# Community-Based Adult Services

## Provider Training

# Agenda

- Provider Registration

- Eligibility Verification

- Prior Authorization

- Case Management

- Claims and Billing

- Grievance and Appeals

- CalOptima Contacts

# Provider Registration

# Provider Registration

- All CBAS providers rendering service to CalOptima members must be registered in our system in order for authorization requests to be processed, and most importantly, to receive payment.

- To register, visit the "For Providers" page at www.caloptima.org and click on "Register As A Provider With CalOptima" or click on the link below to begin your registration:
http://www2.caloptima.org/providerregistration/

# Eligibility Verification

# Eligibility Verification

- **When:** Verify eligibility prior to rendering services

- **Why:** To ensure that services rendered to member is reimbursable by CalOptima

# Eligibility Verification

## How:

| State Eligibility Verification Systems | Description |
|---|---|
| **Automated Eligibility Verification System (AEVS)** (800) 456-2387 | This system returns a Medi-Cal Eligibility Verification Confirmation number (EVC). |
| **Point-of-Service (POS) Device** | This device offers a hardcopy printout of the member's Medi-Cal eligibility as confirmation. |
| **Medi-Cal Website** https://www.medi-cal.ca.gov/eligibility/login.asp | Providers may verify member eligibility on the Medi-Cal website. Providers must have a Personal Identification Number (PIN) to access this system. If you do not have a PIN, please contact the POS Help Desk at 1-800-541-5555. |

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# Eligibility Verification

## How:

| CalOptima Eligibility Verification Systems | Description |
| --- | --- |
| **CalOptima Link*** | CalOptima's provider web portal allows provider to check eligibility, view member information, view claims status and submit authorization requests. |
| **CalOptima Interactive Voice Response (IVR) System**<br><br>(800) 463-0935<br>Available 24 hrs a day | Providers can call the IVR to obtain eligibility inquiries for all CalOptima members. You will need to enter the member's 9-digit Client Identification Number (CIN) and for letters use the # key as follows:<br><br>**A – press 1**      **C – press 2**      **D – press 3**<br>**E – press 4**      **K – press 5**      **F – press 6** |

*Providers must set up an account to use CalOptima Link. To request a username and password, click: CalOptima Link Registration. Please allow 2 – 3 days after registering to receive username and password
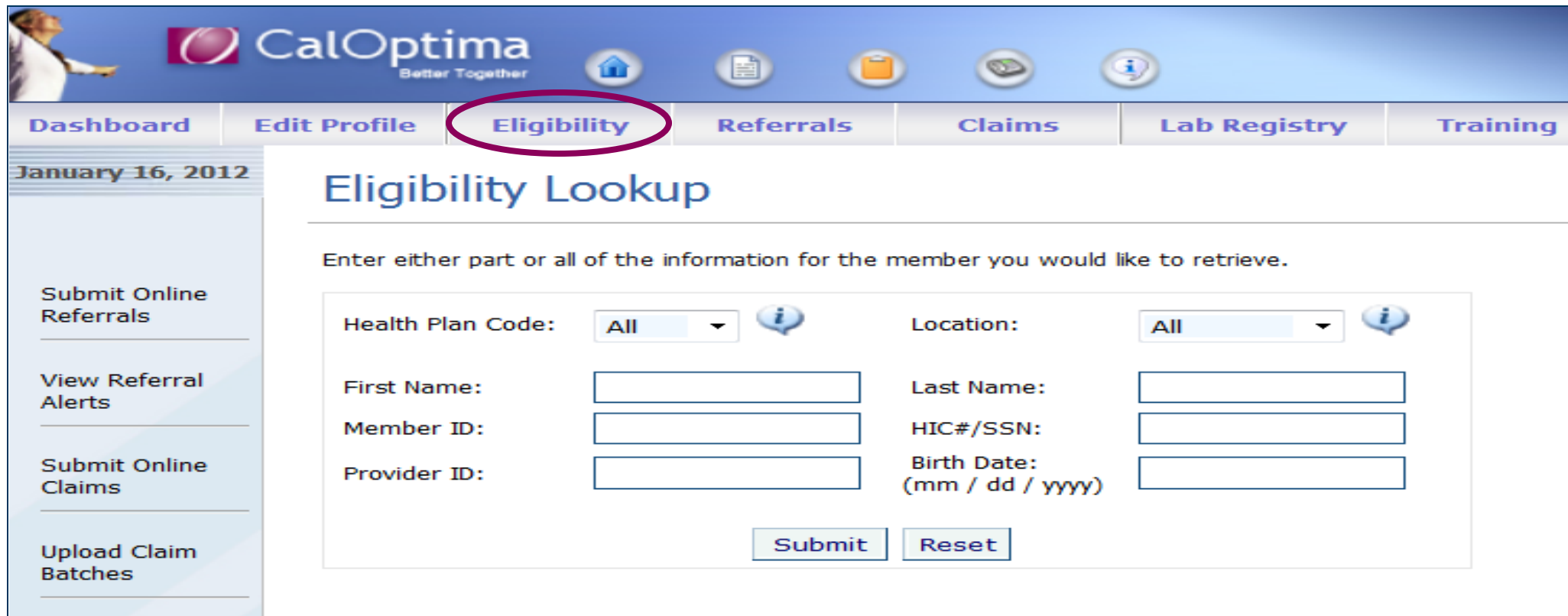
# CalOptima LINK: Dashboard

