Gold Coast Health Plan℠
A Public Entity

Provider Operations Bulletin

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The Provider Operations Bulletin is published quarterly by Gold Coast Health Plan's Communications Department as a service for the provider community.

Information comes from GCHP and its partners. If you have any concerns or questions related to specific content, please contact the Network Operations Department at ProviderRelations@goldchp.org or call the GCHP customer service line 1-888-301-1228 and request to speak to your Provider Relations representative.

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Palliative Care Update

In an effort to focus on patient choice and optimize quality of life, Gold Coast Health Plan (GCHP) implemented a new palliative care benefit on January 1 in accordance with state Senate Bill 1004 and APL 17-015. The Plan's new program is called My*Gold*Care.

- **What is the difference between palliative care and hospice care?**
  Both palliative care and hospice care provide comfort. However, palliative care can begin at diagnosis and take place at the same time as treatment. Hospice care begins after treatment of the disease has stopped and when it is clear that the person is not going to survive the illness.

- **What is the eligibility criteria for the palliative care program?**
  To qualify for palliative care, GCHP members must meet all of the general criteria and at least one of the four disease-specific eligibility criteria:
  - **General Eligibility Criteria**
    All of the following must apply in order for GCHP members to be eligible to receive palliative care:
    1. Likely to or have started to use the hospital or emergency department as a means to manage late-stage disease;
    2. In a late stage of illness, as defined below, and not eligible for or declines hospice enrollment;
    3. Death within a year would not be unexpected based on clinical status;
    4. Has received either appropriate patient-desired medical therapy or for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation; and,
    5. The member and, if applicable, the family/patient-designated support person, agrees to:
       a. Attempt in-home, residential-based or outpatient disease management instead of first going to the emergency department; and
       b. Participate in Advance Care Planning discussions.

  - **Disease-Specific Eligibility Criteria**
    At least one of the four must apply:
    1. Congestive Heart Failure (CHF): Must meet (a) and (b)
       a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned

OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, and
   b. The member has an Ejection Fraction <30% for systolic failure or significant co-morbidities.
2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
   a. The member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 liters (L) per minute, or
   b. The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
3. Advanced Cancer: Must meet (a) and (b)
   a. The beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia, and
   b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 70 OR has failure of two lines of standard chemotherapy.
4. Liver Disease: Must meet (a) and (b) combined or (c) alone
   a. The beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
   b. The beneficiary has ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, or
   c. The beneficiary has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score of greater than 19.

- **Prior Authorization Requirement**
  As of January 1, a Palliative Care Prior Authorization Request Form will be required to bill for services. Click here for the form.

- **Upcoming Certification Requirement for Providers**
  GCHP is required to maintain a network of qualified palliative care providers who will offer care in the appropriate setting based on member needs. Therefore, as of February 1, physician leaders of palliative care teams will be required to have a board certification by the American Board of Hospice and Palliative Care Medicine or the American Osteopathic Association Certificate of Added Qualification in Hospice and Palliative Medicine.

- **Who is in GCHP's palliative care network?**
  GCHP's palliative care network consists of inpatient, outpatient, and homebound agencies. The various networks and authorization requirements are:
  - Inpatient Network: No authorization necessary (occurs with appropriate therapy)
  - Outpatient Network: Authorization required
  - Home Bound Agencies: Authorization required and only appropriate if homebound

- **Who can bill for palliative care services?**
  Billing by the following provider types and settings will be considered for palliative care:
  1. Hospitals
  2. Long-term care facilities
  3. Clinics
  4. Hospice agencies
  5. Home health agencies
  6. Other types of community-based providers that include licensed clinical staff

- **How do I bill for palliative care services?**
  - To process your payment correctly as palliative care services, please submit all palliative care billing to GCHP with **Modifier PE**. If you do not include the modifier with your bill, you will not receive payment and it will default to a capitated service.

- **Opportunities available for a limited time**
  - **Workforce Development**
    In an effort to improve palliative care under SB1004, the state Department of Health Care Services (DHCS) is offering workshops, training, and certifications for palliative care ***free of cost for a limited time***.

