Community HealthChoices | AmeriHealth Caritas Pennsylvania

CONNECTIONS

A Provider's Link to AmeriHealth Caritas Pennsylvania Community HealthChoices

Summer 2021 | Issue 2

COVID-19 vaccine reimbursement update

AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) follows the updated guidelines issued on April 19, 2021, by the Department of Human Services (DHS) Medical Assistance Bulletin (MAB) 01-21-03 outlining and updating the reimbursement for the administration of the novel coronavirus (SARS-CoV-2) vaccines.

What is new?

1. DHS made the decision to again increase the Medical Assistance (MA) program fee schedule rate to that of Medicare for the administration of the SARS-CoV-2 vaccines. We will follow that guidance and update our systems to reflect a $40 reimbursement for the administration of each dose of a SARS-CoV-2 vaccine.
2. This rate increase is effective March 15, 2021. Providers do not need to resubmit claims; we will reprocess and adjust payment.
3. The complete MAB, outlining all appropriate procedure codes, national code descriptions, provider types, provider specialties, places of service, pricing, and/or informational modifiers if applicable, etc., is available at **www.amerihealthcaritaschc.com > For Providers > Resources > Department of Human Services (DHS) news and bulletins**.

Please continue to check the **Providers section** of our website for the latest updates on COVID-19 and the vaccines.

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Reminder: Balance billing Participants is prohibited

As outlined in your provider agreement with AmeriHealth Caritas PA CHC and as outlined in DHS MAB 99-99-06, titled Payment in Full, AmeriHealth Caritas PA CHC strongly reminds all providers of the following points from the bulletin:

The Pennsylvania Code 55 Pa. Code § 1101.63 (a) statement of policy regarding full reimbursement for covered services rendered specifically mandates that:

- All payments made to providers under the MA program plus any copayment required to be paid by a recipient shall constitute full reimbursement to the provider for covered services rendered.
- A provider who seeks or accepts supplementary payment of another kind from DHS, the recipient, or another person for a compensable service or item is required to return the supplementary payment.

To review the complete MAB 99-99-06, visit **www. amerihealthcaritaschc.com > For Providers > Resources > Department of Human Services (DHS) news and bulletins**.

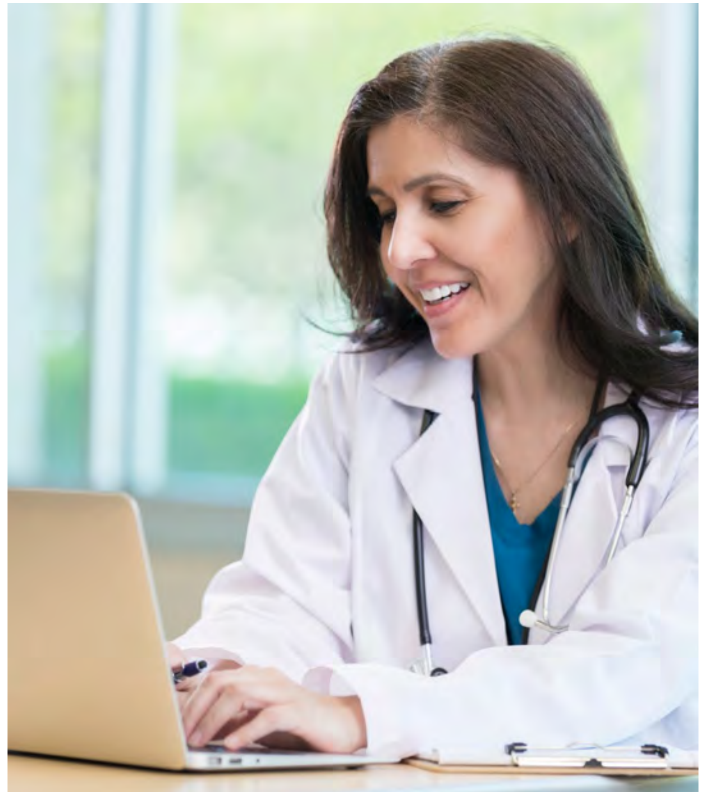
Similarly, the Centers for Medicare & Medicaid Services (CMS) clearly prohibits AmeriHealth Caritas VIP Care providers from balance billing Participants as follows:

- Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing qualified Medicare beneficiaries for Medicare cost-sharing.
- Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas VIP Care to participating providers must be accepted as payment in full for services rendered. Participants may not be balance billed for medically necessary covered services under any circumstances.

