Questions/Suggestions and Meeting Evaluation Forms

• **Questions/Suggestions Form** submit to GCHP staff. To be addressed during the meeting.

• **Meeting Evaluation Form** please complete and turn in at the end of the meeting or email to: ProviderRelations@goldchp.org.
Your question:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Your Name (optional)
________________________________________________________________________

Provider Office
________________________________________________________________________

Specialty
________________________________________________________________________
Your feedback is very important to the Gold Coast Health Plan Team. Every evaluation form is read through and used in order to continuously improve presentations. Please complete this evaluation and place in the “Evaluation Forms” collection box available at the meeting site.

1. Please rate your overall satisfaction with this meeting was high.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

2. Speakers were knowledgeable about the subject matter.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

3. The overall quality of the presentation was high.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

4. The quality of the slides and/or audio was good.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

5. The meeting met my expectations.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

6. The meeting subject and degree of detail was appropriate for the time allotted.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

7. The speaker(s) adequately answered questions and provided clarification when necessary.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Meeting Date _________________________   Attendee ___________________________  
Name and Provider’s Office (Optional)  
I have more questions. Please have a Provider Relations Representative contact me.  
Email  
Phone
Today's Agenda

- Description of Gold Coast Health Plan
- Intro to GCHP Website and Provider Portal
- Health Services Overview
- Long-Term Care Overview
- Referral and Authorization Overview
- UM/CM Overview
- Pharmacy Overview
- Claims Overview
- Provider Services Overview
- Questions and Answers
County Organized Health System

- Established by the County Board of Supervisors
- Governed by an independent Commission
- Serves entire Med-Cal population in a region
- Enrolls all Medi-Cal beneficiaries including Seniors and Persons with disabilities (SPD)
Mission Statement

“Improve the health of our Members through the provision of the best possible quality health care and services.”
Website

www.goldcoasthealthplan.org

• For Providers and Members
• Provider Directories
• Provider Manual
• Link to Provider Portal
• Health Education (info to be posted by 7/1)
• Drug formulary (to be posted prior to 7/1)
• Printable, Current Forms
• Links to Health Care Agencies
Provider Portal

Register for provider access to the Provider Portal at: www.goldcoasthealthplan.org

• Permissions will be maintained by providers
• Ability to check eligibility
• Submit prior authorizations to the Plan
• Claims look up function
• Track services Members are using
Health Services
Department

Pam Kapustay, RN  Director, Health Services  805-981-5327  pkapustay@goldchp.org
Melanie Frampton, RN  Manager, Care Coordination  805-981-5329  mframpton@goldchp.org

Utilization/Case Management Team
Dee Johnston, RN
Diana Lewis, RN
Judy Delp, RN
Kathy Price, RN
Long-Term Care (LTC) Definitions

• LTC = longer than the month of admission + 1 month
• Skilled Nursing Facilities (SNF): require skilled nursing care on an extended basis
• Subacute Facilities: very intensive skilled nursing care for fragile medical conditions (ventilator dependent)
• Intermediate Care Facilities (ICF): less intensive than skilled nursing care
Referral & Authorization

- Physician/Facility submits the request for authorization to GCHP UM with:
  - Completed pre-admission screening (PAS)
  - Minimum Data Set (MDS) and relevant clinical information to support the medical necessity for the LOC requested
  - Medicare or other insurance denial, if applicable
Instructions: Preauthorization is required for all elective inpatient hospitalizations and for most procedures and services. Please check your Provider Manual for a listing or call 888-301-1228 for benefit coverage requirements. Note the preauthorization options include the following:

Electronic Requests: www.goldcoasthealthplan.org
Verbal Requests: Call center (888) 301-1228
Written Requests: Gold Coast Health Plan, P. O. Box 9153, Oxnard, CA 93031.
You may also fax to 888-310-3660.

For Out of Network Referrals, please fill out the bottom of this form and attach the Direct Referral Authorization Form.

MEMBER INFORMATION:
Member Name: ____________________________
Date of Birth: ____________________________
Primary Address: __________________________
City: ____________________________
Primary Phone: ____________________________
State: ____________________________
Other insurance coverage: ____________________________
Secondary Phone: ____________________________

PROVIDER INFORMATION:
Provider Name: ____________________________
Provider #: ____________________________
Tax ID #: ____________________________
Provider Office Address: ____________________________
City: ____________________________
Office Phone: ____________________________
State: ____________________________
Person completing form: ____________________________
Zip Code: ____________________________
Phone: ____________________________
Fax: ____________________________

