CommunityCare

PacificSource

Medicare and Medicaid Provider Newsletter | Winter 2013

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Provider Network

Introduction

CommunityCare was developed to help furnish our providers with faster and easier access to the information you need. This newsletter highlights information specific to PacificSource Medicare and PacificSource Community Solutions (Medicaid) lines of business. *CommunityCare* is separate from our *Provider Bulletin,* currently in production for our Commercial products.

PacificSource Community Solutions is our Coordinated Care Organization (CCO) plan serving the Central Oregon and Mid-Columbia Gorge Oregon Medicaid population. PacificSource Medicare is our Medicare Advantage plan serving counties in Oregon and Idaho. Issues of this newsletter will be available on our website under the Partners/For Providers section at www.Medicare.PacificSource.com and www.CommunitySolutions.PacificSource.com.

Your feedback is welcome and appreciated, please email any comments and suggestions about this publication to providerservicerep@pacificsource.com.

General Information

Submit Claims Electronically Online

PacificSource encourages providers to transmit claims electronically. Some of the benefits of transmitting claims electronically include:

- Faster reimbursement. By eliminating the time it takes for mailing, internal routing, and data entry, claims are in our system much faster and are processed for payment sooner.
- Reduced costs. Electronic billing saves providers money by eliminating the cost of forms, postage, and less processing time for staff.
- Accuracy. Electronic claims transmittal helps prevent errors and omission of required information, which results in more accurate claims processing.
- Greater efficiency and productivity. Your office will realize greater efficiency and productivity through a more streamlined process, which can also mean improved patient relations.

Quick Links

Medicare Info

- InTouch Login
- Medicare Provider Directory
- Formulary
- Authorization Grid
- Notices & Updates
- Claims Billing
- Documents & Forms

Medicaid Info

- CIM Login
- Provider Directory
- Formulary
- Notices & Updates Preapproval Grid
- Claims Billing
- Documents & Forms

Choosing a Clearinghouse:

- Gateway EDI
- Affiliated Network Services
- Emdeon
- HeW (Health E-Web)
- MCPS, Inc.
- Office Ally
- Payer Connection
- RelayHealth

Our payor number IDs are:

- PacificSource Health Plans 93029
- PacificSource Administrators 93031
- PacificSource Medicare 20377
- PacificSource Community Solutions

MCPS:
Payor ID: ORD07 (for professional (837P) / institutional (837I) claims)

RelayHealth Dubuque, IA:

CPID: 4794 (for professional (837P) claims)
CPID: 4972 (for institutional (837I) claims)
RelayHealth Tulsa, OK:
Payor ID: COIHS (for professional (837P) / institutional (837I) claims)

Submit Referral Requests Online

If you submit referral requests online, it can reduce processing time. You can submit requests online through InTouch for PacificSource Medicare members and CIM for PacificSource Community Solutions members. If you need assistance with InTouch or CIM, or if you have questions, please contact your PacificSource Provider Service Representative.

Membership

PacificSource Medicare:
Oregon
10,850 members in Central Oregon & Mid-Columbia Gorge
224 members in Coos/Curry
3,051 members in Lane
1,355 members in PERS

Idaho
2,818 members in Eastern Idaho
2,748 members in Northern Idaho
12,409 members in Southwest Idaho

PacificSource Community Solutions:
30,156 members in Central Oregon
8,875 members in Mid-Columbia Gorge

Customer Service

Each of our plans has a customer service team specially trained for our Medicare and Medicaid lines of business. To get the best service, please call the customer service number that corresponds with your patient's plan.

PacificSource Medicare:
(541) 385-5315 - Bend
(208) 433-4612 - Boise
(541) 225-3771 - Springfield
(888) 863-3637 - Toll-free

PacificSource Community Solutions:
(541) 382-5920 - Central Oregon
(800) 431-4135 - Central Oregon toll-free
(855) 204-2965 - Columbia Gorge toll-free

Medicare Specific

Legislative Change - Outpatient Therapy Limits Effective January 1, 2013

On Wednesday, January 2, President Obama signed into law the American Taxpayer Relief Act of 2012. Section 603 of this act extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD). It also counts outpatient therapy services furnished in a critical access hospital towards the cap and threshold through December 31, 2013.

