AmeriHealth Caritas Pennsylvania
AmeriHealth Caritas Northeast

CONNECTIONS

A Provider's Link to AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast

Provider Satisfaction Survey results 2018

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast (the Plan) provider satisfaction surveys are meaningful and essential sources of information that help identify issues and help develop an effective action plan for quality improvement within our organization. These annual surveys are a tool for opening a dialogue with our provider network to help us recognize new opportunities for efficiency and effectiveness. The survey helps promotes sound, informed decision-making by collecting statistically reliable data. We thank all who responded to our call for feedback in 2018.

Last year's survey ran from September 17, 2018, to November 13, 2018. It was conducted with our network by mail, internet, and phone interview. The total number of surveys distributed was 1,525 (combined) which resulted in the following rates of return:

AmeriHealth Caritas Pennsylvania rate of return

Sample selected	Completed surveys	Response rate %
934	Internet = 8 Mail = 56 Phone = 66 **Total = 130**	14.2%

AmeriHealth Caritas Northeast rate of return

Sample selected	Completed surveys	Response rate %
591	Internet = 5 Mail = 36 Phone = 42 **Total = 83**	14.3%

Our successes

- Provider satisfaction with the Plan is strong compared with "all other" health plans.
- Satisfaction was higher among providers:
  - Who are ancillary (ancillary services for the Plan are defined as ambulance/transportation, durable medical equipment [DME], dialysis, home health, home infusion, hospice, laboratory, skilled nursing, and skilled nursing facilities).
  - Who have a higher volume of Plan members.
- More than nine in 10 providers recommend the Plan to patients and other provider practices.

(continued on page 2)

Spring March 2019

In this issue

Provider Satisfaction Survey results 2018

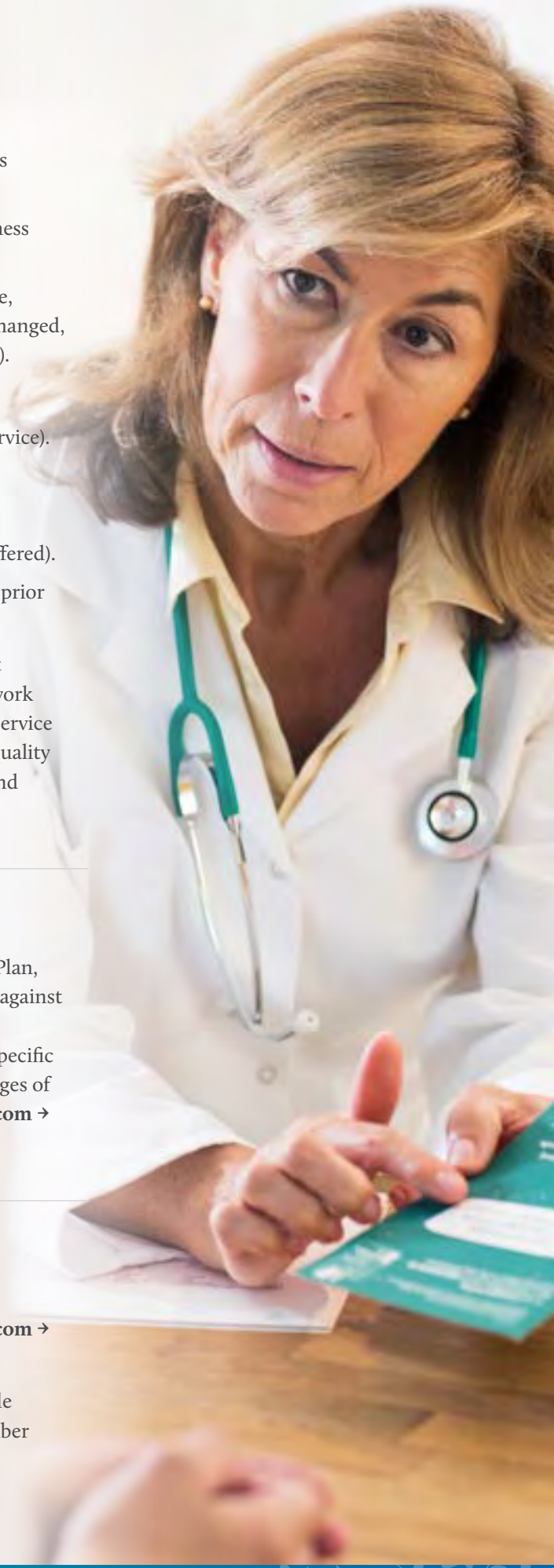
(continued from page 1)

