

Model of Care

The Model of Care is a high-quality, patient-centric medical care delivery system for dual eligible Medicare-Medicaid members. It brings together multiple disciplines as a team to provide input and expertise for a member's individualized care plan. This plan is designed to maintain the member's health and encourage their involvement in their health care.

The development of this team begins with a group of First Choice VIP Care Plus Personal Care Connectors, Community Health Navigators, and Care Coordinators who are responsible for gathering data on each member.

Personal Care Connectors work with members over the phone to:

- Do an initial health screening.
- Assist with locating providers within our network.
- Quote benefits.
- Offer assistance in setting appointments.

Community Health Navigators assist members in person by:

- Going to their homes to do initial health screenings.
- Accompanying them to doctors' appointments.
- Linking them to health and social service systems.
- Helping with other needs they may have, like transportation and shopping.

Care Coordinators are clinicians who will:

- Do a comprehensive in-home assessment of the member and their living conditions within 60 days of enrollment for high-risk members or 90 days for low-risk members.
- Develop an individual care plan (ICP) for the member.
- Be the point of contact for the primary care provider (PCP).
- Be involved in transition care planning.

In addition to the First Choice VIP Care Plus team, each member will be assigned a PCP who may be on the member's multidisciplinary team and play an integral role in coordinating the member's care, determining which services they need, and providing feedback to the plan.

The team will also be comprised of other health care providers, such as specialists, behavioral health care providers, home health care providers, physical therapists, and pharmacists.

Members may also include other people on their teams who play important roles in their care; these could be family members, friends, or pastors. The multidisciplinary team will vary based on the member's needs. This team will be involved in the development and approval of an ICP for each member and will make the ICP available to all providers. Each member will also develop a health action plan to guide his or her achievement of personal health care goals.

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Why is the Model of Care for dual eligibles so important?

Dual eligibles are:

- Three times more likely to live with a disabling condition than the general Medicare population.
- More likely to have greater limitations in activities of daily living, such as bathing and dressing.
- More likely than non-dual eligibles to suffer cognitive impairment and mental disorders.
- Prone to higher rates of pulmonary disease, diabetes, stroke, and Alzheimer's disease.
- Often in need of in-home care providers, plus a range of doctors and other health and social services providers, as a result of these more serious health conditions.

Required annual Model of Care training

Providers are contractually required to participate in annual Model of Care training and may do so in one of the following ways:

- Providers may attend provider orientation and training seminars held statewide each year.
- Providers may contact their Account Executives for on-site Model of Care training.
- Providers may request to have a Model of Care webinar conducted for their sites.
- Providers may take an online version of the training with attestation.

More information on the Model of Care and the annual training requirement is available online at www.firstchoicevipcareplus.com in the Provider Manual.

Free continuing medical education (CME) credit — “Closing the Gap” improves overall cardiovascular health

First Choice VIP Care Plus recently offered a live webinar, “Closing the Gap: Delivering Culturally Competent Care,” presented by Dr. Donald Lloyd-Jones. The webinar is offered as part of our ongoing effort to improve the overall cardiovascular health of our members. Our goal is to provide education and resources to help you help our members take personal control of their health.

The recorded on-demand version is now available online at:

www.firstchoicevipcareplus.com/provider/training-and-education/index.aspx.

This webinar is designed to help your practice meet the challenges of providing appropriate care based on an individual patient's cultural, linguistic, educational, and socioeconomic needs. The webinar offers practical advice on providing culturally appropriate interventions as they relate to cardiovascular disease.

Participation and completion of the post-session evaluation earns one CME credit. Visit the link above to learn more and for access to our electronic tool kit that includes comprehensive tools and resources. We are committed to becoming a more effective partner and look forward to working together on this important initiative.



Cardiovascular disease

Cardiovascular disease (hypertension, coronary heart disease, heart failure, and stroke) is the leading cause of mortality and hospitalizations in the United States. First Choice VIP Care Plus covers all Medicare preventive screening tests. First Choice VIP Care Plus covers cardiovascular disease screening blood tests for early detection of cardiovascular disease in individuals without apparent signs or symptoms of cardiovascular disease. First Choice VIP Care Plus also provides coverage of intensive behavioral therapy (IBT) for cardiovascular disease.

The cardiovascular disease screening blood test benefit covered by Medicare is a standalone billable service. It is separate from the initial preventive physical examination (IPPE) or the annual wellness visit (AWV), although it can be provided at the same time as the IPPE or AWV. First Choice VIP Care Plus members may obtain cardiovascular disease screening blood tests at any time following enrollment in First Choice VIP Care Plus.

First Choice VIP Care Plus covers the following cardiovascular disease screening blood tests:

- Total cholesterol test.
- Cholesterol test for high-density lipoproteins (HDL).
- Triglycerides test.



CPT codes for covered cardiovascular disease screening blood tests*:

CPT code	Code descriptor
80061	Lipid panel. This panel includes the following: cholesterol, serum, total (82465); lipoprotein, direct measurement, high-density cholesterol (HDL cholesterol) (83718); triglycerides (84478).
82465	Cholesterol, serum or whole blood, total.
83718	Lipoprotein, direct measurement, high-density cholesterol (HDL cholesterol).
84478	Triglycerides.