    Education classes are available for a variety of classifications, including physicians, social workers, nurses, and clinic staff. We highly recommend that GCHP's providers take advantage of this opportunity.

    Click here for more information.

  - **Funding Opportunity**
    Multiple leadership organizations recognize that passionate leaders who can move the field forward come from diverse backgrounds and multiple disciplines. Cambia Health Foundation has expanded its Grant Leadership Program to include emerging leaders in palliative care who are physicians, nurses, social workers, physician assistants, chaplains, psychologists, pharmacists and other health system leaders.

    GCHP would like palliative care providers to consider applying to be a Sojourn Scholar. The Sojourns Scholar Leadership Program is designed to identify, cultivate and advance the next generation of palliative care leaders. As part of the scholarship program, Sojourns Scholars receive $180,000 in funding ($90,000/year over two years) to conduct an innovative and impactful clinical, policy, education or research project in the field of palliative care, as well as execute a leadership development plan designed to support growth as a leader in the field.

    Interested parties must submit a letter of intent by February 1. After review, a select group of applicants will be invited to submit full applications by June 1. Click here for details about eligibility.

If you have any questions regarding the palliative care benefit, email ProviderRelations@goldchp.org.

Non-Emergency Medical Transportation (NEMT) Update

Non-Emergency Medical Transportation (NEMT) by ambulance, litter/gurney van, or wheelchair van is covered when the member's medical and physical condition is such that transportation by ordinary means of public or private conveyance is contraindicated because the member cannot safely sit in a car or van due to illness, injury, or severe pain.

Until recently, GCHP required an NEMT Prescription/Attestation Form for each location to which a member requested transportation. When a member received treatment at several different locations, such as a primary care provider (PCP) and a specialist, each office location required a separate form.

Now, when a member's PCP submits an NEMT Prescription/Attestation Form, all requests for transportation to any medically–necessary, GCHP-covered appointments can be fulfilled with that single request form. This change makes it easier for GCHP members to obtain NEMT services when needed and makes requests and approvals more efficient.

When an NEMT Prescription/Attestation form is received from a provider other than the member's PCP, NEMT services will be approved for transportation to and from that provider location only.

If you have any questions, call GCHP's Customer Service Department at 1-888-301-1228.

Non-Medical Transportation (NMT)

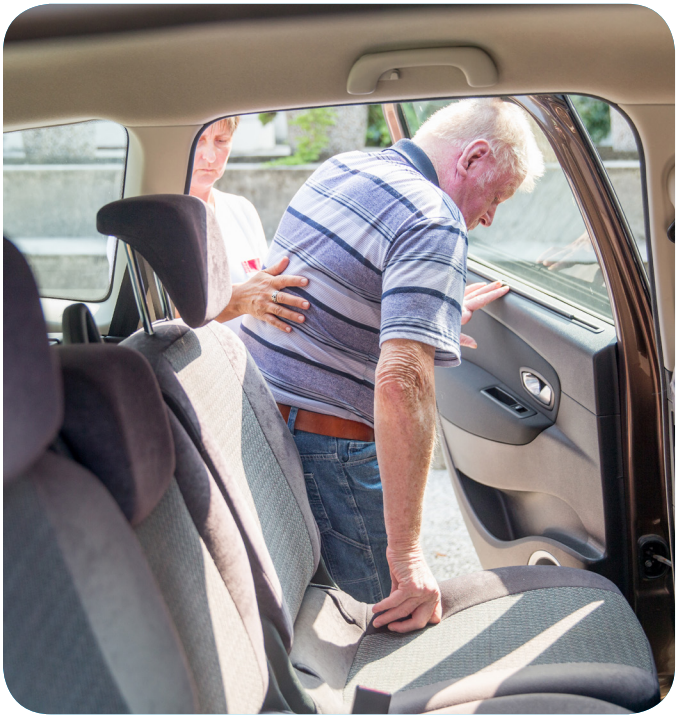
As of October 1, GCHP covers Non-Medical Transportation (NMT) for all medically-necessary services. NMT coverage includes transportation in a car/van/bus for a member and one attendant, such as a parent, guardian, or spouse, to accompany a member in a vehicle or on public transportation, subject to prior authorization at the time of the initial NMT request.

