

Provider Connection™

Volume 5, Number 3
Summer 2010



Mission Statement

Delaware Physicians Care, an Aetna Medicaid Plan, strives for value, integrity and compassion in health care management and consulting.

Vision

The vision of Delaware Physicians Care, an Aetna Medicaid Plan, is to be recognized as the nation's foremost managed care resource by providing the highest value management and consulting services throughout the health care continuum.

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Claims Inquiry

Please call 1-866-543-2167.

Select option #2 for provider, then select option #1 for claims department.

Editor - Jeanne Walsh

Submit Your Claims Electronically

Start submitting electronic claims to Delaware Physicians Care today!

Benefits of electronic claims submission are:

- Streamlined electronic billing means less paperwork, less time wasted and a more efficient office
- Lower claims rejection rates - detailed verification reports of receipt by Delaware Physicians Care
- Faster claim delivery than by traditional mail - clean claims mean less money wasted for reprocessing
- Capability to resubmit claims with missing or invalid data
- Faster claim payment to your office

Our electronic claims vendors are Emdeon – www.emdeon.com - and RelayHealth – www.relayhealth.com. Claims may be electronically submitted to Emdeon, RelayHealth or another HIPAA compliant clearinghouse. All clearinghouses work with Emdeon and RelayHealth.

Some additional clearinghouses are listed below.

Cortex EDI – www.cortexedi.com
HIPAAsuite – www.hipaasuite.com
i-Plexus Solutions – www.iplexus.net
Electronic Commerce Processing (ECP) – www.4ecp.com
Gateway EDI – www.gatewayedi.com
Free Claims – www.freeclaims.com

Please contact your vendor directly to confirm any costs associated with submitting claims. If you are already set up with a clearinghouse, start submitting claims today by simply using Delaware Physicians Care's electronic payer ID 27009. Typically, you will receive an acknowledgement of claims receipt or rejection within 24 – 48 hours.

As always, we are here to assist you. Please contact your Provider Relations representative at 1-800-287-9860 with any questions about electronic submission of claims.



Control Your Heart for the Future Program

IMPROVING QUALITY OF LIFE FOR MEMBERS WITH CONGESTIVE HEART FAILURE (CHF)

Delaware Physicians Care (DPCI) and Christiana Care Visiting Nurses (CCVNA) want to help your DPCI CHF patients improve their quality of life. The focus is on education and interactive biometric in-home monitoring using field based case management.

This 12 week program offers early patient alerts that help avoid inpatient stays and emergency room use by combining DPCI's case management program with CCVNA's heart failure program. It offers physicians the opportunity to identify complex patients with uncontrolled heart failure.

Once the patient is enrolled, the physician and cardiologist will receive a letter outlining the details and a copy of the patients' education materials used in the program. There is no charge to the patient for this intervention with a great potential to improve their overall health.



TELE-MONITORING

Provides an opportunity to identify trends in vital signs that can signal CHF worsening which can be mitigated as soon as it's discovered.

When identified, the CCVNA nurse will assist the physician by:

- Reporting any abnormalities.
- Getting assistance to identify required medication or changes to treatment.
- Obtaining new orders from attending physicians if there are no standing protocols; orders validated by securing physician's signature.

WHO IS ELIGIBLE FOR REFERRAL?

DPCI MEMBERS WHO:

- Are 40 years old or older (individual consideration given if younger)
- Primary or secondary diagnosis of heart failure
- Had three or more hospitalizations or a combination of one hospitalization and four or more ER visits in the last 12 months

To refer an eligible patient, contact Maryellen Bogert, RN, Delaware Physicians Care case manager, at 302-894-6758.

Important information regarding HIPAA 5010 transaction set upgrade

The following is an overview of upcoming federal changes to electronic health care data, specifically addressing the Health Insurance Portability and Accountability Act (HIPAA) 5010 transaction set. As a provider, it is important you understand the HIPAA 5010 upgrade and how to prepare.

HIPAA 5010 transaction set and ICD-10 code set upgrades

On Jan. 15, 2009, the United States Department of Health and Human Services (HHS) released two final rules for electronic data as part of the Administrative Simplification Provision of the Health Insurance Portability and Accountability Act (HIPAA). The following federal provisions will facilitate a nationwide conversion to an electronic health care environment:

- Updated standards for electronic health care and pharmacy transactions (Electronic Data Interface [EDI] HIPAA 5010) – effective Jan. 1, 2012.
- New diagnosis and procedure coding standards (ICD-10-Clinical Modification [CM] and ICD-10-Procedure Coding System [PCS]) – effective Oct. 1, 2013.