- Areas of strength were identified as:
  - Provider Relations (knowledge, accuracy, and helpfulness of responses from staff).
  - Provider Network Management (responsiveness and courtesy, timeliness to answer questions, relevance and timeliness of communications).
  - Care Management (helpfulness of Care Managers in coordinating care, covers and encourages preventive care, timeliness of information exchanged, accuracy of information exchanged, clarity of information exchanged).

Our challenges

- Provider Network Management (relevance of education meetings/in-service).
- Claims (resolution/timeliness of claims payment problems).
- Credentialing (timeliness of credentialing/recredentialing process).
- Care Management (alternative care and community resource options offered).
- Pharmacy Services (variety of drugs on the formulary, ease of obtaining prior authorization for non-formulary drugs).

Information obtained from this survey is being reviewed and improvement strategies developed by our internal departments: Provider Relations/Network Management, Provider Services, Provider Communications (provider self-service website information and Jiva), Claims and Credentialing, Utilization and Quality Management, Care Management (Integrated Health Care Management), and Pharmacy Services.



Members' rights and responsibilities

We are committed to treating our members with dignity and respect. The Plan, its network providers, and other providers of service may not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis prohibited by law. Our members also have specific rights and responsibilities. The complete list is available on the provider pages of **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Provider → Resources → Member rights and responsibilities**.

Member copayments

The most current member copayment schedule is viewable at **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Providers → Billing → Member copay schedule**.

As a reminder, providers may not deny covered care or services to an eligible AmeriHealth Caritas Pennsylvania or AmeriHealth Caritas Northeast member because of the member's inability to pay the copayment amount.
[55 PA Code 1101.63(b)(7)]

Resources for members with special health needs

The Plan offers a number of programs that help us collaborate with you in providing care to our members with specific health needs.

Integrated Health Care Management/complex case management

The Integrated Health Care Management (IHCM) program, which includes complex case management, provides comprehensive case management and disease management services to our highest-risk members.

The program coordinates resources for members who are expected to experience future adverse events, and assists members who have medical, behavioral, and/or social issues that affect their quality of life and health outcomes. Identified issues and diagnoses that would be referred to the program include:

- Multiple diagnoses (three or more major diagnoses).
- Pediatric members requiring assistance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
- Pediatric members requiring in-home nursing services.
- Members with dual medical and behavioral health needs.
- Members with behavioral health diagnoses needing assistance with referral to a behavioral health managed care organization (BH-MCO) or special help with accessing medical care.
- Members with intellectual disabilities.
- Members with elevated blood lead levels (EBLL 5 mcg and above).
- Members with chronic diseases, including:
  - Heart failure.
  - Diabetes.
  - Asthma.
  - Chronic obstructive pulmonary disease (COPD).
  - Coronary artery disease.
  - Sickle cell anemia.
  - HIV/AIDS.
  - Hemophilia.

We provide service through telephonic outreach, assessment, and intervention. The staff makes outreach calls to the member and/or member representative, as indicated, and collaborates with the primary care practitioner (PCP) and specialist to develop a treatment plan.

Integrated Health Care Management/complex case management

AmeriHealth Caritas Pennsylvania
1-877-693-8271, option 2

AmeriHealth Caritas Northeast
1-888-208-5966

Special Needs Unit

This unit coordinates services for new adult and pediatric members and for existing members who have short-term and/or intermittent needs, single-problem issues, and/or multiple comorbidities.

Case Managers help resolve pharmacy, DME, and/or dental access issues; assist with transportation; identify and provide access to specialists; and provide referrals and coordinate with behavioral health providers or other community resources. There is also a dedicated Case Manager who liaises with BH-MCOs for members with both physical and behavioral/mental health issues, and collaborates with government offices, health care providers, and public entities for members with special needs.

