Gold Coast Health Plan℠
A Public Entity

Gold Coast Health Plan Provider Operations Bulletin

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Table of Contents

SECTION 1: Treatment of CCS Eligible Conditions

California Children's Services (CCS) covers certain conditions that are physically disabling or that require medical, surgical, or rehabilitative treatment up to 21 years of age. CCS approved conditions are not covered by Gold Coast Health Plan (GCHP). CCS requires that the treating physician be CCS-paneled and the treating facility be CCS-approved. It is the responsibility of the provider and/or facility to initiate a CCS case by sending a Service Authorization Request (SAR) to CCS. It is also the responsibility of the provider and/or facility to ensure that care is provided by CCS-paneled physicians and in CCS-approved facilities.

GCHP will help identify possible CCS-eligible conditions, facilitate the CCS referral process, and identify CCS-paneled physicians and CCS-approved facilities. GCHP can also help educate providers about the CCS panel process.

INPATIENT CARE IN A NON-CCS PANELED FACILITY

When a child with a CCS-eligible condition is admitted to a facility that is not CCS approved, GCHP will advise the admitting facility upon notification of admission, to transfer the patient to a CCS-approved facility once stabilized. GCHP will authorize up to 2 days of acute inpatient stay under certain circumstances, to allow identification of a CCS-eligible diagnosis and transfer.

INPATIENT OR OUTPATIENT CARE BY A PROVIDER WHO IS NOT CCS-PANELED

GCHP cannot authorize inpatient or outpatient requests for treatment of CCS-eligible conditions by a non-CCS-paneled provider. Care should be directed to a CCS-paneled provider. The Ventura County CCS Provider Relations Office at 805-981-5289 is happy to assist physicians in becoming CCS paneled.

SECTION 2: GCHP HEDIS Documentation Tips

By Julie Booth Director, Quality Improvement

Our 2013 Healthcare Effectiveness Data and Information Set (HEDIS), which is based on 2012 data, will be the baseline year for GCHP and our providers.

To help with documentation this year for great outcomes next year see the GCHP HEDIS documentation tips below!

1. For patients 2 years old and younger – All 10 vaccines must be completed on or BEFORE the 2nd birthday or the measure is non-compliant. Also, we cannot count a vaccination given prior to 42 days after birth.
2. One exception, two influenza vaccines must be given between 180 days after birth and 2 years old.
3. If there is an exclusion for a vaccine, clearly document it.
4. For all measures, if you're a capitated provider: submit encounter data including lab and x-ray. All claims/encounter data is checked first for compliance with the measures using the CPT codes.
5. For the measure on controlling high blood pressure, the latest reading must be used. Measure will only be compliant if blood pressure is less than 140/90, however, you can take multiple readings during the visit. We are allowed to use the lowest systolic and the lowest diastolic reading from multiple entries if on the same date of the visit.
6. For the Postpartum Care Measure - the visit must be documented on or between 21 and 56 days after delivery.
7. For patients 3 to 17 years old, the following must be documented:
    a. BMI **percentile** (height, weight and percentile must be documented)
    b. Counseling for nutrition
    c. Counseling for physical activity

    Note: documentation stating "health education" and/or "anticipatory guidance" cannot be accepted. Tip: Document "Nutrition and physical activity discussed."

SECTION 3: No Prior Authorization is Required for Family Planning and Sensitive Services

GCHP would like to remind our providers that GCHP Members may self-refer to any willing Medi-Cal Provider for family planning and sensitive services ***without prior-authorization***.

Family planning services include birth control, pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, AIDS/HIV testing, sexually transmitted disease testing and treatment, and termination of pregnancy. These services are listed alphabetically below:

- Abortion (legal, unspecified, failed)
- Candidiasis/monilia
- Condyloma acuminatum
- Contraception and contraceptive management
- Diagnosis and treatment of STDs if medically indicated
- Dysplasia
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Genital herpes
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- High-risk sexual behavior
- Inflammatory disease of uterus, except cervix
- Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods
- Limited history and physical examination
- Observation following alleged rape or seduction
- Phthirus pubis (pubic lice)
- PID — unspecified organism
- Pregnancy exam or test, pregnancy unconfirmed
- Provision of contraceptive pills/devices/supplies
- Rape examination
- Scabies
- Screening, testing and counseling of at-risk individuals for HIV and other STDs and referral for treatment Syphilis and other venereal diseases
- Termination of pregnancy
- Trichomonas
- Tubal ligation

SECTION 3: No Prior Authorization is Required for Family Planning and Sensitive Services

- Vasectomy
- Viral warts, both specified and unspecified

SECTION 4: Balance Billing Members

This is a reminder that services that are not the financial responsibility of a GCHP Medi-Cal member under Title 22 may not be billed to the member.

