CENTRAL VISION

2011 Provider Newsletter / page 1

A PUBLICATION BY PHYSICIANS' HEALTHWAYS IPA AND ADVANTAGE CARE IPA

A MESSAGE TO OUR PROVIDERS

Electronic Data Interchange (EDI) – Transition from ANSI X 2 Versions 4010A1 to 5010

The Secretary of the Department of Health and Human Services (DHHS) adopted the Accredited Standards Committee X 12 Versions 5010 on January 16. 2009 as the next Health Insurance Portability and Accountability Act (HIPAA) standard HIPAA covered transactions. PHW and AC IPA will support the 4010 transaction standards through December 31, 2011 and the 5010 transactions which are mandated by DHHS as of January 1, 2012.

As HIPAA covered entities, providers and their vendor must migrate to the new 5010 versions of the HIPAA transactions that they conduct with the IPAs, such as the electronic claim and encounters. During 2011, providers must engage in external testing with the IPAs and other trading partners in order to help ensure a timely transition to the 5010 standards.

PHW and AC IPA are moving to 5010 and will be compliant as of January 01, 2012. Specifically, the IPAs are moving to the 5010m version for 837 encounters and this requires that you take the following actions:

- Educate yourself and your office staff on the HIPAA 5010 compliance requirements by visiting the CMS website.
- If you see a healthcare clearing house to send and /or receive 837 encounter transactions, contact your clearing house account representative to confirm, that they are 5010 compliant and make arrangements to start testing 837 encounter; or
- Ask your vendors such as practice management systems, clinical systems, and billing systems for their plan on converting to a HIPAA 5010 compliant version of your software; or
- If you exchange 837 encounter transactions directly with the IPA, please send an e-mail to 5010-EDI@chmso.org to conduct 837 encounters testing.

Office Ally and Central Care Access – Electronic Claims & Encounter Submission

Physicians' Healthways IPA (PHW IPA) and *Advantage Care IPA* (AC IPA) distributed an official provider memo to all PCP and Specialist on May 1, 2011 regarding electronic submission for claims and encounters. Not only is this an effort to "go-green" but also to have more effective operation through electronic submission.

Effective **September 1, 2011**. Central Health MSO (CHMSO) is no longer accepting paper claims or paper encounters. All claims and encounters are to be submitted electronically through Office Ally or Central Care Access (CCA). All paper submitted claims and encounter after September 1, 2011 will be returned without being processed by CHMSO.

If you are interested in signing up for Office Ally, Please contact Office Ally directly.

OFFICE ALLY	Central Care Access (CCA)
Clearinghouse	PHW and AC IPA
Phone #: (866) 575-4120 opt. 3 E-mail: info@officeally.com Sales@OfficeAlly.com Website:www.officeally.com	If you are interested to apply for Central Care Access (CCA), Please contact IS Department at (626) 388-2300 ext 1195 Or CCA Help Desk 1540 Bridgegate Drive Diamond Bar, CA 91765 Phone#: (866) 314-2427 ext. 1195 (626) 388-2300 ext. 1195

Electronic Auth Submission

Utilization Management Department is requiring all contracted providers (Primary Care, Specialist, and Ancillary) to submit authorization requests via our online Central Care Access (CCA) system effective **November 15, 2011**. After this date, we will **NO** longer accept paper treatment authorization referral (TAR) request form. CCA has the capability to include attachments and is fast and convenient.

The following are benefit highlights of using online referrals submission:

- No more missing referrals, faxes, notes…etc.
- Real time online tracking of referral status…alleviate having to call IPA.
- Attachment capabilities to upload relevant documents for medical justification of referral
- 24-48 hours turnaround time on referrals.

We believe utilizing the online referral submission will minimize some of your administrative burdens and enhance the care coordination for your patients.

Central Care Access Update

Physicians' Healthways IPA (PHW IPA) and Advantage Care IPA (AC IPA) would like to inform you that attachments are now available when submitting authorizations and/or claims through the Central Care Access (CCA) Website.

Attachments are only available for the following conditions:

Authorizations

- New on-line authorization requests.
- A newly submitted authorization requests with status of "Waiting" or "More Info"
- An already submitted authorization request that shows status of "Requested" (this means request was reviewed but requires additional clinical information)

Claims

- New on-line submission
- Claims previously submitted with a status of "In Process"

Below are the types of attachments that will be accepted through Central Care Access.

