Gold Coast Health Plan Provider Operations Bulletin

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Section 1: Affordable Care Act – PCP Rate Increase

In compliance with Section 1202 of the Affordable Care Act, effective for dates of service on and after January 1, 2013 through December 31, 2014, Medi-Cal reimbursement to qualifying providers for specified primary care services will be at the same level as that service is reimbursed by Medicare. However, because of the questions that remain regarding the final rule released in November 2012, and available funding from CMS to the State; the increased reimbursements will not be immediately available. Managed care plans are not required to make higher payments to their primary care providers until they receive additional funding from the state and retro-active payments are not subject to timely filing requirements. Gold Coast Health Plan expects implementation to occur during the summer of 2013. The increases will be retroactive and will apply to all services provided on or after January 1, 2013.

The rate increase applies for eligible physicians for specified primary care services. Per the final rule released by the Center for Medicare and Medicaid Services, the applicable primary care services include Evaluation and Management codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473, or their successor codes. In order to be eligible, physicians must self-attest they are board certified in family medicine, general internal medicine, pediatric medicine, or a related subspecialty. Physicians are also eligible if 60 percent of the services they bill Medi-Cal fall within the designated Evaluation and Management and vaccine administration codes. The increased reimbursement will also be provided to non-physician practitioners who work under the direct supervision of an eligible physician. The California Department of Health Care Services will be developing a mechanism for providers to self-attest and there will be an established timeframe for providers to attest. Qualifying providers who self-attest during the specified timeframe will be eligible for the increased payments.

To access listings of qualified subspecialties visit the following websites:

American Board of Medical Specialties – www.abms.org
American Osteopathic Association- www.osteopathic.org
American Board of Physician Specialties – www.abps.org

It is important for providers (especially capitated providers) to submit claims with all services/encounter included. Without this information, Gold Coast Health Plan will not be able to adequately identify services that are eligible for retro-active payment.

Section 2: Urgent Requests for Authorization

The Health Services Department would like to remind you that requests labeled "Urgent" should only be labeled as such if the life of the member imminently depends on the service being rendered immediately. Cases that are labeled Urgent when there was a delay in the request by the provider, due to not submitting the request to GCHP in a timely manner, will not be handled in an urgent manner. It is the responsibility of each provider of service to plan ahead to allow enough time for the authorization to be processed. The State holds GCHP to a 5 day turnaround time for all "non-urgent" pre-authorization requests. This allows us to gather all pertinent clinical information and make an appropriate decision.

We cover in-network and out-of-network medical emergency services for injuries and for emergency medical conditions. An emergency medical condition is a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including without limitation severe pain) such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably believe that the absence of immediate medical attention could reasonably result in any of the following:

- Placing the member's health in jeopardy
- Serious impairment to bodily function
- Other serious medical consequences
- Serious and/or permanent dysfunction to any bodily organ or part

  For purposes of this definition, a "prudent layperson" includes, but is not limited to, a reasonable member.

Please also be aware that requests submitted through the provider portal are only forwarded to Health Services once every 24 hours. When you fax a request, the Health Services staff will not be able to see your request until the following day. Please do not call for status on the same day you faxed your request.

SECTION 3 : Electronic Funds Transfer (EFT)

Gold Coast Health Plan would like to remind providers that EFT payments can occur anytime between Wednesday and Friday of each week. There is no guarantee that payment will occur on a specific day. Gold Coast Health Plan attempts to make claim payments as quickly as possible; however, California law allows the health plan 30 working days (42 calendar including weekends) to reimburse any uncontested portion of a clean claim. Claim status can be reviewed by utilizing the Gold Coast Health Plan Provider Portal at any time. Please do not call for routine claim status unless 30 working days have elapsed from the date of claim submission.

SECTION 4 : Clarification of Physician Administration Fee for Injections

The Department of Health Care Services (DHCS) recently issued a clarification regarding the reimbursement methodology for physician-administered drugs.

Providers are reminded that the price listed on the Medi-Cal Rates page of the Medi-Cal website for each Physician Administered Drug includes the one-time administration fee of $4.46 for injections. Since the administration fee is paid only once for each drug administered, subsequent units claimed have the administration fee subtracted from the published rate. Under the Medi-Cal program, CPT and HCPCS codes used for drug administration are not separately payable since this in included in the reimbursement rate for each drug.