Title 22 states the following:

(a) A provider of service under the Medi-Cal program shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to:

(1) Collect payments due under a contractual or legal entitlement pursuant to Section 14000.

(b) of the Welfare and Institutions Code.

(2) Bill a long-term care patient for the amount of his liability.

(3) Collect copayment pursuant to Welfare and Institutions Code Section 14134.

(b) In the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763 (a) (5) to a provider, upon giving the beneficiary written notice of intent, the provider may bill the beneficiary as a private pay patient. This shall not apply for beneficiaries covered under Medi-Cal capitated contracting arrangements. Capitated contractor or subcontractor billing beneficiaries covered under Medi-Cal capitated contracting arrangements shall be governed by applicable laws including Welfare and Institutions Code and by; the terms of the contract.

SECTION 5: Affordable Care Act – PCP Rate Increase Updates

GCHP has been talking about the Affordable Care Act (ACA) PCP rate increase for some time now. While we still have not received funding from the State, we wanted to pass along some updates to the GCHP Provider Network.

The ACA requires certain primary care services to eligible providers be reimbursed at parity with Medicare for dates of service during calendar years 2013 through 2014. The purpose of the increase is to improve quality outcomes and to increase access in preparation for Medi-Cal expansion in 2013.

Here is what you need to know:

- 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 (OB/GYN and Emergency Physicians are not eligible), or
  - Board certified in a related subspecialty, or
  - At least 60 percent of the services they bill Medi-Cal fall within the designated Evaluation and Management and vaccine administration codes.
  - Nurse Practitioners and other physician extenders who work under the direct supervision of an eligible physician.
  - *FQHC, RCH and CBRCs that receive wrap-around payments through fee-for-service are not eligible.*
- Providers must be enrolled in Medi-Cal
- The California Department of Health Care Services (DHCS) 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. As soon as GCHP is notified that the self-attestation mechanism has been developed, we will pass the information along to you.
- Plans are not required to pay enhanced payments until they receive finding from DHCS (estimated June/July 2013) – Retroactive payments are not subject to timely filing
- Payments must be passed through to the individual provider rendering the service.

CMS guidance regarding the physician qualification criteria and other frequently asked questions can be found on the CMS website at the following link:
http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Q-and-A-on-IncreasedMedicaid-Payments-for-PCPs.pdf

GCHP is participating in calls with the State and CMS regarding this provision and will continue to provide updates in the Provider Operations Bulletin when they become available.

SECTION 6: Healthy Families Program (HFP) Transition to Medi-Cal

California Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012 provides for the transition of HFP subscribers to Medi-Cal commencing no sooner that January 1, 2013.

As of January 1, 2013 all newly eligible enrollees in Ventura County have been enrolled into Medi-Cal and subsequently have become GCHP members. The remaining enrollees (approximately 20,000 members) will be transitioned to GCHP on August 1, 2013. The newly enrolled members will appear as any other GCHP member.

What Changes:

- Eligibility will be determined through the Ventura County Human Services Agency (previously through MRMIB)
- Benefits will mirror Medi-Cal – GCHP
- Members will have access to CHDP and Vaccine for Children (VFC)
- Dental Services will be covered through Denti-Cal program
- Behavioral health services will be covered through any Medi-Cal behavioral health/mental health provider
- There will no longer be co-payments
- Payment to providers will be at Medi-Cal rates

GCHP is committed to a smooth transition of these members to ensure continuity of care, minimal disruptions and network adequacy. As such, we will make every effort to assist members in maintaining their current Primary Care Provider (PCP) and in continuing ongoing established treatment plans. If provider transition is needed, GCHP wants to ensure that there is no disruption in care.