

## Did You Know?

Following is a list of a few things we thought you might find interesting.

Did you know that P/GLTC is always the payer of last resort? All other payment sources must be exhausted prior to billing Pinal/Gila Long Term Care.

Did you know that timely filing for the primary, secondary and or payer of last resort run concurrently? This means that if you have not received payment from a primary insurance within six months from the date of service, you can submit the claim to P/GLTC knowing it will be denied. This establishes timely filing and can extend the time frame for submitting a clean claim up to one year from the date of service. Claims must be filed within six months of the date of service.

Did you know that we prefer to have claims submitted electronically? To set up this service, contact Cheryl

Davis at (520) 866-6763 or contact her via e-mail at Cheryl.Davis@pinalcountyaz.gov.

Did you know that to ensure that services are paid by P/GLTC, a case manager must approve HCBS services before they are delivered?

Did you know that Network Management and Development is the primary point of contact for any provider related issues?

Did you know that Accounting and Information Systems is the primary point of contact for claim and billing issues?

Did you know that case management is the primary point of contact for issues that are actually related to members?

**What:** Mandatory Assisted Living Facility Billing Forum  
**When:** June 23, 2010  
**Time:** 9:00 a.m. to 11:00 a.m.  
**Where:** 971 N. Jason Lopez Circle, Building D, Florence, AZ 85132  
 Must RSVP by faxing your facility name and number of people attending to (520)866-2906.

**Save The Date!**



**PINAL COUNTY**  
*wide open opportunity*

Pinal/Gila Long Term Care  
 971 N. Jason Lopez Circle,  
 Bldg. D  
 Florence, AZ 85132

Phone: (520) 866-6775

Fax: (520) 866-6720

Website: [www.pinalcountyaz.gov](http://www.pinalcountyaz.gov)

1990—2010

**20**

Years of  
 Service

Pinal/Gila  
 Long Term Care

### MISSION STATEMENT

Pinal/Gila Long Term Care (P/GLTC) provides comprehensive healthcare in an efficient and innovative manner by a skilled, motivated and trans-cultural workforce to enhance the quality of life for our consumers.



**PINAL COUNTY**  
*wide open opportunity*

### Network Management & Development

**Susan Murphy**  
 Interim Director

**Jerry Gafford**  
 Supervisor, Provider Relations  
 Territory Oversight  
 (520) 866-6742

**Rhonda Montgomery**  
 Community Relations &  
 Outreach Coordinator  
 (520) 866-6761

**Gerardo Huerta**  
 Credentialing  
 (520) 866-4419

**Heather Carter**  
 Contract Specialist/  
 Grievances & Appeals  
 (520) 866-6797

**Theresa Bowlby**  
 Contract Specialist/  
 Grievances & Appeals  
 (520) 866-4423

### Representatives

**(All representatives cover Maricopa County)**

**Carmen Wainscott**  
 Territory:  
 Pinal County (except  
 Apache Junction) Chandler,  
 Gilbert & Queen Creek  
 (520) 866-6705

**Todd Pomeroy**  
 Territory:  
 Maricopa County (except  
 Gilbert, Chandler, & Queen  
 Creek) Apache Junction  
 (520) 866-6794

**Vinh Rocker**  
 Territory:  
 Pima County, Eastern Pinal  
 (Mountain Region) Gila County  
 and part of Phoenix  
 (520) 866-6786

# Pinal/Gila Long Term Care

Summer 2010

Edition 21

## Provider Responsibilities

Without a doubt, P/GLTC contracted providers deliver high quality services to our members. As such, each organization is expected to abide by all terms specified in the contract with P/GLTC. The contract includes general and special provisions, reimbursement rates, claim submission requirements, and work statements which detail service delivery. When you determine that the terms of your contract contradict the delivery of appropriate care, we ask that you discuss the issue with your assigned Provider Relations Representative.

Prior to providing services to members, you must verify each member's stated identification and verify eligibility. This can be done by calling **(520)866-6775** or by visiting our website at: [www.pinalcountyaz.gov/Departments/LongTermCare/Pages](http://www.pinalcountyaz.gov/Departments/LongTermCare/Pages). Click on the Claims Status/Member Eligibility link. Services provided to persons misrepresenting their identities will not be reimbursed. Providers work with case managers to resolve member issues prior to requesting a reassignment of the member. They also utilize case managers to coordinate medical and other appropriate care as well as participate in care conferences as requested.