* The tests may be ordered as a lipid panel; however, you may also order them individually. To ensure that Medicare and Medicaid only pay for a laboratory test categorized as “Waived Complexity” under the Clinical Laboratory Improvement Amendments (CLIA), these CPT codes must be billed with the modifier “QW.”

Coverage and payment for these cardiovascular disease screening blood tests is available only if the following screening diagnosis is present:

ICD-10-CM diagnosis code	Code descriptor
Z13.6	Encounter for screening for cardiovascular disorders

First Choice VIP Care Plus offers clinical practice guidelines and clinical policies on many topics, including hypertension, heart failure, and cardiac rehabilitation, on our website at www.firstchoicevipcareplus.com. First Choice VIP Care Plus providers may also contact our Care Management department at **1-888-244-5440** for assistance in contacting members to schedule appointments for these and other preventive services.

Coding diabetic foot care exams

According to the American Diabetes Association, the lifetime risk of a person with diabetes developing a foot ulcer may be as high as 25 percent. Up to 50 percent of older patients with type 2 diabetes have one or more risk factors for foot ulceration. A number of component causes, most importantly peripheral neuropathy, interact to complete the causal pathway to foot ulceration. The principal contributory factors that might result in foot ulcer development are:

- Previous amputation.
- Past foot ulcer history.
- Peripheral neuropathy.
- Foot deformity.
- Peripheral vascular disease.
- Visual impairment.
- Diabetic nephropathy (especially patients on dialysis).
- Poor glycemic control.
- Cigarette smoking.

The most common triad of causes that interact and ultimately result in ulceration has been identified as neuropathy, deformity, and trauma. Identification of those patients at risk of foot problems is the first step in preventing such complications; the diabetic foot exam can help to identify and forestall complications.

While there can be many components to a diabetic foot exam, if a provider performs an examination through visual inspection, sensory exam with monofilament, and pulse exam, please report HCPCS code G9226 along with the patient encounter CPT or HCPCS code. G9226 is used as a measurement code by the Centers for Medicare & Medicaid Services (CMS), so it is important we are able to accurately track which of our diabetic members are receiving foot exams.

Clinical practice guidelines

First Choice VIP Care Plus has adopted clinical practice guidelines for use in guiding the treatment of our members, with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual. The following guidelines can be found on our website at www.firstchoicevipcareplus.com:

- Adults with Systolic Heart Failure.
- Asthma.
- Cardiovascular Disease.
- Cholesterol Management.
- Chronic Obstructive Pulmonary Disease (COPD).
- Depression (adult).
- Diabetes.
- Hypercholesterolemia.
- Hypertension.
- Management of Diabetes Mellitus.
- Medical Management of Adults with Hypertension.
- Medicare Preventive Services Guide.
- Obesity.
- Preventive Services Chart — Medicare (colorectal, mammography, influenza, pneumonia).
- Screening and Management of Hypercholesterolemia.





Care for the older adult

Thank you for caring for our members! We want our members to be healthier, and our older members are faced with many unique issues that can complicate their well-being. We wanted to alert you to a new form available on our website under the provider resources link, which we have created to help you address various health issues while helping us meet HEDIS and Medicare star ratings goals.

Providers treating our members 66 years old and older should complete the following comprehensive assessments annually. To help aid our providers in completing these important assessments, we have included the required elements and CPT II and HCPCS codes on the form, which include the following measures.

Measure	CPT II and HCPCS codes used for each care for the older adult (COA) measure
Advance care planning	1157F, 1158F, 99497, S0257
Pain assessment	0125F, 1125F, 1126F
Functional assessment	1170F
Medication review/list	1159F, 1160F, 90863, 99605, 99606, G8427

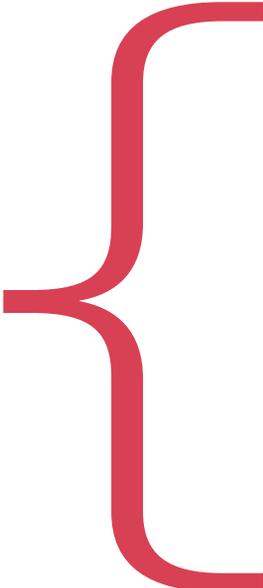
Please help us improve care for our older members by completing this form annually and upon follow-up as needed. Submitting CPT II and HCPCS codes after the assessments are completed helps inform us that you have completed the assessments. Please keep an up-to-date copy of the completed forms in the member's chart. You may also receive a copy of this form with medication review information populated by the clinical pharmacist at our plan. Thank you for helping us improve the health of our membership!

Important vaccines for our over-65 population

Pneumococcal vaccine

Adults 65 years old and older need two vaccines to better protect them from pneumonia, according to a revised vaccination schedule from the 2015 Advisory Committee on Immunization Practices (ACIP). CMS has aligned Medicare coverage to meet the ACIP recommendations:

Adults 65 years of age and older



Single dose of Prevnar 13® (if not previously given, or vaccination history is unknown),¹ followed by Pneumovax® 23 at least one year later.^{2,3,5}

Wait until at least one year has passed since any previous Pneumovax 23 dose to give Prevnar 13.

