



# Provider BULLETIN

NOVEMBER & DECEMBER 2007

## This Bulletin applies to:

- Medi-Cal
- Medicare
- Other programs

## New Alliance Medicare Program

The Alliance has received federal approval to offer a Medicare Advantage Special Needs Plan (SNP) effective January 1, 2008. This new plan, Alliance CompleteCare, is available to residents of Alameda County who are eligible for Medicare (Parts A, B, and D) and full scope Medi-Cal benefits (full Dual Eligibles).

Marketing for Alliance CompleteCare is currently underway. Prospective members may enroll in Alliance CompleteCare beginning November 15, 2007, and their benefits begin January 1, 2008.

To support this new line of business, the Alliance has hired Medicare-dedicated staff in sales, customer service (Care Advisor Unit), and claims. Additional staff will be cross-trained on Medicare processes, as needed.

For more information about marketing efforts, contact Mandy Flores-Witte at (510) 747-4555 ext. 4005. For general information, contact Julia Hutchins at (510) 747-4555 ext. 4006 or Prudence Carter at (510) 747-4555 ext. 4108.

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*What do you think of our new look?  
Let us know by calling (510) 747-4510*

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## Use of Red Ink on Claims

Please do not use red ink when making handwritten or stamped notations on claims. Our scanning machines “drop” the color red off your claim, eliminating your notations from the scanned version.

If you have any questions about making notes on claims, contact your Provider Relations Representative at (510) 747-4510 or the Alliance Claims department at (510) 747-4530.



## Cultural and Linguistic Access and Outcomes

The Alliance is committed to delivering culturally and linguistically appropriate services (CLAS) to all Alliance members. The goal of the Cultural and Linguistic Services Program is to ensure that limited English proficiency (LEP) and sensory impaired members receive equal access to high quality healthcare services that are culturally and linguistically appropriate.

One of the most compelling arguments for improving cultural and linguistic competence in health care is to reduce the disparities in health outcomes among different groups. Consider these examples collected by the U.S. Office of Minority Health:

- Latinos and African Americans are twice as likely as non-Hispanic whites to be diagnosed with diabetes. They are also more likely to suffer complications and death due to diabetes.
- Latina, Asian/Pacific Islander, and Native American women are more likely to die from cervical cancer than non-Hispanic whites.
- Infant mortality is highest for African Americans, at 2.4 times the general infant mortality rate.

The difficulty with addressing health disparities is that they are intertwined with issues within communities as well as issues within the medical system. No one system, office, plan, or county can address the whole of the health inequality problem.

As our partner in healthcare, you can help reduce these disparities by using interpreters to communicate with LEP patients. The federal courts, the State Legislature and MMCD interpret the Civil Rights Act of 1964 to require “meaningful access” to services and “equal care” for people with limited English skills.

Medical Providers are obligated to:

- Offer LEP and hearing-impaired patients a qualified interpreter at no cost to the patients. Providers may access Alliance-paid interpreter services for Alliance members. The new and



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easy to use **Interpreter Services Quick Reference Guide** is now available from the Alliance. Call Provider Services to receive one.

- Document every LEP patient's language in the medical record.
- Do **not** require patients to bring their own interpreters or suggest that they use a friend or family member to interpret.
- Document in the medical record if the LEP patient refuses an interpreter and prefers to use a family member or friend.
- Ensure meaningful access and equal care through culturally competent services.

If you have any questions about cultural and linguistic services, please contact your Provider Relations Representative at (510) 747-4510.

*As our partner in healthcare, you can help reduce these disparities by using interpreters to communicate with limited English proficiency (LEP) patients.*



## Timely Filing Guidelines

Providers frequently ask about Alameda Alliance for Health's (Alliance) claims submission requirements. Timely filing periods are determined by State law and are included in our provider contracts. The Alliance complies with the minimum filing limits for claims established by the California Code of Regulations (CCR), Title 28, and Section 1300.71, which are as follows:

- Contracted providers – 90 days after the date of service or discharge (for inpatient facility claims);
- Non-contracted providers – 180 days after the date of service or discharge (for inpatient facility claims).

The Alliance allows additional filing time for claim submissions in the following scenarios:

- Coordination of Benefits – 90 days after the date of the primary payer's payment or denial notification (typically, the explanation of benefits or remittance advice), claim must be submitted with a copy of the primary payer's notice of payment/denial;
- Corrected Claims – 90 days after the initial claim determination by the Alliance, claim must be marked as a corrected claim;

To ensure timely resubmission of claims when necessary, providers are encouraged to review the remittance advice that is provided by the Alliance. Providers are also encouraged to check

the status of submitted claims within 20 days from the date submitted on the Alliance's Web site or by calling the Claims department at 510-747-4530.

Acceptable Proof of Timely Filing documentation includes:

- Certified mail receipt proving claims were received by the Alliance;
- Copy of the Remittance Advice or Evidence of Benefits (EOB) from the primary payer indicating the date of resolution (payment, date of contest, denial, or notice);
- Copy of the Alliance's Electronic Data Interchange (EDI) Preprocessing Error Report for claims originally submitted electronically;
- Copy of the Alliance's Remittance Advice (RA) indicating the date and reason for the original denial when a claim was denied for incomplete reasons and corrected claim is submitted;
- Documentation of the cause for the delay in submitting a claim to the Alliance when the provider experiences exceptional circumstances beyond his/her control.



