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CMA resources

When you see this icon, that means there are additional resources available free to California Medical Association (CMA) members at the CMA website. To access any of these resources, visit www.cmanet.org/ces.



CMA On-Call

Throughout this publication, you will find references to "CMA On-Call" documents. On-Call is an online library that contains over 4,500 pages of medical-legal, regulatory, and reimbursement information.

On-Call documents are available free to CMA members at www.cmanet.org/member. Non-members can purchase On-Call documents for \$2 per page in the CMA bookstore, www.cmanet.org/bookstore.

CMA Practice Resources (CPR) is a free monthly bulletin from the California Medical Association's Center for Economic Services. This bulletin is full of tips and tools to help physicians and their office staff improve practice efficiency and viability.

SUBSCRIBE NOW: Sign up for a free subscription at www.cmanet.org/news/cpr.

SPREAD THE WORD: Please forward this bulletin to your coworkers and colleagues.

BREAKING NEWS: For breaking news, subscribe to *CMA Alert*, CMA's biweekly member newsletter at www.cmanet.org/news.

Unfair Payment Practice: EOB disclosures

California law requires that for each claim that is denied, adjusted, or contested, the payor must provide the physician with an accurate and clear written explanation of the specific reason(s) for the action taken within 30 working days after receipt of a PPO claim, or 45 working days after receipt of an HMO claim.

Further, whenever a payor contests, adjusts, or denies a claim, it must inform the physician of the availability of the plan's provider dispute resolution mechanism, the procedures for obtaining forms, and instructions for filing a provider dispute. Failure to provide this notice can subject a payor to unfair payment penalties and sanctions.

Physicians should review all Explanation of Benefits (EOBs) from payors to ensure that they have been provided with an accurate and clear explanation as to why the claim was contested, adjusted, or denied. Physicians should also ensure that the payor has properly informed the physician of the availability of the plan's provider dispute resolution mechanism and the procedures for accessing it. Any violation should be reported to the appropriate regulator and to the California Medical Association.



TIP: To review the four easy steps to filing a formal complaint with the regulator, see "Report Unfair Payment Practices" in the May 2010 issue of CPR.



CMA RESOURCES: "Know Your Rights: Identify and Report Unfair Payment Practices;" CMA On-Call documents #1051, "Physician Complaints about Managed Care Plans," #1070, "Managed Care Contractual Protections," #1020, "Disclosure by Managed Care Plans (and their Contracting Medical Groups/IPAs)."

New timely access regulations to take effect January 17

As previously reported in the Jan. 25, issue of *CMA Alert*, the California Department of Managed Health Care (DMHC) finalized regulations requiring that patients be seen in a timely manner. The regulations take effect on Jan. 17.

The "timely access" regulation requires DMHC-regulated health plans (HMOs, Blue Cross of California PPO, Blue Shield of California PPO, as well as their contracting medical groups/IPAs) to ensure that patients can see a provider within certain time frames and that plans have adequate provider networks to meet these requirements.

CMA Center for Economic Services

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Physicians are reminded that health plans, not physicians, are ultimately responsible for ensuring that patients can see a provider within the specified time frames and that plans have adequate provider networks to meet these requirements. Further, the timely access regulations do provide for physician flexibility in patient scheduling. Specifically, 28 C.C.R. §1600.67.2.2(c)(5)(G) states that the applicable waiting times may be extended if the referring or treating physician has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

For more information, see “CMA’s Physician Guide to DMHC’s New Timely Access Regulation,” available at www.cmanet.org/ces.

The California Medical Association (CMA) has learned that most major health plans – including Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA, Health Net and PacifiCare – will retain responsibility for compliance with the regulation, including the triage and screening requirements. However, physicians should keep an eye out for amendments from other health plans, including medical groups/IPAs and ensure that all proposed amendments are reviewed carefully (See “CMA seeking clarification on Blue Cross contract amendment.”) Physicians are reminded that California law requires health plans to provide contracted physicians with at least 45 days prior notice of a material contract change and the opportunity to negotiate or terminate their contract before the effective date of the change.