Providers may verify eligibility two ways:
1. Directly on the Dashboard
2. Using the Eligibility Tab on in CalOptima Link

# CalOptima LINK: Eligibility Lookup Screen

The Eligibility tab allows searches using member's names, birth date, Social Security Number, etc.

# CalOptima LINK: Member FaceSheet Screen

Member FaceSheet displays member's demographic information, eligibility information, referral data, claims data, and links to member's eligibility history.

# Prior Authorization

# Authorization Work Flow



**A**
- CBO Referral
- Physician Referral
- Nursing Facility Referral
- Hospital Referral
- Individual Referral
- Family Referral
- CBAS Provider Referral

Required Expedited Referral Path
– – – →

Standard Referral Path
——→

**B Health Plan**
- ❖ Plan receives request for Assessment
- ❖ Plan Determines Eligibility by completing F2F assessment using CEDT within 30 calendar days
- ❖ Plan refers member to Center for IPC & LOS Recommendation

**C CBAS Center**
- ❖ Multi-disciplinary team performs MDT assessment
- ❖ Prior Authorization with IPC & Level of Service Recommendation created and sent to Plan

Plans and Centers share data for routine and expedited requests

**E CBAS Center**
- ❖ CBAS services begin

**D Health Plan**
- ❖ Plan Adjudicates Prior Authorization with IPC & Level of Service Recommendation within 5 days for standard review and 3 days for an expedited review

