

CCNV Network Update

A Newsletter for Shareholders, Boards of Directors, Providers and Staff Members

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THIRTEENTH ANNUAL CCNV SHAREHOLDERS MEETING

FEBRUARY 18, 2009

Keynote Speaker: Cheryl Austein-Casnoff, MPH

Associate Administrator, HRSA

HILTON GARDEN INN

RICHMOND, VA

5:30PM

RSVP to Izzy Gast at (804) 237-7686

KIOSK VENDOR SELECTION

Over the last year and half, CCNV has made significant progress on the Innovations Kiosk project thanks to the help and efforts of our Innovation Task Force and volunteers from CCNV and Health Center staff within our network.

We are pleased to announce that Seepoint/Kiohealth has been selected as the vendor out of the fourteen initial responses received for this project.

Look for additional information to be circulated later in the first quarter of 2009 as we begin working out the details of this project and our initial pilot phase.

Jeff Czyzewski
Chief Information Officer



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CREDENTIALING NEWS

Welcome new staff member, Antoinette Braggs. Antoinette has relocated to Richmond from New York. She has extensive experience in managed care credentialing and enrollment. Antoinette has also worked in a hospital medical staff credentialing office as well. Antoinette will be primarily responsible for hospital clients, as well as large group clients outside of Virginia. Please join us in welcoming Antoinette.

Changes in Managed Care Organization's Policies Regarding Site Visits

We are all familiar when opening a new office and before you can begin seeing patients, a site visit by either CCNV or a Managed Care Organization was often required. Effective July 1, 2008, the organization that oversees the Managed Care Organizations, NCQA, has changed their policy regarding site visits.

- NCQA is eliminating the requirement for HMO practitioner site visits during initial credentialing for primary care practitioners, obstetricians/gynecologists and potential high volume behavioral health practitioners.
- NCQA will now require the organization to monitor and investigate member complaints related to the quality of all practitioner office sites. Site visits must be conducted for complaints related to physical accessibility, physical appearance and adequacy of waiting-and-examining room space. The organization must perform the site visit within 60 calendar days and institute actions to improve offices that do not meet thresholds and evaluate the effectiveness of those actions at least every six months, until deficient office meets the thresholds.

Some third party payers may elect to do the site visits themselves; others may require CCNV to perform the site visit.

*Leona Roach CPCS, CPMSM
Director of Credentialing Services*

***Policy Change
Regarding Site
Visits for Managed
Care Organizations.***

***CCNV Would Like to Welcome It's
Newest Shareholder***

HARRISONBURG COMMUNITY HEALTH CENTER

***563A Neff Avenue
Harrisonburg, VA 22801***

CENTER FOR DATA AND INFORMATICS

The pilot group was recently opened to all health centers that have accumulated 12 months of EMR data.

With guidance from the CCNV Medical Management Committee, the CDI recently produced the first EMR data reports on the CCNV Core Clinical Measures as part of the CCNV Performance Improvement Program. The reports included EMR data for:

- Blood Pressure Measurement
- Blood Pressure Control
- BMI Measurement
- BMI Control
- HbA1c Measurement
- HbA1c Control
- Lipid Measurement
- Lipid Control
- Aspirin/Antithrombotic Use

Health centers participating in the pilot group received provider-level, site-level, corporation-level and Network-level data for each measure. The provider-led Medical Management Committee guided the development of the CCNV measures from the project's inception to ensure the most meaningful and reliable measurement of clinical performance. The health centers

represented on the Medical Management Committee served as the initial pilot group for the EMR data extraction. Data collection and reporting is now open to all health centers that have accumulated 12 months of EMR data.

Health centers participating in these clinical performance improvement activities have been able to use their center-level EMR data to identify opportunities for improvement, education or training related to CCNV guidelines as well as the EMR system functionality. Additionally, they are able to gauge their performance against other Network health centers with the assurance that all measures and data are calculated using the same methodology.

If your health center is interested in participating in this performance improvement initiative, or if you'd like additional information, please contact Colleen Lynch at clynch@cnva.com.

*Colleen Lynch, RN, MSN, CPHQ
Director, Performance Measurement and Improvement*

Contracting Update

The CCNV Board of Directors has approved the Doral Dental delegated credentialing agreement. The effective date is November 10, 2008. We are very pleased with this latest delegated credentialing agreement because of the association between our dental providers and the state run "Smiles for Children Program".

Corvel was also approved at the October CCNV Board of Directors meeting for delegated credentialing. The effective date is November 1, 2008.

