Provider Operations Bulletin

From Gold Coast Health Plan

EDITION: POB-004 DECEMBER, 2012

The purpose of these bulletins is to assist you and your office staff in understanding some of the operational processes that Gold Coast Health Plan has in place. We hope these bulletins prove useful and would greatly appreciate feedback from you. We want to provide you with all the information you need to make your relationship with Gold Coast collaborative in all respects. If there are topics you feel you would like us to include in these bulletins, please contact the Provider Relations Department at providerrelations@goldchp.org.

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SECTION 1: NEW DEDICATED FAX NUMBER FOR HEALTH SERVICES

Starting (**January, 2013**), the Health Services Department will have a new dedicated fax number for providers to utilize when submitting pre-authorization requests, medical records, and inpatient reviews. The new fax number is **855-883-1552.** In order to better serve our providers to ensure improved response times toward all requests, we have staffed this fax with two indexing team members to ensure efficient and accurate filing.

In order to ensure a smooth transition to the new fax number, **we will be disabling 805-512-8551 and slowly reduce the continued use of 888-310-3660**.

SECTION 2: CLAIMS EDITING SYSTEM

We wish to advise you that GCHP will be implementing a claims editing system beginning January, 2013. Please be aware that claims submitted prior to this date will not be affected.

The addition of this editing system will enable us to manage cost effective health care, delivery and reimbursement and to assist the payer and provider community in complying with Federal and State guidelines in order to provide the best care possible to every member while mitigating claim error and improving processing time.

If you have any questions regarding our new system, please contact Customer Service Department at 888-301-1228.

SECTION 3: INFORMATIONAL MODIFIERS Q4, Q5 AND Q6

The following informational modifiers should be used when the regular physician is unavailable to provide the visit services.

Q4- Service for ordering/referring physician qualifies as a service exemption.

Q5- Service furnished by a substitute physician under a reciprocal billing arrangement.

Q6- Service furnished by a locum tenens physician.

When more than one modifier is used, the functional (or pricing) modifier is placed in the first modifier field. The informational modifier is then placed in the second modifier field. Informational modifiers are used for documentation purposes and can affect the processing or payment of the code billed.

SECTION 4: HEALTH PLAN REIMBURSEMENT FOR ABORTION SERVICES

On behalf of the Department of Health Care Services, Gold Coast Health Plan is taking this opportunity to communicate to the provider network, that it is the responsibility of Medi-Cal managed care health plans' (MC Plans) to provide its members timely access to abortion services.

Abortion is covered by the Medi-Cal program as a physician service. Medical justification and/or prior authorization for abortion may not be required by the plan, provider, independent practice association (IPA) or preferred provider group (PPG). However, non-emergency inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures (see California Code of Regulations [CCR], Title 22, Section 51327). MC Plans are expected to monitor their contracted providers to ensure that prior authorization is not being required for outpatient services.

A beneficiary may go out-of-network/out-of-plan for abortion services at any time for any reason. However, no physician or other healthcare provider who objects to performing an abortion may be required to do so, and no person refusing to perform an abortion may be punished for such a choice (H & S Code, Section 123420). Furthermore, MC Plans must inform potential members when they enroll if hospitals, clinics and other providers, in their network refuse to provide abortions.

MC plans must make payments in compliance with the clean claims requirements, and timeframes outlined in the managed care contract. These requirements must be adhered to by both the MC Plan and its delegated entities.

The Reproductive Privacy Act (Health & Safety Code, Section 123460, et seq.) provides that

the State, and thus, MC managed care plans, as contractors, may not deny or interfere with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when an abortion is necessary to protect the life or health of the woman.

SECTION 5: NEW PREAUTHORIZATION REQUEST FORM, SUPPLEMENTAL REQUEST FOR MRI AND CT SCAN, AND NEW E-FAX ON PREAUTHORIZATION FORM

To assist in expediting the review of radiology and home health services, the Gold Coast Health Services department has created forms specific to these services to ensure all pertinent information is received. In addition, to assist with other pre-authorization requests, the current general request form has been revised to be more specific as to the information needed to complete your request. These forms are available on the Gold Coast Provider website: www.goldcoasthealthplan.org

SECTION 6: PROVIDER PREVENTABLE CONDITIONS (PPC)

The federal Affordable Care Act (ACA) requires that providers report all PPCs that are associated with Medi-Cal payment or with courses of treatment furnished to a Med-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs. Gold Coast Health Plan staff is meeting internally to discuss policies and procedures around reporting and non-payment to ensure compliance with federal requirements. For more information about PPCs visit the Department of Health Care Services website at www.dhcs.ca.gov/individuals/Pages/AI_PPC.

SECTION 7: UB-04 BILL TYPE CODES FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHC), RURAL HEALTH CLINICS (RHC) AND FREE STANDING CLINICS

Providers billing for services performed at a FQHC, RHC or free standing clinic are required to enter the appropriate bill type in box 4 of the UB-04 claim form. The bill type code rules regarding FQHC/RHC/Free Standing Clinics are:

Clinics (Free standing) use bill type 73X

FQHC's use bill type 77X

RHC use bill type 71X

These rules must be followed in order to process claims correctly.

SECTION 8: NEW NON-EMERGENCY MEDICAL TRANSPORTATION PROVIDER (NEMT)

Effective February 1, 2013, NEMT services for Gold Coast Health Plan members is a direct service program with Ventura Transit System (VTS). This means VTS will be responsible for determining eligibility of the recipient, receiving requests, managing authorization of NEMT services, and coordinating and making arrangements for transportation. All Gold Coast Health Plan members will receive notification by mail advising them about the direct service program with VTS.