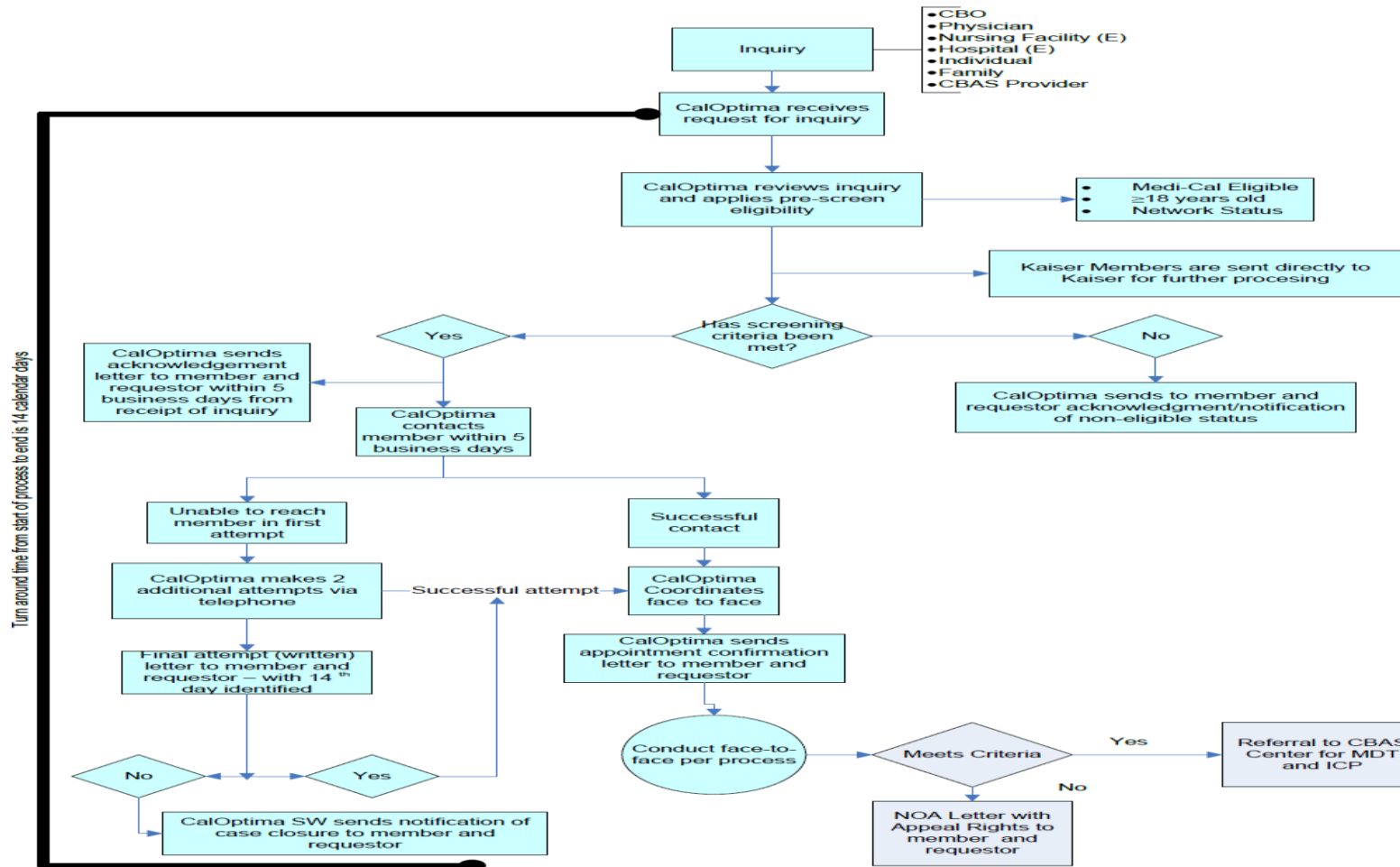# CalOptima PA Process for CBAS Services

1. New Member Process

2. CEDT Process
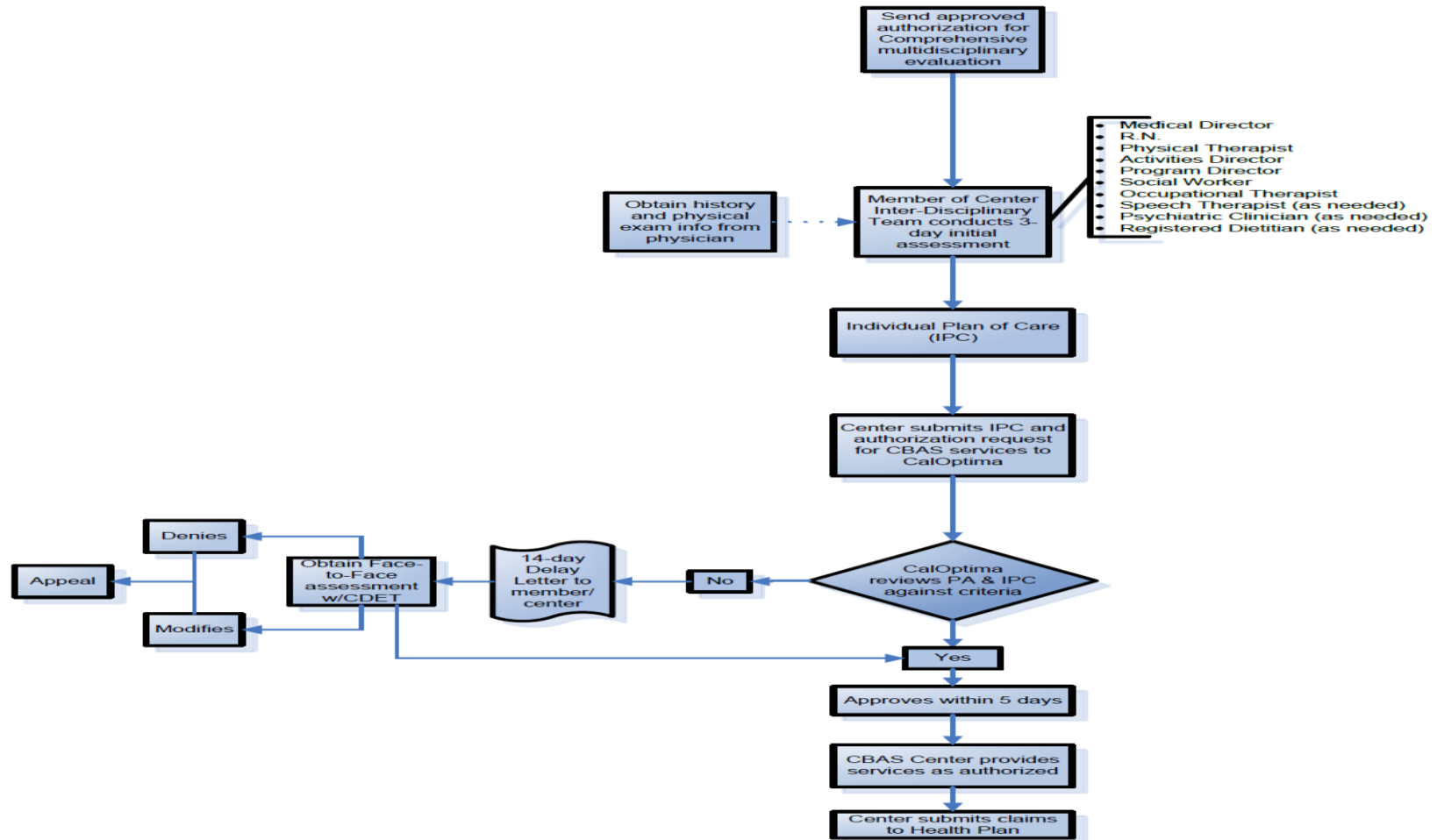
3. Expedited Process

4. Reassessment Process

# CBAS New Member Flow Process #1



CalOptima CBAS Process — Point of Inquiry to Scheduling of Face-to-Face

# CBAS New Member Flow Process #2



CalOptima CBAS Medi-Cal Eligibility and Authorization Process – New CBAS Members

# Inquiry Request Form

# CBAS Eligibility Determination Tool (CEDT)

- CalOptima is responsible for completion of CEDT per DHCS requirements.

- Current CEDT form is in process of being revised by the State.

- CalOptima will have various providers able to complete the CEDT dependent on member choice and location.

- Once eligibility is determined CalOptima will notify the CBAS center of authorization to complete a multidisciplinary team assessment and IPC.

# Expedited Process

- Nursing Facility or Hospital identifies a potential need for expedited CBAS Services in the discharge/transition plan and provider submits a request for inquiry.

- Expedited process is "New Member" process with a tighter time frame.
  - ➢ Plan must complete F2F within 5 business days
  - ➢ Approval or denial of CBAS eligibility communicated within 1 business day of the decision.
  - ➢ Member has right to choose center.
  - ➢ Once approval issued the normal CBAS process occurs.

- CBAS Team schedules F2F at the Nursing Facility or Hospital with member/family immediately

