



CENTRAL HEALTH PLAN of California

CENTRAL HEALTH



E - NEWS
Summer 2008

**A provider newsletter published by
Central Health Plan of California**

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In this issue

Health Education.....1
 Encounter Data Submissions.....2
 Medicare Risk Adjustment.....3
 Advance Directive.....5
 Equal and Fair Values for Our Membership.....6
 2-1-1 Community Resource Line.....7
 Utilization Management.....8
 Quality Care and Service.....9
 Services for the Hearing Impaired.....9
 Pre-Service Authorization.....10
 Compliance.....11



Health Education

Central Health Plan of California (CHPC) hosted a series of Health Education Classes on Diabetes for our Medicare Members as part of CHPC’s Chronic Care Improvement, Quality Improvement, and Case Management Programs. This two-part course presented by Mrs. Claudia Ang, RN, CDE, explained the disease process, diet and exercise. Visual props were used to explain portion sizes of common foods eaten by the general public as well as the impact of fast foods. All participating Members received a free pedometer to encourage increased physical activity. Participating members were also given free glucometers and hands-on training with glucose blood measurements to reinforce how, why, and when to check blood glucose levels.

CHPC welcomes provider and member feedback and suggestions regarding Health Education Classes. CHPC would also like to invite network providers to present or speak at future Health Education Classes. An honorarium is paid to all guest provider speakers.

- Hypertension/Heart Health
- Chinese Alternative Medicine
- Diabetes
- Osteoporosis
- Arthritis

For more information on Health Education classes or to refer members for future Health Education classes, please contact Vanessa Lin, Event Coordinator at (626) 388-2390 ext 1821.

In addition to self-management and health education classes, CHPC also provides individualized case management for members with complex care issues including behavioral health comorbidities, socioeconomic limitations, and multiple comorbidities. For more information on CHPC’s Chronic Care Improvement, Quality Improvement, or Case Management Programs, or to refer members to any of these programs, please contact Robin Highfield, LVN, Quality Management Coordinator at (626) 388-2390 ext 3834.



Encounter Data Submissions

Do you want an increase in your capitation?

Interested in keeping your capitation rates competitive?

How willing are YOU to make a significant impact on increasing higher capitation rates?

In today's Medicare Advantage (MA) realm, the accuracy and timeliness of providers reporting encounter data to Independent Practice Associations (IPA) and health plans makes a significant impact on provider capitation reimbursement rates.

The precision and completeness in reporting valid patient diagnoses codes, known as International Classification of Diseases (ICD-9), determine the appropriate encounter-based risk adjustment.

As a general rule, ICD-9 coding under the "wastebasket category" must be avoided. Most ".9" or "Not Otherwise

Specified," codes are "wastebasket" codes. For example, ICD-9 code 403.9, "Hypertensive chronic kidney disease, unspecified," is a "wastebasket" code.

A valuable online coding tool, called Flash Code, is **FREE** and can make ICD-9 coding much easier by accessing its website at <http://www.icd9coding1.com/flashcode/home.jsp>.

Properly coding a definitive ICD-9 may result in an increased risk-adjusted payment. However, providers must have medical records and documentation supporting the specific coding to avoid improper abusive billing, or worse yet—fraud.

The table below provides general timeliness standards for encounter data submissions:

Encounter Data Submissions Timeline							
Entities	<u>YOU</u> Providers	⇒	IPA	⇒	HP	=	3 Month Process in Total
Submission Criteria		Providers submit to IPA within 60-Days	+	IPA submit to HP within 30-Days		=	

Remember, properly submitting encounter data in a timely manner can make a significant impact on increasing higher capitation rates for encounter-based risk adjustments.

References

Gorman, John K. "Medicare+Choice Risk Adjustment: Don't Leave Money on the Table. Analysis of Principal In-Patient Diagnostic Cost Group Methodology," Healthcare Financial Management, August 2001 Issue.



Medicare Risk Adjustment

The Centers for Medicare and Medicaid Services (CMS) establishes payments to Medicare Advantage (MA) health plans based on the health status of enrollees. This process, known as Risk Adjustment, directly affects payments to health plans and thereby impacts payments to medical groups and participating providers.