- The month of January will be considered a transition month to VTS for members who are currently receiving NEMT services, with full transition to VTS to be completed by February 1, 2013.
- Beginning February 1, 2013, all new requests will be made by the member contacting VTS directly – A written prescription will no longer be required. Members can contact

Ventura Transit System toll free at 1-855-628-7433 (1-855-628-RIDE).

SECTION 9: CHANGES TO THE GOLD COAST PRE-AUTHORIZATION REQUIREMENTS

Gold Coast Health Plan continues to evaluate and monitor the services that require pre-authorization. As a result, the following changes are being made and will become effective January 1,2013.

- No prior-authorization will be required for Dental Anesthesia (all eligibility criteria still apply)
- No prior-authorization will be required for code v5264 (hearing mold)
- Only orthotic/prosthetic services/equipment greater than $200 will require authorization
- No prior-authorization is required for the first 10 Occupational Therapy visits. After the first 10 a treatment plan and prior-authorization will be needed.
- The following injectables will now require authorization:
    - J7312 - Osurdex
    - J7311 - Retisert
    - J9303 - Vectibex
    - J3357 - Stelara
    - J3262 - Actemra
    - J0490 - Benlysta
    - J9228 - Yervoy
    - C9287 -Adcetris
    - C9286 -Nulojix
    - J0725 - Chorionic gonadotropin
    - J1950 - Leuprolide
    - J3355 - Urofollitropin
    - J8499 - Oral clomid ,serophene
    - S0122 - Menotropin
    - S0126 - Folletropin B
    - S0132 - Gamirelux
    - J1110 - Dehydrodrzotamine (DHE)
    - J2315 - Vivtrol
    - J0775 - Clostridial collagenax
    - 90736 - ZosterVax SC
    - J0129- Abatacept, 10 mg

SECTION 10: RULES FOR SUBMITTING CLAIMS WITH MULTIPLE PAGES

When submitting claims that are more than one page, number them appropriately, 1 of 3, 2 of 3, 3 of 3, etc. Do not total each page separately, only total the last page of the claims.

This will minimize the mailroom from scanning each page individually as an individual claim, and allow for quicker processing.

SECTION 11: PAYMENT FOR CHDP SERVICES

Gold Coast Health Plan is rescinding the decision stated in the August 2012 Provider Operations Bulletin stating CHDP payments are included in the Primary Care Provider's

(PCP) monthly capitation. CHDP payments are not included in PCP capitation.

Effective Immediately, encounters and claims should be submitted using the American Medical Association (AMA) Current Procedural Terminology (CPT) codes. Additionally, Gold Coast Health Plan requires that the PM-160 Information Only form be submitted for appropriate reporting to the State.

If you have any questions, please contact provider services at 1-888-301-1228.

SECTION 12: TIMELY SUBMISSION STANDARDS FOR PRE-AUTHORIZATION

Gold Coast Health Services department would like to remind all providers that they are required to adhere to the timely submission standards for pre-authorization requests outlined in the provider manual. While we have been lenient regarding late submissions, beginning immediately any authorization requests received past 60 days of the date services are rendered will not be reviewed. The provider manual is an extension of your provider contract. Please ensure that you read and understand your requirements. If you have questions regarding this policy, please refer to page 46 of your provider manual.

SECTION 13: HEDIS DATA COLLECTION PROCESS

Gold Coast Health Plan will be undertaking its very first HEDIS data collection process beginning in January 2013. Some of the data will be extracted from our claim file and some will require chart review. We would like to ask you for your cooperation as we begin to request medical records from your office. We will make every effort to be efficient and cause as little disruption as possible to your office. We hope to be able to share the results with you sometime in June or July of 2013.

SECTION 14: RECOVERY SERVICES

Gold Coast Health Plan has contracted with Recovery Services Group to provide the following services: hospital credit balance audits, eligibility and coordination services, and claims audit and recovery assistance. Please be advised you may receive written and or verbal communications from the Recovery Services Group starting in January.

SECTION 15: AUDIOLOGY AND HEARING AID BENEFITS

Gold Coast Health Services Department would like to clarify the Medi-Cal benefit for audiology evaluations and hearing aids.

Audiology evaluations (hearing tests) are a limited benefit. This service is covered only for the following members:

- Pregnant women (only if part of pregnancy-related care)
- Members residing in a licensed nursing home such as a Skilled Nursing Facility (SNF), intermediate developmentally disabled (ICF-DD), or Sub Acute Facility
- Children/young adults 20 years old and younger receiving full scope Medi-Cal (Children/young adults 20 years old and younger with suspected hearing loss of 30 db or greater should be referred to CCS.)

Hearing aids are a covered benefit.

To obtain this benefit, the following steps need to be completed.

Members who qualify for audiology coverage under Medi-Cal:

- Referral by PCP to an Otolaryngologist
- Referral for hearing aid evaluation from Otolaryngologist
- Evaluation by an audiologist with results forwarded back to the Otolaryngologist
- Hearing Aid dispenser obtains prior authorization from GCHP for hearing aid by documenting Otolaryngology prescription and qualifying audiology exam.

Members who do not qualify for audiology services under Medi-Cal:

- Referral by the PCP to an Otolaryngologist
- Referral for audiology evaluation from Otolaryngologist
- Evaluation by an audiologist (*at member's expense*) with results forwarded back to the Otolaryngologist
- Hearing Aid dispenser obtains prior authorization from GCHP for hearing aid by documenting Otolaryngology prescription and qualifying audiology exam.

Audiology results must include:

- Pure tone air conduction threshold and bone conduction test of each ear
- Speech tests (aided and unaided)
- Speech Reception Threshold (SRT)
- Sound Field Aided and Unaided with established Speech Scores