

* Requests to PRIME Entity specialists during the measurement period should include the following information: 1) who made the request, 2) date request was made, 3) to which specialty the request was placed.

**Denominator Code/s (CPT, ICD10, other)**

* None

**Denominator Exclusion/s**

* Requests for specialty care expertise originating from the Emergency Department
* Requests for inpatient specialty care expertise.

**Reporting Business Logic**

None

**Definitions as applicable**

**Request for Specialty Care Expertise**: A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient’s condition.

**Specialty Care Expertise**: Provision of provider level medical decision making information.

**Non-In-Person Encounter**: Encounter in which there was no in-person visit with the patient and/or family. As such both telephone and synchronous telemedicine encounters would be included as fulfilling numerator criteria.

**Outpatient:** A patient who receives medical treatment without being admitted to a hospital.

**Other Notes as applicable**

A higher rate indicates better quality.

**Rationale**

Published data on requests for specialty expertise via eConsults describe four categories of responses (Tuot D, et al): (1) those requiring additional diagnostic workup or history before clinical consultation, representing pre-consultative exchange; (2) those that can be managed by the referring clinician with guidance from the specialist without a face-to-face specialist appointment, representing clinical consultation or virtual co-management; (3) those requiring a specialist appointment that can wait for the next available appointment, representing routine referrals; and (4) those requiring an expedited appointment with a specialty provider, representing urgent referrals. Of those in the second category, the percentages tend to be higher for requests for expertise from medical sub-specialties that are more cognitive or lab-based as opposed to requests for expertise from medical or surgical sub-specialities that are more procedural based.

To focus health systems’ resources on those sub-specialties that are more likely to result solely in clinical consultation and/or virtual co-management without the need for in-person specialist visits, this metric has limited the denominator to those medical sub-specialties with data from different health care delivery systems (Tuot D, Keely E, Barnett ML) showing 20% or greater requests resulting in “in-person visits never scheduled”. Unpublished data from the American Association of Medical College’s CORE (Coordinating Optimal Referral Experiences) program, which focuses on electronic consultation in academic medical centers, corroborate that the greatest prevalence of electronic clinical consultation and/or virtual co-management occurs among medical subspecialties rather than surgical subspecialties, which often require a face-to-face visit in anticipation of a procedure (Shipman et al, personal communication; ACP presentation, 05.13.19). Thus, to promote generalizability, surgical sub-specialties that demonstrated greater than or equal to 20% “never scheduled” responses in the two early adopter systems (SFHN and LADHS) are not included in this metric. We do include dermatology in the denominator as the sole non-medical sub-specialty, as the evidence supporting its use for virtual care across the world is quite robust (Liddy et al).

**References**

1. Tuot DS, et al. Leveraging an electronic referral system to build a medical neighborhood. Healthcare (2015), http://dx.doi.org/10.1016/j.hjdsi.2015.04.001i
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3. Barnet ML et al. Los Angeles Safety-Net Program eConsult System Was Rapidly Adopted and Decreased Wait Times to See Specialists. Health Affairs 36, no.3 (2017):492-499. doi: 10.1377/hlthaff.2016.1283
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6. Liddy C, et al. Electronic consultation systems: worldwide prevalence and their impact on patient care—a systematic review. Family Practice, 2016, Vol. 33, No. 3, 274–285. doi:10.1093/fampra/cmw024

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