Risk scores are derived from the ICD-9-CM diagnostic codes that are reported to CMS. Only those codes with a significant cost implication to Medicare are considered “relevant” and grouped into 70 hierarchical condition categories (HCC). Each of these HCCs are designated with a potential risk score contribution value. If an enrollee is reported as having a relevant health condition, then that enrollee’s risk score can potentially increase by the corresponding value of the associated HCC. For example, if an enrollee is reported as having chronic lymphocytic leukemia without remission (ICD-9 204.10), then this enrollee’s overall risk score may

increase by 0.69 points, which is the corresponding value for HCC9—lymphatic, head & neck, brain, and other major cancers. Within certain parameters and restrictions, an enrollee’s risk score generally increases with the number of reported relevant health conditions.

Risk scores signify and predict the frequency and intensity of health care utilization, and CMS uses risk scores to evaluate and adjust the accuracy of health care payments. Risk scores essentially represent ratios of costs and payments in relation to that for the standardized Medicare beneficiary. For example, if the risk score for an enrollee is 1.69 after normalization, then the risk adjusted portion of Medicare costs and payments are 69% higher than that for the standardized Medicare beneficiary.

Data Submission

Risk adjustment is based on the health status of enrollees. As all diagnostic codes used for risk adjustment derive solely from claims and encounters

submitted by Medicare providers, Central Health Medicare Plan recommends that providers accurately and comprehensively report all diagnostic codes by:

- Selecting codes with highest degree of specificity by describing complications and severity whenever possible;
- Maintaining codes for well controlled chronic conditions that continue to affect medical management and decisions;
- Submitting all claims and encounters in a timely fashion; and
- Submitting all claims and encounters using the provider’s assigned National Provider Identification (NPI) number.

Federal law requires that all claims and encounters use exclusively the NPI to identify the health care provider after May 23, 2008. Providers may request an NPI number at no cost by visiting the website: <https://nppes.cms.hhs.gov>.

Data Validation

CMS conducts random and focused audits of medical record documentation to ensure the integrity and accuracy of Medicare payments. Claim and encounter codes are verified against provider notes and other documentation, and discrepancies are subject to repayment and other penalties. Central Health Medicare Plan recommends that providers implement sound documentation practices including:

- Clinically confirming all diagnoses suggested in radiology, laboratory, and pathology reports from physicians who may not have directly examined the patient and independently documenting diagnoses sug-

gested by ancillary providers who are not licensed in the practice of medicine;

- Documenting diagnoses to the highest degree of certainty and avoiding modifiers such as “rule out,” “probable,” “consistent with,” or “working diagnosis” whenever actual diagnoses are known or definitive treatment has been prescribed;
- Documenting all persistent conditions and avoiding descriptors such as “history of” when the condition is contemporary;

Valid medical documentation must be legible, identify the patient, identify the date of the visit, and signed by a provider licensed to practice medicine.

Summary

Central Health Medicare Plan strongly encourages all participating providers to become knowledgeable of Risk Adjustment concepts and to participate fully in the process.

Some providers are already gaining first-hand experience as medical groups have begun to institute incentive programs based on risk adjustment. We understand that our providers commit tremendous time and resources in caring for Medicare beneficiaries, and we fully support efforts to ensure that our valued providers are remunerated for sustaining the high quality of care and attention given to our members.

Medicare Risk Adjustment Activities

Central Health Medicare Plan (CHMP) will soon embark upon a comprehensive effort to improve Risk Adjustment reporting and calculations. The goal of this effort is to capture all significant diagnoses for members, to improve the accuracy of Risk Adjustment, and to sustain competitive Medicare payments to providers.

Essential to success is provider collaboration. Beginning July 2008, providers will receive

requests for medical records of members with dates of service during 2007 and 2008. The requests will provide specific details on which records to retrieve and how to submit these records to CHMP. CHMP greatly appreciates your prompt attention to medical record requests.

CHMP will extract and report all significant diagnoses contained within these medical records to the Centers for Medicare and Medicaid Services (CMS) for

Risk Adjustment. CHMP looks forward to our collaborative efforts to sustain competitive Medicare reimbursement.