SERVICE/PROCEDURE REQUEST INFORMATION:
Member’s Diagnosis: ____________________________
Date of procedure / service: ____________________________
Location for service: □INPT □Outpatient Surgery □SNF □In-Home □Other
Name of procedure/service: ____________________________
ICD 9 Code: ____________________________
CPT/ HCPCS Code: ____________________________
Quantity: ____________________________
Duration: ____________________________
Estimated In-Pt Length of stay: ____________________________

HISTORY/ MEDICAL JUSTIFICATION FOR REQUEST:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Preauthorization Treatment Request Form
Authorization for Services

A LTC authorization is required when the member:

- Is a new admission to the facility
- Has exhausted his/her Medicare benefits
- Medicare or other insurance denies LTC
- Is readmitted to LTC from acute care after day 7 of “bed-hold days”
- Returns to LTC from approved LOA beyond the approved return date
- Is newly eligible with GCHP while residing in LTC
- Changes LOC (ICF to SNF, SNF to ICF, etc)
## Authorizations Required

| Elective Inpatient Hospitalizations | Acute Care and for Acute Rehabilitation:  
|                                  | All elective inpatient admissions must be requested minimally five (5) business days prior to planned procedure / hospital inpatient admission. Please use the Preauthorization Treatment Request Form and provide sufficient clinical information and other relevant information so that there are no delays in obtaining authorization.  
|                                  | Emergency inpatient admission requires notification (not prior authorization). Notification must be provided within 24 hours of admission but no later than the first business day following admission. Hospitals are required to notify Gold Coast Health Plan by submitting an "Inpatient Notification Authorization Request" form or faxing the Inpatient Face Sheet to the above fax number. |
| Surgeries                         | Ambulatory: All outpatient surgical procedures at surgical-centers require prior authorization for payment.  
|                                  | Office: Surgeries considered cosmetic in nature and procedures that require greater than $300 in charges including surgical tray and supplies. |
| Long Term Care                    | All planned admissions to Skilled Nursing Facilities and sub-acute care require prior authorization for payment. |
| Home Health Care                  | For the first three visits following a hospital discharge, only the completion of a Direct Referral Authorization Form is required. After 3 visits a Preauthorization Treatment Request Form is required with relevant information to justify additional visits with treatment plan. |
| Outpatient Diagnostic Studies     | MRI, CT Scan, PET Scan, Nuclear Medicine Imaging, Transcranial Doppler, Sleep Studies/Polysonomnography, Lab Testing billed over $100. |
| Renal, Hemodialysis & Peritoneal Dialysis | Initial authorization is limited to 90 days and extensions will be granted only after receipt of Medicare determination. If not eligible for Medicare = FFS. |
| Phototherapy                      | For dermatological condition |
| DME                               | All equipment, hearing aids, etc. Purchase = >$500; Rental = >$200 |
| Supplies                          | Ostomy, incontinence, all other medical supplies will be authorized only upon physician justification for medical necessity >$200 limit |
| Others                            | Abortion  
|                                  | Cochlear Implant  
|                                  | Dental Anesthesia for children under 21 years of age only. No coverage for dentist.  
|                                  | Drugs / Pharmaceuticals: Contact ScriptCare  
|                                  | EPSDT – Early/Periodic Screening, Diagnosis & Treatment Supplemental Services for children under 21 years of age only. Identify & refer to qualifying agency.  
|                                  | Home Infusion Therapy/TPN/Enteral Feeding  
|                                  | Hyperbaric Oxygen Pressurization  
|                                  | Non-Emergency Transportation based on setting  
|                                  | Nutritional Services including enteral feeding  
|                                  | Pain Management Epidural Injections  
|                                  | Phototherapy  
|                                  | Physical, Occupational, Rehabilitation and Speech Therapies. Medi-reservation = 3 visits/month (no authorization).  
|                                  | Podiatric Office Procedures (limit $300 plus supplies)  
|                                  | Prosthetics and Orthotics (billed charges) |

**NOTE:** All CCS Eligible Conditions are to be immediately referred to CCS. Any questions, please call Gold Coast Health Plan at 1-888-301-1228.
UM/CM Review

• UM Coordinator reviews request for medical necessity and LOC

• Approved:
  – Initial admission: 6-month maximum
  – Re-authorization: 1-year maximum

• Deferred: to Chief Medical Director for determination of medical necessity
Timeframes & Guidelines

Routine Requests

• Determination usually made within 5 business days but *no longer* than 14 business days

• Decisions are faxed within 1 business day of the decision being made

Expedited/Urgent Requests

• Call or fax request to Health Services Dept.

