

Submission of P/GLTC Claims

P/GLTC does not accept claims submitted directly. Currently we exclusively utilize the clearinghouse Claimsnet. Contact information is:

1-800-356-1511
 Customer Service: 800-356-0092
www.claimsnet.com

Claimsnet works with most major practice management software to seamlessly connect providers, laboratories, and billing services to clearinghouses and payers.

The Claimsnet all-payer claims submission system checks each submitted claim against its 20,000-plus payer-specific edits within seconds, so that claims can be corrected before they are sent to the payer. Gain cost and time savings from processing a much smaller number of resubmitted claims.

Claimsnet's easy-to-use browser-based web service means no new hardware or software to maintain. Use your existing hardware and software and a standard Internet browser to experience how fast and simple implementation and training will be for your staff. (Server-to-server claims submission is also available.)

Submit claims electronically and receive valuable information from reports detailing claims received by payers, claims with errors, and other claims activity. Reduce rejected claims and cut down on rework.

Claimsnet companion services complement its full-featured online claims submission service. Additional services include:*

- paper claims scanning,
- automated patient statements,
- online eligibility, and online authorization and referral.

*Please note that you may not be able to utilize all of these services in conjunction with Pinal/Gila Long Term Care.

There are two methods of registration with Claimsnet: Individual providers or groups filing under one tax ID may elect to complete the online registration themselves. A set-up fee of \$200.00 is required for online registration. Or clients with more detailed registrations may use the assistance of a Claimsnet registration specialist for an additional fee. A set-up fee of \$300.00 is required for assisted registration.

The following information will be needed to compete the registration process. Please have this information on-hand prior to initiating registration.

- Practice or company name and address.
- All pertinent physician ID numbers (ex. AHCCCS id and NPI number).
- Tax ID numbers.
- Phone number.
- Contact person name and e-mail address.
- Practice management software name and version.

For questions about registration with Claimsnet contact implementation@claimsnet.com.



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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

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.



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Network Development & Management

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 Supervisor, Provider Relations
 Territory Oversight
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 Contract Specialist/
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 Contract Specialist/
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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

Spring 2010

Edition 20

Insight to Electronic Claims

Electronic claim clearinghouses were devised to step in electronically where the U.S.P.S. mail system cannot. They prescreen for claim errors and act as the air traffic controllers of electronic claim transmittal. Most simply, medical clearinghouses are aggregators (senders and receivers) of medical claim information; almost all of which is managed by software.

Large clearinghouses today process trillions of transactions each year. Here's how it works. Regional clearinghouses enable healthcare practices to transmit electronic claims to insurance carriers. Additionally they provide a biller or office manager a place to manage all their electronic claims *regardless of payor* from one central location – usually an online control panel, similar to online checking.

The Process

Claims are sent (uploaded) to your clearinghouse account. Then they will scrub the claims (check them for errors). Accepted claims will then be securely transmitted via electronic file to the specified payer, meeting standards that have been enacted as part of HIPAA legislation. Claims are received by payors who are then able to import them into their claims payment systems. Claims can then be adjudicated and payment is issued. In the best of instances, claims could be adjudicated the same day they are transmitted by clearinghouses.

The same type of activity takes place every night within the federal banking system as checks and banking activities are sent electronically from local banks to central Automated Clearing Houses (ACH) repositories who in turn send them to banks of origin across the country and then back again to the local location. All of this is done electronically, and somewhat instantly. It is this technology which enables you to pay bills online, or by phone, and to wire money.

The Benefits

Using an electronic clearing house to send claims has many benefits such as:

- Allows one to catch and fix errors in minutes rather than days or weeks.
- Results in significantly higher claims success – fewer rejected claims.

- Rapid claims processing – submitting claims electronically in some cases can reduce your reimbursement times to less than ten days.
- Eliminates the need to prepare claims and manually re-key transaction data repeatedly for each payer.
- Submission of all electronic claims in batch mode, rather than submitting separately to each individual payer.
- Provides a single location to manage all your electronic claims.
- Reduce or eliminate need for paper forms, envelopes and stamps.

FAQs

Q: Why can't I send claims directly to the payor?