NMT does not include transportation of sick, injured, invalid, convalescent, infirmed or otherwise incapacitated members who need to be transported by ambulance, litter vans, or wheelchair vans. NMT does not cover trips to a non-medical location or to appointments that are not medically necessary.

NMT includes transportation to and from:

- A medical appointment for treatment or screening.
- A location to pick up prescriptions for drugs that cannot be mailed directly to the member.
- A location to pick up medical supplies, prosthetics, orthotics and other medical equipment.

GCHP's contracted vendor, Ventura Transit System (VTS), will provide transportation using sedan vehicles at no cost to members. Members must contact VTS directly at 1-855-628-7433. VTS will arrange transportation to any service covered by Medi-Cal – even those not covered by GCHP. No authorization is required; however, members must attest to having no other means of transportation. Members do need to show their GCHP member card to confirm eligibility for the ride.



If you have any questions, call GCHP's Customer Service Department at 1-888-301-1228.

Cardiac Rehab Benefit

GCHP now covers cardiac rehab services. While cardiac rehab is not a covered benefit under the Medi-Cal program, GCHP is offering the services as a benefit enhancement to better meet the needs of the Plan's members.

The following billing codes are applicable:

- 93797 Cardiac Rehabilitation
- 93798 Cardiac Rehabilitation / Monitor
- G0422 Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, Per Session
- G0423 Intensive Cardiac Rehabilitation; with or without continuous ECG monitoring; without exercise, Per Session

Pulmonary Rehab Benefit

Pulmonary rehab is now a covered benefit for GCHP members. This service requires prior authorization.

The following procedure codes have been added to the prior authorization list:

- G0237
- G0238
- G0239
- G0424

Ambulatory Surgical Center Authorization Alignment

Outpatient surgeries still require prior authorization when performed in an Ambulatory Surgical Center. Additional services performed at the center may or may not require authorization, as outlined in GCHP's list of Services Requiring Prior Authorization. The Plan's system has been aligned with the list to prevent services from being incorrectly denied for lack of authorization.

If you have any questions, contact the Plan's Provider Relations Department at ProviderRelations@goldchp.org.

Affirmative Statement about Utilization Management

GCHP's mission is *"To improve the health of our members through the provision of high quality of care and services."* GCHP supports its mission through its vision, *"Compassionate Care, Accessible to All, for a Healthy Community."* In accordance with that, GCHP's Utilization Management (UM) Department has an affirmation statement about UM incentives that is understood by all those involved in UM decision-making:

- UM decision-making is based only on appropriateness of care and services and existence of coverage.
- GCHP does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Clinical Criteria

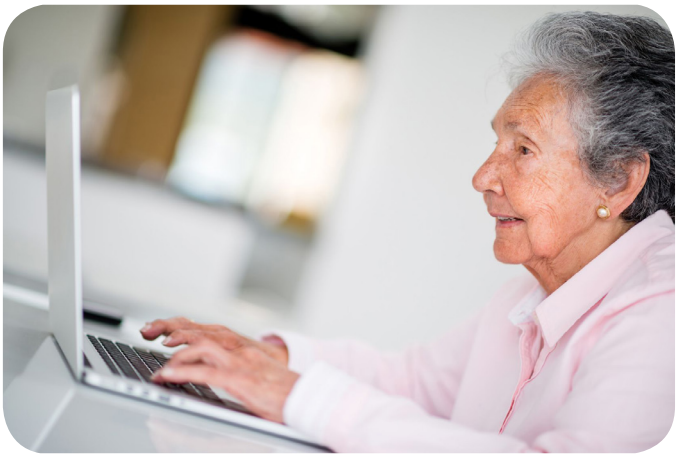
The UM Department uses criteria that is clinically sound, nationally developed, and accepted to make decisions about medical necessity. The clinical criteria used includes, but is not limited to:

- MCG Care Guide Quality Improvement Guidelines
- Other nationally-recognized criteria - Occasionally, a service is requested for which a GCHP clinical guideline is not available. In these instances, GCHP's medical directors and physician reviewers will review guidelines from other national professional organizations. Resources may include, but are not limited to:
  - » UpToDate: An evidence-based physician-authored clinical decision support resource.
- GCHP Clinical Guidelines

The above criteria are available to you upon request, by contacting GCHP's Customer Service Department at 1-888-301-1228.