Advance Directive

Members often turn to trusted health care providers like you for help with planning for and coping with serious illness and unexpected changes in health status. CHMP would like to reinforce the option for members to establish an Advance Directive. Also referred to as a “Living Will,” an Advance Directive addresses decisions for medical care under possible future circumstances. A selected person or persons will be authorized by the Advance Directive to make important medical decisions in the event the member becomes temporarily or even permanently disabled.

Advance Directives help ensure dignified treatment through good and poor health, including when there is no indication of medical recovery or when the member cannot direct his or her own care. It can express how much or how little medical care should be provided according to the member’s specific wishes. Member’s can specify preferences for health care decision making, life-support treatment, artificial feeding, pain control, and organ donation.

Although these forms are entirely optional, in the absence of an Advance Directive the member may receive medical care that conflicts with his or her wishes. In the absence of written wishes, health care professionals will likely seek family members for guidance in making health care decisions, which may be influenced by family hardship, guilt, and personal beliefs. Health care professionals are in a more arduous ethical and legal situation when family and friends express conflicting wishes.

Although a sensitive matter for discussion, preparation can save a lot of heartache in the future. When unprepared, family members may not know if they are making the right decision for the member. By having an Advance Directive in place, families can take comfort in knowing they are making choices according to their loved one’s wishes.

For more information on preparing an Advance Directive, please contact CHMP’s Health Education Department at (626) 388-2390, ext. 3834.

Equal and Fair Values for Our Membership

Established laws make it illegal to discriminate against an individual because of birthplace, ancestry, culture, or linguistic characteristics.

Central Health Plan of California (CHPC) will make all reasonable provisions to ensure that members are not discriminated in the delivery of health care services because of age, race, ethnicity, national origin, religion, sex, mental or physical disability, sexual orientation, genetic traits, or source of payment.

As per Title VI of the Civil Rights Act, CHPC will adhere to the following standards relating to non-discrimination of members. CHPC:

- Will not treat a member in a different manner or provide service or benefits at a different place or time from that which is provided to other members
- Will not deny members any covered service, benefit, or availability of a facility on the basis of age, race, color, creed, sex, handicap, or national origin
- Will not subject a member to segregation or separate treatment on the basis of age, race, color, creed, sex, handicap, or national origin
- Will not restrict a member from having the same advantages or privileges enjoyed by others receiving the same covered services or benefits
- Will not treat a member differently from others when determining whether he/she satisfies any admission, enrollment, eligibility, membership, or other requirements or conditions that all individuals must meet in order to receive any services or benefits

CHPC takes any member concerns regarding the subject of discrimination seriously and will make all efforts to investigate and resolve the situation as soon as possible. All member grievances alleging discrimination shall be submitted through the grievance process to the Member Service Department.

Further references to anti-discrimination laws include:

- Medicare Managed Care Manual, Chapter 4, Section 100
- Title VI of the Civil Rights Act of 1964, 42 U.S. C. section 2000c
- Age Discrimination Act of 1975
- Americans with Disability Act
- Rehabilitation Act of 1973



2-1-1 Community Resource Line

Dial 2-1-1 for free, 24-hour community, health and social services information. Like 9-1-1 for emergency service, 2-1-1 has been set aside by the Federal Communications Commission for the public to easily access community information.

2-1-1 is a toll-free phone number that provides information and referrals for health and social services in the local community.

2-1-1 is free and confidential, and a live, bilingual call specialist assists callers 24 hours a day. Hundreds of community services are available by simply dialing 2-1-1 (or 888-435-7565).

It is a one-stop source of information for people who don't know where to start when they need essential health and human services, from drug treatment to care for a child or aging parent.

The 2-1-1 Operator will transfer the caller to the appropriate agency or provide the necessary contact telephone numbers.

2-1-1 is for everyone providing a multitude of community service resource such as:

- **Adult children seeking services for elderly parents**
- **People who want to donate time, money, or goods to a nonprofit organization**
- **Laid-off workers struggling to feed their families**
- **Disaster victims seeking loved ones, housing, food, counseling**
- **Substance abuse hotlines and resources**
- **Shelters for abused victims**
- **Teachers, clergy, and agency staff seeking help for their clients**



Utilization Management

Central Health Plan of California (CHPC) Utilization Management Program is developed to monitor, evaluate, and manage the quality and cost of health care services provided to our members. It is designed to coordinate medically appropriate services and achieve optimal clinical outcomes for members in the most effective manner.