Providers must prepare for upcoming changes

Delaware Physicians Care encourages providers to prepare for these upgrades. For more information, visit: http://www.aetna.com/healthcare-professionals/policies_guidelines/national_provider_identifier.html

Delaware Physicians Care is currently assessing and planning for all aspects of transaction and code-set conversions. We plan to meet all required dates and specifications of these upgrades. Stay tuned for more information and routine updates from Delaware Physicians Care on the HIPAA 5010 transaction set and ICD-10 code set upgrades.

Questions regarding HIPAA 5010?

Please contact Delaware Physicians Care Provider Relations at 1-800-287-9860.

DMAP Provider Alert Notification - NICCI Special Notice - 09/01/10

SPECIAL NOTICE: MEDICAID MUST IMPLEMENT NATIONAL CORRECT CODING INITIATIVE EDITS

The federal Patient Protection and Affordable Care Act, Section 6507, passed into law earlier this year, mandates that for all claims filed on or after October 1, 2010, State Medicaid Agencies must incorporate and apply editing methodologies of the National Correct Coding Initiative (NCCI).

The Centers for Medicare and Medicaid Services (CMS) is charged by Congress with the responsibility for defining the adjudication rules, provider types, and claim types that will be subject to the NCCI edits. On September 1, 2010, CMS will issue guidance to State Medicaid agencies.

Delaware Medicaid, like all other State Medicaid agencies, will be required to enforce the edits in the claims processing environment. Two types of edits are mandated in the law: procedure-to-procedure, and unit of service. Until CMS sends additional information, we do not know which claims will be affected. Delaware Medicaid will provide additional guidance and clarification about NCCI editing as information becomes available.



For Your Patients with Diabetes

Delaware's Division of Public Health Diabetes Prevention and Control Program is offering a FREE Diabetes Self-Management Program to Delawareans with Type II diabetes. This evidence-based program, developed by Stanford University, teaches skills in the daily management of diabetes to:

- Improve quality of life
- Build confidence, increase knowledge about symptom control and the disease's impact
- Be highly interactive and is focused on skill-building, support and experiential sharing
- Assist in problem identification and solving

Participants will learn:

- Techniques to deal with diabetes symptoms, fatigue, pain, hyper/hypoglycemia, stress and emotional problems such as depression, anger, fear and frustration
- Exercises for maintaining and improving strength and endurance
- Healthy eating and appropriate use of medication
- To work more effectively with health care providers



For more information on dates, times and workshop locations of this 6 week program, please call Delaware's Division of Public Health Diabetes Prevention and Control Program at 302-744-1020.

The Diabetes Self-Management Program brochure can be viewed and downloaded by clicking on our website's home page at www.DelawarePhysiciansCare.com.

Clinical Practice Guideline Updates

Delaware Physicians Care is committed to improving safe clinical practice. We use clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. Each year we adopt evidence-based clinical practice guidelines from recognized sources. These guidelines are reviewed and approved by our Quality Management (QM) committee annually. The QM committee includes board-certified physicians in primary care and certain specialties such as gynecology and endocrinology.

To obtain the full version of these clinical practice guidelines, please visit the Providers page at our website, www.DelawarePhysiciansCare.com, or contact your Provider Relations representative.

Prior Authorization Notes and Reminders

All planned medical and surgical **inpatient admissions** require prior authorization.

Please remember, although the prior authorization requirement tool on our secure web portal is code specific, **some procedures may not require authorization in the outpatient setting. However, all planned inpatient admissions require prior authorization.**



Urgent Prior Authorization Requests: Our prior authorization department receives a high number of urgent prior authorization requests that do not meet the definition of urgent.

We would like to remind you that the definition of Urgent Care is addressed in **Section 14 - Prior Authorization** of the Delaware Physicians Care Provider Manual as follows:

Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- Could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Delaware Physicians Care makes prior authorization decisions in a timely manner to accommodate the clinical urgency of the situation. We adhere to the following timeframes for timeliness of the decision making:

- Routine or non-urgent pre-service decision - decision is made within 14 calendar days of receipt of the request
- Urgent pre-service decision - decision is made within 72 hours of receipt of the request.
- Post service decision - decision is made within 30 calendar days of receipt of the request.