Special Needs Unit

AmeriHealth Caritas Pennsylvania
1-800-684-5503

AmeriHealth Caritas Northeast
1-888-498-0766

Bright Start® program for pregnant members

With a focus on improving prenatal care for pregnant members, this program assesses, plans, implements, teaches, coordinates, monitors, and evaluates options and services required to meet individual health needs.

The program fosters collaboration between the Case Manager, member, obstetrician, and BH-MCO for assessment and interventions to support the management of behavioral and social health issues.

The program's goals are to:

- Identify pregnant members (using a variety of sources including Obstetrical Needs Assessment Forms [ONAFs]; Logical Observation Identifiers, Names, and Codes [LOINC]; and pharmacy data) and obtain accurate contact information.
- Improve health outcomes for neonates.
- Facilitate access to services and resources:
  - Dental screenings.
  - Behavioral health screenings.
- Build relationships with community-based agencies that specialize in services for maternal/child health.
- Encourage prenatal and postpartum care by increasing awareness through member newsletters, media engagements, provider education, and community alliances.
- Assess and address health care disparities in pregnant women.

Members receive interventions depending on the assessed risk of their pregnancies. Case Managers play a hands-on role in coordinating and facilitating care with members' physicians and home health care agencies. Case Managers also provide outreach to ensure member follow-up with medical appointments, identify potential barriers to getting care, and encourage appropriate prenatal behavior.

Using informatics reports and assessment information provided by the obstetrics practitioner, members are triaged into low-risk and high-risk populations:

- Low-risk members receive educational material about pregnancy and delivery, and how to access a Case Manager for any questions or issues.
- Low-risk members receive an outreach call after delivery to complete a postpartum survey.
- High-risk members receive "high touch" case management interventions from a Case Manager.

Bright Start program

AmeriHealth Caritas Pennsylvania: **1-877-364-6797**

AmeriHealth Caritas Northeast: **1-888-208-9528**

THE LET US KNOW PROGRAM

This program is a partnership between the Plan and the provider community to collaborate in member engagement and management.

We have support teams and tools to assist in member identification, outreach, and education, and also clinical resources for providers.

Contact Integrated Health Care Management by faxing the Member Intervention Request Form to **1-866-208-8145**.

Use this form to request interventions such as:

- Noncompliance with prescribed medications.
- Not showing up for appointments or follow-up care.
- Inappropriate use of the emergency room.

Visit our websites to find the Let Us Know program flyer and the form:

www.amerihealthcaritaspa.com or **www.amerihealthcaritasnortheast.com → Providers → Initiatives → Let Us Know**.

Reminder: Use the YO modifier for CONNECT referrals

While all children grow and develop in unique ways, some children experience delays in their development. Children with developmental delays and disabilities benefit from Pennsylvania's Early Intervention program, a state-supported network of parents, service practitioners, and others that builds upon the natural learning opportunities that occur within the daily routines of a child and their family.

Following an EPSDT screen, if the screening provider suspects developmental delay and the child is not already receiving early intervention services at the time of screening, the provider is required to refer the child (ages birth to 5) to the CONNECT Helpline at **1-800-692-7288**. Document the referral in the child's medical record and **submit your claim with the YO modifier**.

For more information about CONNECT, visit **www.dhs.pa.gov/citizens/earlyinterventionservices/index.htm**.

Submit ONAF forms online through Optum®

The ONAF may be submitted online through the Optum OB Care website. Using this submission process provides benefits such as:

- No more faxing.
- No legibility issues.
- No incomplete submissions leading to returns to your office.
- Submission of the first prenatal, 28–32 week, postpartum, or an additional risk visit easily and quickly.

To register and get started, go to https://obcare.optum.com.