Providers may reference CMS MLN Matters number SE1128 for further details.

If you have questions, please contact your Account Executive or Provider Services at **1-800-521-6007**.

Gender-specific editing: billing reminder



AmeriHealth Caritas PA CHC follows all current and correct coding guidelines established by CMS and DHS relating to gender-specific editing. As such, this is a reminder that:

- When the listed diagnosis is not typically performed for a person of the patient's gender, modifier KX must be reported.
- The KX modifier should be billed on the detail line with any procedure code(s) that are gender-specific.
- The billing of the KX modifier will override the edit to deny when, for example, a female is presenting for a typically male-only procedure according to the coding guidelines, and allow the service to continue normal processing.

If you have questions, please contact Provider Services at **1-800-521-6007**.

Sources: ICD-9-CM; ICD-10-CM; CMS policy; AMA and specialty societies.

Obstetrical Needs Assessment Form (ONAF) no longer accepted via fax

As you know from past notifications and trainings, the Optum® OB Care website is now our only submission method for the ONAF as of July 1, 2021. ONAFs submitted after July 1, 2021, via fax to our Bright Start® department will not be processed or eligible for reimbursement.

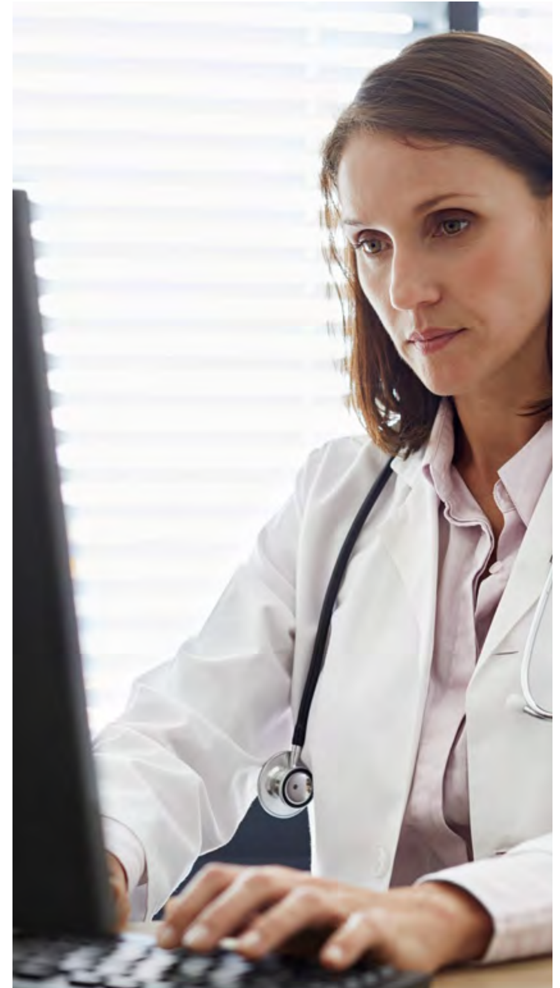
To get started, please visit **www.obcare.optum.com** to take advantage of benefits such as:

- No legibility issues.
- No incomplete submissions leading to returns to your office.
- Easy and quick submission of the first prenatal, 28 – 32 week, postpartum, or additional risk visit.

The OB Care User Guide, a PowerPoint training deck, and a link to the Optum website are all available at **www.amerihealthcaritaschc.com > For Providers > Resources > Provider resources information > Bright Start program**.

Thank you for the continued care that you provide to our pregnant Participants. If you have questions, please contact your Account Executive for assistance or training.

Providers can now run NaviNet® reports at the Tax ID Number (TIN) level



AmeriHealth Caritas PA CHC is very happy to announce that we have enhanced NaviNet to give providers the capability to run certain reports on a "RollUp" basis. Instead of having to run a report for each of the provider ID numbers that may exist for your group, you can now run one report with data consolidated for the practice at the TIN level. The specific reports that can be run at the RollUp TIN level are:

- Administrative Reports.
- Claims Status Summary RollUp.
- Panel Roster Report.
- RollUp Clinical Reports.
- Admit Report RollUp.
- Care Gap Query RollUp.
- Discharge Report RollUp.

