Gold Coast Health Plan
A Public Entity

Memo

To: Providers of Gold Coast Health Plan

From: Rebecca Wright

Date: August 16, 2012

Re: Provider Operations Bulletin

Dear Provider:

The attached Provider Operations Bulletins ("POB") will give you useful information about working with Gold Coast Health Plan. In each POB we will give you information as well as keep you abreast of any changes we have made. Among other things, this publication provides clarification of CHDP capitated services and the updated list of services requiring prior authorization.

We also hope you are utilizing our website so that you will know more about what is happening at Gold Coast Health Plan. Over the last year we have been working to make our website even more user friendly, please take the time to visit the site on a regular basis. We welcome any suggestions you may have that may assist you in accessing information throughout the site.

It is the goal of the Provider Relations Department to help ensure that all Gold Coast Health Plan providers receive the highest level of attention. We hope you will find the POB helpful. Please feel free to contact us via email at providerrelations@goldchp.org or by phone at 1-888-301-1228 with your comments and your ideas for topics you'd like to see covered in future publications. Your contributions are very much appreciated.

Sincerely,
Rebecca Wright
Provider Relations Manager

2220 East Gonzales Road, Suite 200, Oxnard, CA 93036 Member Services: 888-301-1228 Fax: 805-981-5314

Provider Operations Bulletin

From Gold Coast Health Plan

EDITION: POB-001 AUGUST, 2012

This is the first of our Provider Operations Bulletins. The purpose of these bulletins is to assist you and your office staff in understanding some of the operational processes that Gold Coast Health Plan has in place. We hope these bulletins prove useful and would greatly appreciate feedback from you. We want to provide you with all the information you need to make your relationship with Gold Coast collaborative in all respects. If there are topics you feel you would like us to include in these bulletins, please contact the Provider Services department at providerrelations@goldchp.org.

CONTENTS

SECTION 1: MEMBERS WITH BREAST AND CERVICAL CANCER TREATMENT PLAN (BCCTP) BENEFITS

We want to clarify the level of coverage for some of our members with BCCTP aide codes. The following aide codes provide the member with BCCTP coverage and full scope Medi-Cal coverage – OW, ON, OP, and OM. While the Gold Coast Membership card may designate them as Administrative Members, please note that they do have FULL coverage under Medi-Cal for all services not related to their breast or cervical cancer diagnosis.

SECTION 2: RETROSPECTIVE MEMBER ENROLLMENT TO GOLD COAST HEALTH PLAN

Beginning July 1, 2012, the State of California will not be retro-enrolling Medi-Cal members back to Gold Coast Health Plan. Members who qualify for Medi-Cal services but are not assigned to Gold Coast will continue to be covered through the State Fee for Service program. Providers are asked to bill the State for these members. Eligibility under Fee for Service will begin on the day the member is approved for benefits and will roll forward only. (Ex: The member is eligible for services as of July 17, 2012 – services will be covered under Fee for Service from July 17-July 31, 2012. Providers who have rendered services prior to July 17 will need to submit an appeal to the State to seek

reimbursement for those services.)

SECTION 3: CLARIFICATION OF PODIATRY BENEFITS

The State of California policy places restrictions on the podiatry benefit. The following categories only will be covered:

- Pregnant women – if the podiatry care is related to and affects the member's current pregnancy.
- Children under 21 years of age with full scope Medi-Cal.
- Members who live in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
- Members who are developmentally disabled and live in an ICF or Sub-acute facility.

SECTION 4: NOTIFICATION OF HOSPITAL ADMISSIONS

Gold Coast Health Plan requires that ALL elective hospitalizations be pre-authorized. In addition, notification by the hospital of all admissions is required to be made within 24 hours or the next business day. For emergency admissions, no authorization is required but notification of the admission is required according to authorization guidelines. All inpatients days will be reviewed for medical appropriateness.