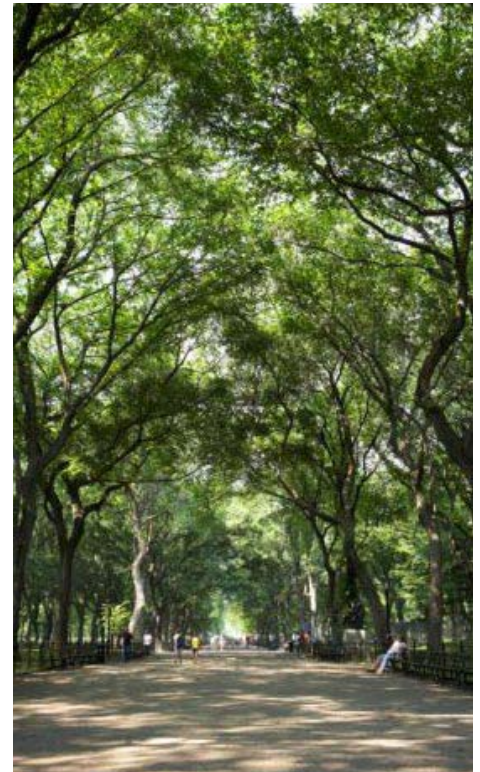
The Utilization Management (UM) Committee is the oversight body for all UM activities and is chaired by the Medical Director with a minimum voting quorum of at least three physicians with unrestricted licenses to practice medicine. The CHPC UM Committee has adopted decision-making resources which include, but are not limited to, the following:

- Milliman Care Guidelines
- Medical Review Criteria Guidelines For Managed Care (Apollo)
- The Merck Manual of Diagnosis and Therapy
- Specialty Society Publications and Guidelines

- National Guideline Clearinghouse (www.guideline.gov) guidelines
- DSM IV Guidelines for Behavioral Health
- CMS Medicare Coverage Determination, Benefit, and Claims manuals
- Central Health Medicare Plan's Evidence of Coverage (EOC) and Internal Guidelines

Independent Practice Associations (IPA) and Capitated Medical Groups (CMG) may use these or other resources for the UM activities for which they have delegated responsibility. Please contact your IPA for additional information.

All UM decisions are based on factors such as medical necessity, appropriateness of services, and existence of coverage. CHPC does not provide financial incentives to staff and/or clinical decision-makers to encourage decisions that result in underutilization. Practitioners and/or other individuals are not specifically rewarded for issuing denials of coverage, service, or care.



Members and providers may contact the UM Department for more information and copies of our UM Program, decision-making criteria, and benefit information. Utilization Management staff are available during normal business hours at (626) 388-2390 to address any routine questions or concerns. Case managers are available after-hours for emergency and inpatient care issues.

CHPC fosters a collaborative partnership with providers to help maintain the highest quality of care for our membership and the greatest satisfaction within our network.

Quality Care and Service

Central Health Medicare Plan (CHMP) is dedicated to ensuring our members receive timely and appropriate services from our providers. To make this happen, CHMP has a written Quality Management Program designed to maintain and improve the quality of care and services. The document explains the program along with planned projects for the year. The written description of the Quality Management Program or aspects of the program is available to physicians and members upon their request.

On a yearly basis, CHMP reviews and updates Preventive Health

Guidelines for prevention and early detection of diseases and illnesses. Preventive Health Guidelines are chosen for our membership and are specific to age, sex, and risk-status of members and cover the following categories:

- **Cardiovascular Screenings**
- **Screening Mammograms**
- **Pap Test & Pelvic Exam**
- **Smoking Cessation**
- **Colorectal Cancer Screening**
- **Flu Shots**
- **Prostate Cancer Screening**
- **Pneumococcal Shot**
- **Hepatitis B Shots**

- **Bone Mass Measurements**
- **Diabetes Screenings**
- **Glaucoma Tests**

Each guideline describes the prevention or early screening exams, and how often the exams are required. These guidelines are taken directly from the Center for Medicare (CMS) website. They were developed in conjunction with American Cancer Society, American Diabetes Association, and American Heart Association. To obtain a copy of the guidelines, just call our Member Service Department at 1-866-314-2427 or view the Medicare website at <http://www.medicare.gov> under Preventive Services.

