CalOptima Community Network (CCN)

Lunch and Learn Meeting

April 19, 2016

Welcome

Michael German, Manager
Provider Relations

Agenda

- Provider Relations Updates

- Utilization Management Update

- Coding Update

- Claims Update

- PACE Update

- Q&A and Closing Remarks

CCN Meeting Materials

- Meeting Agenda
- Notes page
- CCN Question Sheet
  - Complete if you would like CalOptima staff to follow up with you after this meeting.
- Today's Meeting Evaluation
  - Please complete at the end of each presentation.
- Meeting materials are available on the provider webpage at www.caloptima.org.

Please place your cell phones on silent

Provider Relations Updates

CCN Lunch and Learn

April 19, 2016

Jorge Castañeda

Provider Relations Representative

Overview

- CCN Membership Update
- Provider Directory Validation
- Retrospective Authorization Requests
- CHDP Conversion

CCN Membership Update

- Total Members: 56,127
  - Children: 14,984
  - Adults: 39,609
  - 65 years of age and older: 1,534
- Primary Care Providers: 622
  - Group providers: 88
  - Affiliated practitioners: 371
  - Individual practitioners: 163

Data as of April 1, 2016

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Provider Directory Validation

- CalOptima recently updated the demographic information of every provider in the Community Network listed in our online provider directory.
  - ➤ Please verify your provider's information on CalOptima's website, www.caloptima.org
  - ➤ You can report changes to your Provider Relations Representative or contact the Provider Relations department at 714-246-8600.

Retrospective Authorization Requests

- Retrospective authorization requests no longer accepted effective March 1, 2016
  - All routine services requiring authorization must be submitted prospectively.
  - Only services allowable for retrospective authorization are:
    - Out of area (not out of network)
    - Undeterminable eligibility at the time of service
    - Urgent/emergent services which do not require prior authorization
  - Urgent requests
    - Only submit "urgent" when it's medically necessary.

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CHDP Conversion

- Transition from PM 160 form to HCFA 1500 form

- The effective date has been delayed.
  - Initial target date for transition was March 1, 2016.
  - DHCS delayed the transition until no sooner than July 1, 2016.

- Please check the our website at www.caloptima.org or call your Provider Relations representative for more information.

Referral Submission Guidelines

CCN Lunch and Learn

April 19, 2016

Debra Armas, Director

Utilization Management

Retrospective Referral Submission

- Effective March 1, 2016, **all routine services** requiring prior authorization must be submitted prospectively (before services are rendered) to the Utilization Management department for authorization.
  - ➢ **In accordance with CalOptima Policy GG.1500**
  - ➢ **An NCQA regulatory guideline**
  - ➢ **In CalOptima's Provider Manual**
    - ▪ Lack of staff education is not an acceptable excuse for an exception.

- As stated in GG.1500 and NCQA guidelines, a retrospective request can be submitted **if:**
  - ➢ The member is out of area (not out of network).
  - ➢ Eligibility is indeterminable at time services were provided.
  - ➢ Accessing secondary coverage after primary coverage denies.

Urgent Referral Requests

- Only submit an **urgent referral**:

  - When the normal turnaround time frame for authorization will be detrimental to the patient's life or health, jeopardize the patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function.

    - Any urgent referral submitted and approved will have a two-week expiration date for services to be performed.

    - Physician offices may be contacted while an urgent referral is being processed to educate medical office staff on the appropriate submission for urgent referrals when inappropriately submitted.

    - Referrals will be reclassified to routine and follow the regulatory turnaround time frames for processing.

    - Appropriately submitted referrals will facilitate quicker turnaround times.