If an urgent request is submitted and the request does not meet the above definition, we will notify the provider the request will follow the timeline for non-urgent pre-service.

Faxed prior authorization requests **must be submitted** on the current Prior Authorization Request Form. The form is located on our website at www.DelawarePhysiciansCare.com. Click on the Providers page, then Provider Forms.

NOTE: Failure to include correct ICD-9, CPT Codes, or notes may result in the return of the Prior Authorization Request Form, unprocessed.

Billing Requirements for Physician Administered Drugs

The State of Delaware's Division of Medicaid & Medical Assistance (DMMA) has been directed by the Centers for Medicare and Medicaid Services (CMS) to require contracted managed care organizations (MCOs) submit National Drug Code (NDC) data to the DMMA in the encounter reporting process.

DMMA is required by CMS to obtain information such as units, strength and package size by NDC for all drugs dispensed to Managed Care Clients that are paid for by the Managed Care Organizations (MCOs).

Coding instructions describing how such data should be provided is included in the Electronic Claims Submission (ECS) Guidelines which can be found on the Delaware Medical Assistance Program (DMAP) website at the following URL:

<https://www.dmap.state.de.us/downloads/forms/ECS.Guidelines.pdf>

When submitting electronically to Delaware Physicians Care for physician administered drugs, please use the following billing instructions:

If a drug is being billed, the NDC will be entered in the 2400 loop – SERVICE LINE NUMBER in the LIN03 transaction data element Product Service ID. This is a required loop on outpatient claims when revenue, procedure, or drug codes are reported in the SV2 segment. The LIN02 Qualifier ID should equal N4. The LIN03 value should contain the 11 digit NDC. There is a maximum of 3 NDCs allowed per service line.

Thank you for your cooperation in meeting this federal requirement. Please contact your Provider Relations representative at 1-800-287-9860 with any questions.



Gardasil® Coverage for Males

Delaware Physicians Care has received notice from the Division of Public Health (DPH) regarding an update from the Delaware Medical Assistance Program (DMAP) about coverage of Gardasil® for males. Following federal Food and Drug Administration and Centers for Disease Control (CDC) guidelines, Gardasil® for males age 9 to 26 is covered by DMAP, effective June 21, 2010.

Additionally, the Vaccines for Children (VFC) program covers Gardasil® for males through age 18.

Delaware Physicians Care follows DMAP guidelines for coverage of this vaccine. Refer regularly to the DMAP website at <http://www.dmap.state.de.us/downloads/bulletins.html> for current and archived bulletins.

Billing of Medicaid Members

The Delaware Medical Assistance Program (DMAP) and federal regulations generally do not permit providers to bill Medicaid clients for medical services. Please refer to Section 1.16 in the DMAP General Policy Manual at <http://www.dmap.state.de.us/downloads/manuals/General.Policy.Manual.pdf> for specifics. Please note that as a contracted Medicaid provider, billing a Delaware Physicians Care member for a missed appointment is prohibited.



Reminder of Professional Liability Insurance Coverage

Delaware Physicians Care (DPCI) requires limits of liability of not less than one million (\$1,000,000) dollars per occurrence and an annual aggregate of three million (\$3,000,000) dollars for all contracted providers. Failure to secure such professional liability will exclude you and/or your group from participating with DPCI. For existing contracted providers, failure to maintain such professional liability insurance coverage shall constitute a material breach of the DPCI Participating Health Provider Agreement and providers will be terminated from DPCI's network.

Provider Effective Date Policy Change

We want to make you aware of a positive change to the Delaware Physicians Care effective date policy.

Effective March 1, 2010, our process for determining a new provider's participation effective date has changed. Previously, a provider's effective date was the first of the month following the date the provider is approved by Delaware Physicians Care's Credentialing Committee, provided all contract documents have been received by Delaware Physicians Care. If credentialing was not required, the effective date was the first of the month following the date we receive the request to add the provider, or a future date the provider provides to us, whichever was later.

This process limited providers to only becoming effective at the beginning of each month. The new policy will offer an opportunity to become effective on the first or fifteenth of each month.