SECTION 5: PRE-AUTHORIZATION LIST

The attached list is the current list of services that require authorization. Claims for services rendered will be denied if pre-authorization is required and not obtained. (See attached)

SECTION 6: CHDP - IMPORTANT

This attached bulletin provides clarification of all the services that are included in the Primary Care Provider Capitation Rate. In addition, Gold Coast Health Plan is making a change to the way CHDP services are to be billed to the Health Plan. Please read this document carefully. If you have any questions, please contact provider services at 1-888-301-1228. (See attached)

SECTION 7: NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

Non-emergency medical transportation is a MediCal benefit that is indicated when a member's physical condition is such that transportation by ordinary means is medically contraindicated. Members who are wheelchair bound or are in active treatment at a dialysis center can utilize Gold Coast Health Plan's transportation providers. MediCal does not cover NEMT for services that are not a covered benefit. This includes podiatry, adult dental services, psychology services and acupuncture. Members should exhaust all private and public conveyances prior to asking the rendering provider for transportation. Authorization is required for NEMT. Providers will be requested to provide justification of medical necessity for NEMT and should ensure the member has NO other means of transportation.

SECTION 8: UNLISTED CODES

Gold Coast Health Plan is requesting that providers NOT bill with unlisted codes. Claims that are submitted with these codes will be returned for correction. Unlisted codes do not have pricing and create problems for our claims area in paying accurately and timely.

SECTION 9: GLUCOMETER CLARIFICATION

Please be aware that Gold Coast Health Plan Members should be using the glucometer that uses the "true results" test strips. The glucometer that uses the "true tracks" testing strips is old technology. Members who have the "old technology" should go to their pharmacy and they will get a new glucometer.

SECTION 10: ENTERAL NUTRITION

Effective October 1, 2011 revisions were made to the Medi-Cal enteral nutrition product benefit. The new regulation limits the enteral nutrition product benefit to those products administered through a gastric, nasogastric or jejunostomy feeding tube for adults 21 years of age or older. Exceptions are made for products consumed orally for inborn errors of metabolism and those consumed for intestinal malabsorption diagnoses. Members under 21 years of age are exempt from the enteral nutrition product benefit tube feeding limitation. All formula requests must be accompanied by a prescription from a licensed provider. Medical necessity criteria must be met for requests to be approved.

Members eligible for WIC should be referred to the Ventura County WIC office for services. WIC will provide the following formulas in specific quantities.

- Enfamil LIPIL w/iron (milk-based
- Enfamil Lacto Free LIPIL (milk-based)
- Enfamil Gentlease LIPIL (milk-based)
- Enfamil AR LIPIL (mild-based)
- Enfamil ProSobee LIPIL (soy-based)

SECTION 11: CULTURAL AND LINGUISTIC SERVICES

Gold Coast Health Plan is committed to meeting the cultural and linguistic needs of our members.

If you are a network provider and need interpreter services please have the Member ID available when you call:

- Telephonic Interpreter : 1-866-421-3463 (Access Code: 843014)
- American Sign Language: 1-888-301-1228

Members who need help getting an interpreter or understanding something we send them in writing, please call Member Services:

- 1-888-301-1228 (English and Spanish)

Members who are deaf and/or hard or hearing and need assistance, please call Member Services:

- 1-888-310-7347 / TTY Line

Face-to-face interpreter services require advance notice and prior authorization. Please call Health Education Services for assistance:

- 1-805-981-5367

SERVICES REQUIRING PRIOR AUTHORIZATION

SERVICE	EXPLANATION
All Hospital Admissions (All Place of service 21 services require authorization.)	Elective Admission- All hospital admissions require review by Gold Coast Health Plan Health Services Department. For elective admissions, prior authorization is required for the procedure and the hospitalization. Emergency admissions – While the admission for emergencies does not require prior approval, hospitals **MUST** notify Gold Coast Health Plan Health Services department within 24 hours or the next business day of the patient admission. All days will be reviewed for medical necessity.
Ambulatory Surgery (All place of service 24 services require authorization.)	All Outpatient surgeries require pre-authorization
LTC	All Long Term Care and Skilled Nursing Services require authorization
Genetic Testing	81200 81205-81217; 81220-81229: 81240-81245: 81250-81251; 81255-81257; 81260-81268; 81270 81275 81280-81282; 81290-81304; 81310 81315-81319; 81330-81332; 81340-81342; 81350 81355 81400-81408; 83890-83914; 84999 88245-88249; 88261-88264; 88271-88275; 88280-88291; 88384-88386; S0265 S3713