- Adobe Acrobat (PDF)
- TIFF Image (TIF, TIFF)
- Plain Text (TXT)
- Rich Text Format (RTF)
- JPEG images (JPG, JPEG)
- Microsoft Word (DOC, DOCX)
- Microsoft Excel (XLS, XLSX)

Any file types that are different than what is listed above will be rejected.

*Should you have any questions you may contact CCA Help Desk at (626-)388-2300 ext. 1195 or E-mail to ccasupport@chmso.org

Provider Affiliation and Information Change

Our Provider Relations Department is dedicated to the processing of all provider changes in a timely manner. To aid us in expediting your requests, we ask that you follow the below guidelines.

Information Change (address/telephone/fax change)

- A request for information change must be submitted via letter format addressed to Physicians' Healthways IPA and/or Advantage Care IPA with the provider's signature
- All vendor (billing/mailing) address and corporation/ tax ID changes require an updated W-9 for processing. *In your letter, please indicate the effective date of change and if the effective date is based on the date of service or the date claims payment is issued.*
- All provider information changes are effective the date the change is processed unless otherwise indicated by the provider
- For a PCP and OB/GYN, all changes in address require a Facility Site Review before processing

Termination

- A request for IPA or Health Plan termination must be submitted via letter format addressed to Physicians' Healthways IPA and/or Advantage Care IPA with the provider's signature
- According to your contract, the effective date for a *standard termination* is 90 days from the date of receipt of the termination request
- An *immediate termination*, however, is effective the date the termination is processed. Providers who retire or are no longer employed under a medical group qualify for an immediate termination.

Leave of Absence

For Leave of Absence or Vacation, please provide a letter indicating the following information:

1. Physician's period of absence
2. Urgent contact information
3. Covering physician that is also contracted with Physicians' Healthways and/or Advantage Care IPA

General Reminder ...

Should your request be handwritten, please make sure it is legible.

Direct & Automatic Referrals

In 2009, we modified forms to achieve simplicity in the referral process for selected services. The Direct Referral and Automatic Referral Program (ARP) were redesigned for the convenience of our partners in healthcare. The process of each component allows Primary Care Physicians to oversee member utilization referral within your practice without prior authorization from *Physicians' Healthways IPA* and *Advantage Care IPA.*

The following are guidelines for **Direct Referral** and **Automatic Referral Program**:

Type of Referral	Qualification Criteria	Applicable Srvices (NO AUTHORIZATION REQUIRED)	Product Lines & Health Plans Applicable (for specialist initial consultation)	Follow-Up Allowed?
Direct Referral	All PCPs	1. X-Ray - Upper/lower extremities or chest 2. Orthopaedic Care for Fracture - initial consult, 1follow up, and X-Ray 3. Annual Mammography 4. Annual retinal Exam for members with Diabetes 5. Specialist Initial Consults * Commercial and Senior Members Only	All Commercial and Senior lines of business	No (except for fracture care)
Automatic Referral Program (for PHW only)	PCPs who meet: 1. Minimum of 200 members 2. PCP referral rate •Pediatric – 3% •Family Practice – 5% •Internal Medicine – 7%	All specialist initial consultations and follow up visits for all PHW participating providers	All Product Lines & Health Plans	Yes

*** Guidelines applicable to all contracted providers**

Reminder for Specialist:

Copies of all progress notes must be sent to the patient's Primary Care Physician.

California Children's Services medical Eligibility

California Children's Services (CCS) is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the healthcare and services they need.

We are mandated by our partnered Health Plans to direct members with CCS eligible conditions to received medical services from a CCS paneled provider.

We need your assistance in becoming familiar with CCS eligible conditions and when specialty consultations is needed to direct your member to the appropriate CCS paneled provider.

You can access the overview of CCS eligibility list at this web link: http://ww.dhcs.gov/services/ccs/Pages/medicaleligibility.aspx and provider list at http://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx.

Coordination of Care

In today's complicated healthcare environment, it is critical that primary care physicians and specialist communicate with each other so they can better coordinate patient care. Good Practice of Patient's Coordination of Care will improve clinical outcomes, enhance the quality of care, and improve patient satisfaction.