Supporting Evaluation and Management Codes with Clinical Documentation

CCN Lunch and Learn

April 19, 2016

Eloisa Nicol, CPC

Certified Coder

Agenda

- Evaluation and Management (E/M) Documentation Rules
- 99215-99211 Documentation Coding Protocol
- 99215 and 99214 Documentation Example

E/M Documentation Rules

- General principle of E/M services
  - Medical record should be complete and legible.
  - The documentation of each patient encounter should include:
    - Reason for encounter and relevant history, physical examination, findings and prior diagnostic test results
    - Assessment, clinical impression or diagnosis
    - Medical plan of care
    - Date and legible identity of the observer
  - If not documented, the rationale for ordering diagnostic and other ancillary service should be easily inferred.
  - Past and present diagnoses should be accessible to treating and/or consulting physician.
  - Appropriate health risk factors should be identified.

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E/M Documentation Rules (cont.)

➢ The patient's progress, response to and changes in treatment, and revision of diagnosis, should be documented.

➢ The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical records.

- In order to maintain an accurate medical record, services should be documented during the encounter or as soon as practicable after the encounter.

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E/M — 99215 Code Description

99215 — Office or other outpatient for the evaluation and management of an established patient

- Presenting problem/decision-making comprehensive
  - One or more chronic illness with severe acute exacerbation or a severe side effect of treatment of one or more chronic illness(es)
  - An illness posing a threat to life or function
  - Or an abrupt neurologic status change (e.g., transient ischemic attack (TIA), seizure, etc.)

- History of present illness (HPI — extended)
  - At least four of the eight elements (i.e., location, quality, severity, duration, timing, context, modifying factors and associated symptoms)
  - All (complete) elements from past, family and social history (PFSH)
  - Review of system (ROS) complete at least 10 of the 14 systems (i.e., constitutional, eyes, ENT, cardiovascular, respiratory, gastrointestinal, endocrine, etc.)

E/M — 99215 Code Description (cont.)

Or

- Exam: Comprehensive exam
  - ➤ Multisystem exam or single-organ-system exam

- Time factor
  - ➤ Typically, 40 minutes are spent face-to-face with the member and/or family

99215 — Documentation Example

The patient is a 46-year-old male with diabetes. Patient went to the emergency department the day before for acute nausea and was admitted and discharged on the same day. The patient had chest pain and was tested for a possible blood clot with a CT scan that was negative for pulmonary embolism. The patient is no longer with chest pain but complains of fatigue and slight abdominal pain. Patient unable to tolerate food, lives with his wife, and drinks two beers nightly. No family history of heart disease and no allergies.

Medication(s):
Simvastatin, lisinopril, metformin and glyburide
Vitals:
BP 100/60 (last BP 146/86), P 56, WT 240, RR 20, Temp 99.2
General:
Appears older than stated age, dry heaving in office, obese, moderate distress
HEENT
PERRL, slight conjunctival injection, mild pharyngeal edema, deviated septum on right

99215 — Documentation Example

Neck:

No JVD, no thyromegaly

Lymph:

No cervical, axillary or inguinal adenopathy

Cardio/Vascular:

Brady S1/S2, 1/6 systolic murmur

Lungs:

Decreased BS bilaterally without wheeze or crackles, normal effort, no dullness to percussion

Abdomen:

Diffuse mild abdominal pain without rebound or guarding, no organomegaly

Extremities:

No clubbing or cyanosis, 1+ edema bilaterally

Skin:

No rashes, tattoo on left scapula

99215 — Documentation Example

Neurological

CN 2–12 intact; normal DTRs bilaterally, symmetrically; muscle strength seems normal throughout.

Labs

A1C in office 10.2, last A1C 3 months ago 13.4

Assessment/Plan:

1) Acute nausea/vomiting, recent chest pain, mild anemia

2) Suspect lactic acidosis given CT scan and metformin

3) Can be life-threatening so will send to emergency department for potential hemofiltration and IV fluids

The documentation in this example supports code 99215

E/M — 99214 Code Description

99214 — Established patient

- Decision making/moderate complexity (presenting problem)
  - One chronic illness with acute exacerbation
  - Two or more stable chronic illnesses
  - New problem of uncertain diagnosis (e.g., back pain)
  - Acute illness with systemic symptoms or an acute complicated injury

E/M — 99214 Code Description (cont.)