	S3800 S3818-S3855; S3860-S3862; S3865-S3866	
Home Health Care (All Home Health Care requires authorization.)	99341-99350 99374-99375 S5180-S5181 S9122-S9124 T1021-T1022	S9127-S9131 S9490-S9810 S9208-S9214 S9125-S9131 Z6902 Z6920
Outpatient diagnostic Studies (MRI, CT Scan, PET Scans, Nuclear Medicine Imaging, Trans-cranial Doppler, Sleep Studies)	70336 70450-70492 70496-70598 70540-70553 70554-70555 70557-70559 71250 71260 71270 71275 71550-71552 71555 72125-72133 72141-72159 72191-72198 72255 72265 72270 73200-73202 73206 73218-73225 73700-73702 73706 73718-73725 74150-74170 74174-74178 74181-74185	74740-74742 75557-75574 76380 76390-76499 76801-76828 77058-77059 77084 78491 78600-78606 78607-78609 78610-78645 78647 78650 78660 78700-78709 78710 78725-78761 95800-95801 95805-95811 Z7600-Z7602 G0398-G0400

	74261-74263
Pain Management	62350-62351 62360-62362 99601-99602
All Speech Therapy	92506-92508 X4300-X4320 X4544 Z5918-Z5920 Z5962 Z6908 V5362 X4544
All **Occupational Therapy**	97003-97004 X4100—X4120 Z6906
Physical Therapy (Authorization required after 10 visits – includes evaluation and 9 visits.)	97001-97002 97010-97028 97032-97039 97110-97530 X3900-X3936 Z6904
Podiatry Services (Services are limited to the following: Pregnant women if related to their pregnancy; children under 21 years of age with full scope Medi-Cal; members who live in SNF or ICF; those who are developmentally disabled living in an ICF or Sub- acute facility. All Podiatry requires an authorization.)	Provider type PO with the following codes: 10060 10160 10180 99201-99203 99211-99213 11720-11721 11730-11732

	27650-27654 27658-27698 27704 27760-27766 27786-27829 27840-27848 28415 28430-28515 28190 28192-28193
Out of Network Services (All OON services require authorization.)	Non-Participating Facility services require authorization. . Non-Participating Provider services require authorization.
Renal, Hemo, and Peritoneal Dialysis Dialysis requires authorization.	4052F-4054F 4055F 90935-90937 90945-90947 90997-90999 Z600-Z6022 Z6030 Z6036-Z6042
Phototherapy (All Phototherapy requires authorization.)	96900 96910 96912 96913 E0202 S9098 S0812
DME	Authorization required for purchase >$500 and rental >$200 per month.
Dental Anesthesia (All dental anesthesia requires authorization.)	D9210-D9248
Hyperbaric Oxygen Chamber	99183 A4575 C1300

Supplies	Authorization is required for any **like** monthly supply greater than $200

Home Infusion Therapy	99601-99602 S5035-S5036 S5497-S5523 S9325-S9368 S9370-S9379 S9400-S9404 S9490-S9810 S9494-S9497
Non Emergent Transportation	A0080-A0160 A0180-A0210 T2001-T2005 X0200-X0222 X0400-X0416 X0506 – X0522 Z8597
Prosthetics and Orthotics	E1800-1802 E1805-E1806 E1810-1812 E1815-E1816 E1818 E1820-E1821 E1825 E1830-E1831 E1840-E1841 E2631-E2633 L0112-L3649 L3671 L3674 L3720-L3760 L3763-L3766 L3806-L3807 L3891-L3906 L3915 L3936 L3960-L3962 L3967 L3971 L3973 L3975-L3978 L3980-L3982 L4000 L4010-L4070 L4030 L5000-L9900 S1040 V2623-V2629

Hearing Devices	L8614	V5130
	V5030	V5140
	V5040	V5150
	V5050	V5170
	V5060	V5180
	V5070	V5190
	V5080	V5210
	V5090	V5220
	V5095	V5230
	V5100	V5240
	V5110	V5242-V5275
	V5120	V5298

