Gold Coast Health Plan Provider Operations Bulletin

August 20, 2013
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SECTION 1: Affordable Care Act (ACA) – Primary Care Payment Increase Updates

Medi-Cal has released the Self-Attestation form and instructions on the Medi-Cal Website. **Click here** to access the form.

To be eligible for the ACA and 42 CFR 447 enhanced payments, the physician rendering or supervising the service must personally attest to be the following:

- A physician, as defined in 42 CFR 440.50 with a specialty designation of family medicine, general internal medicine, pediatric medicine or a subspecialty within one of the listed specialties.

  AND
- Meeting at least one of the following qualifications:
  ‣ Board certified in a specialty or subspecialty that is recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). Please see the "Related Links" section of this page for links to additional information.

    OR
  ‣ At least 60 percent of total claim volume for the most recently completed calendar year or, for newly eligible physicians, the prior month, were for E&M (99201 – 99499) and Vaccine Administration (90460, 90461, 90471 – 90474, or their successors) services or local codes that correspond to these E&M and Vaccine Administration codes.

GCHP is required to provide payment directly to the eligible rendering provider. Therefore, all providers must provide GCHP with a W9 and complete the GCHP ACA Provider Information Form in addition to completing the Medi-Cal Self-Attestation.

Access the **GCHP ACA Provider Information Form**, **W9 form** and **GCHP ACA FAQ form** by clicking on the appropriate link.

GCHP cannot make the increased payments to providers until they have completed the Medi-Cal Self-Attestation and submitted a W9 and GCHP ACA Provider Information Form.

Payment to providers that have met all criteria will be made once GCHP receives payment from the State. A one-time payment to providers will be made retroactive to January 1, 2013. Subsequent payments will be made monthly.

SECTION 2: Balance Billing

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 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 3: HEDIS Updates

GCHP's HEDIS® 2012 performance review for the Immunizations for Adolescent (IMA) measure showed that many pre-teens are not receiving their recommended immunizations. The IMA performance metric measures the percentage of adolescents who had:

*   One dose of the meningococcal vaccine between their 11th and 13th birthday
*   One dose of the dTap/Td booster vaccine between their 10th and 13th birthdays

The following are great opportunities for physicians to update their patient's immunization status and administer any recommended vaccines:

*   Well-child exams
*   Emergency room or urgent care visits

To help improve HEDIS® IMA performance scores and the quality of care provided to our members:

- Schedule your patients for their annual well-child exams
- Follow the recommended immunization guidelines
- Document the immunization and date administered in the medical record
- Code and bill for any immunizations administered
- Submit claim and encounter data timely
- Utilize the CAIR immunization registry to record immunizations administered to your patients

SECTION 4: Healthy Families Transition and Behavioral Health Services

Healthy Families Program (HFP) members transitioned to Medi-Cal, also known as Gold Coast Health Plan, August 1, 2013. To help facility the process of ensuring that children receive appropriate behavioral health care, GCHP has put together a list of resources for providers to use when working with families in need of services. **Click here to view**.

Healthy Families beneficiaries receiving mental health services from a private provider prior to the start of the August 1st transition, may call Candace Jacobsen, R.N., Ventura Behavioral Health at 805-289-3127, as per the Ventura County Behavioral Health Department. Providers may also direct members to Candace Jacobsen with questions about the Healthy Families transition and behavioral health services. Candace is available to answer questions from Providers and Members.

If a member is seeking new mental health services, they may call the Ventura County Behavioral Health STAR program at 1-866-998-2243. In case of a psychiatric emergency, please contact the STAR Program at 1-866-998-2243.

Nursing Facility Authorizations

It is GCHP's responsibility to assist our nursing facility providers with instructions for the submission requirements of pre-authorization requests. In order to expedite approvals and claims processing in a timely manner it is essential that the documents submitted are completed and legible. In addition, please provide sufficient chart documentation to justify the level of care requested.

Admission Notifications

Nursing facilities must notify GCHP when GCHP members are in their respective facility. The notification must include those GCHP members with other health coverage. The notification can be accomplished with the submission of the pre-authorization request or completion of the monthly census request from GCHP. Remember that GCHP is the Medi-Cal provider and Medi-Cal is always the payer of last resort.

