Provider Operations Bulletin

From Gold Coast Health Plan

EDITION: POB-003 NOVEMBER, 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.

CONTENTS

SECTION 1: PRIOR AUTHORIZATION FOR MEDICARE & OTHER HEALTH COVERAGE (OHC) NON-COVERED SERVICES

Prior authorization is required for Medicare and OHC non-covered, exhausted or denied services that will be billed directly by a provider to Gold Coast Health Plan as straight Medi-Cal claims. For example: Non-Emergency Medical Transportation, is not covered by Medicare and usually not covered by OHC, these services require preauthorization by Gold Coast Health Plan.

SECTION 2: VENTURA TRANSIT SYSTEM AWARDED NEMT CONTRACT

Gold Coast Health Plan has awarded the NEMT contract to Ventura Transit System. Transition will begin on January 1, 2013, with an anticipated full implementation for February 1, 2013. Information about the transition will be in the December 2013 provider bulletin.

SECTION 3: CLARIFICATION OF BILLING WITH MODIFIER 50

Gold Coast Health Plan attempts to recognize and use modifiers as outlined in the AMA CPT manual, as well as modifiers generally used with HCPCS codes. We are providing clarification for Modifier 50 (Bilateral Procedure) – This modifier is used when the exact same service/code is reported for each bilateral anatomical site. Report the bilateral procedures with one procedure code appended with modifier "50". Do not use this modifier when reporting procedure codes that are primarily bilateral by definition (e.g. lengthening of hamstring tendon; multiple, bilateral). Bilateral procedures should be reported as a single line item using the appropriate procedure code, CPT or HCPCS modifier and one unit. Reimbursement on procedure codes billed with this modifier is paid at 150% of the standard allowable amount.

SECTION 4: CORRECTION FOR REIMBURSEMENT OF PROCEDURE CODE 92552

This is a correction to the August Bulletin, Attachment for Section 6, CHDP Services Reimbursed on a For-for-Service Basis. For procedure code 92552: Aural Hearing Test, in error the bulletin states the amount of reimbursement is $6.75. The correct reimbursement is $15.30 for an adult and $19.00 for a child.

SECTION 5: PROVIDER MANUAL UPDATED NOVEMBER 2012

Please visit www.goldcoasthealthplan.org for the updated Gold Coast Health Plan Provider Manual which includes new information on Community-Based Adult Care, Fraud and Abuse and updated prior authorization guidelines.

SECTION 6: HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL MANAGED CARE

The transition of the Healthy Families Program into Medi-Cal managed care plans will be done in four-phases. There are approximately 20,000 children enrolled in the Healthy Families Program in Ventura County who will be included in Phase III of the transition to begin August 1, 2013.

SECTION 7: ELECTRONIC REMITTANCE ADVICE IS NOW AVAILABLE

5010 X12 835 Transactions are now available for GCHP (Payer ID 77160)

Xerox EDI (Electronic Data Interchange) is now capable of accepting and delivering electronic RA's/EOP's from Gold Coast Health Plan, to you, via your Clearinghouse or Software Vendor. To learn more about this service, visit their claims payer list (http://www.acs-inc.com/edi/claims-gateway/available-payers.aspx) and select Gold Coast Health Plan for more information on Trading Partner enrollment and 835 provider authorization.

Once the necessary forms have been submitted and enrollment completed at Xerox EDI, they will forward your enrollment to Xerox Commercial Solutions, GCHP IT Support, to finalize the system set up. IT will confirm via email when this has been completed, and your 835 delivery will begin within one week.

The total set-up requires about two weeks.

Direct any questions on the Xerox EDI set-up, to edicommercialsupportteam@xerox.com.

Direct any questions on the IT Support set-up within IkaSystems' Gold Coast Health Plan, to Diane.VanBuskirk@xerox.com.

Note: you will still receive your paper remittances in addition to the 835.

SECTION 8: AFFORDABLE CARE ACT - MEDICAID PRIMARY CARE PROVIDER RATE INCREASE

On November 6, 2012, the Centers for Medicare & Medicaid Services (CMS) released the final regulations governing the implementation of the Medicaid primary care rate increase as mandated by the federal Affordable Care Act.

CMS and the Department for Health Care Services (DHCS) will implement a rate increase for certain Primary Care Providers and specific evaluation and management codes, based on Medicare rates. The change is effective January 1, 2013 through December 31, 2014.

The DHCS has not yet provided guidance on how managed care plans are to implement this change and they have not provided rates to Gold Coast Health Plan to fund the increased payments. Gold Coast Health Plan will keep you informed as it learns more from DHCS.

The increases will not apply to federally qualified health centers and rural health clinics.

SECTION 9: STERILIZATION CONSENT FORM (PM330) MUST ACCOMPANY CLAIMS

To comply with federal requirements, a legible copy of a valid sterilization *Consent Form* (PM 330) must accompany claims for sterilization services. For reference, a copy of the PM 330 is attached. CPT-4 and HCPCS codes that require the PM 330 include but may not be limited to: 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58661, 58670, 58671, 58700 and A4264.