To help physicians understand their rights and options when a health plan notifies them of a material modification to a contract, policy or manual, CMA has created, “Payor Contract Amendments: An Action Guide for Physicians,” available at www.cmanet.org/ces.



CMA RESOURCES: CMA’s Physician Guide to DMHC’s New Timely Access Regulation; CMA Timely Access Regulations Webinar; CMA On-Call documents #1005, “Access to Physicians,” #1055, “Contract Termination by Physicians and Continuity of Care Provisions,” #1070, “Managed Care Contractual Protections;” Payor Contract Amendments: An Action Guide for Physicians.

Blue Cross announces seventh extension to Healthy Families continuity of care plan

Blue Cross recently announced a seventh extension to its Healthy Families continuity of care plan. The California Medical Association (CMA) has learned that the Department of Managed Health Care is currently reviewing Blue Cross’s Healthy Families physician network. Pending approval of these networks, Blue Cross expects to discontinue the continuity of care plan in early 2011.

CMA is currently working with Blue Cross to understand how and when the final transition will occur. We will provide additional information as it becomes available.

As you may recall, Blue Cross announced in March 2009 that it would require physicians to sign a separate contract and accept reduced rates if they want to continue treating Blue Cross-insured Healthy Families and AIM patients. The new rates vary, but have been dropped generally to barely above Medi-Cal rates.

Although the effective date on the new contracts was Sept. 1, 2009, the insurer has now extended its continuity of care plan through Dec. 31, for patients in all counties except San Bernardino, Riverside and Orange. The continuity of care plan for those three counties expired Aug. 30.

CMA seeking clarification on Blue Cross contract amendment

The California Medical Association (CMA) has received a number of calls from physicians concerned about a new Blue Cross contract amendment. The amendment (www.cmanet.org/news/cpr), according to the notice, was issued to ensure compliance with the Department of Managed Health Care’s “timely access” regulations.

CMA’s review of the amendment has determined that the language in the grid on page two addressing the “in-office waiting room time” standard goes beyond the regulatory parameters. Specifically, the timely access regulations do not address in-office waiting room time requirements.

Additionally, the notice lists “emergency care” and “member services by telephone” standards indicating physicians are required to provide immediate access to emergency care and must also provide enrollees with telephone access to a live person within 10 minutes during normal business hours. However, the timely access regulations specify that triage and screening services are the responsibility of the plan and cannot be delegated to physicians unless the physician expressly agrees to provide the service.

CMA has opened discussions with Blue Cross regarding our concerns. In response, Blue Cross has clarified the emergency care requirement via a footnote in their November newsletter (<http://bit.ly/hVWX3i>). Additionally, Blue Cross clarified that the “in-office waiting room time” is an existing standard that contracting physicians are already required to meet. To view the existing standard, go to www.anthem.com/ca, click on “providers.” After logging in, click on “Anthem Blue Cross PPO Provider Manual,” go to section 10, page three, “Quality Improvement.” CMA will continue to work with Blue Cross to address remaining concerns.

Many health plans and medical groups/IPAs, including Blue Cross, already require physicians to meet specific access standards. Physicians contracting with Blue Cross should note that the new state-mandated timely access timeframes are less stringent than Blue Cross’ existing requirements as specified in Section 4.2 of the standard Prudent Buyer contract.

CMA has prepared a comparison of Blue Cross’ existing access standards and the new standards effective Jan. 17, available at www.cmanet.org/ces.

CAMGMA 2010 staff salary survey – Participate now

The California Medical Group Management Association (CAMGMA) invites you to participate in its 2010 California Salary & Benefits Survey. The results of this annual survey are an effective tool for physician practice staff salary and benefit management. CAMGMA will provide a free copy of the survey results to participating practices. To participate, complete and return the survey participation form, which can be downloaded at <http://bit.ly/hXsUsY>. The survey deadline is Dec. 17.

Contact: CAMGMA, 800/853-8787 or camgma@scfld.biz.

The continuity of care plans provides that in lieu of a newly signed Healthy Families contract, physicians with Prudent Buyer contracts will be paid 125 percent of Medi-Cal for most Healthy Families services.