To create a RollUp report in NaviNet:

4. Under **Workflows for this Plan** on Plan Central, select **Report Inquiry**.
5. Select either **Administrative Reports** or **Clinical Reports**.
6. Select the specific report you would like to run.
7. Select any of the "**Group Name – PIN**" options available in the **Choose a Provider Group** drop-down menu.
8. Click **Search**.

If you have questions, please contact your Account Executive or call Provider Services at **1-800-521-6007**.

Do you know your Account Executive?

To find a list of Account Executives, please visit **www.amerihealthcaritaschc > For Providers > Providers Homepage > Quick contact information**.

Recent provider notices

Visit our website for the most up-to-date notices at **www.amerihealthcaritaschc.com > For Providers > Providers Homepage > Latest updates**.

Health literacy — simple ways to improve patient and physician communication

In our March 2021 issue of *Connections*, we focused on the concept of the teach-back method. The teach-back method is used to ensure patients understand health information and risk and benefit trade-offs associated with treatments, procedures, tests, and medical devices. Another way to engage with your patient is by improving their health literacy.

Health literacy is defined as the ability to communicate with patients in a way that is easy for them to understand and act upon. Patient understanding is a key to better health. Research shows that patients remember and understand less than half of what clinicians explain to them. It is estimated that only 12% of the entire population is proficient in health literacy.[1]

Did you know?

- Nearly 9 out of 10 adults may lack the skills needed to manage their health and prevent disease.
- Patients may try to hide their lack of understanding of health information due to fear of being misunderstood or disrespected.

Enhancing health literacy does not always require additional resources. It is a method for improving the effectiveness of the work you are already doing. Patient behaviors that may indicate low health literacy include:

- Seeking help only when illness is advanced.
- Making excuses for not reading materials in front of the provider ("I forgot my glasses").
- Being quiet or passive.
- Frequently skipping appointments.
- Being noncompliant with medications.
- Being unable to name their medications or explain their medications' purpose.
- Having difficulty explaining their medical concerns.
- Having no questions at all.

We thank you for your constant improvement in the way your build your relationships with your patients — our Participants. If you'd like additional resources on health literacy, please go to **www.cdc.gov/healthliteracy** or ask your Account Executive for our resources on health literacy.

[1] Carolyn Crane Cutilli and Ian M. Bennett, "Understanding the Health Literacy of America: Results of the National Assessment of Adult Literacy," *Orthopaedic Nursing*, Vol. 28, No. 1, pp. 27 – 32, **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2668931.**

Translation services

To help ensure our Participants continue to have access to the best possible health care and services in their preferred language, we are extending to our network providers the opportunity to contract with Language Services Associates (LSA) at our low, corporate telephonic rates.

Visit **www.amerihealthcaritaschc.com** > **For Providers** > **Training** to review a description of services and a letter of commitment for complete details and contact information. You may address any questions you have directly to LSA, since this relationship will be between your office and LSA. Feel free to call them at **1-800-305-9673, ext. 55321**.

Quality and utilization management (UM)

We have adopted clinical practice guidelines for treating Participants, with the goal of reducing unnecessary variations in care. Clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the practitioner's clinical judgment. The practitioner remains responsible for ultimately determining the applicable treatment for each individual patient. All clinical practice guidelines are available at **www.amerihealthcaritaschc.com > For Providers > Resources > Clinical Resources**, or upon request by calling Provider Services at **1-800-521-6007**.

We will provide our utilization management (UM) criteria to network providers upon request. To obtain a copy of the UM criteria:

- Call the UM department at **1-800-521-6622**.
- Identify the specific criteria you are requesting.
- Provide a fax number or mailing address.

You will receive a faxed copy of the requested criteria within 24 hours or a written copy by mail within five business days of your request.

Please remember that we have medical directors and physician advisors available to address UM issues or answer your questions regarding decisions relating to prior authorization, durable medical equipment, home health care, and concurrent review. Call the Medical Director Hotline at **1-877-693-8480**.