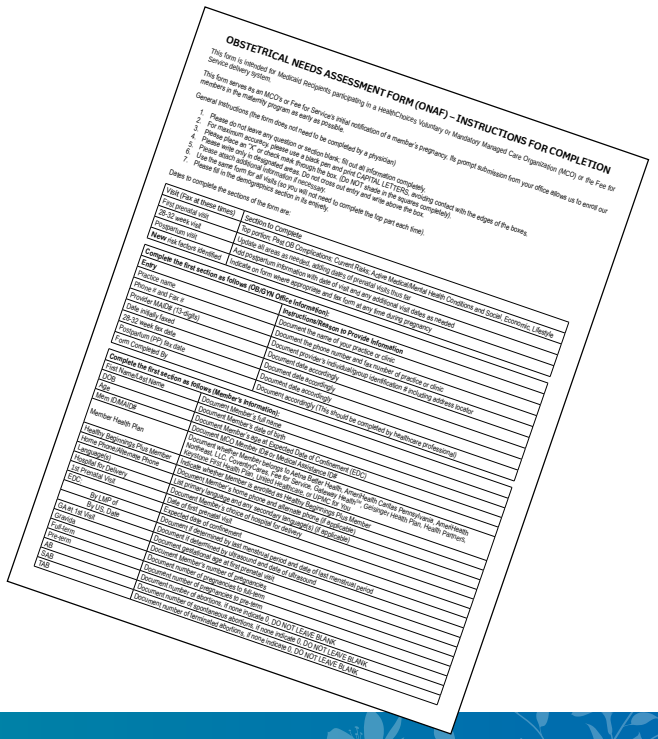
The OB Care User Guide and link to the Optum website are also available at:

www.amerihealthcaritaspa.com or **www.amerihealthcaritasnortheast.com → Providers → Initiatives → Bright Start → Provider information, resources and tools→ Optum OB Care user guide**.

You can also contact your provider Account Executive for assistance or training.

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast will continue to accept all other methods of ONAF submission, but we encourage you to use this quick and easy electronic method.

The ONAF is on our websites at **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Providers → Resources → Forms → Obstetrical Needs Assessment**.


OBSTETRICAL NEEDS ASSESSMENT FORM (ONAF) – INSTRUCTIONS FOR COMPLETION

Formulary updates: January 2019 to date

Additions	
There are no additions to report at this time.	
Removals	**Update**
Pataday (olopatadine hcl) ophthalmic drops	March 2019
Nalfon (fenoprofen calcium) 600 mg capsules	March 2019
Meclofenamate sodium capsules	March 2019
Daypro (oxaprozin) tablets	March 2019
Indocin (indomethacin) oral suspension	March 2019
Zamicet (hydrocodone/acetaminophen) solution	March 2019
Lortab Elixir (hydrocodone/acetaminophen) solution	March 2019
Oxycodone hcl 5 mg capsules	March 2019
Percodan (oxycodone hcl/aspirin) tablets	March 2019
Morphine sulfate suppository	March 2019
Kadian (morphine sulfate) capsules	March 2019
Formulary limit updates	**Update**
Celebrex (celecoxib) 400 mg capsules — **quantity limit:** 1 capsule per day	March 2019
Chemet (succimer) 100 mg capsules — **day supply limit:** 19 days' supply	March 2019
Latuda (lurasidone hcl) 20 mg, 40 mg, 60 mg, or 120 mg tablets — **quantity limit:** 1 tablet per day	March 2019
Latuda (lurasidone hcl) 80 mg tablets — **quantity limit:** 2 tablets per day	March 2019
Arnuity Ellipta (fluticasone furoate) 100 mcg and 200 mcg blister, with inhalation device — **quantity limit:** 1 inhaler per month	March 2019
Single- or combination-ingredient codeine products — **age limit:** 18 years or older	March 2019
Short-acting, long-acting, or combination products with tramadol — **age limit:** 18 years old or older	March 2019
An opioid-containing cough and cold product: **Day supply limit:** 5 days for members ages 21 years and older without prior authorization. **Day supply limit:** 3 days for members ages 18 to 20 years without prior authorization. **Quantity limit:** 120 milliliters per month or 2 capsules per day without prior authorization.	March 2019
Formulary step therapy updates	**Update**
The following products will now require step therapy: • Zyrtec-D (cetirizine hcl/pseudoephedrine). • Claritin-D (loratadine/pseudoephedrine. • Claritin (loratadine) oral disintegrating tablets. **Step therapy:** Allegra (fexofenadine) generic for children under 2 years old, Claritin (loratadine) generic tablets, Xyzal (levocetirizine) generic tablets, Zyrtec (cetirizine) generic tablets or oral solution or pseudoephedrine.	March 2019
Formulary update	
Brand-name Ventolin HFA (albuterol sulfate) 90 mcg/actuation aerosol inhaler and ProAir HFA (albuterol sulfate) 90 mcg/actuation aerosol inhaler will be non-formulary. **Preferred:** Generic Ventolin HFA (albuterol sulfate) 90 mcg/actuation aerosol inhaler.	February 2019