# Reassessment Process
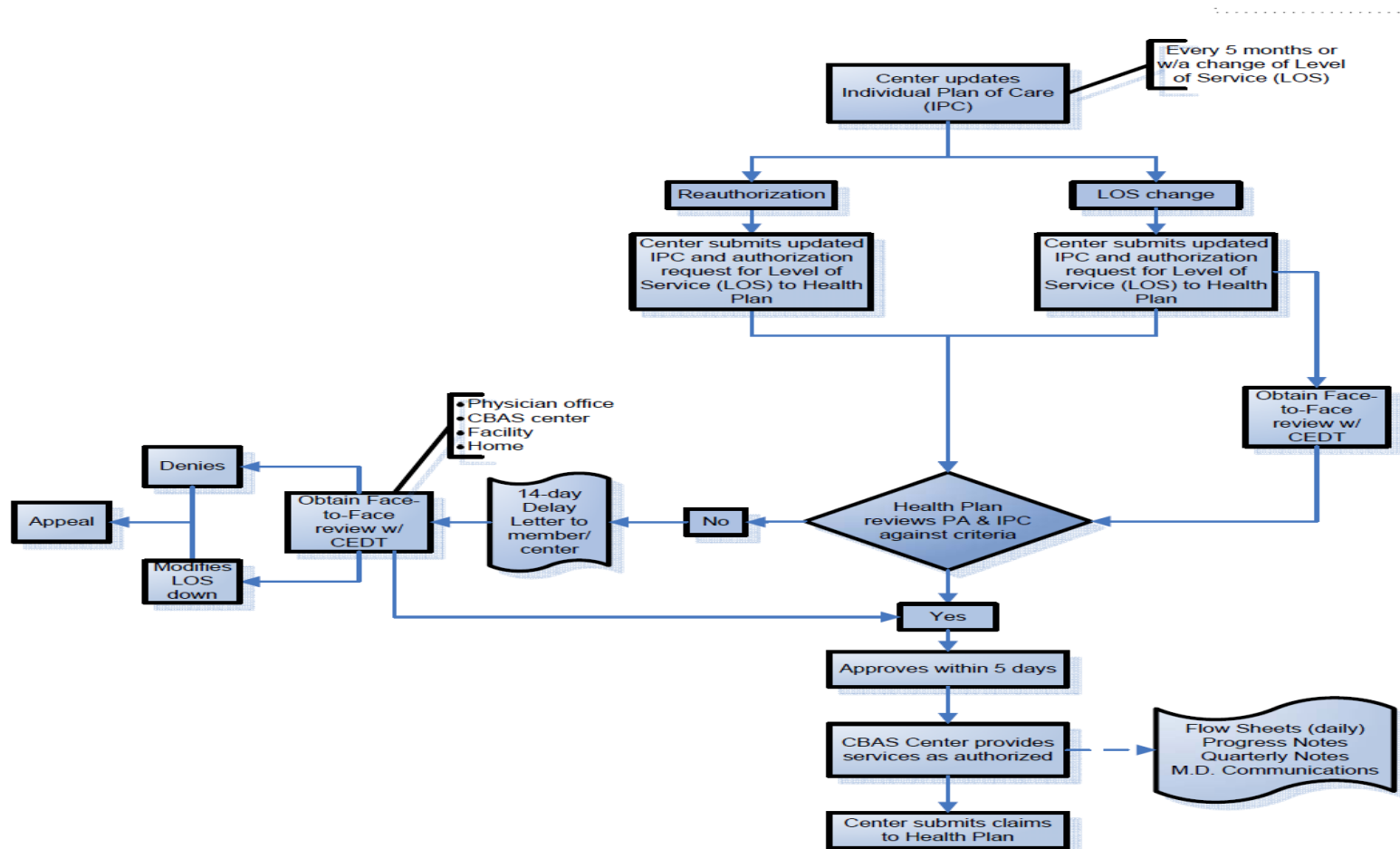
# Case Management

# Case Management Definition

- Case management is the coordination of care and services provided to members who have experienced a clinical event or diagnosis that requires an extensive use of resources or services to facilitate appropriate delivery of care.

# Case Management Triage Process



Member identified for Case Management through Data Sources

Member referred for Case Management

Case reviewed by Triage Nurse

Eligibility reviewed Member COD/CCN?

Assign to Health Network Liaison for referral to Health Network Case Manager

Review diagnosis, reason for referral and recent activity

Yes

No

Does case meet complex case trigger?

