25 de octubre de 2019

A: Todos los Médicos Primarios, Pediatras, Psicólogos, Neurólogos y Psiquiatras contratados por First Medical Health Plan, Inc. para el Plan Vital, Región Única y Población Vital-X (Virtual)

Re: Cubierta Especial de Autismo

Estimado(a) Proveedor(a):

Reciba un cordial saludo de parte de First Medical Health Plan, Inc.

Comprometidos en mantenerlo informado sobre temas relacionados a la salud y bienestar de sus pacientes, a continuación, proveemos información importante para reforzar el proceso de solicitud para la Cubierta Especial de Autismo. Para su conocimiento, se incluyen los criterios esenciales de cualificación según el Protocolo de Autismo establecido por el Departamento de Salud de Puerto Rico.

El Registro para Diagnósticos de Autismo es uno que puede ser de cubierta temporera (6 meses de duración) o cubierta permanente (hasta los 21 años). A continuación, se detalla el proceso para solicitar la Cubierta Especial de Autismo.

Para solicitar el Registro de Cubierta Especial Temporera (6 meses de duración) debe incluir:

1. El formulario de Condición Especial completado en el área establecida para Autismo. El formulario para la cubierta temporera puede ser solicitado por el Médico Primario.

2. Evidencia del cernimiento utilizado, de acuerdo a la edad que establece riesgo para autismo.

3. Certificación de riesgo del Médico Primario y evidencia de la herramienta de cernimiento utilizada:

Edades	Herramientas de Cernimiento
< 16 meses	ASQ-SE-2- Cuestionarios de Edades y Etapas: Emocional Social-2 o CSBS-DP- Escalas de Comportamiento Simbólico de Comunicación-Perfil de Desarrollo.
16-30 meses	M-CHAT R/F- *Modified-Checklist for Autism in Toddlers Revised/Follow up*.
31-66 meses	ASQ-SE-2- Cuestionarios de Edades y Etapas: Emocional Social-2 o SCQ- *Social Communication Questionnaire* (> de 48 meses con edad mental > de 24 meses).
67 meses-11 años	CAST- *Childhood Autism Spectrum Test*.
> 11 años	ASAS: *Australian Scale of Asperger's Syndrome*.

Para solicitar el Registro de Cubierta Especial Permanente (hasta los 21 años de duración) debe incluir:

1. Evidencia del diagnóstico de Autismo por uno de los siguientes profesionales:

   - Psicólogo clínico
   - Psicólogo escolar
   - Psicólogo consejero
   - Pediatra del desarrollo
   - Neurólogo
   - Psiquiatra

2. La evaluación diagnostica debe incluir:

   - El Historial Familiar, del Desarrollo y de Salud
   - Entrevista a los encargados sobre las destrezas, conductas, comunicación e interacciones sociales de la persona.
   - Observación de la conducta de la persona en interacción con otros y en actividades de juego y socialización propias para su edad.
   - Los resultados de la versión más reciente de al menos un instrumento para documentar los comportamientos presentes.

3. Ejemplos de instrumentos diagnósticos:

   - Escala de Observación para el Diagnóstico del Autismo (*Autistic Diagnostic Observation Schedule*) – ADOS.
   - Escala de Valoración del Autismo Infantil (*Childhood Autism Rating Scale*) – CARS.
   - Escala de Valoración de Autismo Gilliam (*Gilliam Autism Rating Scale*) – GARS.
   - Entrevista para el Diagnóstico de Autismo-Revisada (*Autistic Diagnostic Interview Revised*) – ADI-R

4. Después de los 21 años, para continuar bajo la Cubierta Especial de Autismo se requiere:

   - Certificación por Neurólogo o Psiquiatra estableciendo la necesidad del manejo de la condición y tratamiento como adulto.

Para fácil referencia, adjunto a este comunicado encontrará el Registro de Cubierta Especial.

Si usted tiene alguna pregunta relacionada a este comunicado y/o necesita información adicional, siéntase en la libertad de comunicarse con nuestro Centro de Servicio al Proveedor al número libre de cargos 1-844-347-7802 de lunes a viernes de 7:00 a.m. a 7:00 p.m. También puede acceder a nuestra página electrónica www.firstmedicalvital.com.

Cordialmente,

Departamento de Cumplimiento
First Medical Health Plan, Inc.

Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

Physical Special Conditions Registry

<table>
<tr><th colspan="4">I. Beneficiary Information</th></tr>
<tr><td colspan="2">Beneficiary Name:</td><td rowspan="2">Age:</td><td rowspan="2">PMG Number:</td></tr>
<tr><td colspan="2">Beneficiary Identification Number:</td></tr>
<tr><th colspan="4">II. Brief Clinical History</th></tr>
<tr><td colspan="4">(Please document the conditions according to the applicable criteria)</td></tr>
</table>

<table>
<tr><th>Mark</th><th>Diagnostic</th><th colspan="2">Mandatory Accompanying Information</th></tr>
<tr><td></td><td>End-stage Renal Disease (ESRD)</td><td colspan="2">The calculation will be made on the basis of the estimated glomerular filtration rate (GRF). Recent results are required for: ______________________________ Serum creatinine

Level 1 GRF in excess of 90 ml/min/1.73m²
Level 2 GRF in excess of 60-89 m/min/1.73m²
Level 3 Moderate (GRF between 30 - 59ml/min/1.73m2
Level 4 Severe (GRF between 15 y 29ml/min/1.73m2
Level 5 End- Stage (ESRD) (GRF<15ml/min/1.73m2 ESRD - Confirmation by Dialysis Center</td></tr>
<tr><td rowspan="3"></td><td rowspan="3">HIV-AIDS</td><td colspan="2">Certification of registration by primary healthcare physician or HIV clinic specialist, with evidence of:</td></tr>
<tr><td>1. Positive Western Blot (positive IFA Immunofluorescent Antibody Assay),</td><td>2. CD4 Test</td></tr>
<tr><td colspan="2">Evidence of Opportunistic Diseases</td></tr>
</table>

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<table>
<tr><td></td><td></td><td>• Candidiasis
• Cervical Cancer (invasive)
• Coccidioidomycosis, Cryptococosis, Cryptosporidiosis
• Illness caused by Cytomegalovirus
• Encephalopathy (related to HIV)
• Herpes Simplex (severe infection)
• Histoplasmosis
• Isosporiasis
• Kaposi’s sarcoma
• Lymphoma (certain types)
• Mycobacterium avium complex
• Pneumonia caused by Pneumocystis carinii/jiroveci
• Progressive Multifocal Lleukoencephalopathy (PML)
• Septicemia caused by salmonella (recurrent)
• Cerebral toxoplasmosis
• Tuberculosis
• Emaciation Syndrome
• Pneumonia (recurrent)</td></tr>
<tr><td></td><td>Systemic Lupus Erythematosus</td><td>Certification of diagnosis by a Rheumatologist with the following laboratory evidence: ANA Test, DS-DNA, Anti-Sm and Antiphospholipid antibodies.</td></tr>
<tr><td></td><td>Cystic Fibrosis</td><td>1. Sweat test
2. Treatment Evidence
3. Certification of diagnosis by a Pneumology Physician confirming the condition</td></tr>
<tr><td></td><td rowspan="2">Hemophilia</td><td>1. Hematologist’s assessment &- tx. plan
a) Severe: Factor levels VIII<1%
b) Moderate: Factor levels VIII<1%-5%
c) Mild: Factor levels VIII 5-25% with symptoms of severe bleeding.
2. Clotting Factor levels
a) Patients with severe Hemophilia A and B.
b) Patients with severe Hemophilia A and B with the presence of inhibitors.</td></tr>
<tr><td></td><td>Moderate Hemophilia A and B with the presence of inhibitors
1. Results of clotting factor levels
2. Certification of diagnosis by a Hematologist or Hemophilia Clinics, confirming the condition.</td></tr>
<tr><td></td><td rowspan="3">Multiple Sclerosis and Amyotrophic Lateral Sclerosis</td><td>Revised McDonald criteria: The diagnosis is confirmed when there is a combination of:</td></tr>
<tr><td></td><td>1. Two (2) distinct episodes of neurological symptoms verifiable by a Neurologist.
2. Symptoms that indicate an injury or lesion in more than one area of the Central Nervous System, abnormal MRI and laboratory findings consistent with Multiple Sclerosis (MS)
3. Absence of other disease or condition that could be the source of the symptomatology or laboratory findings.</td></tr>
<tr><td></td><td>Condition that could be the source of the symptomatology or laboratory findings.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>1. Result of brain MRI</td><td colspan="2">2 Result of lumbar puncture</td><td>3. Certification of diagnosis by a neurologist confirming the condition and treatment.</td></tr>
<tr><td></td><td>Rheumatoid Arthritis</td><td colspan="4">1. Diagnostic certification by a Rheumatologist with evidence of at least 4 out of the 7 criteria established by the American College of Rheumatology.
□ Beneficiary signs and symptoms
□ Morning numbness
□ Swelling of soft tissue of three of more joints
□ Swelling of the joints
□ Symmetrical Arthritis
□ Presences of nodules
□ Positive test for rheumatoid factor
2. Laboratory tests □ ESR; □ ANA Test; □ CRP;
3. Treatment evidence with a DMARD drug</td></tr>
<tr><td rowspan="3"></td><td rowspan="3">Scleroderma</td><td colspan="4">1. Evidence of positive ANA Test results > or equal to 1.80 [dil]
2. Results of positive skin biopsy
3. Certification of diagnosis by a Rheumatologist confirming the condition.</td></tr>
<tr><td colspan="4">The specialist certification must establish that the diagnosis meets at least one (1) major criteria or two (2) minor criteria (with reference to the College of Rheumatology)</td></tr>
<tr><td colspan="2">Major Criteria (1):

