Advantage PROVIDER NEWSLETTER

SUMMER 2015

archcare Advantage
HMO Special Needs Plan

Welcome to the Summer issue of Advantage, our newsletter for ArchCare Advantage network providers. This edition includes the latest information about ArchCare Advantage HMO Special Needs Plan and looks at new programs and tools for members, our medication transition program, tips to streamline claims processing, and other valuable information for you and your practice.

We welcome your feedback. Please let us know what you think by dropping a note to Advantage Provider News, 33 Irving Place, 11th Floor, New York, NY 10003. Or email us at **AAProviderServices@archcare.org**.

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

JOSEPH BRYANT
Director, Network Development

COMMUNITY CORNER: NEIGHBORS HELPING NEIGHBORS

ArchCare's emphasis on volunteerism and support for members and their family caregivers gained a major boost last fall when ArchCare became the sponsor of the TimeBank, a free volunteer service exchange program that matches people in need of assistance with members of their local communities with the time and desire to help. We are excited to report that the TimeBank has so far grown to more than 800 volunteer members of all ages and backgrounds.

ArchCare TimeBank is currently operating in the Washington Heights/Inwood, Lower East Side, and Battery Park City neighborhoods of Manhattan, and in Sunset Park, Brooklyn.

ArchCare TimeBank welcomes referrals of patients or family members in these areas who could benefit from assistance with shopping, an escort to the doctor, friendly visits, help with household chores, and more. Regardless of where they live, patients may also benefit from friendly phone calls from TimeBank volunteer members.

For more information on ArchCare TimeBank, go to **www.archcare.org/community-resources/timebank, email archcaretimebank@archcare.org**, or call or **844-880-4480**.

UNDERSTANDING MEDICATION TRANSITIONS

Ensuring that ArchCare Advantage members receive the medication that is best suited to their medical needs and past medication experience is a top priority. Sometimes, physicians may choose to prescribe medications for members that are not on our formulary, or that require prior authorization before a prescription is filled, or are subject to limits on the quantity dispensed. Understanding ArchCare Advantage's medication transition policies and processes can help ensure that your patient receives the most appropriate therapy without unnecessary delays.

Only the physician can decide whether a different drug covered by the plan would be appropriate for a particular patient. If you believe that your patient should continue on the non-formulary drug you have prescribed, you or your staff can contact ArchCare Advantage to request a formulary exception.

During the first 90 days of membership in our plan, we may cover drugs not on our formulary to give the member sufficient time to speak with the physician. If the member fills such a prescription, you and the member will both receive a letter with information on the medication transition process and the options available.

If a medication is not on our formulary, or if the member's ability to obtain the drug is limited, we will cover a temporary 30-day supply from a network pharmacy (unless the prescription is written for fewer days). Other conditions may apply.

If the member is a resident of a long-term care facility or lives in an assisted living facility, we will cover a temporary 91-day transition supply (unless the prescription is written for fewer days). We will cover more than one refill of these drugs for the first 90 days of membership in our plan. If the drug is not on our formulary and the member is past the first 90 days of membership in our plan, we may cover up to a 31-day emergency supply of that drug while the member and physician pursue a formulary exception.

To view the current formulary, go to **www.archcareadvantage.org** and click on Prescription Drugs.

To request a coverage determination or formulary exception, call **855-344-0930** (TTY: 866-236-1069), 24 hours a day, 7 days a week.

For any other questions, contact Provider Services at **888-816-7977** (TTY: 866-236-1069), 24 hours a day, 7 days a week.

COMPLIANCE CORNER

DID YOU KNOW...

The U.S. Centers for Medicare and Medicaid Services (CMS) requires ArchCare to monitor all first-tier, downstream, and related entities, including providers, for fraud, waste and abuse.

Some of the specific items we monitor are upcoding, unbundling, medical necessity, and the improper use of modifiers. As a contracted provider, you are required to report noncompliance, fraud waste and abuse to us.

If you are a Medicaid provider with more than $500,000 a year in Medicaid billings, you are also required to have an effective compliance program that includes annual compliance training for your staff.

DO YOUR PART TO PREVENT FRAUD

Please do your part to prevent fraud by reporting suspected medical identity theft to your local law enforcement agency, your state Medicaid agency, or your regional office of the U.S. Department of Health and Human Services. You can also report suspected fraud to ArchCare's Compliance Hotline at **800-443-0463**, or email us at **ComplianceReport@archcare.org**.

CLAIMS CORNER

TRANSITIONING TO ICD-10 IN OCTOBER 2015

CMS has developed multiple tools and resources to help ease the ICD-10 transition. These resources include an overview of ICD-10, implementation guides, tools for small and rural providers, and general equivalency mappings (ICD-9 to ICD-10 crosswalk).

Visit the CMS ICD-10 website, cms.gov/ICD10 to see all the resources available.

SERVICE MONTHS THAT OVERLAP

To avoid delays or claim processing errors, providers are required to submit a separate claim form for services incurred in different services months.

HIPPS CODES FOR SNF AND HHA ENCOUNTERS

All SNF claims/encounters and HHA claims for dates of service beginning July 1, 2014 must include a HIPPS code on each claim/encounter billed for adjudication. For more information about HIPPS codes, go to: **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/hippsusesv4.pdf**.

REVIEW REMITTANCE ADVICE

Be sure to review each remittance advice regularly for messages explaining your claim outcome. In some instances, there may be more than one message explaining a particular claim decision.

If you disagree with the claim outcome, the next step is to request reconsideration of the claim and submit all supporting documents or a corrected claim timely to avoid further delays or possible rejection for untimely resubmission.

REFERRALS AND PRIOR AUTHORIZATIONS

ArchCare Advantage requires both participating and non-participating primary care physicians to complete the appropriate referral or prior authorization form when requesting a service that is subject to prior authorization under our plan. Completed forms should be sent to the Clinical Services Department at least 7 business days prior to the anticipated date of service, and the providers must obtain an authorization number from Clinical Services before providing the service. If the provider fails to submit appropriate documentation or renders service without authorization or in excess of what is authorized, the provider will not receive reimbursement and will need to file an appeal. Documentation submitted must include all relevant information including, but not limited to, medical history, medications, test results, treatment plan, scope of services/procedures being requested, date and location of service, and any other requirements such as medical clearance.

A member of the clinical services team will consult with the provider when necessary and advise the provider of the determination. Approved services will be assigned an authorization number. Incomplete/illegible referral forms that do not contain the required information will not be processed. The clinical staff will attempt to contact the provider by phone to clarify the information. If the provider cannot be reached within 24 hours, the provider and member will be notified that a 14-day extension is needed to make a determination. If there has been no response to the extension notice, the service will be denied. If the required information is received, the case will be re-reviewed and the clinical staff will make a determination of medical necessity within the required timeframe.

TIPS ON DOCUMENTATION AND CODING

- Assess all chronic conditions annually. CMS wipes the slate clean on January 1 and expects conditions to be reported for the New Year.
- Become familiar with official diagnosis coding guidelines.
- Check for basic requirements: signature, patient name, and date of service.
- Thoroughly document and code all active conditions evaluated during each visit, even if the patient presents a simple condition. Do not code for resolved conditions.
- Document the diagnosis code to the highest level of specificity. For example, diabetic conditions and manifestations should be documented and coded for each manifestation.
- Stay away from terms such as "history of" if the condition is a chronic or ongoing condition. "History of" is used to document resolved conditions. Instead, consider the phrase, "ongoing history of" to confirm that the condition is ongoing and currently being treated.
- Review the medical record for new lab reports, consult reports, and inpatient records before each patient encounter.