CARE1ST PROVIDER FORUM

September 2016

Agenda

1. RAFFLE!!
2. Medical Claims
3. Pharmacy Prior Authorization
4. Medical Prior Authorization
5. Claims Disputes and Appeals
6. Developmental Screening
7. Credentialing
8. Provider Network Operations
9. AHCCCS and DDD Benefit Updates
10. MORE RAFFLE!!
11. Dental Claims
12. Dental Prior Authorizations and Tips

Claims

Coding

- Claims coding - AHCCCS guidelines and CCI
  - Available resource material (Encounter Keys, Claims Clues, Biller's Corner)
  - Medicare vs. AHCCCS coverage
  - Maximum Unit allowance

Modifiers

- Update on Care1st's procedures and AHCCCS/DDD requirements
  - Modifier 59 (related modifiers XE, XU, XS) and records
    - 36600, 43210-43239, 45380-45398, 45900-45999, 46600-46615, 49560-49568, 51600-51720, 51725-51798, 52000-52318, 58100-58120, 62310-64640, 69100-69999 (94640 with 94060 same date, 96372 with pain management procedures)
  - Bilateral Surgery billing vs. LT/RT
  - Modifier 25 with EPSDT services

Claims

Developmental Screening Claims

- Trends have been noted with the codes below being billed outside of the established age ranges
- The CPT code 96110 (Developmental Testing; Limited (e.g. Developmental Screening Test Limited, Early Language Milestone Screen, With Interpretation and Report) is billable three times at age intervals of 9, 18 and 24 months with the *EP Modifier. Providers must be trained in the use of the developmental screening tool and currently using the PEDS tool, ASQ tool or MCHAT tool for reimbursement (*Specialists are not required to bill the EP modifier).
- The CPT code 96111 (Developmental Testing; includes assessment of motor skills, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report has a minimum of 0 years and a maximum of 20 (PCP's are not eligible for reimbursement of 96111).

Claims

Covered Services

- Common denials, non-covered diagnosis codes, age limits
- Infertility (N97.0) as a secondary, tertiary diagnosis, billed with covered diagnosis codes
- Age limit denials related to both CPT coding (generally on screening services, EPSDT visits) and diagnosis codes
- Local Coverage determinations (CMS guidelines that establish coverage on CPT codes based on the patients illness)
- Resources - CMS website, Chapter 10 of the AHCCCS provider manual, Care1st claims Customer Service

Claims

Coordination of Benefits

- General COB guidelines and benefit determination
- Handling of secondary claims in which primary carrier billing guidelines differ from AHCCCS/DDD billing guidelines (Surgeries, Maternity)
- Medicare sequestration and how it applies to secondary billing

Referrals to Out of Network Labs

- Sonora Quest is Care1st's exclusive provider of laboratory services
- Top provider specialties by volume that refer to out of network labs
  - Pain Management
  - OB GYN
  - Urgent Care facilities

Claims

Top 5 Claim Denials, August 2016

1. Exact duplicate 3,749 claims
2. Member has other primary coverage 2,342 claims
3. Provider not contracted, authorization required 1,680 claims
4. Provider information not registered with AHCCCS 1,044
5. Member ineligible on date of service 954

Who can request a Pharmacy Authorization?

- Prescriber or the Prescriber's staff on behalf of the Prescriber
- The member may request a Prior Authorization through their Practitioner

NOTE: Prior Authorization requests are **NOT** accepted from Third parties or Pharmacies

Documents Needed for Pharmacy Prior Authorization Review

1. Completed Prior Authorization Form that includes the following required information:
    1. Patient name/DOB/ID
    2. Provider name/specialty/phone#/Fax#
    3. Drug name/Strength/Qty/DS/SIG
    4. ICD-10 Diagnosis
    5. Current medications
    6. All therapeutic alternatives previously used, including start/end dates and outcome
    7. Medical justification

Documents Needed for Pharmacy Prior Authorization Review…CONT

2. Most recent chart notes
3. All relevant lab values related to the patient's medical condition(s). Must be done within 90 days prior to request being submitted.
4. All relevant diagnostic tests and results
5. Patient's complete current medication list

Example Criteria: Prior Authorization for Januvia

- Adult patient with diagnosis of Type 2 diabetes
- Noted compliance to other anti-diabetic agents such as Sulfonylureas, Metformin and TZDs regularly for the last 6 months or has a documented failure, contraindication or intolerance
- Patient's A1c is between 7 and 8

Documentation should include:

Recent A1c lab results and medical records with past history of medications including failed trials, contraindication or intolerance reasons.

