

At A Glance

CMS Proposes New Fraud and Abuse Rules	2
PCA Program Updates	2
Provider Alerts	3

Visit
www.mnscha.org
for Provider
Resources



Spotlight

Receive your bimonthly Provider Network Newsletter and Flash Bulletins automatically via e-mail! Get the most up-to-date information as soon as it is available. Eliminate interoffice routing and distribution by having multiple staff sign up! To start receiving the Newsletter via e-mail go to www.mnscha.org and click on the envelope icon .



SOUTH COUNTRY
HEALTH ALLIANCE



Director's Corner

*Mark Ward, Director
Provider Network Management*

Change in Member County Participation

South Country Health Alliance (SCHA) will be experiencing a change in the number of member counties participating in the program starting January 1, 2011. Cass and Crow Wing counties have elected to end their relationship with SCHA for both the Minnesota Health Care Programs (Medicaid products) and for the Centers for Medicare and Medicaid (CMS) dual-eligible programs (Medicare products) on December 31, 2010.

This decision by Cass and Crow Wing counties **DOES NOT CHANGE** how providers should continue to serve and bill services for current SCHA members in these two counties. As Providers are ordering any services or treatments that may occur after December 31, 2010, please be aware that you will need to check MN-ITS to see what Manage Care Organization (MCO) the member may have chosen for 2011 coverage and obtain any authorization from that MCO. SCHA will be informing the member that we cannot guarantee coverage after December 31, 2010, and that they will need to work with their new MCO. **Everything will continue as "business as usual" through the end of calendar year 2010.**

The Department of Health and Human Services (DHS) has issued a "Request for Proposals" for MCOs interested in serving Cass and Crow Wing counties effective January 1, 2011. SCHA has learned that Blue Plus, Medica, and UCare are MCO options in Cass and Crow Wing counties for PMAP, MSC+ and MinnesotaCare enrollees. SCHA is committed to keeping its Provider Network updated through this process to help ensure a smooth transition, so look for updates in future Provider Newsletters as well as on the SCHA web site.

Health Care Home Update

SCHA is pleased to extend congratulations to Lakewood Health System for obtaining their Health Care Home (HCH) certification from the Minnesota Department of Health (MDH). The five Lakewood Health System primary care locations will be SCHA's first contracted HCHs in our Provider Network. SCHA and Lakewood have begun the process to integrate the care coordination efforts between the organizations with the focus being to optimize our combined efforts for the benefit of the patient/member.

Providers who are pursuing HCH certification are encouraged to contact SCHA at ProviderInfo@mnscha.org so we can plan for adding to your current contract when you receive MDH certification. ■

CMS Proposes New Fraud and Abuse Rules

Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule (CMS-6028-P) that implements various fraud and abuse provisions of the Affordable Care Act. Among the areas addressed are screening procedures for providers and suppliers under Medicare, Medicaid, and SCHIP programs. CMS is required to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse. The types of screening may include criminal background checks, fingerprinting, unannounced or unannounced site visits, and database checks.

Other areas addressed include: (1) an application fee on providers and suppliers; (2) temporary moratoria that may be imposed if necessary to prevent or combat fraud, waste, and

abuse; (3) procedures to terminate providers if terminated by Medicare or another state plan; and

(4) requirements for suspension of payments pending credible allegations of fraud in both the Medicare and Medicaid programs. The proposed rule also presents an approach and requests comments on the provisions of the Affordable Care Act that require providers and suppliers to establish compliance programs.

The proposed regulation was published in the Federal Register today. Comments on the proposed rule are due no later than November 16, 2010. ■

SCHA Provider Network Management Staff

Mark Ward

Director of Provider Network Management

Jim Barkhaus

Provider Network Manager

Melissa Campbell, RHIA, CCS

Provider Education & Coding Manager

Jeanette Garcia

Credentialing Specialist

Christine Irish-Lamont, CCS-P

Coding & Reimbursement Specialist

Beth Eaton

Coding & Reimbursement Specialist

Carolyn Bauman

Provider Data Application Analyst

Carol Mahagnoul

*Dept. Support Specialist,
Provider Network Management*

©2010 by South Country Health Alliance

Provider Network News is a bimonthly publication of South Country Health Alliance. For submission information, or reprint permission, contact: SCHA, 110 West Fremont St., Owatonna, MN 55060, USA

• E-mail: mcampbell@mnscha.org

• Web site: www.mnscha.org

PCA Program Updates

A New Member Rights Document will be used for members receiving PCA services beginning on 12/1/2010. This document will be used by SCHA and all other health plans who serve public program members. The new member rights document indicates that the MCO's need to provide 30 days notice to the member prior to any changes being made in their PCA services.