Grievance & Appeals Update

Provider Reconsideration Request Form



Please remember to attach the Provider Reconsideration Request Form to your Provider Resolution Dispute, Provider Grievance or an Appeal when you are submitting your request.

The Provider Reconsideration Request Form allows you to choose from the following:

- **Provider Dispute:** A request for reconsideration of an original claim that has been previously denied or underpaid.
- **Appeal:** A review by GCHP of an Adverse Benefit Determination, which is a denial, deferral or limited authorization of a requested covered service, including determinations on the level of service; denials of medical necessity; reduction, suspension, or termination of a previously authorized service.
- **Grievance:** A request for reconsideration of a previously-disputed claim in which the provider is not satisfied with the resolution outcome.

Click here for the Provider Reconsideration Request Form.

Check Primary Care Provider (PCP) Assignment

Before scheduling an appointment for a member, please check eligibility to ensure that the member is currently assigned to your PCP/clinic. If the member is not assigned, have the member contact GCHP's Member Services Department at 1-888-301-1228 to select your PCP/clinic. The change will not go into effect until the first day of the month following the change request.

Requesting an Explanation of Benefits (EOB) Through the Automated System

To use the automated system to get a copy of an EOB of a specific claim, call 1-888-301-1228 and follow these prompts:

1. Provider, press 2.
2. Provider Authentication < Enter 10-digit NPI number >
3. For claim status, including detailed payment information, press 1.
4. Enter the eight-digit numeric portion of the GCHP member ID number.
5. Enter the date of birth using two digits for the month, two digits for the day and four digits for the year.
6. Enter the date of service using two digits for the month, two digits for the day, and four digits for the year. Note: All claims with the date of service entered will be played one by one.
7. Once the desired claim is played, press 1 for more detailed information.
8. For a duplicate EOB, press 2.

If you have any problems obtaining this information, please do not hesitate to contact GCHP's Customer Service Department at 1-888-301-1228.

Cultural & Linguistic Services

Language Assistance

GCHP adheres to federal and state guidelines that require health plans to ensure that Limited English Proficient (LEP), non-English speaking, or monolingual GCHP members have access to interpreters and translation services at all key points of medical services.

GCHP offers the following interpreter and translation services:

- Sign language interpreter services for the deaf or hard of hearing
- Telephone interpreter services: Available 24 hours a day, seven days a week.
- In-person interpreter services: Notice of 5-7 business days is needed to arrange for an interpreter to be present at medical appointments.
- Translation of written documents in the member's preferred language
- Alternative text formats, including Braille

If you have a member that needs help understanding health care-related materials or needs translation services, contact GCHP's Cultural & Linguistics Department at **1-805-437-5603** or CulturalLinguistics@goldchp.org. You can also send an eFax to **1-805-248-7481**.

Video Remote Interpreting

GCHP's Cultural & Linguistic Services now provides Video Remote Interpreting (VRI) at the Plan's Camarillo office. The VRI system is an easy way for members who are deaf to successfully communicate with GCHP staff. For more information, call Cultural & Linguistic Services at **1-805-437-5603** or email CulturalLinguistics@goldchp.org.

Consumer Advisory Committee (CAC)

GCHP's Consumer Advisory Committee (CAC) meets quarterly in the Plan's Community Room, located at 711 E. Daily Drive in Camarillo.

Meetings are open to the public and typically last two hours. Agenda and meeting materials are published on the Plan's website.

Member Benefit Information Meetings

GCHP holds member orientation meetings three times a month for all members. These meetings are held throughout the county and are presented in English and Spanish.

At the meetings, members will learn about their rights and responsibilities as GCHP members, as well as how to:

- Establish a medical home.
- Select a PCP.
- Get medical services.
- Get necessary medications.
- Locate and use resources available in the community.

Meeting times and locations vary monthly. Members can call GCHP's Member Services Department at 1-888-301-1228 for meeting times and dates.

Click here for the current schedule.

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For additional information, contact
Network Operations at 888-301-1228
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