The 2013 cap for physical therapy and speech language pathology services combined is $1,900. There is a separate cap of $1,900 for occupational therapy. Reference the entire document at:

http://www.CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8129.pdf

Due to this extension, PacificSource Medicare no longer requires prior authorization for physical therapy, occupational therapy, and speech language pathology services rendered in an outpatient hospital setting. However, any services requested that exceed the cap limit will still require a prior authorization. We are currently identifying affected claims to ensure therapy services accurately apply to the cap limits.

If you have any questions regarding this change, please contact your Provider Service Representative by email at providerservicerep@pacificsource.com or by phone at (800) 624-6052 ext. 2580.

AIM Specialty Health for Medicare Plans

Beginning January 1, 2013, we implemented AIM Specialty Health's prior authorization process for Medicare Advantage plans to maintain consistency across our commercial and Medicare lines of business.

Please submit to AIM all prior authorizations of nonemergency advanced diagnostic imaging services performed in an outpatient setting.

To submit a prior authorization request, go to the AIM portal at www.AmericanImaging.net. If you are not currently enrolled with AIM, you can sign up at www.AmericanImaging.net/goweb. Access is available 24 to 48 hours after completing your registration. If you have questions, you can reach them by phone at (877) 291-0510.

Covered under this program are:

- **Imaging Services**
  - Computer Tomography Scans (CT/CTA)
  - Magnetic Resonance Imaging (MRI/MRA/MRS/MRM/MRI)
  - Nuclear Cardiology
  - Positron Emission Tomography

- **Locations**
  - Freestanding Imaging Centers
  - Outpatient Hospital
  - In-office use of physician-owned equipment

Imaging services performed in the locations listed below **do not** require prior authorization:

- **Exclusions**
  - Emergency room services
  - Inpatient hospitalization
  - Outpatient surgery (Hospitals and free standing surgery centers)
  - Hospital observation

Outpatient studies performed for urgent or emergent conditions will be subject to a retrospective clinical claims review by PacificSource Medicare.

A complete list of services that require prior authorization is available on our website at www.Medicare.PacificSource.com. Services requiring AIM authorization are identified in the description field.

MEDIC

The Centers for Medicare & Medicaid Services (CMS) contracts with the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) to investigate potential fraud, waste, and abuse matters. Our Medicare providers have a contractual and compliance responsibility to cooperate with the federal government in its ongoing efforts to combat fraud, waste, and abuse.

Health Integrity, LLC (the NBI MEDIC) routinely mails a prescription verification form to Medicare prescribers. The verification form contains the member's name, the name of the member's medication, the date prescribed, and the quantity provided. This form asks the prescriber to respond within two weeks by checking "yes" or "no" to indicate whether the prescriber wrote the prescription. The investigator will send a second request if they do not receive a response.

Because the response from Medicare prescribers has been low, the MEDIC has issued notices to health plans across the country. Please remember that an untimely response or lack of response to a MEDIC request is contrary to your written contract with us. These actions may also limit the MEDIC's ability to effectively combat fraud, waste, and abuse.

Please review your current process to ensure your office staff is aware of the MEDIC's request and are prepared to respond to the MEDIC timely and completely. Should you have any questions, please contact your Provider Service Representative toll-free at (800) 624-6052 ext. 2580.

Altegra Audit

The Centers for Medicare & Medicaid Services (CMS) reimburses health plans based on the health risk of individual Medicare members. Using CMS requirements, we are conducting data validation for submission to CMS for a portion of risk-adjusted payment. We ask for your assistance in providing medical records for a risk adjustment chart review.

Risk adjustment is a payment methodology CMS provides to health plans and is dependent on accurate diagnosis coding. Coding ongoing chronic conditions, as supported by your progress notes, may result in additional payment. By reviewing medical chart documentation, we are able to identify the conditions you noted in progress notes but:

1. Were not coded at the time of the visit, and/or
2. Were not coded to the highest degree of specificity at the time of the visit.