No

Does case require clinical intervention

No

Assign to Service Coordination Medical Assistant

Aids
Cancer with Mets
High Utilization with Multiple Chronic Conditions
Multiple Chronic Conditions with Social Issues
Active Transplant
Spinal Cord Injuries
Serious Trauma

Yes

Assign to Complex Case Management Nurse

Assign to Care Coordination Nurse

# Case Management Process



**Column 1 (Complex Case Manager):**

- Complex Case Manager receives case
- CM contacts member and completed the Initial NCQA Assessment, Community Resource Assessment and Preventative Measures Assessment
- CM creates an indivicualized care plan, including prioritized goals
- Member specific educational material mailed to member
- CM implements care plan and sets follow up timeframe
- CM contacts member/ service providers to reassess progress towards goals
- CM identifies barriers to meeting goals and modifies care plan as needed
- Case is closed when all CM goals are met

**Column 2 (Care Coordination Nurse):**

- Care Coordination Nurse receives case
- CM contacts member and completes the focused initial assessment, Community Resource Assessment and Preventative Measures Assessment
- CM creates an indivicualized care plan, including goals
- Member specific educational material mailed to member
- CM implements care plan and sets follow up timeframe
- CM contacts member/ service providers to reassess progress towards goals
- CM identifies barriers to meeting goals and modifies care plan as needed
- Case is closed when all CM goals are met

**Column 3 (Service Coordinator):**

- Service Coordinator receives case
- MA contacts member to determine needs
- MA works with member and provider to resolve issues
- If MA unable to resolve issue/issue is clinical, refer to Care Coordination

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# Referral to Case Management

- Members can be referred for case management via:
  - Email to cmtriage@caloptima.org
  - Fax to (714) 338-3192

- Contact  Ann Raney, Mgr, Case Management at (714) 246-8469

# Claims and Billing

# Billing Codes

| HCPCS Code | Description |
|------------|-------------|
| H2000 | Comprehensive multidisciplinary evaluation |
| S5102 | Day care services, adult; per diem |
| T1023 | Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter |

# Claim Pre-Submission Checklist

- **Eligibility** – Verification of eligibility must be obtained prior to billing

- **Provider NPI** – Must be actively registered with CalOptima

- **Prior Authorization** – Required for initiation of all CBAS services

- **Date of service** – Submit claims with dates of service on or after 7/1/12

# Claims Submission – Paper Claims

- Claims must be billed on a UB-04 claim form
- All required fields must be completed or your claim will be rejected back to you

Mailing Address:

CalOptima Claims Department
P.O. Box 11037
Orange, CA 92856

# Sample Claim Form

• All required fields must be completed

Revenue Code **3103** must be indicated on each line in Box 42

Authorization number must be indicated in Box 63

9-digit Tax Identification Number (TIN) must be indicated in Box 5

CBAS center NPI must be indicated in Box 56

# Claims Submission – Electronic Claims

- CalOptima is contracted with two data clearinghouses for the submission of electronic claims

  - **Office Ally:** (866) 575-4120, Payer ID: CALOP
    - If the provider does not have an account, please contact:

      Jenny Rattray

      (360) 450-2668

      jenny.rattray@officeally.com
    - Questions on how to complete the electronic UB04 form, please contact:

      Nicole Ackerman

      (866) 575-4120 ext 105

      nicole.ackerman@officeally.com
  - **Emdeon:** (877) 271-0054, Payer ID: 99250

- Claims can be submitted directly to either one of these vendors; you do not need to submit claims through CADCare unless you choose to

# Provider Dispute Resolution Process

- PDRs are considered as Level 1 appeals and are used primarily to address underpayment or overpayment issues

  - If your claim was denied for no authorization, contact the Prior Authorization department at (714) 246-8686. Do not submit a PDR until you obtain an authorization.

