Delaware Physicians Care

News to Use

Insurance Payor Workshop

March 21, 2012

DELAWARE PHYSICIANS CARE
AN AETNA HEALTH PLAN℠

Welcome and Introductions

Dwayne Parker, Director - Provider Relations, Credentialing, and Member & Provider Appeals

Chris Bruette, Manager – Provider Relations

Lois Battallio, Network Consultant - New Castle County Physicians

Chandra Freeman, Network Consultant - Kent and Sussex County Physicians

Stephanie Savini, Network Consultant - Ancillary Providers

Amy Seramone, Network Consultant - Behavioral Health

Deena Fields, Network Account Manager – Hospitals

Provider Relations Updates

* Long Term Care
* Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
* Provider Disclosure Forms
* Delaware Physicians Care website
* ICD-9 CM Coding Persistency
* 2011 Provider Satisfaction Survey Results

Diamond State Health Plan-Plus (DSHP-Plus) Overview

- **April 1, 2012 implementation**.

- **Statewide, mandatory** managed/integrated Medicaid long term care program expansion.

- The **financial and medical eligibility enrollment process** remains with the Division of Medicaid and Medical Assistance (DMMA). Delaware Physicians Care becomes responsible for the member after they have completed this process and have been assigned to us as their managed care organization.

Diamond State Health Plan-Plus (DSHP-Plus) Overview

- Individuals currently receiving Long Term Care services began receiving letters from the state in December, informing them of the change to the program and assigned them to one of two Managed Care Organizations –

  Delaware Physicians Care or UnitedHealthcare Community Plan.

- Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) case managers have also been explaining the change to the members during their visits.

Diamond State Health Plan-Plus Population

- **Nursing Facility/Institutionalized (all ages, all needs)**
  - Existing residents
  - New residents
- **Home & Community Based Services (HCBS) groups**
  - Existing E/D and AIDS waiver participants; existing 1915c waivers will be "folded into" the 1115 waiver
  - New individuals who qualify for and will benefit from community-based supports and services
- **Community full-dual eligible individuals**
  - Those in the community who are receiving full Medicare/Medicaid coverage. This population will receive the DSHP (Core) Benefits, however are excluded from DSHP Plus (Enhanced) Benefits.
- **Money Follows the Person**

EFT/ERA

Electronic Funds Transfer

* EFT is a safe, convenient way to receive payments
* Quick and easy to sign up
* Electronic Remittance Advice (ERA) on-line
* **EFT and ERA forms on the website**

Provider Disclosure Forms

* Providers are required to complete the disclosure forms annually.

* Providers will only need to complete the form once for the State or Delaware Physicians Care.

Our Websites

www.DelawarePhysiciansCare.com

Contains valuable information such as:

* Provider **Resources** – forms, guidelines, processes and materials to assist provider interactions with Delaware Physicians Care
* View and download **Provider Newsletters**
* Searchable **Provider Directory**
* View and download the **Provider Manual** and Provider Manual updates
* **Fraud and Abuse** information and reporting
* **Member Rights and Responsibilities**

Secure Web Portal Highlights

Provider Utilization	2010 YTD	2011 YTD	Diff
Logins	185,189	229,092	24%
Eligibility Check	182,409	242,895	33%
Claim Check	97,745	97,672	-1 %
Authorization Inquiry	61,685	69,945	13%
Authorization Submits	25,693	31,646	23%

Billing and Claims

* Electronic Claims Submission (EDI)
* EDI payer number is **27009**
* Paper claims
* Mailing address:

Delaware Physicians Care
Attn: Claims Department
PO Box 62145
Phoenix, AZ 85082-1145

Billing and Claims

- Coordination of Benefits (COB) process
- Claims for dual eligible members
- Timely filing is 120 days from the date of service
- National Provider Identifier (NPI)
  - Be certain that your claim form has a NPI number to match each corresponding name
  - Facilities must include the National Provider Identifier (NPI) of the attending physicians, if applicable.

Resubmissions/Reconsiderations

* **Resubmissions and corrected claims can be submitted via EDI.**

* **Reconsiderations for timely filing requires a copy of denied claim along with proof of timely filing and should be mailed.**

ICD-9 CM Coding Persistency

What is ICD-9-CM (diagnosis) coding persistency?

