AmeriHealth Caritas Northeast

Participating Provider Orientation
Orientation Agenda

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VI. **Closing**
Mission Statement

We help people:
   Get care
   Stay well
   Build healthy communities

We have a special concern for those who are poor
AmeriHealth Caritas Northeast Health is a HealthChoices Physical Health Managed Care Organization contracted by the Department of Human Services to provide physical health services in the HealthChoices New East zone.

## Medicaid Managed Care (MCO)
- **AmeriHealth Caritas Pennsylvania** (*131,393 Members*)
- **AmeriHealth Caritas Louisiana** (*143,340 Members*)
- **AmeriHealth District of Columbia** (*110,714 Members*)
- **AmeriHealth Caritas Northeast** (*57,209 Members*)
- **Arbor Health Plan** (*23,179 Members*)
- **Keystone First** (*307,104 Members*)
- **MDwise Hoosier Alliance** (*150,952 Members*)
- **Select Health of South Carolina** (*347,724 Members*)
- **TrueBlue** (*2 Members*)

## Medicare VIP Plans
- **AmeriHealth VIP District of Columbia**
  - VIP Select (*24 Members*)
  - VIP Care (*119 Members*)
- **AmeriHealth VIP Louisiana**
  - VIP Select (*19 Members*)
  - VIP Care (*14 Members*)
- **First Choice VIP Care** (*585 Members*)
- **Keystone VIP Choice** (*1,661 Members*)

## Behavioral Health Managed Care
- **PerformCare** (*550,947 Members*)

## Pharmacy Benefits Management
- **PerformRx** (*3,284,523 Members*)
II. Member Information
Eligibility is determined by the Pennsylvania State Department of Human Services (DHS)

• Benefit Consultants
  1-800-440-3989
  • Assist recipients in the selection of an HMO and PCP
  • Educate recipients on plan benefits, referral system, and provider network
  • Notifies DHS of plan selection
  • DHS notifies AmeriHealth Caritas Northeast of member’s plan and PCP selection
Member Rights and Responsibilities/Complaints, Grievances and Appeals

• Refer to the Provider Manual and to the Member Handbook for detailed instructions.

• The Provider Manual is available on the Provider Center at www.amerihealthcaritasnortheast.com.
Cultural Competency

DHS defines Cultural Competency as:
*The ability of individuals to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.*

• Communication is the first step in establishing a physician-patient relationship

• If an AmeriHealth Caritas Northeast member requires or requests translation services because they are either non-English or limited English speaking, or the member has some other sensory impairment, the provider has a responsibility to make arrangement to procure translation services for those members, and to facilitate the provision of health care services

• Providers who are unable to arrange for translation services contact Member Services at 1-855-809-9200
Title III of the American with Disabilities Act (ADA) states that public accommodations, including healthcare provider sites must comply with basic non-discrimination requirements that prohibit exclusion, segregation, an unequal treatment of any person with a disability.
Health Literacy

• Health literacy is the ability to communicate with members in a way that is easy for them to understand and act upon

• Members with both high and low reading levels can have limited knowledge of health care resulting in low health literacy

• Low health literacy is a growing problem and difficult to detect with no outward signs

• Members with low health literacy tend to be less compliant, which leads to lower quality of life and higher health care costs

• Low health literacy leads to problems with understanding:
  ✓ Physician instructions
  ✓ Consent forms
  ✓ Medical brochures
  ✓ Instructions for medications
Strategies to improve health literacy:

• Build Relationships
  ✓ Take patient’s values and preferences into account

• Ensure Understanding
  ✓ Use plain, everyday words or pictures that are clear
  ✓ Provide easy-to-read health materials
  ✓ Encourage dialogue about diagnosis or medications to determine comprehension
Eligibility

Verify eligibility in 8 ways:

1. NAVINET
   Internet address is https://navinet.navimedix.com/Main.asp - complete the sign in fields (username and password)

2. Member's ID card and PA Access card

3. Monthly Panel Listing

4. PROMISe Online
   Internet address is http://promise.dhs.state.pa.us/ and click on PROMISe Online

5. EVS Software
   MA HIPAA-Compliant PROMISe Ready Software is available free-of-charge by downloading from the OMAP PROMISe website at: www.dhs.state.pa.us/provider select Provider → Doing Business with DHS → Software and Service Vendors → Eligibility Verification Information.

To order on CD-ROM, call 1-717-975-4100. There is a $19.95 shipping and handling charge.
6. POS Card Swipe Devices

*Consult DHS website ([http://www.dhs.state.pa.us/](http://www.dhs.state.pa.us/)) for approved PROMISe compliant POS boxes under Approved 270/271 Eligibility Software and Service Vendors.*

7. PA State Medical Assistance EVS Telephone Line

   1-800-766-5387  *(Must use 13-digit provider number)*

8. Provider Services Eligibility Hotline – 24 hours/7days

   1-888-208-7370
Available Benefits

• Members are eligible for the benefits covered under their Program under the Pennsylvania Department of Human Service’s Medical Assistance Program subject to the Co-Pay Schedule.