SECTION 10: NOVEMBER IS DIABETES AWARENESS MONTH

November is diabetes awareness month. Below you will find helpful websites to local, state, and national organizations on diabetes prevention, healthy eating, and ways of managing diabetes. Visit the following websites for more information about support groups and classes:

www.goldcoasthealthplan.org

www.diabetes.org

www.healthyventuracounty.org

www.cdc.gov/diabetes/about.htm

www.CMHShealth.org

www.dignityhealth.org

www.Caldiabetes.org

www.lmwvna.org

www.aging.ca.gov/ebhp

SECTION 11: NEW – PROVIDER DISPUTE RESOLUTION FORM

The Provider Dispute Resolution has been replaced with a new form designed to address provider issues. For your reference the new form is attached, and it is also available on the website and ready for use. Please check the appropriate box that reflects your issue.

Any questions, contact our Member Services Department or Provider Relations Department providerrelations@goldchp.org.

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

_____ . When I first asked for
(doctor or clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

_____ .
(Name of procedure)

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____/____/____ .
Mo Day Yr

I, _____
Last

_____ _____
First *M. I.*

hereby consent of my own free will to be sterilized by

_____ by a
(Doctor's name)

method called _____ .
(Name of procedure)

My consent expires **180 days** from the date of my **signature below**.

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

_____ *Date:* ____/____/____
Signature of individual to be sterilized *Mo Day Yr*

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent

form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ *Date:* ____/____/____
Signature of Interpreter *Mo Day Yr*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
(Name of individual to be sterilized)

consent form, I explained to him/her the nature of the sterilization

operation _____, the fact that it
(Name of procedure)

is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ *Date:* ____/____/____
Signature of person obtaining consent *Mo Day Yr*

_____
Name of Facility where patient was counseled

_____
Address of Facility where patient was counseled *City* *State* *Zip Code*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on
(Name of individual to be sterilized)

____/____/____ *(Date of Sterilization)*, I explained to him/her the nature of the
Mo Day Yr

sterilization operation _____ ,
(Name of procedure)

the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of Alternative Final Paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested**.)

A ☐ Premature delivery date: ____/____/____ Individual's **expected date**
Mo Day Yr

of delivery: ____/____/____ (Must be 30 days from date of patient's signature).
Mo Day Yr

B ☐ Emergency abdominal surgery; describe circumstances: _____

_____

_____ *Date:* ____/____/____
Signature of Physician performing surgery *Mo Day Yr*

PM 330 (1/99)

Gold Coast Health Plan℠
A Public Entity

PROVIDER DISPUTE RESOLUTION

Grievance & Claims Correction Form

INSTRUCTIONS

Gold Coast Health Plan has simplified the Provider Dispute Resolution process by making this grievance & claims correction form available to providers in accordance with various regulations that govern the health plan. These grievances, or disputes, may take various forms, including, but not limited to, the following: "Appeals" (requests to change a previous decision, i.e. regarding Authorization Requests, Medical Authorization Requests, or claims), or "Complaints" (an expression of dissatisfaction). In order to be effectively addressed, we have provided this form for providers to use when submitting grievances to Gold Coast Health Plan. If submitting a grievance please complete this form, attach all supporting documentation, and clearly describe the reason for your grievance. Grievances lacking information required for resolution will be returned to you with a request for more information.

Gold Coast Health requests that you file an appeal only in situations where Gold Coast Health has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. If your claim was denied for timeliness of submittal or timeliness of follow-up, please do not submit an appeal unless you are also submitting verification of timeliness that meets criteria, or you have a valid Delay Reason Code.

Gold Coast Health Plan will acknowledge receipt of your grievance within 15 business days and send a written resolution to your grievance within 45 business days after the date of receipt. For claims corrections, your explanation of payment will serve as acknowledgment and resolution.

Please submit this completed form with all supporting documentation attached to:

Grievance Type

CLAIMS	HEALTH SERVICES	REFUNDS
☐ **Claim Correction** *(copy of EOP attached)*	☐ Retro-Review	☐ Overpayment
☐ Claims Billing Dispute	☐ TAR Denial	☐ Response to refund request letter
☐ Claims Payment Dispute	☐ Records for Review	☐ Wrong Provider Paid
☐ Claims Appeal *(Appealing Dispute Outcome)*	☐ Appeal of Medical Necessity	☐ Other _____
☐ Other _____	☐ Other _____	
Gold Coast Health Plan Attn: Provider Dispute / Claims Correction P.O. Box 9176 Oxnard, CA 93031	Gold Coast Health Plan Attn: Health Services Correspondence P.O. Box 9153 Oxnard, CA 93031	Gold Coast Health Plan Attn: Refunds Department P.O. Box 9176 Oxnard, CA 93031

*Provider Name:	Billing Provider NPI::
*Provider Address:	

Provider Type: ☐ MD ☐ Hospital ☐ SNF/LTC ☐ DME ☐ Home Health ☐ Ambulance ☐ Vision ☐ Transportation ☐ Other___

Claims Information: ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:*____

Name of person submitting grievance:	Relationship to Provider: ☐Self ☐Office Staff ☐Billing Service ☐Other_____ Address of person submitting grievance:

Member ID #:	**Member First & Last Name:**	**Claim ID #:**

Date (s) of Service: *(*Required for Claim, Billing, and Reimbursement of Overpayment Disputes)*	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

Description of Grievance or reason for claim correction (please indicate specific line #'s, if applicable, and/or attach additional pages as needed and include all available supporting documentation):

[ ] ***Check here if additional information is attached***