* Persistency in coding refers to the ongoing identification of members with chronic medical or behavioral health conditions on a CMS-1500 form through the use of coding from one year to the next. The “persistence rate” is the percentage of members coded with the chronic condition in year 1, who are also coded for the chronic condition in year 2.

ICD-9 CM Coding Persistency

Who does persistency of correct ICD-9-CM coding affect and how?

* ***Provider***
  * Accurate diagnosis in the chart accomplishes quality and continuity of care goals
  * Improved quality of care standards
  * Improved risk stratification of patients – higher risk scores for members with more co-morbidities.
  * Avoids office interruptions for clarification of claims information.
  * Improves office administrative efficiencies by decreasing unnecessary payer requests for additional information during the prior authorization or clarification of claims information.
* ***Patient***
  * Better and earlier identification of patients with chronic conditions allow us to employ quality targeted interventions and education with the patient.
  * Funding from the State and Federal governments is dependent upon documented morbidity of the population.
  * Persistency in risk scores from year to year potentially results in more dollars being available to purchase services for Medicaid patients.

ICD-9 CM Coding Persistency

Why is it important to code the care that is documented?

* Specificity in diagnosis documentation results in accurate ICD-9-CM coding.
* Documentation that supports the diagnosis has always been important from a quality of care perspective.
* Accurate ICD-9-CM coding achieves accuracy in the diagnosis portion of the claim.

ICD-9-CM Coding Facts

* Diagnosis codes submitted on claim forms establish the necessity for services performed.
* The codes submitted on the claims are used by outside agencies and organizations to forecast health care trends and needs.
* The provider of services is the only person who has authority to formulate and determine a diagnosis. Nonclinical staff should not choose a diagnosis for a patient, but may accurately convert a narrative description to a diagnosis code, ideally after they've been trained on the proper use of the ICD-9-CM Manual.
* Proper diagnosis coding requires using the ICD-9-CM Volumes I and II to choose appropriate codes.

Provider Satisfaction Survey

- The Myers Group (TMG) conducted the survey from November 2011 – December 2011
- Surveys were mailed to 1,202 providers with a 24.9% response rate
- 100% of the top 3 composites rated higher than “All Other Plans” and The Myers Group *Medicaid Book of Business (MBOB)
- Your feedback, both positive and negative, enables us to improve our service to our provider and member communities

*Includes 36 Medicaid plans which The Myers Group conducts surveys

Satisfaction Composites

- **Call Center/Member Services**
  - Process of obtaining member information, eligibility and benefits
- **Provider Relations**
  - Representatives responsive, courtesy and timeliness to answering questions and resolving issues
  - Quality of provider orientations, provider education and in-service materials
  - Written communication and materials
  - Dissemination of quality improvement initiatives and results
- **Network**
  - Adequacy of specialty network

Satisfaction Composites

- **Utilization**
  - Prior authorization: helpfulness of staff, timeliness of phone access and timeliness of decisions, prior authorization process
  - Timeliness and consistency of review decisions, timeliness of appeals
  - Access to case management, community resource options, and disease management referral process
- **Finance**
  - Accuracy and timeliness of claims processing, resolution of claims issues, reimbursement rates
- **Overall Satisfaction and Loyalty**
  - Overall satisfaction with Delaware Physicians Care
  - Recommending Delaware Physicians Care to other physicians and patients

Provider Satisfaction Survey

Composites/Attributes	Summary Rate Definition	2011 Top 3 Summary Rates		DPCI Trend Data Top 3 Summary Rates	
		DPCI	All Other Plans	2010	2009
Call Center/Medical Services	Excellent, Very good, or Good	96.1%	86.9%	94.9%	91.9%
Provider Relations		86.5%	77.9%	84.9%	82.6%
Network		83.4%	82.2%	80.6%	76.9%
Utilization & Quality Management		85.2%	76.2%	80.0%	79.2%
Finance Issues		80.4%	72.6%	76.5%	74.6%
Overall Satisfaction and Loyalty[1]		**93.8%**	**NA**	**92.4%**	**90.5%**
Recommend to other physicians	Definitely or Probably Yes	95.9%	NA	93.3%	92.2%
Recommend to other patients		95.2%	NA	94.4%	92.1%
Overall satisfaction	Very/Smwt Satisfied	**90.4%**	**84.6%**	**89.5%**	**87.2%**

Questions

Thank You!