CCNV's contracting list now consists of 26 delegated credentialing agreements and 6 non-delegated credentialing agreements. What does this mean for our Shareholders? Plenty. The staff has more time to work on other projects and the providers spend less time answering questions and filling out paperwork. The concept of delegated credentialing is an easy one. Your providers complete the CCNV application, they are approved by the CCNV Board of Directors, their information is sent to all of the health plans we have entered into network master agreements with CCNV within 10 days of board approval. They become participating within 45-60 days. Faster participation, quicker reimbursement and more lives made healthy.

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(Contracting continued)

What to look for ahead:

Medicare Improvements for Patients and Providers Act (MIPPA) in (Pub. L. 110-275) provides guidance for new requirements for Medicare Advantage (MA) plans offering a Private-Fee-For-Service (PFFS) plan; for plan year 2011.

Some of those changes include:

- Beginning plan year 2011, in counties where there is availability of two or more network based plans (HMO, PPO, POS) a PFFS plan operating in these counties must have established a network of contracted providers to furnish services.
- PFFS plans through agreements now have the flexibility to establish specific providers payment rates that are above the rates listed in the terms and conditions
- In counties where there are no network-based plan options, or there is only one other network-based plan, the statute allows PFFS to meet access requirements whether they contract with providers or continue to use the “deeming” process; as long as the deeming conditions are met.
- The PFFS plans operating in counties that are not network areas can continue to meet access requirements by paying rates at least as high as rates under Medicare Part A or Part B to providers using the deeming process.



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***United Healthcare Premium designation program-
Assessment results are out.***

You may have received your assessment results based on claims data recently. If your providers have not received their reports these can be found on the following website <https://ereports.uhc.com/ReportCard>. More information about United Healthcare's Premium designation program can be found on their website: www.UnitedHealthcareOnline.com

Travel schedule for site visits during the 1st quarter during 2009:

Tri Area Health Clinic - January 2009

Peninsula Institute for Community Health - January 2009

Horizon Health Services

-Surry Medical Center, Waverly-February-2009

Stony Creek Community Health Center – February 2009

Southwest Virginia Community Health Systems - March 2009

Bland County Medical Clinic - March 2009

*Evelyn-Pena Morton, BA
Director of Contracting*

ICD-10-CM/PCS: WHAT DO WE NEED TO KNOW IN 2009?

Background:

On August 22, 2008, a proposed rule was published in the Federal Register to modify the standard code sets used for coding diagnoses and inpatient hospital procedures. The proposed rule discusses the adoption of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). These new code sets would replace the current ICD-9-CM, Vol. 1 & 2 and ICD-9-CM, Vol. 3, respectively. The purpose behind a new diagnostic coding system is to increase the specificity of the codes and to allow for increased clinical information as advancements in medicine take place.

ICD-10-CM: – The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in health care treatment settings within the United States. Diagnosis coding under this system uses a combination of 3 – 7 alpha and numeric digits to describe a condition. This diagnostic code set will be used by all providers, physicians and suppliers who submit claims for reimbursement for medical services.

ICD-10-PCS: – The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings **ONLY**. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM (Vol. 3) coding system uses 3 or 4 numeric digits. ***NOTE: The ICD-10-PCS will not affect the way physicians, outpatient facilities and hospital outpatient departments use the CPT to code for procedures. CPT codes will continue to be used for all procedures in these settings.***

Benefits of ICD-10-CM:

- Flexibility – allows for addition of new diagnoses and procedures as medicine advances
- Specificity – codes are exact enough to identify diagnoses and procedures more precisely.
- Better overall diagnostic data for:
 - Measuring care furnished to patients
 - Updating payment systems
 - Processing claims
 - Making clinical decisions
 - Identifying fraud, and
 - Conducting research.

Compliance Date for Implementation:

The Final Rule for the implementation of ICD-10-CM/PCS was published on January 16, 2009. The required date to be in compliance with using the ICD-10 coding system is **October 1, 2013**. The Final Rule publication can be found at <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>.

The required date to be in compliance with using ICD-10 coding system is October 1, 2013.

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(ICDM-10-CM/PCS continued)

What To Do Now:

With a compliance date in place for ICD-10-CM/PCS implementation, it is recommended that practices begin some strategic planning:

- Begin discussions with software vendors to get estimated time frames for making changes to accommodate ICD-10-CM/PCS codes
- Develop a cross-functional team to discuss the impact of ICD-10 on the organization. Members should be in clinical, financial and information systems areas of the organization.
- Develop a strategic plan and identify goals to be met (staff education, information systems change plans that includes testing & “go live” dates, documentation changes needed, etc.)
- Be selective in purchasing any educational materials. It is not recommended that practices provide full training on ICD-10 to staff members at this time. Taking advantage of educational sessions such as those from CMS would be beneficial. Any complete training of staff should wait until further information is available.