Billing/Tracking PCA Hours

A 275 Hour/ Month Reimbursement limit for individual PCAs providing services to SCHA members is being enforced. PCA provider agencies will not receive payment for services provided by an individual

PCA that exceeds the 275 hour/1100 unit/month limit. DHS is working with all MCOs and through FFS to enforce this hour limitation.

24 hour/day (96 unit) limit edit is in place which will not allow PCA agencies to be paid for more than 96 units per day for any individual PCA provider in any given day of providing service.

2011 changes

Beginning on July 1, 2011, new legislation will bring changes to the PCA ADL assessment requirements, additional information will be available in the coming months. ■

CLICK ON ME!

Get the most up-to-date information as soon as it is available. Go to www.mnscha.org and

click on the envelope icon!



REPORTING Fraud, Waste and Abuse

SCHA believes it is the responsibility of everyone to report suspected fraud, waste or abuse. You can report anonymously through our REPORT-IT hot line by calling 1-877-778-5463. You can also make a report at www.reportit.net. Username: SCHA, Password: Owatonna

Provider Alerts

180 Day Time Frame for Filing Claims

Effective January 1, 2011

Providers will no longer have 365 days to file their claims to South Country Health Alliance. Clean claims must be filed within 180 days from the date of service.

Reference: Minnesota Statute 62Q75, Prompt Payment Required

Standards

- Claims and encounter data must be submitted to South Country Health Alliance within 180 days from the date of service or date of discharge on inpatient claims. (The inpatient discharge date will be used to determine timeliness.) Providers who do not receive an acknowledgement should contact the Provider Call Center (800-995-4543) to verify receipt of the claim. Initial Claim submissions received after 180 days from the date of service/discharge will be denied as untimely filing, “provider responsibility”.
- Coordination of Benefits (COB) claims must be submitted within 180 days from the date of service or 6 months from the date of the primary carrier remittance advice, whichever is greater. COB claim submissions received after 6 months from primary carrier’s remittance advice or 180 days beyond the date of service, whichever is greater, will be denied as untimely filing, “provider responsibility”.
- Replacement Claims must be submitted by provider within 6

months from the date of the original SCHA provider remittance advice or within 180 days from the date of service or discharge, whichever is greater. Corrected Claims include: 1) claims where SCHA has requested additional information to pay the claim; or 2) claims resubmitted by provider which contain claims data not available/present on the original claim submission. Corrected Claims received after 6 months of SCHA’s remittance advice or 180 days from services dates, whichever is greater will be denied as untimely filing, “provider responsibility”.

- Claims denied erroneously by SCHA (due to system error or incorrect information from county or state) may be resubmitted within 180 days from date of service or up to 6 months from date of county or health plan correction, whichever is greater. Documentation must be made available at time of submission to be considered.
- Providers who encounter a significant disruption of normal operations that materially affect the ability to conduct normal business will be given an additional 6 months to submit claims or adjustments. Provider must communicate to SCHA in writing providing sufficient evidence and plan of action as soon as they are aware this disruption has occurred before claims will be considered.

Timely Filing Reconsideration Policy

- The provider has 6 months from the date of the original SCHA provider remittance advice or 180 days from date of service or discharge date where no remittance advice was issued, to submit proof of timely filing and follow-up ef-

forts. If the provider is disputing a timely filing denial of a claim, the following proof must be submitted with the claim and the Claim Reconsideration Form.

- Electronically: SCHA will accept, as proof of timely filing, the acceptance report from the clearinghouse or health plan showing that the claim(s) were accepted by SCHA. Documentation must support the claim(s) being submitted within 180 days from the date of service. Additional documentation from the practice management system may be submitted to support or clarify the report sent.
- Paper: The provider must submit supporting documentation from his/her practice management system or a UB-04 or 837I, CMS-1500 or 837P, with the original date billed in order for SCHA to reconsider the claim. Documentation must support the claim(s) being submitted within 180 days from the date of service or discharge date.