• Reviewed within 72 hours (3 days) after receipt
LTC Aid Codes

- From acute care to permanent SNF
- Aid Code Changed
  - Facility social worker
  - Family
Pharmacy Benefits

• **ScriptCare** is the Pharmacy Benefits Manager (PBM) for Gold Coast Health Plan

• The PBM contracts with Plan pharmacies

• The PBM processes pharmacy claims

• The PBM helps the Plan set Rx policy

• The Plan Formulary will be posted to the website at: [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)
Part D

Dual-Eligibles Prior to Donut Hole

Pharmacy submits Rx Claim to Medicare

- Medicare Accepts
  - Medicare pays as primary payor
    - Rx Covered by Medicaid as secondary payor for Medicare deductible, coinsurance or co-payment
      - Member subject to $0 copay

- Medicare Declines
  - Medicaid covers medication at 100%
    - Member subject to $0 copay
Other Coverage

- **GCHP is payer of last resort**
- **Blue Cross, Kaiser or any other health plan is always primary carrier; Medi-Cal never is primary**
- **Medi-Medi (Medicare/Medi-Cal “dual coverage”)**
  - Medicare Part A & B – can see any willing provider; Member not required to choose PCP
  - Medicare Part A (hospital care only) – can see any willing Medi-Cal provider, not required to choose PCP
  - Medicare Part D (Rx only) – required to choose a PCP, most drugs covered by Medicare
Claims Submission

- Electronic Claims (EDI):
  Enrollment to be available on 6/14/2011 at [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org) or telephone support @ 800-952-0495
- Paper Claims:
  Gold Coast Health Plan
  ATTN: CLAIMS
  PO BOX 9152
  Oxnard, CA. 93031
- Continue to code (CMS1500/UB04) and bill the same way
Claim Payment

- Required to pay within 30 days from the receipt of a clean claim
- Paid once per week
- Child Health & Disability Prevention Program (CHDP) claims to GCHP with the PM 160 form
- The Comprehensive Perinatal Services Program (CPSP) claims to GCHP
Claim Status

- Research 45 days after submission
- Telephone – 888-301-1228
- Portal – [www.goldcoasthealthplan.org](http://www.goldcoasthealthplan.org)
- Mail – Use paper claims billing address
Adjustments and Disputes

- **Dispute Resolution Request Form**
- **Written dispute indicating reason for filing**
- **Request must be made within 365 days of action**
- **Gold Coast Health Plan**
  **ATTN: Provider Relations Department**
  **PO BOX 9176**
  **Oxnard, CA. 93031**
- **Written response within 30 days**
PROVIDER DISPUTE Resolution REQUEST

INSTRUCTIONS
- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- Mail the completed form to: Gold Coast Health Plan/Provider Grievances
  P O. Box 979
  Oxnard CA 93031

*PROVIDER NPI: __________________________  PROVIDER TAX ID: __________________________
*PROVIDER NAME: __________________________
PROVIDER ADDRESS: __________________________

PROVIDER TYPE  MD  Mental Health Professional  Mental Health Institutional  Hospital  ASC
  SNF  DME  Rehab  Home Health  Ambulance  Other  (please specify type of "LIKE")

CLAIM INFORMATION  Single  Multiple "LIKE" Claims (complete attached spreadsheet)  Number of claims __________

* Patient Information  Date of Birth: __________________________

* Health Plan ID Number: __________________________  Patient Account Number: __________________________  Original Claim ID Number: __________________________

Service "From-To" Date: (Required for Claim, Billing, and Reimbursement Of Overpayment Disputes) __________________________

Original Claim Amount Billed: __________________________  Original Claim Amount Paid: __________________________

DISPUTE TYPE
- Claim
- Appeal of Medical Necessity / Utilization Management Dismissed
- Disputing Request for Reimbursement Of Overpayment

- Seeking Resolution Of A Billing Determination
- Continued Dispute
- Other: __________________________

* DETAILED EXPLANATION OF REASON FOR DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print): __________________________

Title: __________________________

Phone Number: __________________________

Signature: __________________________

Date: __________________________

Fax Number: __________________________

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)

ICIE Approved 10/6/07, effective 1/1/08

TRACKING NUMBER: __________________________  PROVID ID: __________________________

CONTRACTED ______  NON-CONTRACTED ______

For Health Plan Use Only:
Reasons for Disputes

- Authorization was not obtained
- Authorization does not cover services rendered
- Claim denied due to untimely filing
- Underpayment/overpayment for services
- Denial due to availability of other coverage
Provider Relations Department

- Paul Roberts, Director Provider Relations & Contracting
  805-981-5321, proberts@goldchp.org

- Michelle Reyes, Provider Relations Representative
  805-981-5342, mtarver@goldchp.org

- Rebecca Wright, Provider Relations Representative
  805-981-5343, rwright@goldchp.org

- Lezli Stroh, Provider Relations Administrator
  805-981-5339, lstroh@goldchp.org