Pharmacy Prior Authorization Review (Routine)

Turnaround Time

- Care1st's pharmacy department makes every effort to make the decision as quickly as possible. Average turn around time is 3 business days.
- If additional information is required, we can extend a request for up to 28 days

STAT/Urgent Prior Authorizations

- These should be submitted ONLY when a provider or Care1st determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function
- Care1st's pharmacy and medical departments makes every effort to make the decision within one business day
- AHCCCS/DDD guidelines indicate that we have 3 business days to complete a request
- If additional information is required, we can extend a request for up to a total of 17 days

Documents needed for Medical Prior Authorization Review

Completed Treatment Authorization Form (TAR) and recent records that correspond to the practitioner's request. If there are no recent records with a physical exam (PE) then the request will be delayed.

Records need to reflect:

- Why the procedure/service is requested – *practitioner documentation of clinical need (if member driven request please document)*
- History of previous procedure/service(s) with length of trial and outcome- *plain films completed with indeterminate results and worsening symptoms after exercise/PT; number of medication(s) tried and failed*
- Physical Exam documenting clinical need- *Neuro exam with pain scale / Dermatology Referral needs a corresponding PE of the skin lesions (enlarging, irregular, bleeding)*

Example Criteria: MRI of Lumbar Spine for Low Back Pain

Milliman Guideline for Lumbar Spine MRI ACG: A-0059

Pain localized to low back or radicular in nature, subacute or chronic, as indicated by **ALL** of the following(53)(54)(55)(56)(57)(58)(59):

- **Failure to improve after 6 or more weeks of nonoperative treatment**, as indicated by **1 or more** of the following(59)(63)(65):
  - Analgesics and NSAIDs
  - Exercise
  - Modification of activity that exacerbates or produces symptoms
  - Physical therapy
- **Patient being considered for invasive treatment (eg, epidural steroids, surgery)**
- **Significant interference with daily function**

Continued Example Criteria: MRI of Lumbar Spine for Low Back Pain

Milliman Evidence Summary includes:

- …In the absence of urgent ("red flag") indications, such as suspected infection, cancer, significant neurologic compromise, or inflammatory disease, expert consensus guidelines note that diagnostic imaging is usually not clinically helpful in the early course of an episode of back pain.

Care1st Criteria for MRI of Lumbar Spine for Low Back Pain

Care1st criteria for an MRI of the lumbar spine includes

- the pain needs to significantly affect daily activities; and
- the member failed to improve after 6 weeks or more of conservative treatment such as home exercises, PT or medicines (such as ibuprofen, acetaminophen); and
- is being considered for invasive treatment such as shots into the back or surgery

And the medical records need to reflect a recent physical examination that shows nerve changes or suspected infection. The physical exam must include testing of the muscle strength, reflexes, sensation, straight leg raise, sitting knee extension.

Based on Milliman Guideline including Evidence Based Literature

Claims Disputes and Appeals

Claim Dispute is:

- A formal legal challenge of a health plan's disposition of a claim
- A time sensitive process that is without exception

A Claim Dispute is not:

- An alternate claim submission or resubmission process
- A billing and/or write off requirement
- A means for a contracted provider to seek an exception of claims rules

Please review Section VIII of the Care1st Provider Manual for additional information: https://www.care1st.com/az

Claims Disputes and Appeals

All requests for dispute must include:

1. A completed claim dispute form or a letter detailing the factual and legal basis for the dispute. The claim dispute form is available on our website in the "FORMS" section of the Provider menu or by contacting Provider Network Operations. Please use one form per dispute action.
2. A copy of the original claim and remittance advice
3. Supporting documentation for reconsideration, including a narrative describing the reason for the dispute and clinical notes if needed

Mail the completed claim dispute form(s) and documentation to:

Care1st Provider Claims Disputes

2355 E. Camelback Rd, Suite 300

Phoenix, AZ 85016

Claims Disputes and Appeals

Dispute Timeframes

- AHCCCS guidelines require all claim disputes be submitted in writing within 12 months from the date of service; the date of AHCCCS eligibility posting; or within 60 days of the last adverse action, whichever is greater
- Care1st acknowledges disputes within five business days. If an acknowledgement letter is not received, please contact the CD&A department at 602-778-8352.
- Disputes are researched and decisions are issued within 30 calendar days of receipt
- Disputes may be extended an additional 14 days if the need for additional information is established. Care1st will notify you if an extension is necessary.
- Care1st issues all decisions, whether approved or denied, in writing