Additionally, we would like to remind you of our affirmation statement regarding incentives:

- UM decision-making is based only on appropriateness of care and the service being provided.
- We do not reward providers or other individuals for issuing denials of coverage or services.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Quality Improvement (QI) updates

Our QI program monitors and assesses the health care services used by our Participants to ensure that these services:

- Meet quality guidelines.
- Are appropriate.
- Are efficient.
- Are effective.

The Quality Assessment and Performance Improvement (QAPI) Committee oversees the QI program and coordinates efforts to measure, manage, and improve the quality of care and services for Participants. The committee is made up of local health care providers, along with clinical and nonclinical associates. Each year, the QI program sets goals to improve Participants' health outcomes by using data and conducting activities to meet those goals. AmeriHealth Caritas PA CHC evaluates the QI program at the beginning of each year and determines the successes and new activities to focus on. The QI program supports our organization's mission to help people get care, stay well, and build healthy communities.

QI program recent successes (2020)

- We achieved accreditation from the National Committee for Quality Assurance (NCQA) for Medicaid Plan and Long-Term Services and Supports (LTSS) Distinction.
- We developed and implemented a training curriculum for Service Coordinators.
- Staff was trained on the procedures for preventable serious adverse events (PSAEs) in nursing facilities. Throughout 2020, all staff were educated on the policies and procedures for critical incidents.
- The Home- and Community-Based Services (HCBS) CAHPS® Survey was conducted in the third quarter of 2020.

Goals for 2021

- Maintain accreditation status and LTSS Distinction.
- Identify and prioritize opportunities to implement or redesign clinical programs to reduce health care disparities.
- Achieve improvement in the following HEDIS measures:
  - Comprehensive Diabetes Care.
  - Controlling Blood Pressure for Participants with hypertension.
- Improve Participant satisfaction as measured by overall Adult CAHPS and HCBS CAHPS satisfaction scores.
- Help our providers stay informed and up to date on the care that our Participants receive.
- Empower Participants to work more collaboratively with their Service Coordinators to enhance or create their service plans to maintain and/or improve their health status and achieve goals.

Formulary updates

Additions	Update
Iron supplements, ferrous sulfate, ferrous fumarate, ferrous gluconate, etc. (various; see supplemental formulary for full listing)	January 18, 2021
Removals	**Update**
Isoniazid 50 mg/5 mL oral solution	April 5, 2021
In-Check Oral Flow Meter and In-Check Nasal with Mask	April 5, 2021
Clever Choice Peak Flow Meter	April 5, 2021

Pharmacy prior authorization: no phoning or faxing — just a click away!

Use our online prior authorization request form to submit pharmacy prior authorization requests instantly. To get started, go to: **www.amerihealthcaritaschc.com** > **For Providers** > **Pharmacy services** > **Pharmacy prior authorizations** > **Online prior authorization request form**.

Please visit the Pharmacy Services section of our website at **www.amerihealthcaritaschc.com** > **For Providers** > **Pharmacy services** for up-to-date information, including:

- A list of pharmaceuticals, including restrictions and preferences.
- An explanation of limits or quotas.
- Drug recalls.
- How to use pharmaceutical management procedures.
- Prior authorization criteria and procedures for submitting prior authorization requests.
- Changes approved by the Pharmacy and Therapeutics Committee.

Home- and Community-Based Services (HCBS) Provider Satisfaction Survey summary

AmeriHealth Caritas PA CHC sincerely thanks the HCBS providers who participated in our HCBS Provider Satisfaction Survey conducted in late 2020. We take provider input and recommendations seriously. We value your insight and appreciate the time taken to participate in the survey. We are here to support you in the care of our Participants. The survey results identified key areas where AmeriHealth Caritas PA CHC ranked high as well as opportunities to improve service.

Key strengths identified in the survey include:

- Provider relations/network management.
- Responsiveness and courtesy of Account Executives.
- Provider Services staff.
- Knowledge, accuracy, and helpfulness of responses to telephone inquiries.
- Claims reimbursement process.
- Accuracy of claims processing.
- Service coordination/care management.
- Health plan's facilitation/support of appropriate clinical care for patients.