Reimbursement is determined by the cost of the injection, plus the physician's administration fee. Since the administration fee is paid only once for each drug administered, subsequent units must have the administration fee subtracted from the published rates listed on the Medi-Cal rates page of the Medi-Cal website.

DHCS Clarified Method

J0886 - EPOETIN ALFA 1000 UNITS ESRD

The price in the Medi-Cal rate table is $18.88, which includes the administration fee of $4.46. If a provider administered this drug one time with multiple units (total of 3 units), the reimbursement of this drug should be as follows:

First unit: $14.42 + $4.46 = $18.88
Second unit: $14.42 + 0 = $14.42
Third unit + : $14.42 + 0 = $14.42
Total reimbursement = $47.72

GCHP will adopt the DHCS clarified method for dates of service July, 1, 2011, and after. Claims previously paid under the incorrect method will be recovered by our recovery specialist.

SECTION 5 : HIPAA Conversion of Various Physician-Drugs

Effective for dates of service on or after February 1, 2013, some Medi-Cal “local codes” for specific Physician Administered Drugs (P.A.D.) injections will be converted to corresponding National HCPCS Level II codes and there are a few Medi-Cal “local codes” that will be terminated since there is no crosswalk code available.

For specific code details, please refer to the following link:
http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/gm201301.asp#a6

SECTION 6 : Dialysis Claim Billing

Unlike billing the State of California, Gold Coast Health Plan is able to accept dialysis claims with 22 lines per page. The 15 line limit was specific for State billing; however, Gold Coast Health Plan can accept the entire 22 lines. If you are currently billing multiple pages (i.e., 1 of 3, 2 of 3, 3 of 3, etc.) only add the total charge to the last page of the multiple page claim. This process will help expedite data entry and claims processing turnaround time, as well as reduce possible errors associated with the receipt of multiple pages.

SECTION 7 : Retro -Authorization

For claims denied for “AUTHORIZATION REQUIRED”, providers will have 60 days from the date of the initial determination to request retro-authorization. If your request is not received within the 60 days, your request will be denied without review.

SECTION 8 : Notice to Long Term Care (LTC) and Skilled Nursing SNF Providers

For Long Term Care (LTC) and Skilled Nursing Facility (SNF) providers, you will be given 5 days to notify GCHP Utilization Management Department of any new beneficiary received in your facility. If your new beneficiary is Medi-Medi (Medicare and Medi-Cal), and has Medicare Part A, bill Medicare first to cover the first 100 days under the Medicare benefit period.

SECTION 9 : Important Reminder for 2013 CPT-4/HCPCS Updates for Medi-Cal

Gold Coast Health Plan would like to remind contracted providers that the State Department of Health Care Services has not yet configured the CPT-4/HCPCS codes that are new in 2013. To avoid denials or delays in payment, please do not use these new codes when submitting claims. Please continue to use those CPT/HCPCS codes currently in effect until the State makes the update or until further notice from Gold Coast Health Plan.

SECTION 10 : Long Term Care – Diagnosis Codes

The purpose of this Provider Update is to educate Gold Coast Health Plan's Long Term Care (LTC) providers of acceptable ICD-9-CM coding conventions when submitting claims for members in LTC facilities.

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, these codes are considered unacceptable as a principal diagnosis on the submitted claim.

Gold Coast Health Plan will continue to allow the claims to pay until March 31st but after this date, will deny and return claims to the provider.

A brief description of the types of coding errors that we are seeing is below. For a complete list of unacceptable codes, please see attached.

E-code as Principal Diagnosis

Unacceptable Principal Diagnosis
There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, these codes are considered unacceptable as a principal diagnosis. Click here for a list of Unacceptable Principal Diagnosis codes.

Manifestation Code as Principal or Admit Diagnosis
Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and therefore, should not be used as a principal diagnosis. Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition to be sequenced first followed by the manifestation. Wherever such a condition exists, there is a "use additional code" note at the etiology code and a "code first" note at the manifestation code. Click here for a list of Manifestation codes.

Questionable Admission
There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of: 4011 – Benign Hypertension. This patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission to a hospital. Click here for a list of Questionable Admission codes.