CommunityCare

PacificSource

Medicare and Medicaid Provider Newsletter | Winter 2014

In This Issue

Contact Us

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

Electronic Medical Records (EMR) Access

PacificSource requests remote access to providers' Electronic Medical Records (EMR) system for a variety of reasons, including:

- Health Services review
- HEDIS review
- Pharmacy review
- Risk adjustment data validation

The benefits for allowing PacificSource EMR access are:

- Provides members with "real time" case management.
- Reduces interruptions and financial burdens for the provider and plan staff.
- Allows for greater efficiency in obtaining needed information for case management and discharge planning.

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

If your office is interested in providing PacificSource with EMR access, please contact your Provider Service Representative to coordinate this partnership.

Medicare and Medicaid 2014 Authorization Grid Changes

Notification of changes to PacificSource Medicare and PacificSource Community Solutions authorization grids for 2014 were emailed in October. You can view the 2014 Authorization Grids online at www.Medicare.PacificSource.com and www.CommunitySolutions.PacificSource.com.

Did you know you can submit preauthorization requests online? Online submission can reduce processing time. You can submit requests online via InTouch for PacificSource Medicare members and CIM for PacificSource Community Solutions members. If you need assistance with InTouch or CIM, please contact your PacificSource Provider Service Representative.

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.

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)

ICD-10: The Value of Physician Engagement

Being able to articulate the benefits of ICD-10 to physicians is a critical step in obtaining their engagement. For physicians, the specificity available in ICD-10 offers the potential for improved patient care, quality, and safety.
Kelly Caverzagie, MD, notes the importance of physician engagement in the success of quality improvement initiatives, defining that engagement as "active enrollment and doing it for the right reason."

Organizations with high levels of physician engagement demonstrate the following positive outcomes:

- Higher revenue and earnings per admission and per patient day
- Increased referrals from engaged physicians
- Reduced physician recruiting costs
- Sustained significant growth and profitability

Some physicians remain unconvinced of the need for ICD-10. Last November, American Medical Association delegates voted to "work vigorously to stop the implementation of ICD-10." While the Department of Health and Human Services reiterated its support of the new code set, in April it proposed a one-year delay for the final compliance date.

There is an obvious need for better communication and increased understanding within the healthcare industry of the widespread benefits of ICD-10-CM/PCS. There are many experts on the new code set that can assist organizations with messaging and communication efforts to engage physicians and their affiliated associations and societies.

Tips for Physician Engagement in ICD-10 Planning

The following strategies may be useful in developing physician engagement and readiness plans:

- Develop a set of "ICD-10 Awareness" slides or materials to share with physicians. Keep it short and simple. Request time at a medical staff meeting to present this information; invite the physician office staff to participate in order to increase an understanding of the scope and impact of ICD-10.
- Create documentation and coding examples with ICD-10 terms and codes. Provide these to medical staff as part of the overall educational plan. Remind physicians that ICD-10-CM is simply an extension of ICD-9-CM with added specificity for laterality and other relevant clinical details.
- Contact the hospital medical staff office and ask to publish regular ICD-10 articles, tips, and information in the medical staff newsletter or bulletin.

For more helpful tips, please see the online article "Engaging Physicians in ICD-10 Planning: The Documentation Link."

Please also see our ICD-10 web page for additional information: http://www.pacificsource.com/ICD10/.

This article adapted from: Bryant, Gloryanne. "Engaging Physicians in ICD-10 Planning: The Documentation Link." Journal of AHIMA 83, no.5 (May 2012): 54-55.

Take our ICD-10 Survey for a Chance to Win a Nook Tablet!

ICD-10 is less than a year away. Will you be ready? The cutoff date is still October 1, 2014. Help us help you by participating in our brief ICD-10 survey to identify where you may need assistance and where you are in your ICD-10 planning. All participants in this survey will be entered into a drawing to win a full-color Nook HD 7-inch tablet! Take the survey now.

Discounted 2014 Code Books Now Available

As a participating provider, you can preorder code books through PacificSource at a discounted rate, and delivery is free! Due to upcoming ICD-10 and other coding changes, we have extended the deadline for ordering code books to March 31, 2014. To order, simply complete the 2014 Code Book Order Form and mail it to us with your check. Full payment is required prior to delivery.

Medicare Specific

Altegra Audit

The Centers for Medicare & Medicaid Services (CMS) reimburses health plans based on the health risk of the individual Medicare member. CMS requires that we conduct this audit with providers. Using CMS guidelines, we are conducting a data validation audit prior to submitting 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, however, were not:

1. coded at the time of the visit,
2. coded on the claim submitted, and/or
3. coded to the highest degree of specificity at the time of the visit.

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

- Quarterly audits
- 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 contact our Provider Network department at: (800) 624-6052 ext. 2580.