Therapies (Sclerotherapy, Proton Beam, Neutron Beam, MEG, IMRT)	36470	77520-77525
	36471	77435
	36475	61796-61800
	36476	63620-63621
	36478	95965-95967
	36479	77422-77423
	37799	77301
	36468	77338
	96999	77418
	S2202	0073T
Injectables	J0725	J7312
	J1950	J7311
	J3355	J9303
	J3490	J3357
	J8499	J3262
	J3590	J0490
	J1110	J9228
	J2325	J9999
	J2315	C9287
	J0775	C9286
	S0122	S0128
	S0126	S0132
IN NETWORK BUT OUT OF AREA	**AUTHORIZATION REQUIRED FOR ALL OUT OF VENTURA COUNTY PROVIDERS INCLUDING THOSE WHO HAVE CONTRACTS WITH GCHP.**	

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP)

Purpose:
The purpose of this bulletin is to provide clarification to Gold Coast Health Plan (GCHP) Capitated Primary Care Providers (PCP) that Child Health and Disability Prevention (CHDP) services that are included in their capitation rate.

Services included in the capitation rate
CH01N– Preventive Medicine office visits (New)
CH01R – Preventive Medicine office visits (Established)
CH02-CH05 – Dental, Nutrition, Anticipatory Guidance and Developmental Assessments
CH07 – Hearing, audiometric
CH08 – Hemoglobin/Hematocrit
CH09 - Routine UA
CH10 – UA with Microscopy
CH013 – Automated Hemogram
CH025 – Blood glucose

For additional services that are included under capitation please reference Attachment B1 of the PCP Capitation Agreement.

Immunization administration fees will continue to be reimbursed on a Fee for Service basis.

Starting on October 1, 2012, Gold Coast Health Plan is requesting that all providers begin submitting encounters and claims using the American Medical Association (AMA) Current Procedural Terminology (CPT) codes on the Health Insurance Claim Form (HCFA-1500) and discontinue using CHDP codes. However, as mandated by the Department of Health Care Services (DHCS), Gold Coast Health Plan requires that the **PM-160 Information Only** form be submitted to the Health Plan for appropriate reporting to the State.

Beginning on October 1, 2012 encounters should be submitted using the codes below. Please also submit any claims for services outside the scope of capitation using the appropriate CPT codes.

OFFICE VISITS

CPT Code – New Patient

99201	Problem focused history and exam; straight forward; 10 minutes
99202	Expanded problem focused history and exam; straight forward; 20 minutes
99203	Detailed history and exam; low complexity; 30 min
99204	Comprehensive history and exam; moderate complexity; 45 minutes
99205	Comprehensive history and exam; high complexity; 60 minutes

Established Patient

99211	Minimal Problem; physician supervised services; 5 minutes
99212	Problem focused history and exam; straight forward; 10 minutes
99213	Expanded problem focused history and exam; straight forward; 15 minutes
99214	Detailed history and exam; moderate complexity; 25 minutes
99215	Comprehensive history and exam; high complexity; 40 minutes

PREVENTIVE MEDICINE SERVICES

New Patient

99381	Initial Evaluation and Management of Healthy Individual < 1yr or age
99382	Early Childhood – age 1 to 4 years
99383	Late Childhood – age 5 to 11 years
99384	Adolescent – age 12 to 17 years
99385	18 – 39 years
99386	40 – 64 years
99387	65 years and older

Established Patient

99391	Periodic Reevaluation and management of Healthy Individual < 1yr of age
99392	Early Childhood – age 1 to 4 years
99393	Late Childhood – age 5 to 11 years
99394	Adolescent – age 12 to 17 years
99395	18 – 39 years
99396	40 – 64 years
99397	65 years and older

MINOR SURGICAL AND OTHER MISCELLANEOUS PROCEDURES

Surgical Procedures

10060	Drainage of Boil
10080	Drainage of Pilonidal Cyst
10120	Remove Foreign
10140	Drainage of Hematoma
10160	Puncture Drainage of Lesion
11740	Drain Blood from under Nail
11900	Injection into Skin Lesions
16000	Initial Treatment of Burn(s)
20600	Arthrocentesis, Aspiration and/or Injection; Small Joint, Burns or Ganglion Cyst
26720	Treat Finger Fracture, Each
28490	Treat Big Toe Fracture
28510	Treatment of Toe Fracture