Services for the Hearing Impaired

The California Relay system is a state wide program to provide services for the hearing impaired. It will allow a hearing impaired (deaf or hard of hearing) member who utilizes a TTY telephone device to communicate with the provider. The California Relay system is a third party caller who serves as a translator between the provider and the member. The provider simply dials 711, give the Relay Operator the member's phone number, who will then call the member. The Operator will type the provider's conversation to the member and read to the provider what the member is typing.

The service is free of charge except for long distance charges outside of California. Additional information about hearing impaired services can be obtained from the Customer Service Department.

California Relay

For communication between hearing, deaf, hard-of-hearing and speech-impaired persons: available 24 hours a day.

Relay: 711

TTY: 1-800-735-2929

Spanish TTY: 1-800-855-3000

Customer Service: 1-800-735-0373



Pre-Service Authorization

Primary Care Physicians (PCP) play a crucial role in coordinating all of the health care services required by enrollees. Services that are beyond the scope and expertise of PCPs may require pre-authorization from the enrollee's Independent Practice Association (IPA) or from Central Health Medicare Plan (CHMP). Providers who identify need for specialty services and testing should submit requests for authorization to the IPA, if applicable. Behavioral Health and Part D Pharmacy services can be requested directly from CHMP.

Organization Determinations

CHMP and its delegated IPAs review authorization requests and issue organization determinations based on established timeliness requirements. The following are Medicare notification requirements for initial requests of outpatient medical services:

Type of Request

Standard Initial Organization Determination (Pre-Service)

Notification Timeframe

Within 14 calendar days after receipt of request

Type of Request

Expedited Initial Organization Determination

Notification Timeframe

Within 72 hours after receipt of request

Delegated IPAs are required to factor in the time it takes to coordinate applicable organization determinations with CHMP to ensure that notifications are provided within timeframe.

Behavioral Health

CHMP provides Medicare covered behavioral health services. CHMP does not delegate utilization management for behavioral health services, and providers can submit requests for mental health care and substance abuse services directly to CHMP instead of the IPA. Forms and instructions are available by calling (626) 388-2390, faxing (626) 388-2363, or visiting the website at <http://www.centralhealthplan.com>.

Part D Pharmacy

CHMP is pleased to cover all enrollees with Medicare Part D Prescription Drug benefits. CHMP has eliminated Step Therapy and Prior Authorization requirements for a significant number of previously restricted drugs. Providers will find that most outpatient drugs commonly prescribed to Medicare beneficiaries are on the CHMP formulary without any utilization management restrictions.

Occasionally, prescribers will be required to submit a supporting statement for drugs that are otherwise not available on the Part D formulary. The timeframe for notification of standard Part D coverage determinations is within 72 hours of receipt.

CHMP does not delegate coverage determinations for Part D Pharmacy benefits, and providers should submit requests directly to CHMP. Forms and instructions are available by calling (626) 388-2390, faxing (626) 388-2363, or visiting the website at <http://www.centralhealthplan.com>.

Compliance Department

In our last provider newsletter, we learned about Central Health Plan of California's (CHPC) commitment to reducing the risk of health care fraud and abuse. To fulfill this commitment, CHPC has developed and implemented a comprehensive anti-fraud policy, with the following four key components:

- Anti-fraud education for employees and contracted providers, including applicable laws and the importance of detection and reporting;
- Oversight and monitoring processes to detect potential fraud on the part of the Plan, its employees, contracted providers, and members;
- Prompt investigation of all instances of suspected fraud and, as necessary, reporting suspected fraud to the appropriate government or law enforcement agencies;
- Corrective Action to mitigate damage and reduce or elimi-

nate the chance of recurrence if actual fraud is confirmed.

As part of our anti-fraud education series, here is some additional information for providers to know:

I. Who's policing corporate compliance, and what are they looking for?

As more government agents and government-hired contractors are on the lookout for provider noncompliance than ever before, it is important to know who the major enforcers of healthcare corporate compliance are:

- **The Department of Health and Human Services' Office of Inspector General** (DHHS' OIG) represents DHHS' enforcement operations. OIG representatives investigate suspicions of healthcare fraud and abuse and negotiate corporate integrity agreements. In addition, the agency provides compliance education and guidance to the industry.