Some pointers to remember in coordinating patient care in the office setting:

- If referring to a specialist, contact the specialist before the patient's appointment. Have staff set up a quick phone appointment. Fax over the patient's medical history
- Remind the Specialist that you would need the consultation or follow-up visit report within 10 days
- Keep track by using a Referral Log of specialty services referrals. Know if Specialist will submit the referral request directly to the IPA to avoid delay in service.

The Importance of Behavioral Health Referrals

PCPs and behavioral health practitioners need to join forces in order to maximize the effectiveness of treatment.

Coordination of care between primary care physicians and behavioral health practitioners is important for members with behavioral health conditions. If can facilitate accurate diagnosis and maximize the effectiveness of treatment for the member.

Providers are encouraged to make referrals when patients show presence of acute or severe symptoms, a complex mixture of depression and substance abuse, or a long history of mental health and psychosocial difficulties.

Referral information should include the following:

- Risk (Suicidal, homicidal)
- Co-morbid medical issues

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- Co-morbid medical issues

Consent from the member maybe required for specialists to release information to the PCP. Therefore, the PCP and the member should discuss the benefits of sharing clinical information when the referral is issued. HIPAA regulations permit disclosure of protected health information for the purpose of care coordination.

Healthy HIPAA habit – Protect Patient Confidentiality

Privacy regulations contained in the Health Insurance Portability and Accountability Act ("HIPAA") can greatly impact the daily operations of physician practices. Whereas physicians and staff were once free to discuss medical cases in informal settings, HIPAA had added new restrictions to such discussions as they relate to patients' Protected Health Information ("PHI"). In adopting health HIPAA habit, physician practices can ensure compliance and promote patients' right to privacy and confidentiality.

Remember, sensitivity in dealing with privacy issues is appropriate behavior for physicians and medical staff and important for managing your medical practice liability. New HIPAA rules have changes the way the office handles privacy violations.

For more information about HIPAA and Protected Health Information, please call our QM Department at 626-388-2300.

Claims Compliance

In order for Central Health's Claims Department to expedite claims payment to our valued providers, please be reminded that health plan regulations allow the following timeframes for reimbursement:

DEPARTMENT OF MANAGED HEALTH CARE REGULATIONS			
Line of Business	Contracted Provider Timely Submission From DOS	Non Contracted Provider Timely Submission From DOS	Reimbursement Timeframe from Date Received
Medi-Cal Healthy Family Commercial Point of Service	90 Calendar Days 90 Calendar Days 90 Calendar Days 90 Calendar Days	180 Calendar Days 180 Calendar Days 180 Calendar Days 180 Calendar Days	30 Calendar Days 64 Calendar Days 64 Calendar Days 64 Calendar Days

CENTERS FOR MEDICARE AND MEDICAID SERVICES REGULATIONS			
Line of Business	**Contracted Provider Timely Submission From DOS**	**Non Contracted Provider Timely Submission From DOS**	**Reimbursement Timeframe from Date Received**
Medicare - Contracted Providers	90 Calendar Days	Maximum of 1 Calendar Year from Date of Service	60 Calendar Days
Medicare - Non-Contracted Providers "Clean Claim"	90 Calendar Days	Maximum of 1 Calendar Year from Date of Service	30 Calendar Days
Medicare—Non-Contracted Providers "Unclean Claim"	90 Calendar Days	Maximum of 1 Calendar Year from Date of Service	Once "New" info received 60 Calendar Days

In the event that non-contracted providers take the initiative to call Central Health for claims status inquiries, please allow the appropriate timeframe listed above before calling in to check status.

Check Cashing

***Please cash your payment checks within 14 calendar days of receipt.**

Medicare Timeline – New Regulations for Claim Submission

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Section 6404 of the PPACA amended the timely filing requirement to reduce the maximum time period for submission of all Medicare fee-for-services (FFS) claims to one calendar year after the date of service.

The following rules apply to claims with date of service prior to January 1, 2010:

a) Claims with date service October 1, 2009 through December 31, 2009, must be submitted by December 31, 2010. (Since this timeframe for claims submission has expired, PHW and ACIPA will not accept claims for prior dates of service beyond the December 31, 2010 submission.)

b) Claims with date service before October 1, 2009, must follow the Pre-PPACA timely filing rules.