A: In many cases you can. Larger payors, such as Medicare and BlueCross, act as their own intermediary allowing you to submit claim information directly to them. The advantages are the elimination of a middle man and no recurring fees. However, not all payors accept claims directly. The testing/certification process can take weeks or months to complete as all details unique to that payer must be worked out. Going direct to each payer would mean repeating this process each time you want to add a new one. Additionally, submitting claims directly to more than a single entity can put an extra, unnecessary burden on billing staff. Other disadvantages include:

- Lack of centralization (claim and claim data at many locations).
- Hidden costs – often you must purchase additional software components, which can impact your regular software support fees.
- Multiple profile information to remember.
- Multiple data entries increasing the opportunity for errors.
- Lack of efficient claim management tools.
- Little or no support.

Q: How do I know if I need a clearinghouse?

A: You can easily determine if you would directly benefit from subscribing to an electronic claim clearinghouse service by answering a few questions:

1. Does your practice bill (or plan to bill soon) electronically?

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Understanding Reimbursements and Contracts

P/GLTC contracted providers are selected because of their ability to provide high quality services to eligible members. Contracted providers are expected to abide by all terms specified in their contract with P/GLTC. A P/GLTC contract includes general and special provisions, reimbursement rates, claim submission requirements and work statements detailing service delivery.

As a provider, if you determine that the terms of your contract contradict the delivery of appropriate care, please contact your assigned Provider Relations Representative to discuss the issue.

Non-contracted providers are utilized only in instances when there are no contracted P/GLTC providers available.

In order to be eligible for payment of services provided to P/GLTC members, non-contracted providers are expected to be registered with AHCCCS. Non-contracted providers are reimbursed at the AHCCCS fee-for-service rates, cost-to-charge ratios or hospital tiered per diem as established by AHCCCS for the provider service type and facility

classification. Non-contracted providers are also expected to comply with all AHCCCS rules and regulations pertaining to their category of service. Non-contracted providers should contact the P/GLTC Network Development and Management Section for questions related to service delivery and conflicts.

Services provided to persons misrepresenting their identities will not be reimbursed. Providers shall work with case managers to resolve member issues prior to requesting reassignment of a member. Providers shall utilize case managers to coordinate medical and other appropriate care and participate in care conferences as requested.

Prior to providing services to P/GLTC members, providers are expected to verify each member's stated identification and eligibility.

This can be done by calling P/GLTC directly at **(520) 866-6775** or by visiting P/GLTC's website at: <http://pinalcountyz.gov/Departments/LongTermCare/Pages> and clicking on the Claims Status/Member Eligibility link.

For timely and appropriate payment, claims should be submitted within six months of the date of service and an explanation of benefits (EOB) must be attached if Medicare or TPL is the primary payer source. An additional six months are allowed for resubmission when claims are returned for correction. Any claim submitted more than twelve months after the date of service, will not be honored. Providers are encouraged to submit claims at the same time that claims are submitted to Medicare or to the TPL.

In the event an EOB for a claim is not received within six months of the date of service, the Provider shall bill the Division and attach a copy of the claim submitted to the primary payer.

¿ Hablan Espanol?

Do you provide healthcare services to a P/GLTC member whose primary language is something other than English? You should know that interpretation services are provided at no cost to P/GLTC members 24 hours a day, seven days a week for visits to health care providers.

We encourage all P/GLTC providers to ask the patient which language they prefer to speak, instead of asking what languages they can speak. The Language Line service should be the first resource you access if your staff do not speak the member's primary language. Ultimately, the patient must decide who they prefer to have translate for them.

To access the Language Line dial 1-800-367-9559. When prompted, enter your client identification number 544047. You will be asked to press 1 for Spanish or press 2 for all other languages. When prompted for your access code, enter your phone number with area code. In most cases, an interpreter is available within seconds. Once the interpreter is on the line, explain the purpose of the call and give the interpreter specific questions or information to interpret. You are in charge of the conversation.

Reorganization

You may have noticed a few changes at P/GLTC. The Network Development and Management (NDM) department has been enhanced to better serve the needs of contracted providers.

Three Provider Relations Representatives have been assigned to service contracted providers in Pinal and Gila counties. Please refer to the list of territory assignments listed on the front of this newsletter. Two new positions were added in July 2009, a Provider Relations Supervisor and Community Relations and Outreach Coordinator. Both positions were created to further complement the department. In addition, credentialing is now managed within the department and these responsibilities are handled by Gerardo Huerta, Credentialing Coordinator. Two Contract Specialists present the issuance of provider contracts, to create and monitor the contract approval process.