Documentation is required to support Timely Filing Reconsideration requests. Acceptable documentation includes: other carrier’s EOB, notes from provider’s practice management system, face sheets documenting insurance information from the member, copies of billing statements, paper claims with the original billing date, acceptance reports for electronic claims, or other documentation SCHA determines to be appropriate.

Procedure

- Provider will complete the Claim Reconsideration form using the current date, Provider Name, Provider Number – NPI, Provider Address, Member Name, Member

180 Day Time Frame continued on page 4

Identification Number, Date of Service, and Claim Number – if applicable.

- South Country Health Alliance will have 45 days to review the Reconsideration/Appeal.
- If SCHA finds the provider to have sufficient documentation to support the appeal, the claim will be reprocessed and paid.
- If SCHA finds the documentation does not support the appeal, the denial of appeals letter will be mailed to the provider with the final denial decision.
- The Claims Reconsideration Form is located at http://mnscha.org/providers_forms.htm.

Electronic Remittance Advice (ERA) 835

This notice applies to providers billing batch claim files and is meant to inform you about the process to receive the Electronic Remittance Advice (ERA) for South Country Health Alliance claims from our third party administrator (TPA) MMSI.

- Providers who elect an electronic remittance advice will continue to receive both the paper copy and the electronic 835 for 45 days.

This notice does not apply to providers who solely use MN E-Connect to submit their claims. You will continue to receive the remittance advice on paper until further notice.

The last phase of the electronic transactions required by Minnesota Statue, section 62J.536, requires all Minnesota health care providers and licensed group purchasers to exchange remittance advices (835s) electronically. MMSI has contracted with the clearinghouse, Emdeon, for this process. MMSI's Payor ID number is 41154.

All providers/organizations that would like to receive MMSI's Electronic Remittance Advice (ERA) from Emdeon must be contracted and/or implemented to receive ERAs, either directly, via a third party organization such as a software vendor, a billing service, or another clearinghouse that is contracted for ERA with Emdeon.

The ERA Provider Setup Form must be completed and returned to Emdeon's Enrollment Dept. The completed form should be submitted via email to batchenrollment@emdeon.com or faxed to 615-885-3713. To access this form, go to www.emdeon.com. Under the Resources heading, choose Enrollment Forms. Under the Setup Forms heading, choose ERA Provider Setup Form.

The Emdeon Enrollment Guide and Enrollment Frequently Asked Questions document are found on the Enrollment page. Please see links below. Questions may also be directed to 800-845-6592, Option 1.

Links to Emdeon Forms:

<http://www.emdeon.com/enrollment/documents/ERAPSF.pdf>

<http://www.emdeon.com/enrollment/documents/Enrollment%20Guide.pdf>

<http://www.emdeon.com/enrollment/documents/EnrollmentFAQ.pdf>

Providers will continue to receive paper remits from MMSI for 45 calendar days after enrolling with Emdeon.

Electronic Funds Transfer

Electronic Funds Transfer (EFT) is the most cost-effective and paperless way of doing business for our valued providers for claim payments. Through a secured automated clearinghouse (ACH) process, you will be able to receive your claim payments

directly deposited into your bank account and streamline your account receivables. To sign up with MMSI for EFT, complete and submit the EFT Authorization form to MMSI per the instructions on the form. You can access this form at www.mmsiservices.com. From the home page, select the Forms tab and then select Provider Forms. Scroll down the page and the EFT Authorization form is located under the MMSI Provider Network heading.

Providers who bill batch claims and elect not to register with EMDEON will continue to receive paper remittance advices.

Please Note: After 45 calendar days MMSI will discontinue paper remits and will no longer be able to print paper remits. ■

DID YOU KNOW?

As part of their benefits, South Country members can get a home blood pressure monitor with a prescription from their provider. Most pharmacies or other contracted DME supplier can dispense any brand or model that is certified for accuracy. Suppliers can work with individual patients to provide the best model for the particular patient, although wrist models are not recommended. South Country encourages members to check with their pharmacies or local DME supplier first before attempting to submit a prescription for the monitor. ■