- To submit a Provider Dispute Resolution Request, providers should complete a PDR form (located on CalOptima's website at www.caloptima.org)

- PDRS must be submitted within one year from the date of the last determination or they will be denied for timely filing

- PDRs will be acknowledged within 15 working days from receipt and resolved within 45 working days of receipt

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# Grievance and Appeals

# Definitions

- Complaint
  - An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program

- Appeal
  - A request by the Member or the Member's authorized representative for review of any decision to deny, modify or discontinue a covered service

- Grievance
  - An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member

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# Submitting Complaints or Appeals

➢ Submission
- ▪ Accepted in person, verbally, online or written
  - Customer Service (714) 246-8500 or (888) 587-8088
  - 505 City Parkway West, Orange CA 92868
  - www.caloptima.org

    http://caloptima.org/en/Members/Medi-Cal/~/media/Files/CalOptimaOrg/Members/Medical/Medi-CalCommonForms/MC_MemberComplaintForm_English.ashx

➢ CalOptima's Response
- ▪ An acknowledgment letter sent within 5 days
- ▪ Investigation and resolution within 30 days

# Member Appeals

- Submission
  - Accepted in person, verbally or written, or by provider on member's behalf
  - Customer Service (714) 246-8500 or (888) 587-8088
  - FAX (714) 481-6499
  - 505 City Parkway West, Orange CA 92868, attn:GARS
- CalOptima's Response
  - An acknowledgment letter sent within 5 days to the member
  - Standard Appeal
    - Investigation and resolution within 30 days
  - Expedited Appeal
    - Criteria- delay would seriously jeopardize life, health or ability to regain maximum function
    - Medical review to confirm meeting criteria: Notification of acceptance
    - Accepted as expedited: Investigation and resolution within 72 hours

# Provider Appeals

➤ UM Appeal through CalOptima UM Department

- Filed after receipt of Notice of Action (NOA)
  - Decision is denied, modified or deferred
- Must be filed within 90 days of NOA
- Accepted by mail or fax
  - 505 City Parkway West, Orange CA 92868 : attn:UM
  - FAX (714) 246-8609
- Mark clearly as an 'Appeal'
- Include all relevant documentation, clinical records and supporting information

➤ Level 1 Provider Dispute Resolution (PDR)

- Processed in the CalOptima Claims Department
- Related to payment issues

# Provider Appeals

- Level 2
  - Handled by the Grievance and Appeals Department
    - Mail or FAX

      CalOptima Grievance & Appeals Resolution Services

      505 City Parkway West

      Orange, CA 92868

      Fax: (714) 481-6499
  - Must be filed within 180 days of Level 1 PDR decision
  - Form located online at  www.caloptima.org

  http://caloptima.org/Home/Providers/~/media/Files/CalOptimaOrg/Providers/ProviderManuals/ProviderManualForms/MC_ProviderDisputeResolutionRequestFormLevel-II.ashx

  - An acknowledgment letter sent within 15 days
  - Investigation and resolution within 45 working days
  - Decisions at Level 2 are final

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# CalOptima Contacts

# Provider Relations(PR) Representative

- Your primary contact at CalOptima for general CBAS questions

- Connection to departments within CalOptima

- Assistance can be provided via phone or in-person training

- You may contact Quynh Nguyen directly by phone at:
  **(714) 347-3224**, qnguyen@caloptima.org

# Prior Authorization Contacts

- CBAS dedicated phone line: **(855) 227-1314**

- CBAS dedicated e-mail: <u>cbasteam@caloptima.org</u>

- CBAS dedicated fax line:
  **(714) 481-6423** (routine)
  **(714) 481-6422** (emergent/urgent)

# Claims Contacts

- CalOptima Link – online claims status and payment information
  - Requires registration to obtain logon and password

- Claims Provider Customer Service: **(714) 246-8885**
  - Monday – Friday, 8:00am-4:00pm (closed 12:00-12:30)
  - General claims questions

- Mary Eden, E-Business Manager:

  **(714) 246-8719**, meden@caloptima.org
  - Electronic claim submission questions or issues with Office Ally or Emdeon

# Other CalOptima Contacts

- Credentialing:

  Rick Quinones **(714) 246-8505**, rquinones@caloptima.org


- Contracting:

  Nancy Mackey **(714) 246-8755**, nmackey@caloptima.org


- Change in provider information:

  (**714) 246-8468**, provideronline@caloptima.org


- CalOptima Link (login ID, password and technical difficulties):
  Cerecons **(800) 864-8160**

# Community-Based Adult Services (CBAS) Provider Training Assessment

- Please click on the link below to access the CBAS Provider Training Assessment. The questions are based on the information provided in this presentation. There are a total of ten questions.

(CBAS) Provider Training Assessment