PCP and Dental Care

FLOURIDE VARNISH

- Training is required prior to applying fluoride varnish:
  - Training is available at www.smilesforlifeoralhealth.org
  - Upload your certificate to CAQH
- Upon Completion of training, PCPs and mid-levels are encouraged to apply fluoride varnish during EPSDT visits:
  - Begin varnish application at 6 months of age or at 1st tooth eruption
  - Continue application every 6 months up to 2 years of age
  - Use code 99188

Developmental Screenings

- Developmental screenings/surveillance should be done at every visit
- Reimbursement is available for completion of a Developmental Screening **at 9, 18 and 24 months only and if**:
  - An AHCCCS approved Developmental Tool is used
  - Required training on the use of the Tool is completed
  - Proof of training/certification is uploaded to CAQH
- Bill with CPT code 96110 and EP modifier

AHCCCS Approved Developmental Screening Tools

- PEDS Tool – Parents Evaluation of Developmental Status
- ASQ – Ages and Stages Questionnaire
- MCHAT – Modified Checklist for Autism in Toddlers
  - Used for children **16 – 30 months of age** to screen for autism when medically indicated

Training information for these tools is available on the Arizona Department of Health Services website:

- http://www.azdhs.gov/clinicians/index.htm
  - Click on Training Opportunities and then on Developmental Screenings

Credentialing

- All plans participate in the AzAHP – Arizona Alliance of Health Plans
  - Only one practitioner data form is needed!
- APERTURE – the contracted Credentialing Verification Organization (CVO)
- CAQH – maintain your information
  - KEEP YOUR INFORMATION CURRENT!!
    - Contact Information
    - Training Certificates
    - Attestations
    - Approvals for health plans to view your information
  - HELP DESK: **(888) 599-1771 or** providerhelp@ProView.CAQH.org

Re-credentialing

- Re-credentialing process begins about 4 months prior to credentialing date
- Your re-credentialing date will align with all health plans
- Keep CAQH updated to avoid delays!
  - Contact Information
  - Training Certificates
  - Attestations
  - Approvals for health plans to view your information

AMRR ALLIANCE

Coming soon!

AzAHP has formed an alliance to complete medical record reviews. Results will be shared within the alliance in an effort to reduce the burden on providers.

- Reviews will be completed once every three years unless deficiencies are found
- If deficiencies are found, the review will be repeated the following year
- Providers will be notified of results

AMRR ALLIANCE

- AzAHP has contracted with AdvantMed to perform the medical record reviews
- AdvantMed will reach out to you when your review is due.
- Per AHCCCS regulations, requested records must be submitted at no cost
  - Please notify your medical record management vendor service, if applicable, that records must be provided **no cost** to avoid delays.

Provider Network Operations

Provider Loading Process

- A request (AzAHP Practitioner Data Form) is received by the Provider Network Operations (PNO) Team to add a provider to your group
  - Reminder – all elements must be completed
- That request is added to the PNO database and forwarded to credentialing
- Credentialing cannot begin unless the CAQH application is updated and complete
- When credentialing is completed, the provider is loaded into our claims payment system and
- A welcome letter is sent notifying the practice of the effective date

Provider Network Operations

Other Changes to the Practice

- Changes to the practice should be communicated to Care1st to ensure accurate processing of claims, payment and directory information
  - Includes providers who left, address changes, fax or phone numbers, etc
- Please send notification by faxing us at 602-778-1875 or by email pnoaz@care1st.com. You can also contact your provider rep directly.

Provider Network Operations

Plan Resources

- Provider Network Representatives
  - Maricopa Representatives
    - Cecilia Carroll – South Valley Representative 602-778-4137
    - Ivette Gastelum – Northeast Valley Representative 602-778-4144
    - Linda Patterson – Northwest Valley Representative 602-778-1876
  - Pima Representative
    - Lorita Smith – Pima County Representative 520-331-8112
- Claims Liaisons
  - Anthony Crooks 602-778-8374
  - Afa Iupeli 602-778-1877

Provider Network Operations

Care1st Website

https://www.care1st.com/az

- Territory Assignment Grid
  - Providers > Provider Rep Contact Info
- Blast Faxes
  - Providers > Blast Faxes
- Forms
  - Providers > Forms
  - Practice Updates (Adds, Terms, Changes)
- Our Network
  - Providers > Our Network
    - Search function
    - PDF version available

Home Arizona

Provider Login | ONECare

Search Site Go

Select Language

Welcome Providers

You play a very important role in the delivery of health care services to our members. Care1st is committed to working closely with you. We continually work to remove administrative barriers so that you can focus on caring for our members.

Medical administration including Member Services, Prior Authorization, Claims, Provider Network Operations, Case Management, Disease Management, Concurrent Review, Quality Management and Behavioral Health are housed in the same central location in Phoenix, fostering close communication and coordination between all areas.