Some opportunities for improvement that will be of particular focus are in the areas of:

- Service Coordinator/Personal Care Connector access.
- Timeliness and accuracy of claims processing, and resolution of claims payment problems/disputes.
- HHA eXchange and NaviNet usage and barriers.
- Cultural and linguistic diversity, especially in the use of translator or translation services for Participants with limited English proficiency.

Addressing these identified areas of needed improvement will be the focus of strategic workgroups within AmeriHealth Caritas PA CHC. We are here to support you in the care of our Participants. We look forward to working with you to address any issues identified in the survey and we continue to welcome your ideas and comments.

Reporting a critical incident

A critical incident is an occurrence of an event that jeopardizes a Participant's health or welfare. Reportable critical incident category definitions are available at **55 Pa. Code § 52.3 Definitions**.

Did you know?

- Deaths from natural causes do not need to be reported.
- Once the Participant is discharged from the hospital, and the risk has been mitigated ensuring the Participant's health and safety, the critical incident can be closed in the Enterprise Incident Management System (EIM).
- Adult Protective Services (APS)/Older Adult Protective Services (OAPS) determination of Substantiated, Unsubstantiated, or Inconclusive must be obtained to close a critical incident associated with a protective services investigation. (If a determination is unable to be obtained from APS/OAPS, the Participant's safety needs must be identified and efforts to mitigate any potential risks must be documented in the critical incident report before the incident can be closed in EIM.)
- Adult Protective Services can be contacted via their hotline at **1-800-490-8505**.

Reminder: Two important nursing facility requirements effective August 1, 2021

We would like to remind AmeriHealth Caritas PA CHC nursing facilities of the two requirements below for both public and non-public nursing facilities.

1. Nursing facility admissions of AmeriHealth Caritas PA CHC nursing facility ineligible (NFI) Participants will require notification upon admission, effective August 1, 2021.
   - Notification is to be made within 48 hours of each admission. Failure to notify AmeriHealth Caritas PA CHC within 48 hours of an NFI Participant's nursing facility admission will result in claim denial.
   - Nursing facility admission notifications should be submitted to our Concurrent Review fax line at **1-855-540-7068**. Registered NaviNet users can also submit admission notifications via the secure NaviNet portal.
2. Effective August 1, 2021, when billing for patient pay liability, the gross amount must be billed with value code 23 and the net amount must be billed with value code 66.
   - Both value codes are required when billing patient pay liability amounts.
   - Failure to bill both value codes will result in a claim denial for invalid billing.

If you have any questions about these requirements, please contact your Account Executive or call Provider Services at **1-800-521-6007**.

Enterprise Incident Management System (EIM) user identification — quick tips

No matter which Community HealthChoices managed care organization (CHC-MCO) the Participant is enrolled in, providers use the same EIM user ID for all CHC Participants.

Providers must ensure they check the Search for CHC Participants check-box in order to view or create critical incidents on CHC Participants.

Reminder for Direct Service Providers

Direct Service Providers must inform the Participant's Service Coordinator of a critical incident within 24 hours of an incident occurring. While a critical incident report must be submitted in the EIM system by the Service Coordinator or provider agency within 48 hours, Direct Service Providers must communicate with the Service Coordinator about the issue within 24 hours of the critical incident discovery. Direct Service Providers should take action to prevent further incidents and discuss options, concerns, and resolutions with the Service Coordinator and Participant. All critical incident reports must include:

- Discovery time and date of the incident and occurrence date of the incident. (The discovery date cannot be before the occurrence date.)
- Reporter information.
- Participant demographics.
- Event details and type.
- Description of the incident.
- Actions taken to immediately secure the Participant's health and welfare.

Prior to entering a critical incident report in the EIM system, please search EIM to determine if a report has already been initiated. (It is imperative that providers communicate with the Service Coordinator to determine who will enter the incident since Providers are unable to see an incident entered by a Service Coordinator in EIM.)

- It is mandatory to report any suspected abuse to APS within 24 hours of the knowledge of an incident.
- The entity or individual that first discovers or learns of the critical incident (if they are not present when it occurs) is responsible for reporting it.
  - The Service Coordinator or provider agency that discovers or has independent knowledge of the critical incident **must submit the critical incident report within 48 hours** by directly entering the incident into the EIM system. If the critical incident occurs over the weekend, a written report must be entered the first business day after the incident occurred.