1. Proximal scleroderma
2. Loss of skin elasticity
3. Hyperpigmentation and Hypopigmentation of the skin in a “salt and pepper” pattern</td><td colspan="2">Minor Criteria (2):

1. Sclerodactyly
2. Loss of bulk from the finger pads
3. Pulmonary fibrosis in both lungs.</td></tr>
<tr><td></td><td>Leprosy</td><td>1. Evidence of Skin Biopsy result</td><td>2. Positive infection culture</td><td colspan="2">3. Certification of diagnosis by an Infectologist or Dermatologist confirming condition.</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">Tuberculosis</td><td colspan="4">Certification by a Respiratory Physician with treatment plan and evidence of:</td></tr>
<tr><td colspan="4">1.Result of the Tuberculin test
2.Chest X-ray (infiltrates, cavities, consolidation, hilar lymphatic nodules, disseminated nodules, miliary [sic]).</td></tr>
</table>

		3.Sputum samples for AFB and culture for M. tuberculosis or Bronchoalveolar Lavage if patient unable to expectorate. 4.Biopsies of the affected site, if applicable. 5.Result of HIV Test
	Aplastic Anemia	1.Hematologic Assessment: a. Absolute Neutrophil Count <500/mm3 b. Platelets <20,000/mm3 c. Reticulocytes < 1% d. Results of Bone Marrow aspiration and/or biopsy e. Diagnostic certification by a Hematologist/Oncologist
	Autism	A. **Provisional Special Coverage**: The provisional coverage will last for six months. If the evaluation process is not completed, the provisional coverage may be renew for six additional month. (Mark what screening tools where used for evaluation) ☐ <16 months – Ages & Stages Questionnaires: Social Emotional-2 (ASQ-SE-2) or Communication Symbolic Behavior Scales -Developmental Profile (CSBS-DP) ☐ 16-30 months – Modified Checklist for Autism in Toddlers: Revised Follow-Up (M-CHAT R/F) ☐ 31-66 months – Ages & Stages Questionnaire-Social Emotional-2 (ASQ-SE-2) ☐ ≥48 months – Social Communication Questionnaire (SCQ mental age > 2 years) Communication & Symbolic Behavior Scales Developmental Profile (CSBS-DP) ☐ 67 months-11 years – Childhood Asperger Syndrome Test (CAST) ☐ > 11 years – Australian Scale for Asperger Syndrome (ASAS) (See, Protocol of Autism from the Department of Health) B. **Permanent Special Coverage**: For **<u>permanent registration</u>** is required any of the following: Diagnosis certification by a: • Clinical Psychologist, • School Psychologist, • Counselor Psychologist, • Neurologist, • Psychiatrist, • Pediatric developmental specialist. Professionals should have training or experience in the area of Autism, as required by the Protocol of Autism from the Department of Health of PR.

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<tr><td></td><td>Post-Transplant Cases (Heart. Liver, Lung, Bone Marrow)</td><td colspan="3">1. Certification by specialist with evidence of the transplant and Care Plan;
2. Immunosuppressant therapy used;
3. ¿Medicare Coverage? Part A ____ Part B _____ Parts A y B_______</td></tr>
<tr><td></td><td>Cases of Adults with Phenylketonuria (PKU)</td><td>1. The registry must be completed by PCP or Geneticist.</td><td>2. Include treatment history</td><td>3. Include evidence of genetic study results.</td></tr>
<tr><td></td><td>Pulmonary Hypertension</td><td>1. Diagnosis certification and treatment plan by the Pneumologist or Cardiologist and evidence of supporting test(s).</td><td>1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of Pulmonary Hypertension or its complications.
2. All medical services provided or ordered by the pneumologist or cardiologist to treat the condition or its complications.</td><td>1. Medication prescribed by pneumologist or cardiologist to treat the condition or its complications</td></tr>
</table>

<table>
<tr><td rowspan="4"></td><td></td><td rowspan="4">Doses</td><td></td><td colspan="2">Physician Name:</td></tr>
<tr><td></td><td></td><td colspan="2">Physician Signature:</td></tr>
<tr><td></td><td></td><td>Specialty:</td><td>Telephone Number:</td></tr>
<tr><td></td><td></td><td>License</td><td>Fax Number</td></tr>
</table>

				NPI