Do you know the difference?

"Clean Claim"

A clean claim is defined as "one which can be paid as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of services, and billed amounts." If all information necessary to process a claim form non-affiliated providers is available within the health plan, provider group, or hospital, the claim is clean. Emergency services or out-of-area urgently needed services do not require authorization to be considered "clean".

"Unclean Claim?"

A claim is "unclean" if it does not have a diagnosis that is immediately identifiable as emergent or out-of-area urgent and it lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergent care. A claim is also considered unclean if it appears to be fraudulent or is in a foreign language or currency.

What is the False Claims Act?

The False Claim Act prohibits any person fro knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval of government funds. Under the federal False Claims Act, any person who knowingly submits a false or fraudulent claim to a Medicare, Medi-Cal or other federal healthcare program is liable to the federal government for three (3) times the amount of the federal government's damages plus penalties of $5,000 to $10,000 per false or fraudulent claim.

Physician's Healthways (PHW) IPA is contractually entitled to perform office audits and report to regulatory agency of select IPA network providers when fraudulent activity is suspected or identified. An indication may include notice that claims and/or encounter submissions are out of proportion to the population of a provider's capitated members. Audits may include verification of encounter and claim data through a review of medical records and patient sign-in sheets. As a reminder, documentation in the medical record must support the level of care reported by CPT and ICD-9 codes.

ABUSE: An Intentional pattern of conduct, which is inconsistent with sound ethical, medical, business, or fiscal practices and which could directly or indirectly result in unnecessary cost and/or payments.

FRAUD: An intentional deception to obtain a payment to which one is not entitled.

Examples of Healthcare Fraud:

- Billing for health care services that were never rendered
- Billing twice for the same service
- Billing for more costly service or procedure than was actually provided
- Creating a false medical records or treatment plans to increase payments
- Failing to report and refund overpayments or credit balances
- Physician billing without personal involvement for services rendered by medical students, interns residents or fellows in teaching hospitals
- Giving and/or receiving unlawful inducements to healthcare providers for referrals for services.

Red Flags of Fraud:

- Unusual and/or inconsistent provider billing practices
- Discrepancies between diagnosis and treatment
- Diagnosis and/or treatment services outside the scope of practice
- Suspicious and/or unusual place of service and provider activity
- Alterations and/or omissions on claims and encounter submissions
- Resubmitted claims with suspicious changes, additions, or omissions
- Claims and/or encounter submissions made without a patient visit
- Same day encounter visit submitted multiple times

Qui Tam Whistleblower Provisions:

The False Claims Act contains qui tam, or whistleblower, provisions. Qui Tam is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, in order to recover the stolen funds. In compensation for the risk and effort of filing a qui tam case, the citizen whistleblower or "relator" may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A qui tam suit initially remains under seal for at least 60 days during which the Department of Justice can investigate and decide whether to join the action.

Additional information regarding the administrative process can be found in the United Stated Government Code 31 USC § 3801 to 3808, at http://www.qpoaaccess.gove/uscode/browse.htm

Fraud, Waste and Abuse

Centers for Medicare & Medicaid Services (CMS) have specific emphasis on the training of Fraud, Waste and Abuse (FWA) Program as it is a highly focused area of concern. All participating providers need to be award of the importance of such subject and share with your office staff.

What You Can Do To Stop Fraud, Waste and Abuse

Health care fraud cost taxpayers billions of dollars each year. Examples of Fraud, Waste and Abuse include the following:

- Billing for services that were never rendered
- Billing for more expensive services or procedures than were actually provided or performed. e.g. up-coding
- Performing medically unnecessary se vices solely for the purpose of generating insurance payments.
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that aren't medically necessary
- Unbundling – billing each step of a procedure as if it were a separate procedure.
- Billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract.
- Accepting kickbacks for patient referrals
- Providing services that do not meet professionally not recognized standards
- Billing Medicare based on a higher Fee Schedule that is used for patients not on Medicare

Reporting suspected Fraud, Waste and Abuse

It is in your best interest to prevent and detect FWA by reporting suspected individuals, entities, and activities. Participating providers should notify the appropriate health plan of any situations where provider billing fraud/abuse may have occurred, or where members have engaged in fraudulent or abusive activity.