- History
  - HPI (extended) at least four elements reviewed (i.e., location, timing, severity, etc.)
  - At least one (pertinent) from past medical, family or social history (PFSH)
  - ROS (extended) at least two systems examined (i.e., general, cardiovascular, endocrine, etc.)

Or

- Exam: Detailed exam (of the affected area and related organ system)
- Time factor
  - Typically, 25 minutes are spent face-to-face with the patient and/or family

99214 — Documentation Example

Follow-up Osteoarthritis

Interval history: The patient states his bilateral knee arthritis is no longer controlled on Tylenol. He complains of bilateral knee pain described as a dull ache, which has been worsening for the past two months. The pain is worse after walking long distances and is sometimes associated with swelling in both knees.

Medications:

HCTZ 12.5 mg po qd, atenolol 25 mg po qd, acetaminophen 650 mg po q4h prn.

ROS:

Cardiovascular — negative for chest pain, orthopnea or PND.

Eyes:

Eye grounds clear with normal posterior segments

Neck:

No JVD or carotid bruits

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99214 — Documentation Example (cont.)

Lungs:

Clear to auscultation and percussion

CV:

Regular rate and rhythm, no murmurs, rubs or gallops, and normal PMI

Abdomen:

Soft, non-tender, no HSM

Skin:

Normal turgor; no rash

Extremities:

Digits and hands show no active tenosynovitis or nodules; both knees have small effusions and demonstrate moderate crepitus and decreased range of motion; normal joint stability with no evident laxity; no peripheral edema, brisk pedal pulses bilaterally

99214 — Documentation Example (cont.)

- **Plan**

  1) Start ibuprofen 400 mg po tid.

  2) Continue current blood pressure medications unchanged.

  3) Patient was educated about GI risks of increasing doses of ibuprofen, especially when combined with alcohol.

  4) NSAIDS can also lead to worsening hypertension, so asked the patient to monitor his blood pressure more frequently.

  5) Return visit scheduled in two months with CBC and renal profile.

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99214 — Documentation Example (cont.)

- The documentation in this example **does not** support code 99214. What elements are needed to support code 99214?
  - ➤ Pertinent PFSF
  - ➤ ROS-specifically musculoskeletal (i.e. muscle weakness, joint warmth, etc)
  - ➤ General appearance
  - ➤ Vitals (i.e. BP, weight, height, etc)
  - ➤ Assessment (i.e. findings/diagnosis)

E/M — 99213 Code Description

99213 — Established patient

- Decision making/Low complexity (presenting problem)
  - One stable chronic illness
  - Two or more self-limited illnesses or an acute uncomplicated illness
- History
  - HPI (brief) at least one element out of the eight elements (i.e., location, vital signs, general appearance, etc.)
  - PFSH not needed
  - ROS pertinent to the presenting problem

E/M — 99213 Code Description (cont.)

Or

- Exam: Expanded problem focused (of the affected area and related organ system)
- Time factor
  - Typically, 15 minutes are spent face-to-face with the patient and/or family.

E/M — 99212 Code Description

- 99212 — Established patient
- Decision-making/straightforward (presenting problem)
  - Self-limited or minor (e.g., insect bite right arm, left arm pain, etc.)
- History
  - HPI (brief) at least one out of three elements (i.e., location, vital signs, general appearance, etc.)
  - ROS not needed
  - PFSH not needed

Or

- Exam (problem focused)
- Time Factor
  - Typically, 10 minutes are spent face-to-face with the patient and/or family

E/M — 99211 Code Description

- 99211 — Established patient
- Decision-making (presenting problem)
  - ➢ Minimal (e.g., suture removal, peak flow instructions, dressing change)
- History
  - ➢ HPI not needed
  - ➢ ROS not needed
  - ➢ PFSH not needed
  - ➢ Exam not needed
- Time Factor
  - ➢ Typically, five minutes are spent performing or supervising these services. (Does not require the presence of physician. Code most typically used to identify a nurse visit ,e.g., suture removal)

Websites

- MLN Matters
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- CMS
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
- CMS
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Provider Disputes

CCN Lunch and Learn

April 19, 2016

Robert Flournoy, Claims Manager

Claims Administration

Common Reasons for Disputes

- Underpayments
- Authorization issues
- Corrected claims
- High cost exclusions

PDR Filing and Resolution Timelines

- Medi-Cal: The provider has 365 days from the initial approval/denial date to file.

