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 Relations Department at providerrelations@goldchp.org.

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**IMPORTANT** Coming Soon – Updated Preauthorization Request Form and New E-Fax #

**SECTION 1: PRIOR AUTHORIZATION FOR MEDICARE & OTHER HEALTH COVERAGE (OHC) NON-COVERED SERVICES**

Prior authorization is required for Medicare and OHC non-covered, exhausted or denied services that will be billed directly by a provider to Gold Coast Health Plan as straight Medi-Cal claims. For example: Non-Emergency Medical Transportation, is not covered by Medicare and usually not covered by OHC, these services require preauthorization by Gold Coast Health Plan.

**SECTION 2: VENTURA TRANSIT SYSTEM AWARDED NEMT CONTRACT**

Gold Coast Health Plan has awarded the NEMT contract to Ventura Transit System. Transition will begin on January 1, 2013, with an anticipated full implementation for February 1, 2013. Information about the transition will be in the December 2013 provider bulletin.
SECTION 3: CLARIFICATION OF BILLING WITH MODIFIER 50

Gold Coast Health Plan attempts to recognize and use modifiers as outlined in the AMA CPT manual, as well as modifiers generally used with HCPCS codes. We are providing clarification for Modifier 50 (Bilateral Procedure) – This modifier is used when the exact same service/code is reported for each bilateral anatomical site. Report the bilateral procedures with one procedure code appended with modifier “50”. Do not use this modifier when reporting procedure codes that are primarily bilateral by definition (e.g. lengthening of hamstring tendon; multiple, bilateral). Bilateral procedures should be reported as a single line item using the appropriate procedure code, CPT or HCPCS modifier and one unit. Reimbursement on procedure codes billed with this modifier is paid at 150% of the standard allowable amount.

SECTION 4: CORRECTION FOR REIMBURSEMENT OF PROCEDURE CODE 92552

This is a correction to the August Bulletin, Attachment for Section 6, CHDP Services Reimbursed on a For-for-Service Basis. For procedure code 92552: Aural Hearing Test, in error the bulletin states the amount of reimbursement is $6.75. The correct reimbursement is $15.30 for an adult and $19.00 for a child.

SECTION 5: PROVIDER MANUAL UPDATED NOVEMBER 2012

Please visit www.goldcoasthealthplan.org for the updated Gold Coast Health Plan Provider Manual which includes new information on Community-Based Adult Care, Fraud and Abuse and updated prior authorization guidelines.

SECTION 6: HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL MANAGED CARE

The transition of the Healthy Families Program into Medi-Cal managed care plans will be done in four-phases. There are approximately 20,000 children enrolled in the Healthy Families Program in Ventura County who will be included in Phase III of the transition to begin August 1, 2013.

SECTION 7: ELECTRONIC REMITTANCE ADVICE IS NOW AVAILABLE

5010 X12 835 Transactions are now available for GCHP (Payer ID 77160)

Xerox EDI (Electronic Data Interchange) is now capable of accepting and delivering electronic RA's/EOP's from Gold Coast Health Plan, to you, via your Clearinghouse or Software Vendor. To learn more about this service, visit their claims payer list (http://www.acs-inc.com/edi/claims-gateway/available-payers.aspx) and select Gold Coast Health Plan for more information on Trading Partner enrollment and 835 provider authorization.

Once the necessary forms have been submitted and enrollment completed at Xerox EDI, they will forward your enrollment to Xerox Commercial Solutions, GCHP IT Support, to finalize the system set up. IT will confirm via email when this has been completed, and your 835 delivery will begin within one week.

The total set-up requires about two weeks.
Direct any questions on the Xerox EDI set-up, to edicommercialsupportteam@xerox.com.

Direct any questions on the IT Support set-up within IkaSystems’ Gold Coast Health Plan, to Diane.VanBuskirk@xerox.com.

Note: you will still receive your paper remittances in addition to the 835.

SECTION 8: AFFORDABLE CARE ACT - MEDICAID PRIMARY CARE PROVIDER RATE INCREASE

On November 6, 2012, the Centers for Medicare & Medicaid Services (CMS) released the final regulations governing the implementation of the Medicaid primary care rate increase as mandated by the federal Affordable Care Act.

CMS and the Department for Health Care Services (DHCS) will implement a rate increase for certain Primary Care Providers and specific evaluation and management codes, based on Medicare rates. The change is effective January 1, 2013 through December 31, 2014.

The DHCS has not yet provided guidance on how managed care plans are to implement this change and they have not provided rates to Gold Coast Health Plan to fund the increased payments. Gold Coast Health Plan will keep you informed as it learns more from DHCS.

The increases will not apply to federally qualified health centers and rural health clinics.

SECTION 9: STERILIZATION CONSENT FORM (PM330) MUST ACCOMPANY CLAIMS

To comply with federal requirements, a legible copy of a valid sterilization Consent Form (PM 330) must accompany claims for sterilization services. For reference, a copy of the PM 330 is attached. CPT-4 and HCPCS codes that require the PM 330 include but may not be limited to: 55250, 55450, 58565, 58600, 58605, 58611, 58615, 58661, 58670, 58671, 58700 and A4264.

SECTION 10: NOVEMBER IS DIABETES AWARENESS MONTH

November is diabetes awareness month. Below you will find helpful websites to local, state, and national organizations on diabetes prevention, healthy eating, and ways of managing diabetes. Visit the following websites for more information about support groups and classes:

www.goldcoasthealthplan.org
www.diabetes.org
www.healthyventuracounty.org
www.cdc.gov/diabetes/about.htm
www.CMHSHealth.org
www.dignityhealth.org
www.Caldiabetes.org
www.lmwvna.org
www.aging.ca.gov/ebhp
SECTION 11: NEW – PROVIDER DISPUTE RESOLUTION FORM

The Provider Dispute Resolution has been replaced with a new form designed to address provider issues. For your reference the new form is attached, and it is also available on the website and ready for use. Please check the appropriate box that reflects your issue.