A copy of the notice that was recently sent to physicians is available at www.cmanet.org/news/cpr.

Cal-Net Physicians IPA files for Chapter 7 bankruptcy

Cal-Net Physicians IPA filed for Chapter 7 bankruptcy on Nov. 7, in federal bankruptcy court. As previously reported in the July 2010 issue of CPR, Cal-Net served approximately 5,500 Medi-Cal HMO enrollees in San Diego County.

The California Medical Association (CMA) is working closely with the trustee assigned by the court to handle Cal-Net's liquidation. At this time, the trustee does not believe there are assets or property available to pay creditors, including physicians. However, the court will notify creditors if it is determined that there are assets to distribute and physicians will be required at that time to file proof of claim with the court.

A copy of the notice sent by the bankruptcy court to impacted physicians can be found at www.cmanet.org/news/cpr.

CMA encourages physicians to routinely monitor the financial health of contracting medical groups/IPAs. To assist physicians with this process, CMA has published a Payor Solvency Checklist at www.cmanet.org/ces. This resource also discusses options available to physicians in the event a payor stops paying claims.



CMA RESOURCES: Cal-Net Physicians IPA: Important Information for Physicians; CMA On-Call documents #0106, "Bankruptcy of IPAs or Health Plans;" and #0131, "Insolvency of Health Plan, IPA or Other Entities that Contract with Health Plans," CMA Payor Solvency Checklist.

Physicians must decide Medicare participation status by December 31

It's that time of year again – time for physicians to decide about their participation in Medicare. Physicians have through Dec. 31, to declare their status.

Participation decisions are binding for one year, unless physicians choose to opt out entirely. Once you opt out, you cannot opt back in for two years.

As always, physicians have three choices regarding Medicare: be a participating provider; be a nonparticipating provider; or opt out of Medicare entirely. A participating physician must accept Medicare allowed charges as payment in full for all Medicare patients.

A nonparticipating provider can choose to accept or not accept assignment on Medicare claims on a claim-by-claim basis. Nonparticipating physician fees are 95 percent of participating physician fees. If you choose not to accept assignment, you can charge the patient 9.25 percent more than the amounts allowed in the participating physician fee schedule.

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Medicare Part D covers pertussis vaccine

The Centers for Medicare and Medicaid Services recently expressed concern about the significant outbreak of pertussis in the state of California and recommended coverage for seniors over the age of 64. Payment for seniors receiving the pertussis booster, also known as Tdap, is covered under Medicare Part D. If a physician provides and administers the vaccine, the beneficiary is responsible for the entire charge, including all components. The physician should provide a bill to the beneficiary with enough detail that would allow them to submit a paper claim to the Part D sponsor for reimbursement for both the cost of the vaccine and the administration fee. For plan-specific information, physicians should contact the Medicare Part D Plan Sponsor or Medicare Advantage Organization listed on the patient's enrollment card.

Health plan provider newsletters

To make sure that you are aware of important news from your contracting health plans, we encourage you to regularly read plans' provider newsletters and bulletins. Follow the links below to access the current issues.

AETNA: www.aetna.com. Click on "Health Care Professionals" in the main menu, then on "News for Providers" in the left sidebar.

BLUE SHIELD: www.blueshieldca.com. Click on "I'm a Provider," then on "Announcements" under "News and Features."

CIGNA: www.cigna.com. Click on "Health Professionals" under "Customer Care" in the main menu. Then, scroll down and click on "Newsletters."

ANTHEM BLUE CROSS: www.anthem.com/ca. Click on "Providers" in the main menu, then on "Professional Network Update" under "Spotlight."

HEALTH NET: www.healthnet.com. click on "I'm a Provider" and then "California." Enter username and password, and then click "Online News."

MEDI-CAL: www.medi-cal.ca.gov. Click on "Publications" in the main menu, then on "Provider Bulletins."

MEDICARE/PALMETTO GBA: www.palmettogba.com/j1b. Click on "Publications" in the left sidebar, then on "Medicare Advisory."