• Co-Pays are not applied to office visits (with the exception of podiatry and chiropractic services)
Self-referred Benefits

- All OB and GYN visits
- First visit with a chiropractor
- Diagnostic tests/procedures
- Ambulance - Emergency use only
- Dental
- Vision –Members receive routine eye exams through Davis Vision
  - Eyeglasses and contact lenses are covered for members
Benefits (Continued)

• Family planning services are covered without a referral or prior authorization. Members may self-refer for routine family planning services and may go to any physician or clinic.

• Hysterectomies, sterilization or abortion services require additional approval steps

• County-specific Mental Health/Substance Abuse

• Durable Medical Equipment (DME)
  • Less than $500 billed – prescription only
  • Over $500 billed – authorization required
  1-888-498-0504 to Prior Auth DME
Benefits (Continued)

• Hospitalization

• Home Health, Skilled Nursing, Rehab and Hospice Care
  • Covered with an authorization

• Laboratory Services

• Specialty Care Services

• Rehabilitation Services
Benefits (Continued)

• Pharmacy
  • Formulary
    • Generic – NO COPAY!
  • Brand Name – $3 copay (requires Letter of Medical Necessity when generic is available)
  • Non Formulary – requires Prior Authorization

• Over-the-Counter Medications (OTC)
  • List of covered OTC medications is provided in the drug formulary

• Vitamins (some restrictions)

• Web-based Prior Authorization Form and Formulary may be found at www.amerihealthcaritasnortheast.com
Injectable Medications

- Multi-source branded products, injectables and non-formulary medications require prior authorization through the pharmacy direct line: **1-888-208-1020**

- Injectable products require prior authorization except formulary insulin products, EpiPen, haloperidol decanoate, and fluphenazine decanoate

- Specific Prior Authorization forms for injectable products may be found at [http://www.amerihealthcaritasnortheast.com/pharmacy](http://www.amerihealthcaritasnortheast.com/pharmacy)
III. Key Departments
Provider Services

1-888-208-7370

- 24 Hours/7 Days
- Request forms or literature
- Ask questions regarding policy and procedure
Patient Care Management

1-888-498-0504

- Monday to Friday, 8:00 am to 5:00 pm
- Prior Authorization
- Admission Notification
Procedures requiring prior authorization include, but are not limited to*:

- DME over $500 billed per item
- Any services/products not listed on the MA fee schedule
- Elective hospital admissions
- Home Health Care
- Skilled Nursing Facility
- Ambulance transportation (non-emergent)
- CAT Scans, MRI/MRA, PET Scans, Nuclear Medicine: contact National imaging Associates (NIA) at 1-800-588-8142, www.RadMD.com

*Refer to the Provider Manual for a complete listing
• AmeriHealth Caritas Northeast prides itself on having a Provider Account Executive available to you

• Provide on-site education, issue resolution, assists with credentialing

• The Council for Affordable Quality Health Care (CAQH) is used to streamline the data collection process for credentialing and recredentialing

• Access CAQH online at http://www.caqh.org/ for fast and easy credentialing

If you prefer a paper credentialing process, send PA Standard Application credentialing information to:

AmeriHealth Caritas Northeast
ATTN: Credentialing
8040 Carlson Rd., Ste. 500
Harrisburg, PA 17112
Quality Management

• Ensures that members receive the highest standard of care from providers

• Conducts periodic audits and surveys to ensure these standards are met (HEDIS)

• QI Program Evaluation available on the Provider Center of our website and is also available upon request
• Blended model that provides comprehensive case management and disease management services to adult and pediatric members

• Care Managers support and assist members with Asthma, Diabetes, CAD, COPD, HIV, Sickle Cell, and members with complex needs that may include behavior and/or social issues that impact their quality of life and health outcomes

• To refer a member call 1-888-208-5966
• Provides coordination of services to both new and existing member with short term and/or intermittent needs

• Resolves problems/issues that members have while navigating the healthcare system

• Ensures each member’s medical needs are met

• To refer a member call 1-888-498-0766

Special Needs Unit
Bright Start
Maternity Unit

• Care Managers outreach to high-risk pregnant members to coordinate care and address various issues throughout pregnancy and postpartum, including dental and depression screening

• Referrals – Call: 1-888-208-9528

• Members may self-refer for OB care

• OB Care Provider must complete an Obstetrical Needs Assessment Form (ONAF) and fax to 1-855-809-9205 within 5 business days to be eligible for incentive payment

• Submit CMS 1500 form to London, KY for incentive payment using code T1001-U9

• Diagnostic tests and pregnancy-related services, such as ultra sound, non-stress tests, childbirth education, and smoking cessation counseling, do not require a referral
Postpartum visits: Invoiced as individual visits (not included with delivery fee)

Bill with CMS 1500 form using standard CPT codes

Vaginal deliveries: one (1) postpartum visit

C-section deliveries: two (2) postpartum home care visits allowed; requires no authorization
IV. Provider Information
PCP’s:
Scheduling Procedures
- 6 or less patients/hour/physician
- Emergent Care
  - Immediately or referred to ER
- Urgent Care
  - Within 24 hours
- Routine Care
  - Within 10 business days of member’s call

