Welcome to our summer issue of Advantage, our newsletter for ArchCare Advantage network providers. This edition includes the latest updates on ArchCare Advantage HMO Special Needs Plan as well as other important information to help you deliver the best care possible for our members.

We welcome your questions and feedback. Please let us know what you think by dropping a note to Advantage Provider News, 205 Lexington Avenue, 14th Floor, New York, NY 10016. Or email us at AAProviderServices@archcare.org.

As always, thank you for your continued commitment to ArchCare Advantage and our members.

Jeannette Gutierrez

Jeannette Gutierrez
Contract Manager - Provider Relations

ARCHCARE ADVANTAGE CONTINUES TO GROW

ArchCare Advantage is now available in more places than ever before. Eligible residents of all five boroughs of New York City, Putnam and Westchester counties, and upstate New York's Onondaga County are reaping the benefits of the personalized care coordination and other attractive features that ArchCare Advantage offers.

We are continuing to expand our provider network and pursuing strategic partnerships to bring our services to the growing number of communities we serve. Our goal is to deliver the same top-caliber preventive care and attention to members' individual health challenges to our newest enrollees in Kings, Queens, Putnam and Onondaga counties that we do for our long-time members.

In April, residents of the 450-bed Loretto Health and Rehabilitation Center in Syracuse, NY, began enrolling in the plan as Loretto became the first long-term care provider outside the New York metropolitan area to partner with ArchCare Advantage.

Loretto is Central New York's largest elder care provider, with 22 specialized health and long-term care programs serving more than 6,000 seniors and their families throughout Onondaga County. Like ArchCare, Loretto is a provider-based healthcare system anchored by Catholic roots. Our two organizations share similar values and a commitment to delivering excellent care with dignity, integrity and respect to those we serve.

Sample membership card for residents of Onondaga County, New York.

ARCHCARE ADVANTAGE LAUNCHES HEART FAILURE IMPROVEMENT PROGRAM

Sheree Starrett, M.D., M.S.
Medical Director, ArchCare Advantage

Heart failure is a leading cause of hospitalization and death in the elderly. According to the American College of Cardiology and the American Heart Association, between six and 10 percent of people over 65 have heart failure. Of those hospitalized with the condition, four out of five are older than 65. Heart failure is also a leading cause of 30-day hospital readmissions.

ArchCare Advantage claims data reveals that fully half of our members have been diagnosed with heart failure. They account for half of all hospitalizations and a disproportionate number of 30-day readmissions.

The Centers for Medicare and Medicaid Services (CMS) requires ArchCare Advantage to have a Chronic Care Improvement Program (CCIP). Because so many of our members are diagnosed with heart failure, we have submitted a CCIP aimed at improving the care of those with this very serious condition.

Our heart failure CCIP is focused on educating patients and their families about the condition, and equipping them to more effectively monitor and manage their own symptoms. Our caregivers are reinforcing self-management tips such as:

• Recommending moderately restricting salt;
• Encouraging smoking cessation;
• Emphasizing the importance of monitoring changes in weight;
• Recognizing the early warning signs of worsening heart failure; and,
• Being aware of subtle changes in symptoms such as increased fatigue, lethargy, increasing edema or weight change, loss of appetite, cough, and worsening shortness of breath, and reporting them to their physician, nurse or care manager.

Providers can find additional resources in the National PACE Association Practice Guideline for Congestive Heart Failure, which is available on our website at http://www.archcareadvantage.org/downloads/2012-PACE-CHF-Guidelines.pdf.

We recognize that guidelines are an adjunct to and not a replacement for sound clinical judgment, and that each patient's care goals and co-morbidities must be carefully considered in developing a treatment plan for heart failure. However, for those members for whom standard treatment is appropriate, we will review pharmacy data to determine whether ACE inhibitor or ARB therapy and beta blocker treatments have been initiated and are properly dosed. In cases where we do not see the standard treatments, the member's ArchCare Advantage care manager and/or physician will be contacted so the recommended therapy can be considered and ordered if appropriate.

We believe better education, more effective self-management, and closer oversight of medication adherence can significantly reduce hospital admissions and readmissions and provide relief from symptoms and a better quality of life for our members with heart failure.