- Medicare: The provider has 365 days from the initial approval/denial date to file.

- CalOptima has 45 working days (or 62 calendar days) to resolve a dispute.

How to Submit a Provider Dispute

- Provider disputes should be submitted using the Provider Dispute Resolution Request form, which when completed, provides all information necessary to resolve the disputed claim(s).

- A copy of the original claim form is not necessary; however, when a correction is required, a corrected claim should be submitted with the dispute for consideration.

- Provider Dispute forms are located on the CalOptima website: https://www.caloptima.org/Home/Providers/CommonForms aspx

PACE

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Program of All-Inclusive Care for the Elderly

CCN Lunch and Learn

April 19, 2016

Rena Smith

Director, PACE

What is PACE?

- Program of All-Inclusive Care for the Elderly (PACE)
- Community-based program that provides all necessary medical and social services to seniors
- A "one-stop shop" that makes health care easier
- CalOptima has the first and only PACE center in Orange County
  - ➢ Located at 13300 Garden Grove Blvd., Garden Grove
- Throughout California there are 11 PACE centers.
- Nationally, there are 118 PACE centers in 32 states.

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Eligibility

- To be eligible, a person must:
  - ➤ Be age 55 or older
  - ➤ Reside in our PACE service area
  - ➤ Meet California nursing facility level of care requirements, after an assessment by CalOptima PACE staff and state approval
  - ➤ Be able to live safely in the community

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What Services Does PACE Cover?

- Onsite Medical Clinic
- Activity/Day Center
- Transportation (Home to Center to Home)
- Rehabilitation (Physical/Occupational Therapy)
- Meals and Healthy Eating Tips
- Home Care
- Medicines
- Medical Equipment
- Hospital Care
- Long-Term Care

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How Much Does PACE Cost?

- If the participant has Medicare and Medi-Cal (with no Share of Cost), all CalOptima PACE services are covered at no cost to them.

- If the participant has Medicare and Medi-Cal (with a Share of Cost), they must pay their own Share of Cost.

- If the participant has only Medicare, they pay a monthly premium to take part in CalOptima PACE. They will also be responsible for the Medicare Part D premium.

- If the participant has Medi-Cal only (with no Share of Cost), all CalOptima services are covered at no cost to them.

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Authorizations and Billing

- PACE Clinic creates an order with an authorization number.
- Authorization number is faxed to provider with request for service.
- Service is provided; invoice is sent to CalOptima PACE.
- Invoice is checked against order, and payment is sent.

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Referral Process

- Once a prospective enrollee has been identified by you or your staff, you need to obtain participant's permission to refer to PACE. Once you receive permission, you can:
  - ➢ Ask the participant to call PACE
  - ➢ Call PACE with the participant in the room.
  - ➢ Use the referral form located in your handouts — or it can be sent to you electronically, filled out and then faxed to the number on the referral form.

Further Information

- CalOptima PACE Information
  - General Information
    - **714-468-1100**
  - Enrollment Coordinator
    - **714-468-1070**

- CalOptima PACE Center Hours
  - Monday–Friday, 8 a.m. to 4:30 p.m.

- PACE Information
  - www.caloptima.org

Questions

CCN Lunch and Learn Q & A

- Evaluation Form — Please complete and leave behind.

- In your packet, there is a form on which you can write any questions about anything that we have not addressed today.

- What questions do you still have?

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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