Effective March 1, 2010, a provider's effective date is determined according to the following standard scenarios:

Credentialing Required: The effective date is either the first or the fifteenth day of the month following the date the provider passes credentialing.*

Credentialing Not Required: The effective date is either the first or the fifteenth day of the month following the date we receive the completed contract, or a future date the provider provides to us, whichever is later.*

* The cutoff date for an effective date for the first of the following month is the fifteenth (15th) of the current month. If received between the sixteenth (16th) and the last day of the current month, the effective date is the fifteenth (15th) of the following month. For illustration purposes:

Network Development Cut Off Date	Provider Effective Date
Received on or before January 15, 2010	February 1, 2010
January 16, 2010- January 31, 2010	February 15, 2010
February 1, 2010- February 15, 2010	March 1, 2010
February 16, 2010- February 28, 2010	March 15, 2010

Please note, if services are provided to a Delaware Physicians Care member **prior** to the provider's effective date, claims will not be paid.

If you have any questions, please call your Provider Relations Representative at 1-800-287-9860.

Provider Relations Team

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Our website is always open!

Get the latest updates, communications and resources, such as our Provider Manual, Provider Newsletters, important forms, bulletins, clinical and preventive guidelines, and more by visiting www.DelawarePhysiciansCare.com. It is also the gateway to our secure provider portal and prior authorization requirement tool.

Potential Fraud or Abuse Issues and Concerns

Delaware Physicians Care provides a number of avenues to report compliance matters, including potential fraud or abuse issues. This is especially important when you or your office suspect or identify these scenarios:

- Members living out of the state of Delaware
- Use of a Medicaid ID that is not the member's
- Potential drug seeking members

You can report suspected fraud or abuse to us in the following ways:

- Write to Delaware Physicians Care
Attn: Compliance Officer, 252 Chapman Rd, Ste 250,
Newark, DE 19702
- Email our Compliance Officer: Bianca.Pagan@Aetna.com
- Fax your concern to 1-860-907-2300
- Call our compliance hotline toll free at 1-866-781-6403 - 24 hours a day, 7 days a week
- Log on to www.DelawarePhysiciansCare.com. Click on the Fraud and Abuse tab, complete the electronic form and hit submit

Everything we do at Delaware Physicians Care has some connection to living by our values, meeting commitments and following the laws and regulations that govern our business. We believe that our providers agree that compliance is everyone's business and thank you for your partnership and commitment.

Provider Orientation Schedule

We offer free monthly provider office orientation sessions, held at various central locations throughout the state, for new providers, offices with new staff and offices that need a Delaware Physicians Care refresher. Feedback from orientation participants has been extremely positive, especially in transitioning new providers and their staff to our processes and policies. Join us for light refreshments and great information about working with us

THE NEXT FOUR ORIENTATION SESSIONS ARE:

SEPTEMBER 17, 2010

DPCI Health Plan

9:30 a.m. to 12 p.m.

OCTOBER 15, 2010

Nanticoke Memorial Hospital

9:30 a.m. to 12 p.m.

NOVEMBER 19, 2010

Bayhealth Medical Center

Kent General Hospital in Dover

9:30 a.m. to 12 p.m.

DECEMBER 17, 2010

DPCI Health Plan

9:30 a.m. to 12 p.m.

Contact Christine Byrom at 302-894-6795 or christine.byrom@aetna.com for directions and to register for any date.

Claims Reconsideration Process vs. Provider Appeal Process

Delaware Physicians Care has two separate and distinct processes designed to assist providers with issue resolution.

The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal.



	CLAIMS RECONSIDERATION	APPEAL
FORM (available at www.DelawarePhysiciansCare.com)	Claims Reconsideration/Resubmission Form	Appeal Form
ADDRESS	Delaware Physicians Care Attn: Claims Resubmission/Reconsideration PO Box 61145 Phoenix, AZ 85082-1145	Delaware Physicians Care Attn: Appeals Department 252 Chapman Rd, Ste 250 Newark, DE 19702-5406 Fax: 877-473-8125
APPROPRIATE CATEGORIES	<ul style="list-style-type: none"> • Claim resubmissions • Corrected claims (including missing/incomplete/invalid diagnosis, procedure or modifier denials) • Timely filing • COB (missing/illegible primary explanation of benefits) 	<ul style="list-style-type: none"> • Denied days for inpatient stays • Authorization denials for late notification • Claims denials for no authorization/precertification • Services denied per finding of a review organization
TIMEFRAME FOR SUBMISSION	Claims reconsiderations / resubmissions must be submitted within 12 months of the date of service.	Claim denial appeals must be submitted within 12 months of the date of service. Authorization denial appeals must be submitted within 90 days after the date of the adverse action (denial letter).