As always, the NDM department's purpose is to be supportive to all contracted providers as we strive to improve our service delivery. You are valued and the service you provide to P/GLTC members is appreciated.

Behavioral Health Services

Referrals for behavioral health (BH) services may be made by the member, their family/designated natural resources/guardian, PCP, case manager, nursing facility staff, or by any health care professional in coordination with the assigned case manager utilizing contracted BH providers.

During all visits, case managers assess members for BH needs. They use the Psychological Functioning screen in the case file, and if needed, they use the following forms: Geriatric Depression Scale (GDS), TIME and CAGE-AID. Services are set up as determined by the member and their designated natural resources.

Those case managers who are not a BH professional and have members receiving BH services will staff those members with the designated Qualified Behavioral Health Professional (QBHP) or designee, at least initially, quarterly and as the member's condition dictates. The staffing evaluates the need, or continued need, for BH services.

The member's PCP is notified when a member is initially authorized to begin BH services. The quarterly staffing form includes the provider's treatment goals, member/natural resources report on progress and comments from the case manager and the QBHP; it is submitted to the member's PCP, and other involved parties as appropriate, for

review and comment. If you feel that a P/GLTC patient may require BH assistance, we suggest you ask a few questions first:

1. If the member says that s/he is thinking of hurting themselves or someone else, complete a TIME form (T is for thoughts or what are they thinking, I is for Intent or what are they going to do and do they have access to it, M is for Method or what is their plan, and E is for Experience or have they made prior attempts or know someone who did).
2. If they seem to be in immediate danger to themselves or others, call or have someone call 9-1-1. If they have a gun, knife, etc., call 9-1-1. The crisis team can be called in after the police have stabilized the situation. Or, they will take them to a hospital and the crisis team will be called from there.

To determine the appropriate resource to call, you must identify which county the person needing help is in. This is not necessarily the county where they live.

For Pinal or Gila counties call:
Nursewise (866)495-6735
For Maricopa County call:
EMPACT (480)736-4944
Or (480)784-1514
For Pima County call:
SAMHC (520)622-6000

Osteoporosis

Each year fractures due to low bone mass or osteoporosis cause over 432,000 hospital admissions nationwide.

Since prevention, detection, and treatment of osteoporosis should be a mandate of primary care providers, the following are some clinical recommendations from the National Osteoporosis Foundation (NOF) for the prevention, risk assessment, diagnosis and treatment of osteoporosis in postmenopausal women and men age 50 and older:

- Counsel on the risk of osteoporosis and related fractures
- Advise avoidance of tobacco smoking and excessive alcohol intake
- In women age 65 and older and men age 70 and older, recommend bone mineral density (BMD) testing
- In postmenopausal women and men age 50-69, recommend BMD testing when you have concern on their risk factor profile
- Recommend BMD testing to those who have had a fracture, to determine degree of disease severity
- Initiate treatment in those with hip or vertebral fractures.

Complete NOF guidelines are available at: www.nof.org/professionals/Clinicians_Guide.htm

Electronic Claims Continued

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2. Does your practice bill a number of insurances, or just one or two?
3. Is your staff experienced at billing electronically?
4. What is your claim volume? (Remember the cost of a clearinghouse is often offset by no longer having to send in paper claims.)
5. Do you have better things to do than to be on hold for hours with payors trying to figure out errors?

Q. What should I look for when selecting a clearinghouse?

- A. The answer is not always simple. Here are some important things to look for:
- Payer list.
 - Make sure that the insurances you bill on a regular basis are on their payer list. This list is most often available online at their website.
 - Software compatibility and ability.
 - Before signing up, let them know what billing software you utilize and ask if they have other billers using it on their system – successfully.
 - If you don't have billing software capable of creating a claims file, a clearinghouse will allow you to upload claims information via a spreadsheet.

- Error reports and control panel.
- Easy navigation within the management area, and claim errors and rejections to be reported in clear concise language, not merely as numbers which can be extremely confusing.
- Advanced features.
- Over and above just transmitting electronic claims, some clearinghouses offer highly desirable advanced features such as:
 1. Eligibility verification.
 2. Sent file status.
 3. Claims status reports.
 4. Rejection analysis.
 5. Paper claims (created for you and mailed when necessary).
 6. Secondary claims processing.
 7. Electronic Remittance Advice (ERA).
 8. Patient statement services (you no longer have to mail out all those patient statements each month).
 9. Payment processing.
 10. Transaction summaries of all your clearinghouse activity.