We look forward to partnering with you to achieve better outcomes and to increase patient satisfaction and access to preventive care.

Care1st Home

For Providers

- Blast Faxes
- Compliance Resources
- Community Resources
- Dental
- Disease Management
- Forms
- Formulary
- Forums
- ICD-10
- Login
- Mailings and Newsletters
- Manual
- Our Network
- Practice & Preventive Health Guidelines
- Prior Authorization Guidelines & Criteria
- Provider Rep Contact Info
- Quality Measure Results

Forms

Prior Authorization

- Pharmacy Prior Authorization Request PDF
- Medical Prior Authorization Form PDF
- Sterilization Consent PDF
- Authorization/ Pregnancy Risk Assessment PDF
- RSV Prophylaxis Eligibility Assessment PDF

Case Management / Behavioral Health

- Care1st Case Management Referral Form PDF
- MMIC Referral for Behavioral Health Services Form 3.3.1 Effective 4-1-14 PDF
- CIC Referral for Behavioral Health Services Form - Pima County Effective 10-1-15 PDF

Credentialing & Contracting

- AzAHP Practitioner Data Form PDF
- AzAHP Organizational Data Form PDF
- AzAHP Facility Application PDF

Other

- Claim Dispute PDF
- Electronic Funds Transfer Authorization Form (ETF) PDF
- EPSDT Order PDF
- EPSDT Tracking PDF
- No Show Log PDF
- Newborn Reporting PDF
- Primary Care Physicians Change Request PDF
- Provider Directory Correction Request PDF

- Mailings & Reference Materials
- Manual
- Our Network
- Practice & Preventive Health Guidelines
- Prior Authorization Guidelines & Criteria
- Provider Rep Contact Info
- Quality Measure Results

Provider Manual

Click on the appropriate section title below to view and/or print the contents of a particular section or view the entire manual

TABLE OF CONTENTS:

SECTION I - INTRODUCTION

- Welcome
- Mission Statement
- Introduction to Care1st
- Department Organization

SECTION II - QUICK REFERENCE CONTACT LIST

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- Website
- Contracted Vendors
- Arizona Health Care Cost Containment System (AHCCCS)
- Hearing Impaired
- Translation Services

SECTION III - PROVIDER ROLES AND RESPONSIBILITIES

- PCP Gatekeeper Role
- Specialist Responsibility
- Service Delivery Responsibilities
- Care Coordination
- Appointment and Wait Time Standards
- Provider Network Changes
- Removal of Member from Panel
- Provider Inquiries, Complaints, Requests for Information & General Grievances/Disputes
- Provider Directory
- Eligibility Verification
- Cancelled and Missed Appointments
- AHCCCS Cost Sharing & Co-payments
- Provision of Covered Services
- ASIIS
- Referrals and Prior Authorization
- Submitting Claims and Encounters

Provider Manual Sections

I. Introduction
II. Quick Reference Contact List
III. Provider Roles and Responsibilities
IV. Member Rights and Responsibilities
V. Eligibility and Enrollment
VI. Covered Services
VII. Behavioral Health Services
VIII. Claim Disputes and Appeals
IX. Medical Operations
X. Quality Management
XI. Billing, Claims and Encounters
XII. Fraud, Waste and Abuse

AHCCCS and DDD Benefit Updates

- Podiatry October 1, 2016
  - AHCCCS is covering Podiatry services when ordered by a PCP
  - Care1st requires Prior Authorization for Podiatry Services
- DDD members who are 21 years and older
  - Beginning October 1, 2016 or upon CMS approval (whichever is later), dental services, including dentures, are covered for AHCCCS DDD members 21 years of age and older
  - Dental services are limited to a total benefit amount of $1,000 per member for each 12 month period beginning October 1, 2016 through September 30, 2017
  - Coverage is member specific and the benefit limit remains in place even if member transfers plans
  - Unused benefits do NOT roll over
  - General Anesthesia (GA) will be covered and count towards the benefit limit. GA also requires prior authorization.
    - This includes dentists or physicians performing GA

AHCCCS and DDD Benefit Updates

- Differential Payments for Integrated Clinics
  - An integrated clinic is a provider licensed by the Arizona Department of Health Services as an Outpatient Treatment Center which provides both behavioral health services and physical health services
  - For contract year October 1, 2016 through September 30, 2017, a differential payment of 10% over the AHCCCS fee schedule will be paid for select physical health services
  - Qualified physical health services include Evaluation and Management codes, vaccine administration codes, and a global obstetric
    - Specifics codes can be found on the AHCCCS website