2014 PacificSource Medicare Advantage Plan Changes

Changes to PacificSource Medicare plans will be effective January 1, 2014. We notified members of their plan changes in their Annual Notification of Change (ANOCs) letter at the end of September. Generally, members have an opportunity to change plans each year during the Medicare Annual Enrollment Period from October 15 through December 7.

You can view a complete list of benefit changes by plan. To do this, please refer to the ANOC available by plan name on our website at www.Medicare.PacificSource.com.

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

Hospice Billing for PacificSource Medicare

We would like to remind our providers to please bill all Medicare-covered services for members who have elected hospice care to Original Medicare not PacificSource. When submitting your claims to Original Medicare, please be sure to use the appropriate modifiers such as GW and GV.

Although a member can revoke hospice at any time, claims should continue to be paid by Original Medicare until the first of the month following hospice termination. We have created the table below as a quick reference guide.

If the patient:	Submit all claims to:
Enrolls in hospice on the 1st of the month.	Original Medicare
Revokes their hospice election on or after the 1stof the month.	Original Medicare
Enrolls in hospice after the 1st of the month.	Original Medicare
Enrolls in hospice after the 1st of the month and revokes their election the same month.	Original Medicare
Enrolls in hospice at the 1st of	Original Medicare first. Submit

the month, but services billed are not covered by Original Medicare.	Medicare EOB and claim to PacificSource Medicare second.

Medicare's "2 midnight" Rule

On October 1, 2013, Medicare adopted a "2 midnight" rule that states if a patient is in the hospital for a stay that does not span at least two midnights, then hospitals will be reimbursed for that patient as an outpatient instead of an inpatient.

This is the language from Medicare's final rule:

"Medicare's external review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing 2 ''midnights'') in the hospital receiving medically necessary services after inpatient admission."

"Services spanning less than 2 midnights and not involving services designated by CMS as inpatient-only should have been provided on an outpatient basis, unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary required care spanning at least 2 midnights even though that did not ultimately transpire."

"We are specifying that for those hospital stays in which the physician expects the beneficiary to require care that crosses 2 midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, we are specifying that hospital stays in which the physician expects the patient to require care less than 2 midnights, payment under Medicare Part A is generally inappropriate. This will revise our guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Part A."

To view the final rule, please click on the below link.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html?DLPage=1&DLSort=0&DLSortDir=ascending

Medicaid Specific

HealthyKids Update

The Oregon HealthyKids Connect part of the HealthyKids Program was eliminated on December 31, 2013. However, the Oregon Health Plan (OHP) part of HealthyKids will continue. Current members who fall between 200% and below the 301% of the Federal poverty level will move to OHP. Members will automatically be enrolled into their local Coordinated Care Organization (CCO) or Managed Care Organization (MCO) if no CCO is available in their area. Members above the 301% Federal poverty level were directed to elect a new plan through Cover Oregon. Please note, 2014 services for these members may require a new referral and/or authorization to be submitted to the member's new plan carrier.

Outpatient Billing Requirements

Outpatient observation services are services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation shall be reimbursed. An outpatient observation stay that exceeds 48 hours must be billed as inpatient.

Please note, if an outpatient claim is billed with more than 48 hours of observation, the claim will be denied as provider billed in error.

New Oregon Health Plan (OHP) Waiver

The State of Oregon recently approved and released a new OHP waiver form. The OHP Client Agreement to Pay for Health Services form can be used by providers and their Oregon Health Plan patients. By signing the form, patients agree to pay the provider for health service(s) not covered.

We have updated our website, www.CommunitySolutions.PacificSource.com, with the links to the new form. Please click the link below to be directly taken to the new form.

OHP Client Agreement to Pay for Health Services Form

CCO Quality Incentive Program Clarification

We would like to provide clarity for the CCO Quality Incentive Program, specific to the "Developmental Screening in the First Three Years of Life". Below, please find several key points regarding the billing of this program.

- The OHA requires screening tools to be standardized, validated and reliable. Providers are recommended to use one of the following tools:
  - Ages and Stages Questionnaire (ASQ)
  - Parents Evaluation of Developmental Status (PEDS), with or without Developmental Milestones (DM).
  - The ASQ-SE and M-CHAT are specific screens, and should NOT be used for general development screening.
- Screenings may be conducted external to the PCP setting (e.g. through a community-based organization or by a nurse home visitor). In order for this to "count" toward the CCO measure, the PCP must review and interpret results with the family, include appropriate documentation in the chart and bill for the screening procedure.
- Developmental screening can be billed in addition to an evaluation and management (E/M) service. When adding the 96110 screening code to an E/M visit, the provider should append modifier-25 to the E/M code, indicating a significant and separate service from the screening procedure.
- Bright Futures (American Academy of Pediatrics) is a helpful resource, which provides tools for preventive care documentation and recommended screening schedule.

For complete details regarding this measure, please refer to the OHA Guidance for billing and coding questions.

Thank you for your continued partnership and all the great work on these measures.

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 an HMO/PPO plan with a Medicare Contract.
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