## Access Standards for Providers

Alliance contracted providers must ensure that their assigned members receive equal access to services without regard to health status, cost, high risk population, marital status, religion, age, sex, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric or medical condition.

It is also the primary care provider's (PCP's) responsibility to provide access to care for his/her assigned members on a 24-hour, seven day per week basis. This includes arranging for on-call coverage when the PCP is not available. The table below outlines the Alliance's standards for timely access to medical services.

Access Standards		
Service	Definition	Standard
Adult or Pediatric Routine Physical	Medical examination to determine a member's health or physical condition	Within 28 calendar days of patient's request for an appointment unless a more prompt exam is warranted
Emergency Care	Emergency care services needed to evaluate or stabilize an emergency medical condition (i.e. acute symptoms of sufficient severity that	Immediately; or direct member who is not at a provider's office to call 911



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Access Standards		
Service	Definition	Standard
	<p>a prudent layperson with average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in:</p> <ul style="list-style-type: none"> <li>■ Placing the member's health in serious jeopardy</li> <li>■ Serious impairment to bodily functions</li> <li>■ Serious dysfunction of any bodily organ or part</li> </ul>	or go to the nearest Emergency Room
Initial Health Assessment	Evaluation conducted by the PCP to assess the member's acute, chronic, and preventive health needs. The PCP will assume responsibility for effective management of the member's health care service needs	Within 90 days of enrollment
Preventive Care	Routine evaluation, non-symptomatic, such as adult well exam and woman's annual exam	Within 30 days of patient's request for an appointment
Routine PCP Care	Routine evaluation intended to promote wellness by early identification of health problems and treatment and prevention of disease or illness	Within 7 calendar days of patient's request to make an appointment
Routine Specialty Referral	Routine care is defined as covered preventive and medically necessary health care services, which are non-emergent or non-urgent	Within 14 calendar days of patient's request to make an appointment
Urgent Care	Urgent care services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e. sore throat, fever, minor lacerations and some broken bones)	Within 24 hours of patient's request for an appointment



## ICD 9 Code Revision Reminder

Every year, ICD 9 code revisions become effective on October 1<sup>st</sup>. Under the new HIPAA Transaction and Code Set Rule, providers are required to use national medical code sets that are valid at the time a service is provided. Because the government no longer allows a grace period for annual code sets and revisions, it is important that all providers update their Superbills and obtain a copy of the 2008 ICD-9 Codes. ICD-9 Code Books can be purchased online at, [www.amazon.com](http://www.amazon.com), [www.medicalcodingbooks.com](http://www.medicalcodingbooks.com), [www.medetrac.com](http://www.medetrac.com), and educational teleconferences regarding the ICD 9 code revisions may also be booked and purchased at

<http://www.codingbooks.com/osb/itemdetails.cfm/ID/1388>

For more information on the 2008 ICD 9 Codes revisions, as well as an addenda and information containing new, invalid, and revised diagnosis and procedure codes, please visit the Center for Medicare & Medicaid Services at [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/)

Please remember, CPT and HCPCS code revisions also become effective January 1st. In order to meet this requirement, you must have the revised CPT, HCPCS, and ICD-9-CM codes in your possession before the implementation dates. If you have further questions, please contact the Claims department at 510-747-4506.



## Clinical Laboratory Services Capitated to Quest Diagnostics

The Alameda Alliance for Health (Alliance) clinical laboratory services are covered through Quest Diagnostics, which includes multiple testing sites throughout Alameda County. Contracted providers are required to refer members to Quest Diagnostics for laboratory studies.

Quest Diagnostics customer service representatives are available 24/7 at (800) 288-8008.

For more information about clinical laboratory services, please call a Provider Services Representative at (510) 747-4510.



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## Provider Updates

Alameda Alliance for Health requires receiving all changes made to a provider's practice in writing via mail, fax or internet. It is important to have the most current information regarding your practice in our system. These may include but are not limited to the following changes: address or suite number, phone and fax, tax identification number (TIN), ownership or group name change, provider staff additions and deletions, or any practice limitations. Please note that a W-9 form will be required for any changes regarding a group name, new ownership or TIN.

The following are a list of providers no longer participating within the Alliance network:

First Name	Last Name	Degree	Group Name	Address	City	Phone	Term Date
Pratima	Gupta	MD	Oakcare Medical Group	1411 E 31st St	Oakland	510 437-4323	10/31/2007
David	Adler	MD	Oakcare Medical Group	1412 E 31st St	Oakland	511 437-4323	10/31/2007
Reza	Mina-Aragh	MD	Oakcare Medical Group	1411 E 31st St	Oakland	510 437-4323	10/31/2007



## Holiday Reminder

Alameda Alliance for Health will be closed in observance of the Christmas and New Year's Holiday's, Monday, December 24, 2007, Tuesday, December 25, 2007, and Tuesday, January 1, 2008. If you have any questions, please contact the Provider Relations department at 510-747-4510.