CCNV is keeping up with all published information pertaining to ICD-10 implementation and will update our Network Centers on how to plan for this change.

Helpful Resources:

Final Rule to Adopt the ICD-10-CM/PCS Coding Set:

<http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>

CMS Overview of ICD-10:

http://www.cms.hhs.gov/ContractorLearningResources/Downloads/ICD-10_Overview_Presentation.pdf

MLN Matters Article: The ICD-10 CM/PCS – The Next Generation of Coding:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf>

*Stephanie Anderson, CPC
Research Coordinator*



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From the Central Business Office

DID YOU KNOW???!?!.....

***Beginning
March 1, 2009,
the ABN-G and
ABN-L will no
longer be valid.***

Medicare Secondary Payer

Under the Medicare law, as enacted in 1965, Medicare was the primary payer for services except those covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional *primary plans*. The purpose was to shift costs from the Medicare program to private sources of payment. *These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at section 1862(b) of the Social Security Act (the Act). These provisions prohibit Medicare from making payment* if payment has been made or can reasonably be expected to be made by *the following primary plans when certain conditions are satisfied: group health plans, workers' compensation plans, liability insurance, or no-fault insurance.* If payment has not been made or cannot be expected to be made promptly by a *workers' compensation plan, liability insurance, or no-fault insurance,* Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. *Conditional payments are made subject to repayment when the primary plan makes payment.* When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second.

The Advance Beneficiary Notice

An ABN is a written notice which a physician or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary before he or she receives specified items or services that probably will not be paid for on that particular occasion, i.e: lab work. The ABN allows the beneficiary to make an informed decision whether or not to receive the items and or services. After an ABN is signed the modifier GA is inserted on to the Medicare claim, this notifies Medicare the beneficiary was informed. If you do not enter the GA modifier Medicare will adjust the item or services as non covered and the patient will not be held responsible.

Beginning Monday, March 3, 2009, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L), and NEMB (Form CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid.

Here is the link which includes ABN forms in English and Spanish.....

<http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip>

*Diane Harris
Director of the Central Business Office*



eClinicalWorks Tip of the Month!!

eCW TIP – With the advent of clinical measures reporting for UDS a Best Practice measure is to have the values for HgA1c lab tests manually input prior to a bi-directional interface with your labs.

Also, providers should choose a result when reviewing labs so the information will show on flowsheets, be visible in the lab screen and searchable using the Registry function.

The screenshot shows the 'Labs (Test, Robert)' window. On the left is a tree view of 'Lab Categories' including ANATOMIC PATH/CYT, BLOOD BANK, BLOOD GASES, CHEMISTRY, COAGULATION, GENETICS, HEMATOLOGY, HEMATOLOGY/COAGL, IMMUNOLOGY, IMMUNOLOGY RAST, MICROBIOLOGY, MISC BODY FLUIDS, TOXICOLOGY/DRUG M, URINALYSIS / URINE C, URINE CHEMISTRY, and URINE STUDIES. The main area displays a table with columns: Id, Order Date, Coll. Date, Result Date, Name, Reason, Received, Result, Reviewed, and a checkbox. The table contains three rows of data:

	Id	Order Date	Coll. Date	Result Date	Name	Reason	Received	Result	Reviewed	
	C	10/27/2008		11/22/2008	HbA1C			High	Yes	
	V	10/06/2008			Prostate Specific Antig		Yes			HM
	C	04/30/2008		05/06/2008	PSA			Abnormal	Yes	
	C	04/30/2008		04/30/2008	HbA1C			Critical high	Yes	



eClinicalWorks Tip of the Month!

NOTE: WHEN RUNNING THE UDS REPORTS FROM ECLINICALWORKS YOU MUST RUN THE ENCOUNTER POOL REPORT FIRST BEFORE ANY OF THE OTHER REPORTS AVAILABLE.

Check out eClinicalWorks support portal to tour UDS videos on configuration and running reports. There are also live presentations and documentation available!

Practices on Version 8.0 **or** planning to upgrade to Version 8.0 should be taking advantage of the webinars available on eCW's support portal specific to this new version.

Need onsite V8.0 training? Contact Dianne Fore at dfore@ccnva.com to make arrangements.

Dianne Fore
Information Technology Instructor

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 Blue Ridge Medical Center
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 Central Virginia Health Services, Inc.
 Clinch River Health Services, Inc.
 Daily Planet
 Eastern Shore Rural Health System, Inc.
 Greater Prince William Community
 Health Center
 Harrisonburg Community Health Center
 HealthCare on the Square
 Highland Medical Center
 Horizon Health Services, Inc.
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 New Horizons Healthcare
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