Primary Care Physicians (PCPs) serve as the gatekeeper and coordinator in referring a member for specialty medical, behavioral health, and dental services. Coordination of medical care and acting as a gatekeeper include, but is not limited to, the following responsibilities:

- Initiate and coordinate all medically necessary and appropriate referrals to contracted providers. When appropriate and necessary, refer members to an out-of-network provider in order to obtain services.
- Oversee drug regimens to prevent negative interactive effects.
- Follow-up for all emergency services.
- Coordinate inpatient care.
- Coordinate the provision of medically necessary dentures, as applicable.
- Maintain continuity of care for each assigned member.
- Maintain the member's medical record,

which incorporates documentation of all services provided to the member by the contractor as well as any services rendered by other providers. For PCPs, adequate coverage and accessibility during regularly scheduled working hours must provide:

- ◆ Routine care appointments within twenty-one (21) days.
- ◆ Urgent care appointments within two days.
- ◆ Emergency appointments within the same day, or within twenty-four (24) hours of the member's phone call or other notification. PCPs will strive to ensure that the member's office wait time for scheduled appointments does not exceed forty-five (45) minutes. PCPs will provide member referrals to specialists, dentists or therapists when medically necessary and medically appropriate. For specialty referrals, the provider will provide:
  - \* Routine care appointments will be scheduled within forty-five (45) days of referrals.
  - \* Urgent care appointments will be scheduled within three days of referral.
  - \* Emergency appointments will be scheduled within twenty-four (24) hours of referral.
- ◆ For behavioral health services, the provider will:
  - Provide routine appointments within thirty (30) days of referral.
  - Emergency appointments within twenty-four (24) hours of referral.
- ◆ For dental appointments, the provider will provide:
  - Routine care appointments within forty-five (45) days of request.
  - Urgent appointments within three days of request.
  - Emergency appointments within twenty-four (24) hours
- ◆ For maternity care, the provider will provide initial prenatal care appointments for enrolled pregnant members as follows:
  - First trimester - within fourteen (14)

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## Missed Appointments

In order to ensure appropriate continuity of care for our members, every contracted provider is encouraged to report missed appointments by completing a "no-show" electronic form. The form can be found at [www.pinalcountyaz.gov/lc](http://www.pinalcountyaz.gov/lc). Then go to the tab for Online Services and select No Show Submission from the drop down menu.

P/GLTC identifies members who are reported for missing scheduled appointments and follows up with them. Our case managers will provide education to those members and will continue to remind them to keep their appointments.

Providers are required to have a system in place to document and follow-up on missed appointments. Please be sure to include the following information in your documentation:

- The member's name and AHCCCS ID number
- Address and current home or telephone number
- Dates of missed appointments
- Any efforts made to contact and educate the member

As a reminder, providers electing to remove members from their panel must first notify the member and provide at least a 30-day notice to P/GLTC. If you have any concerns or feedback, please let your provider services representative know how we can assist your practice with this important issue.



Caregivers are a very important part of P/GLTC's service delivery and we appreciate the special care that is provided to our members. That is why we would like to take this opportunity to clarify the process for ambulance transports.

When a member is transported to a hospital via an ambulance, the caregiver WILL NOT be paid if they follow the ambulance. The paid caregiver role ends once the ambulance takes over the member's care and provides the transportation.

This means that as a caregiver, you will not be paid and your claim will be denied if you submit a claim for your services under these conditions.

## Responsibilities Cont'd

(Continued from page 1)

days of request.

- Second trimester - within seven days of request.
- Third trimester - within three days of request.
- High-risk pregnancies - within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

## Advanced Directives

One of P/GLTC's Performance Improvement Projects (PIP) for AHCCCS is the documentation of member's advanced directives. The purpose of this project is to increase the use of advanced directives by members, as documented in their medical records, with the overall goal that all members over the age of 18 will have an advance directive in place. Acceptable documentation for this study includes:

- a copy of the living will or health care power of attorney
- a copy of a document used by a skilled nursing facility or other residential facility
- a signed and dated notation in the medical chart stating that an advance directive has been executed and where it is located.

As a health care provider, talk to your patients regularly about advance directives. Research shows that provider conversations about end-of-life planning tend to have the greatest impact on a person who is undecided about whether or not to execute an advance directive. P/GLTC recognizes that this is not always an easy conversation to have and we are happy to provide in-services to those who wish to become more familiar with:

- advance directive forms
- cultural perspectives of death and dying
- and having conversations with patients about advanced directives.