Prior authorizations for specialty medications

Providers can specify a dispensing pharmacy on a prior authorization form when requesting coverage of specialty medications. Specialty medications can be filled at any specialty pharmacy in the Plan's specialty network, and all prior authorization forms should indicate the requested specialty pharmacy.

The Plan will allow access to medications dispensed at out-of-network pharmacies when the drug(s) cannot be obtained at a network pharmacy (limited distribution) or if the network pharmacy cannot serve the member in the time frame needed to prevent a negative impact.

Our Specialty Network Providers directory is available on our websites at **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Pharmacy → Pharmacy directory → Specialty pharmacy directory (PDF).**

If you have questions, please contact Pharmacy Services at:
AmeriHealth Caritas Pennsylvania **1-866-610-2774**
AmeriHealth Caritas Northeast **1-888-208-1020**

Pharmacy resources on our websites

Please visit the Pharmacy section of our websites at **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Pharmacy** for up-to-date pharmacy information, including:

- Changes approved by the Pharmacy and Therapeutics (P&T) Committee.
- Drug formulary listing, including restrictions and preferences; an explanation of limits or quotas.
- Drug recalls.
- How to use pharmaceutical management procedures.
- Prior authorization criteria and submission procedures.

Pharmacy prior authorization: No phoning or faxing — just one click away!

Use our online prior authorization request form to submit pharmacy prior authorization requests instantly. To get started, go to **www.amerihealthcaritaspa.com** or **www.amerihealthcaritasnortheast.com → Pharmacy → Prior authorization**.

Credentialing information

Please remember that the Plan encourages all practitioners to use the free Universal Provider DataSource through the Council for Affordable Quality Healthcare (CAQH) for simplified and streamlined data collection for credentialing and recredentialing. Through the CAQH, credentialing information is provided through a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate in the CAQH. The complete list of Plan credentialing guidelines and related forms, as well as practitioners' credentialing and recredentialing rights, is available at **www.amerihealthcaritaspa.com** or **www.amerihealthcaritasnortheast.com → Providers → Join our network**.

Practitioner credentialing rights

After the submission of the application, health care providers have the following rights:

- To review information submitted to support their credentialing application, with the exception of references, recommendations, and peer-protected information obtained by the plan.
- To correct erroneous information. When information obtained by the Credentialing department varies substantially from information provided by the provider, the Credentialing department will notify the provider to correct the discrepancy.
- To be informed, upon request, of the status of their credentialing or recredentialing applications.
- To be notified within 60 calendar days of the Credentialing Committee/Medical Director review decision.
- To appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision.
- To know that all documentation and other information received for the purpose of credentialing and recredentialing is considered confidential and is stored in a secure location that is only accessed by authorized plan associates.
- To receive notification of these rights.

To request any of the above, the provider should contact the AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast Credentialing department at:

AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
Attn: Credentialing Department
200 Stevens Drive
Philadelphia, PA 19113

What is an appeal?

An appeal is a written request from a health care provider for the reversal of a denial by the Plan through the Plan's formal provider appeals process. Two types of issues that may be addressed through this process are:

- Disputes not resolved to the network provider's satisfaction through the Plan's informal provider dispute process.
- Denials for services already rendered by the health care provider to a member, including denials that:

  (a) Do not clearly state that the health care provider is filing a member complaint or grievance on behalf of a member (even if the materials submitted with the appeal contain a member consent), or

  (b) Do not contain a member consent for a member complaint or a consent that conforms to applicable law for a grievance filed by a health care provider on behalf of a member.