AHCCCS and DDD Benefit Updates

- KidsCare Re-Instated September 1, 2016
  - AHCCCS coverage for children under 19 who are not eligible for other AHCCCS health insurance (Includes a monthly premium)
- Treat and Refer Recognition Program January 1, 2017
  - Emergency teams will be able to treat a patient at the scene and then refer to PCP, Behavioral Health, Urgent Care or other Specialist for further care
  - Recognized providers can bill A0998 with appropriate modifier
- AzEIP Speech Therapy Rate Increase October 1, 2016
  - The rates for AzEIP members have been increased for speech therapy services (procedure code 92507)
  - Care1st will pay the greater of the AHCCCS rate or the Contracted rate

Dental

Advantica Website

https://www.advanticabenefits.com/

- Online Provider Portal
  - Providers > Provider Login
- Dental Clinical and Billing Guidelines
  - Providers > Provider Login > Log on > Reference Manuals
  - Guidelines also are available on Care1st website: www.care1st.com/az Providers > Dental

Dental

Advantica Website

Dental Claims

Electronic Data Interchange (EDI)

- **CHANGE Healthcare (Emdeon)**
  - Contact your software vendor to set up electronic submissions to CHANGE Healthcare (Emdeon)
  - For CHANGE Healthcare (Emdeon) Dental Connect support or questions 888-255-7293 or dentalproducts@changehealthcare.com or dentalsupport@changehealthcare.com
- **EHG – EDI Health Group, Inc.–DentalXChange**
  - Enroll online http://www.dentalxchange.com/partners/WebClaim or call (800) 576-6412, ext. 455
- **Tesia**
  - Enroll online www.tesia.com or call (800) 724-7240
- **Advantica Web Portal**
  - Register at www.advanticabenefits.com/providers

Dental Claims

Electronic Funds Transfer (EFT)

- Advantica partners with CHANGE Healthcare (Emdeon)
- **Options for enrolling**
  - Enroll online at https://www.emdeondental.com/
  - Enroll via phone at (888) 255-7293 Mon-Fri 8am-7pm EST
  - You no longer are required to enter an NPI to complete enrollment

Benefits to moving electronic

- Increase Staff Productivity
- Reduce risk of theft or fraud
- Achieve more predictable cash flow

Dental Claims

Top 5 Dental Denials

1. Duplicate services previously submitted and processed
2. Service(s) not covered when rendered by out of network provider
3. Claims filing deadline has expired
4. FQHC claims must be submitted with the facility NPI. Please resubmit.
5. A Narrative and x-ray of the treatment area is required to determine benefit. Please resubmit with narrative and x-ray.

Dental Claims

Claim Tips

- Guidelines & documentation requirements are available at:
  - Advantica Website - www.advanticabenefits.com - Providers > Provider Login > Log on > Reference Manuals
  - Care1st Website - www.care1st.com/az - Providers > Dental
- When submitting a COB claim – Please ensure primary carrier information is included on the claim form:
  - Subscriber's Name
  - Date of Birth
  - Primary Insurance Member ID Number
  - Employer Group

Dental Prior Authorization

Prior Authorization Tips

1. Services that require Authorization are identified with an * on the Clinical and Billing Guidelines
2. Submit prior auth requests online for fast turnaround time – Standard requests are processed within two (2) business days and urgent requests are processed within one (1) business day
3. Only request prior auth for services that require authorization. *Example* – Stainless steel crowns (D2930) for primary posterior teeth do not require a prior authorization.

Dental Prior Authorization

Prior Authorization Tips continued

4. Prior auth requests for general anesthesia should include name of the anesthesiologist or anesthesia group and the estimated treatment time
5. Prior auth request for general anesthesia also should include a narrative as to why anesthesia is requested and previous experience with attempts to treat (ie. Nitrous, OCS, etc). Medical and behavioral conditions should also be included.
6. Periodontal scaling and root planning prior auth submissions require X-rays, perio charting and documentation of patient's oral hygiene

Dental Prior Authorization

Other Tips

1. D9230 is not covered with D9248
2. D9240 is not covered on the same day as hospital or ACS procedure, service/treatment
3. D0210 and D0330 cannot be billed in conjunction and only 1 is allowed every 36 months
4. Porcelain crowns and crown build-ups are not covered if tooth has not been endo treated
5. Porcelain crown is not covered for patients under 18 years of age
6. Space maintainers for 1st primary molars are not covered after 6 year molars have erupted into occlusion
7. FQHC Tips
   - Please add “FQHC” in the remarks section of the ADA form and bill with appropriate fees

Advantica Customer Service: 866-429-0495

Q & A