When you are interacting with a P/GLTC member who belongs to the Hispanic community, please consider the following which could be a result of their cultural beliefs:

- Time and punctuality may be flexible.
- Many Hispanics are averse to a hurried pace.
- A person's sense of well-being is believed to be dependant upon a balance in emotional, physical, and social arenas.
- Depression is not talked about openly.
- Exercise is often not perceived as a health practice.

## Contracting With P/GLTC

P/GLTC requires specific documentation from you in order to submit a contract or amendment to be considered for approval by the County Board of Supervisors. These documents include the following:

- W-9
- License (for all locations and providers)
- Insurance
  - Commercial General Liability
  - Professional Liability
  - Auto Liability (if transporting P/GLTC members)
- Contract Inclusion (listing of all providers and locations to be included under the contract)

If you have any questions regarding these requirements, you are encouraged to contact your Provider Relations Representative as listed on the front of this newsletter.

## Functions of Medical Management

Medical Management is responsible for assuring that P/GLTC members receive quality medical and medically related services of an appropriate level and duration according to industry established standards. In addition, Medical Management provides preventive care and monitors certain diseases through the P/GLTC Disease Management Program.

The five primary functions of Medical Management are:

1. **Prior Authorization** is a process of utilization review by which P/GLTC determines in advance of services provided, whether a covered service will be reimbursed based upon medical necessity. P/GLTC has established a five-day a week (Monday-Friday) prior authorization system to review and respond to requests for authorization of all non-emergency acute care services. An after hours notification system for emergency services, inpatient admissions, and non-emergency transportation is available to providers and members during weekends, holidays and after normal working hours.

2. **Concurrent Review** is the daily process of assessing whether or not a member's medical condition meets standard medical criteria for the current level of care they are receiving or for continued Inpatient Hospitalization. This process is only completed for members that have P/GLTC as their primary payer source. The hospital will be

notified of those members who do not meet the standard medical criteria for continued inpatient hospitalization or for the current level of care they are receiving and directly relates to whether or not they will be compensated for hospital days from that point forward or, if the level of care would reflect a lower rate of pay for continued stay or, if the review concurs with continued stay at the same level.

3. **Quality Management (QM)** is the function responsible for monitoring the quality of services provided to P/GLTC members. Performance Improvement Plans (PIPs) are established by AHCCCS and P/GLTC. QM is responsible for the monitoring and reporting of these PIPs.

4. **Utilization Management (UM)** is the function that provides administrative oversight of the level and type of service delivered by providers to P/GLTC members. The UM nurse works directly with the P/GLTC Chief Medical Officer to determine appropriate utilization of medical and medically related services.

5. **Disease Management (DM)** monitors preventive care and health care management of P/GLTC members. The Disease Management Program focuses on specific medical conditions such as osteoporosis, congestive heart failure, COPD, pneumonia, and diabetes.

If you have additional questions or concerns, please see your Provider Relations Representative (see list on page one) for educational materials regarding disease management.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

A well child visit is synonymous with an EPSDT visit. P/GLTC staff are more than happy to provide carbon-copy well-child visit forms to you, if you wish. In addition, P/GLTC is willing to provide specialized EPSDT in-services on topics ranging from periodicity schedules and vaccine promotion to AHCCCS requirements and guidelines. For more information, please contact your P/GLTC Provider Services Representative.

## False Claims Act

As part of our yearly reporting we are required to advise you on certain topics. The purpose of the False Claims Act is to eliminate fraud, waste and abuse in the Medicaid program. This public law is found under 109-171, section 6032. (a) (3) and states, "Any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments shall-establish written policies for all employees of the entity." This law pertains to health plans, hospitals, medical facilities, health care professionals. It also provides that any entity that receives or makes annual Medicaid payments (under the state plan) of at least \$5 million, shall establish written policies. The written policies must be provided to all employees and management to include contractors and agents. Activities covered under the False Claim Act include:

- Knowingly presenting (or causing to be presented) to

the Federal Government a false or fraudulent claim for payment

- Knowingly using (or causing to be used) a false record or statement to get a claim paid by the Federal Government
- Conspiring with others to get a false or fraudulent claim paid by the Federal Government and,
- Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Federal Government.

In general, the False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud.

For training information or to learn more go to: [www.azahcccs.gov/DRA/Downloads/DRA\\_Training.pdf](http://www.azahcccs.gov/DRA/Downloads/DRA_Training.pdf).