Examples of appeals include, but are not limited to, the following:

- The health care provider submits a claim for reimbursement for inpatient services provided at the acute level of care, but the Plan reimburses for a nonacute level of care because the health care provider has not established medical necessity for an acute level of care.
- A home health care provider made a total of 10 home care visits, but only seven visits were authorized by the Plan. The home health care provider submits a claim for 10 visits and receives payment for seven visits.
- DME that requires prior authorization by the Plan is issued to a member without the health care provider obtaining prior authorization from the Plan (e.g., bone stimulator). The health care provider submits a claim for reimbursement for the DME and it is denied by the Plan for lack of prior authorization.
- A member is admitted to the hospital as a result of an ER visit, and the inpatient stay is for a total of 15 hours. The hospital provider submits a claim for reimbursement at the one-day acute inpatient rate but the Plan reimburses at the observation rate, in accordance with the hospital's contract with the Plan.

Types of issues that may **not** be appealed through the Plan's formal provider appeals process include:

- Claims denied by the Plan because they were not filed within 180-day filing time limit; claims denied for exceeding the 180-day filing time limit may be appealed through the Plan's informal provider dispute process.
- Denials issued as a result of a prior authorization review by the Plan (the review occurs prior to the member being admitted to a hospital or beginning a course of treatment); denials issued as a result of a prior authorization review may be appealed by the member, or by the health care provider with written consent of the member, through the Plan's member complaint and grievance process.
- Provider terminations based on quality of care reasons may be appealed in accordance with the Plan's Provider Sanctioning Policy, and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements.

For more information about provider dispute/appeal procedures, as well as member complaints, grievances, and fair hearings, go to Section 7 of the Provider Manual at **www.amerihealthcaritaspa.com** or **www.amerihealthcaritasnortheast.com → Providers → Resources → Provider manual**.

Cultural competency

As part of our mission, the Plan strives to provide health care in a respectful, understandable, and effective manner to an increasingly diverse population. As a recipient of federally financed health care dollars, our Plan and the health care providers in our network must abide by the Office of Civil Rights directives of the Civil Rights Act of 1964, Title VI, Section 601, which states:

No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Why is culturally competent care important?

Health care services that are respectful of and responsive to the health beliefs and practices and cultural and linguistic needs of diverse patient populations are more effective at improving the quality of life of our members — your patients.

For some patients, language is the first barrier to health care. Along with language barriers, different cultures can influence:

- A person's health, healing, and wellness belief systems.
- How he or she perceives an illness or disease and its causes.
- Their attitudes toward health care providers.

The provider who looks at the world through his or her own set of values or experiences can unintentionally compromise the delivery of services to patients of different cultures.

To help you serve diverse populations, the Office of Minority Health, part of the U.S. Department of Health and Human Services, offers the following free, online accredited continuing education program: **https://www.thinkculturalhealth.hhs.gov/education/physicians**.

The U.S. population is changing racially, ethnically, and linguistically. Each group brings its own cultural traits and health profiles, which presents a challenge to the health care industry. The provider and the patient's individual learned patterns of language and culture must be transcended to achieve equal access to quality health care.

Remember, to be compliant with federal law and state contractual requirements, the Plan and its participating providers have an obligation to provide interpreter services to members with limited English proficiency (LEP) and to make reasonable efforts to accommodate members with other sensory impairments.

(continued on page 11)

Cultural competency (*continued from page 10*)

Providers are required to:

- **Provide written and oral language assistance** at no cost to our members with LEP or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- **Provide members verbal or written notice** (in their preferred language or format) about their right to receive free language assistance services.
- **Post and offer easy-to-read member signage and materials** in the languages of the common cultural groups in the provider's service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.
- **Discourage members from using family or friends** as oral translators.
- **Advise members that translation services are available** through our Plan if the provider is not able to procure the necessary translation services for a member.

Under the standards for Culturally and Linguistically Appropriate Services (CLAS) (https://www.thinkculturalhealth.hhs.gov/) from the Office of Minority Health, network providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all members in a manner compatible with the members' cultural health beliefs and practices and in their preferred language or format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in the provider's service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of CLAS services.
- Establish written policies to provide interpretive services for members upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all member medical records.

Translation services

To help ensure our members 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 Plan's low, corporate telephonic rates.