UNITED HEALTHCARE: www.unitedhealthcareonline.com. Click on "Tools & Resources" in the main menu, then on "Network Bulletin."



CMA RESOURCE: Find up-to-date profiles on each of the major payors in California at www.cmanet.org/ces.

Physicians who opt out of Medicare are bound only by their private contracts with their patients. Medicare's limiting charges do not apply to these contracts, but Medicare does specify that these contracts contain certain terms. When a physician enters into a private contract with a Medicare beneficiary, both the physician and patient agree not to bill Medicare for services provided under the contract.



CMA RESOURCES: CMA On-Call document #0151, "Medicare Participation (and Nonparticipation) Options."

New California Pre-Existing Condition Insurance Plan utilizing Blue Shield Network

As a result of the federal Affordable Care Act of 2010, California has contracted with the U.S. Department of Health and Human Services to establish a federally-funded high risk pool program to provide health coverage for eligible individuals.

The state program opened for enrollment on Oct. 25 and will continue through Dec. 31, 2013, when private insurers will be required to accept all applicants regardless of pre-existing conditions. After that date, there will no longer be a need for high risk pools because federal rules will not allow insurers to reject persons with pre-existing conditions or charge them higher rates than those without such conditions.

The federally-funded program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals. The program is available for individuals who have not had health coverage for 6 months and have been declined coverage from a carrier due to their pre-existing condition or have been offered coverage at a rate higher than the preferred provider premium rate of the state's high risk pool.

Blue Shield recently notified physicians that PCIP is utilizing the Blue Shield PPO network and HealthNow Administrative Services for services provided to PCIP subscribers. For contracting physicians, PCIP claims will be reimbursed at the physician's current Blue Shield fee schedule. Claims for services provided to PCIP enrollees should be submitted to the address on the back of the PCIP member's identification card.

The Blue Shield notice, found at www.cmanet.org/news/cpr, also states that authorizations, eligibility, benefits, and payments will be handled by HealthNow Administrative Services, a third party administrator. Contact information can be found on the back of the PCIP member's card, and also in the sample card copy provided in the notice.

CMA is working with PCIP to obtain additional information on program details.

More information on the PCIP can be found on its website www.pcip.ca.gov or by calling 877/629-1500.

Tell us what you think

The California Medical Association (CMA) is interested in your feedback. Let us know which topics you would like to see addressed in future issues.

Contact CMA's Center for Economic Services at 916/551-2061 or economicservices@cmanet.org.

Problems getting paid?

The California Medical Association's Center for Economic Services provides direct reimbursement assistance to CMA physician members and their office staff.

• REIMBURSEMENT HELP LINE 888/401-5911

- One-on-one educational and reimbursement assistance to physician members and their staff

• PRACTICE EMPOWERMENT

- Tools and resources to empower physician practices
- Seminars and toolkits for physicians and their staff

• EXPERIENCED STAFF

- Staffed by practice management experts with a combined experience of over 125 years in medical practice operations

To access our reimbursement advocates, your physician must be a CMA member. For membership information, contact CMA Member Services at 800/786-4CMA (4262) or memberservice@cmanet.org.

Save the Date:

Upcoming CMA events

The California Medical Association offers our members programs to educate physicians and staff on a range of practice management issues. Space is limited, so register soon. Events marked with an asterisk (*) are PMI CEU Credit Approved.

12/8: ICD-10 Update

Members-only webinar (12:15 -1:15 pm)

In this members only webinar, Maxine Collins with Practice Management Institute, Inc. presents the new ICD-10 coding system.

For more information or to register for any of these events, visit www.cmanet.org/calendar.

Education and networking opportunities

There are numerous educational and networking opportunities for office managers and administrators throughout California. Many county medical societies host forums for practice managers and are an excellent resource. The California Chapter of the Medical Group Management Association (CAMGMA) also offers a broad range of practice leadership, professional development, educational opportunities, and networking activities. For more information or to register for upcoming CAMGMA events, visit www.camgma.com/calendar.cfm.

Got questions?

If you have questions related to any articles, please contact the California Medical Association's reimbursement help line, 888/401-5911 or economicservices@cmanet.org.