END-OF-LIFE OPTIONS: THE PALLIATIVE CARE INFORMATION ACT

Under the Palliative Care Information Act, physicians and nurse practitioners are required by law to offer terminally ill patients information and counseling concerning palliative care and the end-of-life options available to them. Under the law, this information and counseling must be offered to patients with an illness or condition that is reasonably expected to cause death within six months. The Act defines palliative care as "health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care."

The Act was created to ensure that patients are fully informed of the options available to them, and empower them to make choices that are consistent with their beliefs, preferences and desired quality of life. When the patient lacks medical decision-making capacity, the information and counseling is to be provided to the person with authority to make health care decisions on his or her behalf.

The law is not intended to limit the options available to those who are terminally ill, nor should it discourage conversations about palliative care with patients whose life expectancy exceeds six months. In many cases it may be appropriate to discuss palliative care with patients earlier in the progression of their illness.

The attending practitioner is required to offer the information either orally or in writing, including:

• The patient's prognosis;
• The range of options appropriate for the patient;
• The potential risks and benefits of various options; and,
• The patient's legal right to comprehensive pain and symptom management at the end of life.

If necessary, a practitioner may arrange for information and counseling to be provided by another qualified individual. If the provider is not willing to provide the necessary information and counseling, he or she must arrange for another physician or nurse practitioner to do so, or must refer or transfer the patient to another physician or nurse practitioner.

Diagnosis coding errors delay payments and disrupt the productivity and cash flows of countless provider practices every year. Claims may be paid incorrectly, or not paid at all. The bigger the practice, the greater the impact and the more challenging coding errors can become.

The Centers for Medicare and Medicaid Services (CMS) requires accurate and complete diagnosis coding in accordance with official guidelines and CMS regulations. Practicing sound recordkeeping and good coding is the easiest way to prevent unnecessary errors.

WHAT CONSTITUTES A GOOD MEDICAL RECORD?

A good medical record is one in which the proper documentation accompanies all reported diagnoses. Coders must ensure that documentation is:

- Clear
- Concise
- Consistent
- Complete
- Legible

HOW CAN I MAKE SURE MY PRACTICE IS SUBMITTING PROPER DOCUMENTATION?

Be sure your coders observe these simple rules:

- All medical records must have a legible signature, including provider credentials.
- Electronic medical records must be authenticated with the statement "electronically signed by" followed by the provider's name and credentials.
- Ensure that all codes are as specific as required and fully explain the symptom or diagnosis in the medical chart. For example: code 250.00, not 250.
- Avoid unspecified codes.
- Be on the lookout for discrepancies between the diagnosis code being billed and the written description of the diagnosis in the medical record.
- Documentation must indicate if diagnoses are being monitored, evaluated, assessed/addressed, or treated.
- The patient's treatment status, i.e., whether the patient is still being treated or not, must be clear, and the treatment documented.
- Chronic conditions must be coded as such and must also be documented in the patient's medical record at least once a year. Acute and chronic conditions may pay differently.
- Report mandatory manifestation codes when necessary, e.g., diabetes with renal complications.
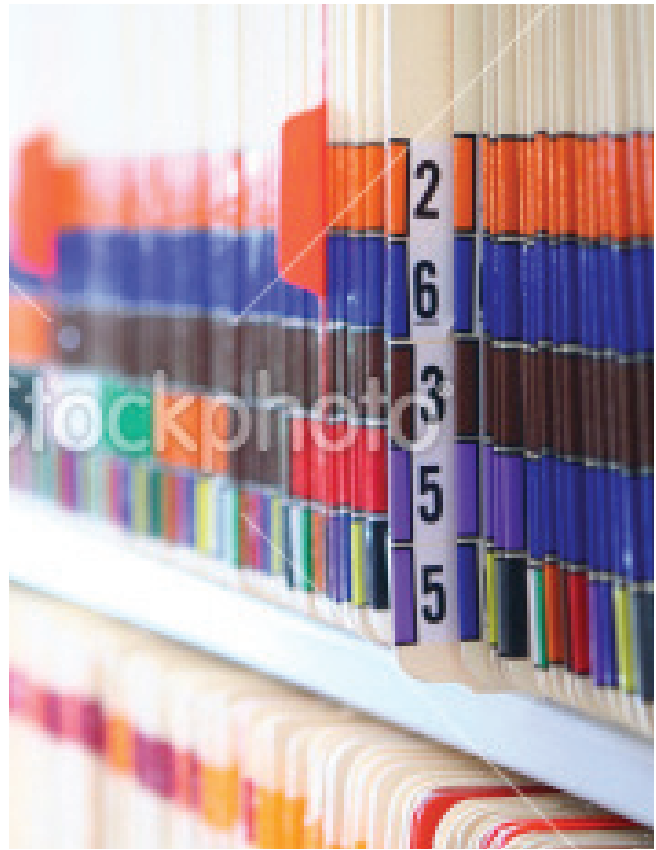
USING CPT CATEGORY II CODES