Visit **www.amerihealthcaritaspa.com** or **www.amerihealthcaritasnortheast.com→ Providers → Initiatives → Cultural Competency** to review a description of services and a letter of commitment for complete details and contact information. You may address any questions you have to LSA, since this relationship will be between your office and LSA. Feel free to call them at **1-215-259-7000, ext. 55321** or **1-800-305-9673**.

As a reminder, on July 3, 2018, the Pennsylvania Department of Human Services (DHS) issued Medical Assistance Bulletin 27-18-09, **Updates to the Pediatric Dental Periodicity Schedule**, which incorporated changes resulting from the recommendations by the American Academy of Pediatric Dentistry (AAPD).

To view the entire bulletin, go to our website at **www.amerihealthcaritaspa.com** or **www.amerihealthcaritasnortheast.com → Providers → Communications → DHS/Medical Assistance Bulletins**. You can also find the bulletin on our dental provider web portal.

In addition to the recommendation that members should begin receiving clinical examinations, fluoride treatments, and a caries risk assessment by age 1, it is also recommended that our members and your patients are assessed for sealants upon the eruption of their first permanent molars.

As oral health professionals, you are aware of the importance of placing sealants as closely as possible to the eruption of permanent premolars and molars. Dental sealants are one of the most universally used preventive materials today. Eighty percent of decay in young permanent teeth occurs in pit and fissure areas, and sealants have proven to be a useful tool for prevention.[1]

However, the success of sealants greatly depends on the application process and the ability to maintain a dry and clean environment. Factors that can assist with sealant retention include isolation and prevention of saliva contamination, proper technique by experienced operators, proper tooth preparation, and never applying sealants to partially erupted teeth.

Sealants are not meant to be permanent but can last up to 10 years, so make sure the integrity of the sealant is intact at every visit. Talk to your patients' parents and caregivers about sealants at every visit.

[1]Mehta, V. (2014). Five Key Criteria for Sealant Success. Spear, 2014. **www.speareducation.com/spear-review/2014/03/five-key-criteria-for-sealant-success**.

Fraud, waste, and abuse

Preventing fraud, waste, and abuse

Under the HealthChoices program, our Plan receives state and federal funding for payment of services provided to our members. In accepting claims payments from the Plan, health care providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. As a provider participating in the Plan's network, you are responsible to know and abide by all applicable state and federal laws and regulations and abide by the fraud, waste, or abuse requirements of the Plan's contract with DHS.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste: The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather misuse of resources.

Abuse: Includes provider reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the health program.

Examples of **provider** fraud, waste, or abuse include but are not limited to:

- Billing for services not rendered or not medically necessary.
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services that are not medically necessary.
- Misrepresenting the services rendered.
- Submitting a claim for provider services on behalf of an individual who is unlicensed or has been excluded from participation in the Medicare and Medicaid programs.
- Billing an incorrect provider or service location.
- Retaining Medicaid funds that were improperly paid.
- Failing to perform services required under a capitated contractual arrangement.

Up-coding to a more expensive service than was rendered (such as billing for more time or units of service than provided, or billing a brand name for a generic drug).

Provider screening of employees for exclusion from participation in federal health care programs

As required by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and as outlined in DHS Medical Assistance Bulletin 99-11-05, all providers who participate in Medicare, Medicaid, or any other federal health care program are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in any of the aforementioned programs.

Employees should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search.

To search the list of excluded individuals/entities (LEIE) database, please visit **https://oig.hhs.gov/exclusions/index.asp**.

The Medicheck (Precluded Providers) List is available at **www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medichecklist/**.

The System for Award Management (SAM) is an official website of the U.S. government. Search for entity registration and exclusion records at **https://www.sam.gov/SAM/**

Examples of **recipient** fraud, waste, or abuse include but are not limited to:

- Member has prescriptions filled at more than two pharmacy locations within one month.
- Member has prescriptions written by more than two physicians per month.
- Member fills prescriptions for more than three controlled substances per month.
- Member obtains refills (especially of controlled substances) before recommended days' supply is exhausted.
- Duration of narcotic therapy is greater than 30 consecutive
  days without an appropriate diagnosis.
- Prescribed dose is outside of the recommended therapeutic range.