The **Department of Justice** prosecutes healthcare organizations for healthcare fraud and abuse. Most of these cases are negotiated and settled by healthcare organizations.

- The **Federal Bureau of Investigation** (FBI) assists the Department of Justice by investigating suspected healthcare fraud. The FBI's healthcare fraud unit continues to grow and is funded under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The **Centers for Medicare & Medicaid Services** is recognized primarily for its rulemaking authority. However, because it is responsible for Medicare under its integrity program, it has contracted private organizations to review Medicare claims. These contractors look for abnormalities that might result in increased reimbursement.
- **State Medicaid fraud units** use the techniques devised by the federal agencies to spot possible fraud and abuse in state programs.

- The **Office of Civil Rights** oversees violations of the patient privacy rules within HIPAA.
- The **Medicaid Integrity Program** (MIP) is mandated by the Deficit Reduction Act of 2005. The program will be staffed with federal agents to lead national Medicaid fraud enforcement. Plans call for the MIP to become a \$75-million-per-year operation by fiscal year 2009.



II. What do government agents look for?

Government agencies, along with fiscal intermediaries and carriers, are on the lookout for billing practices that could constitute fraudulent or abusive billing practices. In the case of a health care provider, **abuse** is a pattern of practice that is inconsistent with sound fiscal, business or health service practices. Abuse results in unnecessary increased costs to CHPC or in reimbursement for services or products not medically necessary. **Fraud** can include making material false statements or representations to CHPC or other health care programs to obtain some benefit to which one is not entitled.

The following practices by a provider may be deemed to be abusive/fraudulent:

- Billing for noncovered services, supplies, or both
- Billing for services without necessary documentation
- Duplicate billing for a single service
- Misrepresentation of facts on the claim, such as services rendered and dates of services or charges
- Failing to return overpayments in a timely manner to the appropriate fiscal intermediary
- Unbundling laboratory services to receive higher reimbursement
- Billing for medically unnecessary services
- Repeatedly submitting claims using procedure codes that overstate the level or amount of health service provided
- Repeatedly submitting claims for health services that are not reimbursable by CHPC
- Failing to disclose or make available to CHPC a member's health record or a provider's financial records as defined in the provider contract
- Failing to keep financial records for the services provided to CHPC members as required by federal and state law
- Repeatedly submitting or causing submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification or a second medical opinion
- Submitting a false or fraudulent application for provider status
- Soliciting, charging or receiving payments from CHPC members, in violation of the provider agreement with CHPC
- Repeatedly billing CHPC for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability
- Obtaining remuneration in return for the provision of health care services in violation of the Stark Law (42 U.S.C., sect. 1395nn) or the Anti-kickback Statute (42 U.S.C., sect. 1320a-7b(b))



III. Why is it important to be in compliance?

Risks of noncompliance

When you are faced with an instance of noncompliance on the job, consider the risk posed to your workplace. Organizations suspected of fraud or abuse must deal with government audits, reviews, and interviews of employees. These investigations can usually result in:

- hefty legal expenses for the provider
- mandated government compliance programs
- exclusion from government healthcare payment programs (e.g., Medicare and Medicaid)
- the potential for a costly civil monetary settlement
- possible criminal prosecution and incarceration for intentional and egregious acts.

- negative public perception
- a general disruption of operations

Committing an act of non-compliance may take only a few minutes, but the consequences could mean years of repayments and enforcement actions for your organization. Take the time and take the care you need to meet compliance regulations.

How do you report noncompliance?

Participating providers should notify CHPC of any situations where provider billing fraud/abuse may have occurred, or where members have engaged in fraudulent or abusive activity. Examples of the former include billing for services not rendered, upcoding or unbundling. Member abuse includes falsification of enrollment information, altering

or fabricating claims, or prescription drug forgery.

The contact information is:

CHPC Compliance Officer

**1051 Park View Drive
Ste. 120**

Covina, CA 91724

Phone: (626) 388-2390

Email: compliance@centralhealthplan.com

To report anonymously, please mail unsigned letter to CHPC's Compliance Officer. If you choose to report anonymously, consider that one disadvantage of this method is that you may never find out how the matter is resolved. CHPC's antiretaliation policy prohibits retaliation for reporting a good-faith complaint.