Splints

29105	Application of long arm splint (shoulder to hand)
29125	Application of short arm splint (forearm to hand); static
29126	dynamic
29130	Application of finger splint; static
29131	dynamic
29505	Application of long leg splint (thigh to ankle or toes)
29515	Application of short leg splint (calf to foot)

Strapping – Any Age

29200	Strapping; thorax
29240	shoulder (eg.Velpeau)
29260	elbow or wrist
29280	hand or finger
29520	Strapping; hip
29530	knees
29540	ankles
29550	toes
46600	Diagnostic Anoscopy
51701	Insertion of non-indwelling bladder catheter
51702	Insertion of temporary indwelling bladder catheter
65205	Removal of Foreign Body, Eye
69200	Clear Outer Ear Canal
69210	Remove Impacted Ear Wax

Laboratory

81000	Urinalysis with Microscopy
81002	Routine Urine Analysis
81005	Urinalysis; Chemical, qualitative
82948	Stick Assay Blood Glucose
82947	Glucose; Quantitative
85014	Hematocrit
85018	Hemoglobin, Colorimetric
85025	Automated Hemogram
87081-87084	Bacteria Culture screen only, e.g., Rapid Strep test
87205	Smear, Stain & Interpretation - Routine Stain
87210	Smear, Stain & Interpretation – Wet Mount
87220	Tissue Examination for Fungi (KOH Slide)

ECG, HEARING TEST, SUPPLIES

93005	Electrocardiogram, tracing only
93041	Rhythm ECG, Tracing
99070	Special Supplies
92551-92552	Audiometry

SERVICES REIMBURSED AT FEE FOR SERVICE AS OF 10/01/2012

The following services will be reimbursed on a Fee for Service basis:

- D1203: fluoride treatment
- 57410: pelvic exam (includes PAP, Gonorrhea, & Chlamydia test prep)
- 99173: Snellen Eye Test
- 86580: Mantoux TB test.
- 82270: Blood Occult, Feces
- 81025: Pregnancy Test

VFC VACCINE ADMINISTRATION REIMBURSED ON A FEE FOR SERVICE BASIS

Vaccine administration fees will continue to be reimbursed on a Fee for Service basis. Providers who administer vaccines to children are required to participate in the Vaccine for Children Program. When billing, providers using VFC vaccines **MUST** bill with the codes listed below and the SL modifier code.

90633	Hepatitis A Vaccine/Pediatric/Adolescent (Vaqta®, Havrix®)
90647	Haemophilus Influenzae b (Hib) Vaccine (PedvaxHIB®)
90648	Haemophilus Influenzae b (Hib) Vaccine (ActHIB®)
90649	Human Papilloma Virus Vaccine (Gardasil®)
90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90655, 90656	Influenza Vaccine (preservative-free Fluzone®)
90657	Influenza Vaccine (Fluzone®)
90658	Influenza Vaccine (Fluvirin®)
90660	Influenza Virus Vaccine, live, for intranasal use (FluMist®)
90669	Pneumococcal Vaccine (younger than 5 years of age) (Prevnar®)
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90680	Rotavirus Vaccine, oral (RotaTeq®) (3 dose schedule)
90681	Rotavirus Vaccine, oral (2 dose schedule)
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTap-IPV)
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) for intramuscular use (Pentacel)
90700	DTaP Vaccine (Tripedia®, Daptacel®, Infarix®)
90707	MMR Vaccine (MMR II®)
90710	MMRV Vaccine (ProQuad®)
90713	Inactivated Polio Vaccine (IPOL®)
90714	Diphtheria and Tetanus Toxoids adsorbed, preservative free (7 years of age and older) (Decavac®)
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), (7 years of age and older) (Boostrix®, Adacel®)
90716	Varicella Vaccine (Varivax®)
90723	DTaP-HepB-IPV Vaccine (Pediarix®)
90734 *	Meningitis Vaccine (Menactra or Menveo)
90743	Hepatitis B Vaccine (Recombivax HB®)
90744	Hepatitis B Vaccine (Engerix B®)
90748	Hepatitis B and H. Influenza b (Hep B-Hib) (Comvax®)

**Members of high risk population bill with SK modifier code.*

If you have any questions regarding the information in this bulletin, please contact the Provider Services Department at 1-888-301-1228.