Monthly Census Notification Process

GCHP will contact the participating nursing facilities on a monthly basis, in order to obtain an accurate census. Census documentation is required for all GCHP members in nursing facilities and should also include hospice members.

Other Health Coverage (OHC)

If a member has Other Health Coverage (OHC) and the skilled level of care is denied by the member's primary insurer, then GCHP will require a denial letter from the OHC. If the member has Medicare as their primary insurance then the nursing facility should notify GCHP on or before the 21st day of their stay.

Reauthorization Request

A request for reauthorization can be received by GCHP on or before the first working day following the expiration of a current authorization.

Retro Authorization Requests

The time limit for reviewing a retro authorization is 60 days from the initiation of service. Please reference the GCHP website and then view page five of the December 2012 provider operation bulletin.

Long-Term Care

The following is required for a Long Term Care admission review:

1. Pre-authorization Treatment Request Form (revised 1/2013). **Click here** to access the form. (This form is to be used for each admission and reauthorization).
2. Preadmission Screening/Preadmission Screening Resident Review (PAS/PASARR). Sections I through VII are required. The form is available at **www.medi-cal.ca.gov**, select "References", "Forms", and then "TAR Supplemental Forms".
3. Medicare or other health care insurance denial letter.
4. MDS (Minimum Data Set)
   - Version 3.0 Nursing Home Comprehensive (NC) Version 1.10.4 Effective 4/1/2012. (Admission)
   - Version 3.0 Nursing Home Quarterly (NQ) Version 1.10.4 Effective 4/1/2012. (Need for Authorization)
   - Include all the sections listed below:
     A. Identification, admission information
     B. Hearing, speech, vision
     C. Brief Interview for Mental Status (BIMS)
     D. Behavior: wandering, inappropriate behavior, refusing or rejecting care
     E. Functional status
     F. Bowel and bladder
     G. Active Diagnosis. On admission and as condition changes.
       ‣ Confirm Principal Diagnosis Code by checking; List of Unacceptable Diagnosis Codes, Manifestations Not Allowed as Principal Diagnosis and Questionable Admissions. Available from **www.goldcoasthealthplan.org**, select Providers, Resources, Provider Operations Bulletins, Provider Bulletin 2/26/2013. Section 10, there are 3 parts.
     H/I. Swallowing, nutrition, G-Tubes
     J. Skin ulcers, wounds, precautions
     K. Special treatments, oxygen, dialysis
5. Sufficient chart documentation to justify the level of care requested.
6. Authorization initially valid for 1 (one) year.

Short Term Skilled Nursing Care

The following is required for a Short Term Skilled Nursing admission review:

1. Pre-authorization Treatment Request Form.
2. Physical Therapy, Occupational Therapy, and Speech Therapy clinical notes submitted every 2 weeks.
3. Sufficient chart documentation to justify level of care requested.
4. Authorization valid for two (2) weeks.

Intermediate Care

The following is required for an Intermediate Care nursing admission review:

1. Pre-authorization Treatment Request Form.
2. Use Certification from Tri-County Regional Health HS 231. Available from **www.medi-cal.ca.gov**, select "References", "Forms" and then "TAR Supplemental Forms".
3. Authorization valid for 1 (one) year.

Sub-Acute Level of Care

The following is required for a Sub-Acute level of care admission review:

1. Pre-authorization Treatment Request Form.
2. Preadmission Screening/Preadmission Screening Resident Review (PAS/PASARR).
3. Information for Authorization/Reauthorization of Sub Acute Services-Adult Sub Acute Program DHCS 6200 A.
   ‣ Available at **www.medi-cal.ca.gov**, click on References, Forms, Tar Supplemental Forms.
4. Sufficient chart documentation to justify level of care requested.
5. Authorization valid for 6 (six) months.

Hospice Care

The following is required for hospice care review:

1. Pre-authorization Treatment Request Form (PTRF).
2. Certificate of Terminal Illness. (Use the form adopted by your Hospice Agency or Referring MD).
3. Authorization valid for 90 (ninety) days.

SECTION 6: Upcoming Events

Provider Advisory Committee Meeting (open to the public)
August 20, 3:30 PM
2240 E. Gonzales Rd – Large Conference Room 200
Oxnard, California 93036