Health Education

The Health Education (HE) Department is an excellent resource for assisting providers in promoting health improvement and wellness of our IPA members. Through health education and promotion, we can assist our providers in meeting the state-mandated and health plan requirements for health education. For available health education materials that you can distribute to members, please contact our Health Education Department.

Initial Health Assessment (IHA)

IHA is a state mandated comprehensive assessment that enables the PCP to evaluate and manage the acute, chronic, and preventive health needs of the member. For adults, please use the UD Preventive Services Task Force (USPSTF) for providing preventive screening, testing, and counseling services. For members below 21 years of age, preventive services are specified by the American Academy of Pediatrics (AAP) age-specific guidelines and periodicity schedule.

Individual Health Education Behavioral Assessment - IHEBA ("Staying Healthy")

During an Initial Health Assessment visit, it is imperative that the members complete an IHEBA in the appropriate age category for them. The IHEBA can help you identify risk and health behavior to promote a positive lifestyle.

Important California WIC Changes Benefits Patients

Beginning October 1, 2009, the WIC food packages will change in California. New WIC foods will support both the American Academy of Pediatrics feeding guidelines and Dietary Guidelines for Americans.

New WIC Food Packages and Breastfeeding Incentive

- For the first time, fruits and vegetables are available to all WIC participants.
- Incentives for breastfeeding include reducing the formula allowance for partially breastfed infants and expanding the amount of food for nursing mothers.
- Infants 6 to 11 months old will receive less formula and more baby food items.
- Infants will no longer receive juice.
- Allowances for milk, eggs, and juice have been reduced.
- Soy-based beverages and tofu can be substituted for milk and cheese.

Documentation Requirements:

Due to the greater number and variety of WIC foods, you must now use WIC's revised WIC Referral Form to document both the type and amounts of WIC foods to issue to infants and children with special needs. Also, a qualifying condition will be required for children who receive soy milk or tofu from WIC.

For more information about the new WIC benefits, please e-mail MD-WIC@cdph.ca.gov or contact your local WIC dietician at www.wicworks.ca.gov.

Cultural & Linguistics

Language Assistance Program (LAP):

Effective January 1, 2009, Senate Bill 853 requires our Primary Care Physician and Specialist network to offer patients a language assistance program that is available through materials in their preferred language and access to interpreter services.

Language access for patients with limited English proficiency is not only the law; it also improves patient care and satisfaction. Interpreters are available by phone without advance notice and in person with a minimum of 7 days notice.

The following LAP services are offered at no cost to you and our members:

- Telephonic interpreter services
  - Professional interpreters' available 24-hours/7-days a week
- Translated materials into threshold language upon request
  - Material translated to 11 language threshold that are member-specific

Best Practice - Medical Records Documentation Requirements:

- Member's preferred spoken and written language
- Use or refusal of professional interpreters
- Communication aid used for the visit (professional interpreter, family, friend, office staff)
- Grievances related to cultural & linguistics

Important Telephone numbers to remember when accessing language assistance. Please call the health plans' Member Services department for interpreter services.

	Medi-Cal	Commercial
Aetna	1-800-525-3148	1-800-525-3148
Anthem Blue Cross	1-888-285-7801	1-888-254-2721
Blue Shield of California	1-800-541-6652	1-866-346-7198
Care 1st	1-800-605-2556	1-800-544-0088
CHMP	1-866-314-2427	-
Cigna	1-800-244-6224	1-800-244-6224
Community Health Plan	1-800-475-5550	1-800-475-5550
Health Net	1-800-977-3073	1-800-522-0088
IEHP	1-800-440-4347	1-800-440-4347
LA Care Health Plan	1-888-839-9909	1-888-839-9909
Molina	1-888-665-4621	1-888-665-4621
PacifiCare	1-800-624-8822	1-866-867-0700

Hearing/Speech Impaired

call California Relay Service:

1-888-877-5379

Deaf/Disabled:

TTY 1-877-735-2929 or 711

OTHER RESOURCES

- On-line Cultural Competence Training from DHS Office of Minority at www.thinkculturalhealth.org
- Health Care Interpreting (short course for Bilingual Health Care Workers who interpret for patients) www.lacare.org
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations www.iceforhealth.com

For additional information, please contact our Cultural & Linguistics Department at 626-388-2300 ext. 2204.