Incidents must be completed in EIM within 30 calendar days from the date of discovery.

Each critical incident report should include:

- Discovery time and date of the incident and occurrence date of the incident.
- What steps were taken immediately to ensure the Participant's health and welfare.
- What fact-finding steps were taken, and what information was found.
- What corrective steps were taken.
- How the critical incident will be prevented from happening in the future.
- Any changes to the Person-Centered Service Plan (PCSP) because of the critical incident.
- Coordination of any backup supports that may need to be mobilized.
- Contact with other parties who may need to assist or support the Participant (i.e., APS, emergency medical services, law enforcement, etc.).

Claims submission via Change Healthcare

As of May 2021, Change Healthcare has transitioned from WebConnect to ConnectCenter. ConnectCenter is designed to improve claims management functionality previously experienced with Emdeon Office/WebConnect. Providers who have a limited ability to submit claims through their hospital or project management system may now benefit from key features of the new ConnectCenter tool. There is no cost to providers to use ConnectCenter.

Key features are:

- Claims users no longer need to choose between data entry of claims and upload of 837 files. All users may do both.
- Secondary and tertiary claims can be submitted.
- Institutional claims are supported.
- Claims created online are fully validated in real time so providers can correct them immediately.
- Whether providers upload their claims or create them online, the claim reports are integrated with the claim correction screen for ease in follow-up.
- Dashboard and work list views enable providers to streamline their billing to-do list.
- Remittance advice is automatically linked to a provider's submitted claim, providing a comprehensive view of the status of their claim.

To transition to the new portal go to **ConnectCenter Sign-Up**. Change Healthcare customer support is available through online chat, or call **1-800-527-8133, option 2** for assistance.

You can find more information on electronic claims submission, payment, and remittance advice services, including a video tutorial and user guides, on our website at **www.amerihealthcaritaschc.com > For Providers > Claims and billing > Electronic claims submission, payment, and remittance advice services**.

Join our Participant Advisory Committee (PAC) and Health Education Advisory Committee (HEAC)

Our PACs and HEACs are always looking for new committee members! Committee members consist of Participants and also physical health, behavioral health, and LTSS providers. The commitment involves in-person or virtual participation in our quarterly meetings. Tentative dates are identified in the beginning of the year, and the remaining dates for 2021 are:

Southwest: September 15 and December 15

Northwest: September 7 and December 7

Central/Lehigh Capital: September 23 and December 16

Northeast: September 7 and December 7

Please reach out to the Community Outreach Program Manager, Maritza Padua, at **mpadua@amerihealthcaritaschc.com** for more information.

Community events calendar

As we prepare to get back out into the community, the AmeriHealth Caritas PA CHC Community Outreach team wants to hear from you! Do you have any special events or community events planned for the year? Please reach out to the Community Outreach Program Manager, Maritza Padua, at **mpadua@amerihealthcaritaschc.com** and share the details.

Fraud tip hotline

If you or any entity with which you contract to provide health care services on behalf of AmeriHealth Caritas PA CHC becomes concerned about or identifies potential fraud or abuse, please contact us by:

Calling the toll-free fraud, waste, and abuse hotline at **1-866-833-9718**.

Emailing **fraudtip@amerihealthcaritas.com**.

Mailing a written statement to:
Special Investigations Unit
AmeriHealth Caritas Pennsylvania Community HealthChoices
200 Stevens Drive
Philadelphia, PA 19113

Information may be left anonymously.

For more information about Medical Assistance fraud and abuse, please visit the DHS website at **https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx**.

Mandatory training: Reporting Fraud, Waste, and Abuse

AmeriHealth Caritas PA CHC is committed to detecting and preventing acts of fraud, waste, and abuse and has a webpage dedicated to addressing these issues and mandatory screening information. Visit **www.amerihealthcaritaschc.com > For Providers > Resources > Fraud, waste, abuse, and mandatory screening information**.

Topics include:

- Information on screening employees for federal exclusion.
- How to report fraud to AmeriHealth Caritas PA CHC.
- How to return improper payments or overpayments to us.
- Information on mandatory provider fraud, waste, and abuse training.

Note: After you have completed the training, please complete the attestation.

Coverage by AmeriHealth First.

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