(continued on page 14)

Fraud, waste and abuse (*continued from page 13*)

- Same/similar therapy was prescribed by different prescribers.
- No match between therapeutic agent and specialty of prescriber.
- Fraudulent activities (forged/altered prescriptions or borrowed cards).
- Repetitive emergency room visits with little or no PCP intervention or follow-up.
- Same/similar services or procedures in an outpatient setting within one year.
- Member receives cash assistance (Supplemental Nutrition Assistance Program [SNAP] benefits, heating/energy assistance [LIHEAP], child care, Medical Assistance or other public benefits) **and** does not report income, ownership of resources or property, or others who live in the household.
- Member allows another person to use his or her ACCESS/MCO card.
- Forging or altering prescriptions/medications, trafficking SNAP benefits, or taking advantage of the system in any way.

Recipient Restriction program

If the results of recipient fraud review indicate misuse, abuse, or fraud, the member will be placed on the Restricted Recipient program, which means the member can be restricted for five years to a single:

• PCP. • Pharmacy. • Hospital/facility.

Restriction to one network provider of a particular type will ensure coordination of care and provide for medical management.

The Recipient Restriction Subcommittee is responsible for identifying, evaluating, monitoring, and tracking potential misutilization, fraud, waste, and abuse by members.

Go to our mandatory Fraud, Waste, and Abuse Provider Training presentation on our websites at:

www.amerihealthcaritaspa.com and **www.amerihealthcaritasnortheast.com → providers → resources → fraud.aspx**.

After you have completed the training, please complete the attestation at: www.surveymonkey.com/r/FWAAttest.

How to report fraud, waste, and abuse to the Plan:

Call the toll-free Ethics and Compliance Hotline at **1-866-833-9718**.

E-mail fraudtip@amerihealthcaritas.com.

Mail a written statement to:

AmeriHealth Caritas Pennsylvania/
AmeriHealth Caritas Northeast
Special Investigations Unit
200 Stevens Drive
Philadelphia, PA 19113

Reports can be made anonymously.

How to report fraud, waste, and abuse to the Commonwealth:

Phone: **1-844-DHS-TIPS** or **1-844-347-8477**

Online: **www.dhs.pa.gov**

Fax: **1-717-772-4655**
Attn: MA Provider Compliance Hotline

Mail: Bureau of Program Integrity
MA Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17105-2675

How to return improper payments or overpayments

Medical providers

Contact our Provider Services department immediately at:

AmeriHealth Caritas Pennsylvania	**1-800-521-6007**
AmeriHealth Caritas Northeast	**1-888-208-7370**

There are two ways to return overpayments to the Plan:

- Have the Plan deduct the overpayment/improper payment amount from future claims payments.
- Return the overpayments directly to the Plan by:

  – Using the Provider Claim Refund form available on our websites at **www.amerihealthcaritaspa.com** or www.amerihealthcaritasnortheast.com → Providers → Resources → Forms.

  –Mailing the completed form and refund check for the overpayment/improper payment amount to:

  Claims Processing Department
  AmeriHealth Caritas Pennsylvania/
  AmeriHealth Caritas Northeast
  P.O. Box 7118
  London, KY 40742

(*continued on page 15*)

Fraud, waste, and abuse *(continued from page 14)*

Provider self-audit protocol

Providers may also follow the DHS Medical Assistance Provider Self-Audit Protocol to return improper payments or overpayments. Access this voluntary protocol at **http://www.dhs.pa.gov/learnaboutDHS/fraudandabuse/medicalassistanceproviderselfauditprotocol/**.

Dental providers

Contact Dental Provider Services at **1-855-434-9241**.

To return dental overpayments to the Plan, please contact your dental Account Executive. Contact information is available at **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Providers → Communications → Account executives**.

For complete information about fraud, waste, and abuse, see our Provider Manual at **www.amerihealthcaritaspa.com** and **www.amerihealthcaritasnortheast.com → Providers → Resources → Provider manual**.

Contact us:

provider.communications@amerihealthcaritaspa.com

providercommunications@amerihealthcaritasnortheast.com

Coverage by AmeriHealth First.

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