Any questions, contact our Member Services Department or Provider Relations Department providerrelations@goldchp.org.
CONSENT FORM  
PM 330  

STATEMENT OF PERSON OBTAINING CONSENT  

Before ________________ signed the  
consent form, I explained to him/her the nature of the sterilization operation ________________.  
I explained that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.  
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.  
I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.  
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.  

Signature of person obtaining consent: ___________________________  
Date: ________________  

(Please print)  

Name of facility where patient was counseled: ___________________________  
Address of Facility where patient was counseled: ___________________________  
City: ___________________________  
State: ___________________________  
ZIP Code: ___________________________  

PHYSICIAN’S STATEMENT  

Shortly before I performed a sterilization operation upon ________________, I explained to him/her the nature of the sterilization operation ________________.  
I explained that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.  
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.  
I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.  
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.  

(Instructions for use of Alternative Final Paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraphs below which is not used.)  

(1) At least thirty days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.  

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances:  

☐ Premature delivery date: ________________  
☐ Individual’s expected date of delivery: ________________  
☐ Must be 30 days from date of patient’s signature.  

☐ Emergency abdominal surgery: describe circumstances: ________________  

Signature of Physician performing surgery: ___________________________  
Date: ________________  

(Please print)  

CONSENT TO STERILIZATION  

I have asked for and received information about sterilization from ___________________________.  
When I first asked for the information, I was told that the decision to be sterilized is completely up to me.  
I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.  

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.  
I was told about the temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.  
I understand that I will be sterilized by an operation known as ________________.  

(Choose one)  

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.  
I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.  
I am at least 21 years of age and was born on ________________.  

Signature of individual to be sterilized: ___________________________  
Date: ________________  

(Please print)  

I hereby consent of my own free will to be sterilized by _________________.  
I understand that I will be sterilized by a method called ________________.  
My consent expires 180 days from the date of my signature below.  
I also consent to the release of this form and other medical records about the operation to:  
• Representatives of the Department of Health and Human Services.  
• Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  
I have received a copy of this form.  

Signature of individual to be sterilized: ___________________________  
Date: ________________  

(Please print)  

INTERPRETER’S STATEMENT  

If an interpreter is provided to assist the individual to be sterilized, I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ________________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.  

Signature of interpreter: ___________________________  
Date: ________________  

(Please print)
**PROVIDER DISPUTE RESOLUTION**

**Grievance & Claims Correction Form**

**INSTRUCTIONS**
Gold Coast Health Plan has simplified the Provider Dispute Resolution process by making this grievance & claims correction form available to providers in accordance with various regulations that govern the health plan. These grievances, or disputes, may take various forms, including, but not limited to, the following: "Appeals" (requests to change a previous decision, i.e., regarding Authorization Requests, Medical Authorization Requests, or claims), or "Complaints" (an expression of dissatisfaction). In order to be effectively addressed, we have provided this form for providers to use when submitting grievances to Gold Coast Health Plan. If submitting a grievance please complete this form, attach all supporting documentation, and clearly describe the reason for your grievance. Grievance lacking information required for resolution will be returned to you with a request for more information.

Gold Coast Health requests that you file an appeal only in situations where Gold Coast Health has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. If your claim was denied for timeliness of submittal or timeliness of follow-up, please do not submit an appeal unless you are also submitting verification of timeliness that meets criteria, or you have a valid Delay Reason Code.

Gold Coast Health Plan will acknowledge receipt of your grievance within 15 business days and send a written resolution to your grievance within 45 business days after the date of receipt. For claims corrections, your explanation of payment will serve as acknowledgment and resolution.

*Please submit this completed form with all supporting documentation attached to:*

**CLAIMS**
- Claim Correction (copy of EOP attached)
- Claims Billing Dispute
- Claims Payment Dispute
- Claims Appeal (Appealing Dispute Outcome)
- Other __________________________

**Grievance Type**
- Retro-Review
- TAR Denial
- Records for Review
- Appeal of Medical Necessity
- Other __________________________

**HEALTH SERVICES**
- Gold Coast Health Plan
  - Attn: Provider Dispute / Claims Correction
  - P.O. Box 9176
  - Oxnard, CA 93031

**REFUNDS**
- Overpayment
- Response to refund request letter
- Wrong Provider Paid
- Other __________________________

**Gold Coast Health Plan**
- Attn: Refunds Department
  - P.O. Box 9176
  - Oxnard, CA 93031

*Provider Name: __________________________ Billing Provider NPI: ________

*Provider Address: __________________________

**Provider Type:** ☐ MD ☐ Hospital ☐ SNF/TC ☐ DME ☐ Home Health ☐ Ambulance ☐ Vision ☐ Transportation ☐ Other____

**Claims Information:** ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) Number of claims: ________

Name of person submitting grievance: __________________________ Relationship to Provider: ☐ Self ☐ Office Staff ☐ Billing Service ☐ Other____

Address of person submitting grievance: __________________________

**Member ID #: ________ Member First & Last Name: __________________________ Claim ID #: ________

**Date(s) of Service:** __________________________ Original Claim Amount Billed: ________ Original Claim Amount Paid: ________

**Description of Grievance or reason for claim correction (please indicate specific line #’s, if applicable, and/or attach additional pages as needed and include all available supporting documentation):**

[ ] Check here if additional information is attached

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2220 E. Gonzales Road Suite 200 • Oxnard, CA 93036 • 1.888.301.1228 • goldcoasthealthplan.org

OCHP Provider (Issue) 11/12