Specialty Care Providers:
Scheduling Procedures
- Emergent Care
  - Immediately upon referral
- Urgent Care
  - Within 24 hours of referral
- Routine Care
  - Within 10 business days of referral
The Referral Process

• Electronic Referrals Submission and Inquiry are now available via NaviNet

• Paper Referral process is available

• Referrals are valid for 180 days

• Unlimited visits within the 180 days

• Specialty Care Provider can contact Provider Services to extend referrals past 180 days for up to 1 year by calling 1-888-208-7370
Expanding a Referral

Specialist:

• Should call for expansion of diagnostic and treatment procedures

• Must be same specialist/group as in original referral

• Services must be related to the same episode/diagnosis of care as original referral
  
  • May be expanded for up to 1 year
Is your practice taking advantage of all the available functions on NaviNet?

How many times have you wished that you knew more about a member’s condition or what tests or procedures they have or have not received? NaviNet can give you those answers and more!

Log on to www.navinet.net to register for free, fast and easy to use access to the following information:

• Enhanced Eligibility including Eligibility History
• Claim Status
• Referral Submission and Retrieval
• Care Gaps Alerts
• Member Clinical Summary
• Panel Roster
Care Gaps

Care Gaps – A summary of the age/sex appropriate health screens that a member should have and the opportunity to improve your practice’s Quality Enhancement Program score.

• Care Gap alerts will appear when checking a member’s eligibility
• View and print for members coming in to your office
• Customize your own reports and target at risk members
The Member Clinical Summary Report is a snapshot in time that contains the following data for a specific patient:

- Demographic information (member and PCP)
- Medications (filled within the past 6 months)
- Chronic Conditions
- Gaps in Care (based upon diagnosis compared to clinical recommendations)
- ER Visits (within the past 6 months)
- Inpatient Admissions (within the past 12 months)
- Office Visits (within the past 12 months)

This summary is provided either in a PDF format or as a CCD formatted file.
• Prior authorization and admission related functions
• Only accessible through NaviNet Plan Central

**JIVA** enables you to:
• Request inpatient, outpatient, home care and DME services
• Submit extension of service requests
• Request prior authorization
• Verify elective admission authorization status
• Receive admission notifications and view authorization history
• Submit clinical review for auto approval of requests for services

• Log on to [www.navinet.net](http://www.navinet.net) to register to become a NaviNet user
• Specialists are reimbursed based on the MA fee Schedule

• The MA fee schedule is on the DHS website:
  http://www.dhs.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm

Access the MA Web site if you have questions regarding CPT coding

• Hospitals are reimbursed based on Pennsylvania Medical Assistance rates and payment policies and contracts are individually negotiated

• Inpatient stays are paid under APR DRG methodology and outpatient services are paid based on the Medical Assistance fee schedule
  • http://www.dhs.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm
Outpatient Lab Services

• AmeriHealth Caritas Northeast contracts with its participating hospitals and Quest Laboratory to provide outpatient laboratory services. If no lab is designated on the member’s ID card, any other participating laboratory may be utilized.

• Laboratory draws (36415 and associated draw codes) are not eligible.

• No referral is required; only a script from requesting physician is needed.
  • Includes STAT and PAT’s
• Members have direct access to ER

• Referrals or prior authorizations are not required for emergency or urgent/quick/convenient care services

• Non-emergent care should be provided in the physicians office, and not referred to the ER

• Follow-up care must be coordinated by the member’s PCP
V. Payment Process
Claims Submission and Processing

- Professional and institutional services should be billed on the appropriate CMS1500, UB-04 or electronic format

- Must be submitted within 180 days from date of service (or 60 days from receipt of primary EOB). Resubmissions within 365 days from date of service

  Submit claims to:
  AmeriHealth Caritas Northeast
  Claims Processing Department
  P.O. Box 7118
  London, KY 40742

- To be set up to bill electronically call EDI at 1-855-859-4103 (AmeriHealth Caritas Northeast uses Emdeon)
Both professional and institutional corrected claims may be submitted electronically.

Resubmit within 365 days of the date of service.

Handwritten claims are not accepted.

Mark paper claim as “Corrected Claim” using black ink.

Claims being mailed should be sent to the claims address with “Corrected Claim” clearly marked on outside of envelope.

Do not mix corrected claims with new submissions.
Appeals Process

**Administrative**
- Incorrect claims payment
- Timely filing

**Medical**
- Denials based on medical necessity
- Prior authorization denials
- Refer to the Appeals Policy
• AmeriHealth Caritas Northeast is always the payer of last resort

• Submit claims involving COB within 60 days of receipt of primary carrier’s remittance with the following:
  • Claim form
  • Primary carrier’s EOB or Denial Notification (dates and dollars must match)

• Primary Insurer
  • Must follow requirements for both plans
THANK YOU FOR YOUR TIME AND PARTICIPATION TODAY!

Questions?

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