We encourage providers to code and submit CPT Category II codes. Using CPT II codes helps minimize the need for medical record abstraction and chart review, and reduces the administrative burden on providers and quality measurement organizations.

CPT II Codes are supplemental tracking codes that aid in the collection of quality of care data.

They describe:

- Clinical components, such as those typically included in evaluation, management, or other clinical services;
- Results from clinical laboratory or radiology tests and other procedures;
- Processes intended to address patient safety; and,
- Services reflecting compliance with state or federal law.

In general, CPT II codes are optional and not required for correct coding, and they may not be used in place of Category I codes. CPT II codes have no relative value associated with them and must be billed with a $0.00 charge amount.

Category II codes are published biannually on January 1 and July 1. For more information, a list of current codes, and recent guidelines, visit www.ama-ass.org/go-cpt.

CLAIMS CORNER

ELECTRONIC CLAIMS SPEED PAYMENTS AND BOOST PRODUCTIVITY

At ArchCare Advantage, we strongly encourage all providers to submit claims electronically. Electronic data interchange, or EDI, can have a significant positive impact on the productivity and cash flow of your practice. The benefits include:

- Reduced paperwork and expenses associated with printing and mailing paper claims;
- Shorter processing time;
- Quicker resolution of claim problems, since incorrect claims can be corrected and re-submitted electronically;
- Better accuracy, including fewer transcription errors and claims filed with missing or incorrect data; and,
- The ability to track the status of all claims electronically.

Electronic claim submission for ArchCare Advantage is easy to establish. Here are three methods:

- Submit your claims directly to Emdeon. Providers should call 1-866-924-4634 Ext. 4 or go to www.emdeon.com for system requirements and set-up instructions.
- Contact your clearinghouse with instructions to forward ArchCare Advantage claims to Emdeon.
- Enroll your office in online claim submission via MD On-line, a free service for non-facility providers who do not have claims submission software. Visit www.tbsmdol.com to register.

ARCHCARE ADVANTAGE'S PAYER ID # IS 31144.

We also recommend that providers regularly review all EDI acknowledgement and rejection reports returned to their practice.

NEW REQUIREMENT FOR HOME HEALTH CLAIMS

Home health providers are required to bill on the UB-04 paper claim form or using the electronic 837-I format, which is ArchCare's preferred method.

Effective July 2013, all home health providers are required to submit Health Insurance Prospective Payment System (HIPPS) codes for all encounters.

Beginning October 2013, home health providers are required to use Type of Bill 032X for all home health services provided under a plan of treatment.

If all of the required and correct elements are not submitted in accordance with CMS billing guidelines, claims may be denied.

COMPLIANCE TIP

Issue:	Medicare is denying an increasing number of claims because documentation submitted for diagnostic tests does not include signed test orders or evidence of intent (MD progress notes listing tests needed) and evidence of medical necessity (description of clinical conditions and treatment showing the need for the testing).
Guidance:	While the physician's signature is not required when initially ordering clinical diagnostic tests, upon review by Medicare contractors there must be evidence to support the physician's intent to order the tests performed, and documentation of medical necessity is required. Claims may be denied if any are missing. If the physician's signature is not legible on an order or progress note, providers may submit a signature log or attestation to support the identity of the illegible signature.

For more information, please refer to the Medicare Learning Network® publication titled Complying with Medicare Signature Requirements at http://go.cms.gov/RFOOWD (link is case-sensitive).

Providers must report non-compliance, fraud, waste and abuse to 1-800-443-0463 or to ComplianceReport@archcare.org