We have retained the services of Altegra Health to conduct medical record chart reviews for this project. Here's what you can expect:

- Audits are conducted quarterly.
- Altegra Health will fax a list of patient names/medical records for chart review. Please **DO NOT** pull medical charts when you receive the list.
- Altegra Health will call your office to schedule a time for chart review. Once the chart review date is confirmed, please **DO** pull the requested medical charts.
- A certified professional coder or medical record technician will come to your office to review the charts.
- Please designate a well-lit area where the coder or technician can sit to review charts.
- If the number of charts to review is less than ten, Altegra Health will offer the provider the option of faxing the requested medical charts to a secure fax.

PacificSource Medicare has executed a confidentiality agreement with Altegra Health and their employees on behalf of our physicians and members. Any information shared during audit activities and reviews will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws and HIPAA requirements regarding the confidentiality of the patient.

If you have any questions regarding this project, please feel free to contact our Provider Network department at (800) 624-6052 ext. 2580.

HEDIS® Reporting Requires Medical Record Collection

Each year PacificSource Medicare participates in Healthcare Effectiveness Data and Information Set (HEDIS) reporting. CMS requires HEDIS reporting of all Medicare plans and requires review of medical records for specific patients. This year we have contracted with Verisk/MediConnect Global to help collect records.

If medical records for your patient are required, our vendor will contact you by mail, fax, or telephone to arrange for convenient collection of that information. You can fax, email, upload the records, or arrange for them to be collected in your office. You also have the option to have us review your records through online access. Please contact Syd Patton at (541) 330-8106 if you are interested in online review.

Under HIPAA privacy rules, disclosure of Protected Health information (PHI) is permitted for accreditation and certification activities, such as HEDIS reporting. These disclosures may be made to a business associate, acting on behalf of the covered entity. Please be assured

that Verisk/MediConnect Global has executed HIPAA-compliant business associate agreements with us to collect medical records.

InTouch for Providers

InTouch for Providers is our secure, interactive website for Medicare providers. This site is available through OneHealthPort Oregon, a web portal that provides access to local secure health plan websites with a single user ID and password. If you are already a registered OneHealthPort user, you do not need to register again for InTouch access.

Through InTouch for Providers, you can:

- Find out if a patient has coverage with PacificSource Medicare.
- Submit and check status of prior authorization or referral requests.
- Check claims status and payment details.
- Select a date and get a detailed listing of all claims processed on that date for your office.
- Use Point of Service Direct to access real-time, accurate, patient liability information and your actual charges for each procedure billed during a visit.

Helpful Hints:

- EOPs generally are posted Thursday morning.
- Search for a member by using less information, such as the member ID or member name and/or date of birth.
- Do not search by Social Security number, as this is not a requirement for Medicare members' information.

To Register:

Providers can register for OneHealthPort through their website at www.OneHealthPort.com/register. For questions or assistance with the registration process, please contact OneHealthPort's Help Desk at (800) 973-4797.

Training Available:

If you are interested in InTouch training, please contact your PacificSource Provider Service Representative.

Medicaid Specific

Referrals for Below the Line Conditions

We would like to remind you that referrals for Below the Line (BTL) conditions may be auto approved.

While more than one office visit may be auto approved, it is important to know that only the initial visit to confirm a diagnosis will be covered. If you are submitting a referral for a BTL condition, we ask you to limit your initial request to one office visit.

Subsequent visits for the BTL condition are subject to funded conditions and medical necessity. For subsequent visits:

- Submit a pre-approval request along with chart notes for coverage determination.
- Mark it as an "Exception Request" when submitting your pre-approval requests for BTL conditions.

If you have questions, please contact your PacificSource Provider Service Representative.

Submit Pre-Approval Requests Online

Reduce processing time by submitting pre-approval requests online. You can submit requests online through CIM for PacificSource Community Solutions members. If you need assistance with CIM, please contact your PacificSource Provider Service Representative.

Contact Us

Provider Network

Please feel free to contact a Provider Service Representative at (800) 624-6052 ext. 2580 or providerservicerep@pacificsource.com.

Sincerely,

The Provider Network Department
PacificSource Community Health Plans, Inc.
PacificSource Community Solutions, Inc.

PacificSource Community Health Plans, Inc. is a health plan with a Medicare Contract.
Y0021_PR1809_Plan Approved 02212013