Those who received one or more doses of the 23-valent vaccine before age 65 for any indication should receive another dose at age 65 or older once five years have elapsed since their previous Pneumovax 23 dose.

Note that giving both vaccines to today's seniors is estimated to prevent 230 cases of invasive pneumococcal disease and 12,000 cases of community-acquired pneumonia over their lifetimes.⁴

As of February 2016, there was an interval change for 13-valent pneumococcal conjugate vaccine (PCV13) followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23) from six to 12 months to at least one year for adults age 65 and older who do not have immunocompromising conditions, anatomical or functional asplenia, cerebrospinal fluid leaks, or cochlear implants.

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration.

¹ Any dose of Prevnar 13 counts if given at younger ages.

² CDC. PCV13 (pneumococcal conjugate) vaccine. Recommendations, scenarios and Q&As for healthcare professionals about PCV13 for adults. Last reviewed/updated September 3, 2015. <http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm>. (Accessed October 4, 2015.)

³ CDC. Pneumococcal disease. Epidemiology and prevention of vaccine-preventable diseases. The Pink Book: Course Textbook. 13th Ed. 2015. Last updated September 8, 2015. <http://www.cdc.gov/vaccines/pubs/pinkbook/pneumo.html#schedule>. (Accessed October 4, 2015.)

⁴ Tomczyk S, Bennett NM, Stoecker C, et al. Use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults aged ≥65 years: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep* 2014;63:822 – 5.

⁵ Kobayashi M, Bennett NM, Gierke R, et al. Intervals between PCV13 and PPSV23 vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep* 2015;64:944 – 7.

Influenza vaccine

Human immune defenses become weaker with age. Therefore, adults 65 years old and older are at greater risk of serious complications from the flu compared to younger adults. While flu seasons can vary in severity, during most seasons, people 65 years old and older bear the greatest burden of severe flu disease. In recent years, for example, it's estimated that between 80 percent and 90 percent of seasonal flu-related deaths have occurred in people 65 years old and older, and between 50 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in that age group². So influenza is often quite serious for people 65 years old and older. People 65 years old and older have two flu shots available to choose from: a regular-dose flu vaccine and a newer flu vaccine designed specifically for people 65 years old and older with a higher dose. Here are some frequently asked questions which the Centers for Disease Control and Prevention (CDC) has addressed regarding the high-dose vaccine (www.cdc.gov/flu/protect/vaccine/qa_fluzone.htm):

Does the higher dose vaccine produce a better immune response in adults 65 years old and older?	Data from clinical trials comparing Fluzone [®] to Fluzone [®] High-Dose among persons age 65 years old or older indicates that a stronger immune response (i.e., higher antibody levels) occurs after vaccination with Fluzone High-Dose. Whether or not the improved immune response leads to greater protection has been the topic of ongoing research. A study published in the New England Journal of Medicine indicated that the high-dose vaccine was 24.2 percent more effective in preventing flu in adults 65 years old and older relative to a standard-dose vaccine. The confidence interval for this result was 9.7 percent to 36.5 percent).
Is Fluzone High-Dose safe?	The safety profile of Fluzone High-Dose vaccine is similar to that of regular flu vaccines, although some adverse events (which are also reported after regular flu vaccines) were reported more frequently after vaccination with Fluzone High-Dose. The most common adverse events experienced during clinical studies were mild and temporary, and included pain, redness at the injection site, headache, muscle aches, and malaise. Most people had minimal or no adverse events after receiving the Fluzone High-Dose vaccine.
Who can get this vaccine?	Fluzone High-Dose is approved for use in people 65 years old and older. As with all flu vaccines, Fluzone High-Dose is not recommended for people who have had a severe reaction to the flu vaccine in the past.
Does CDC recommend one vaccine over another for people 65 and older?	The CDC and ACIP have not expressed a preference for any flu vaccine indicated for people 65 years old and older. CDC recommends flu vaccination as the first and most important step in protecting against the flu.

Medicare covers the costs of both the vaccine and its administration by recognized providers. Both the pneumococcal and influenza vaccines are covered at 100 percent³ for Medicare beneficiaries.

¹ MLN Matters[®] Number: MM9051 cms.gov.

² cdc.gov.

³ Of the Medicare Fee Schedule.

Statin use in patients with diabetes

The Pharmacy Quality Alliance (PQA) has endorsed a new CMS display measure for 2017: the use of statins in diabetic members. This Medicare Part D measure calculates the percentage of patients between ages 40 and 75 who received at least two fills of diabetic medications and a statin during the same period. We would like to collaborate to improve this measure. You may receive calls specific to this measure for our members in your care, and, if so, a statin may be appropriate for that member. We offer several generic options on our formulary, so there are options to treat these members appropriately.

It's not always bad to be a quitter!

Quitting smoking is tough, but we are here to help our members. We understand the positive effects of quitting can be seen almost immediately. Within 12 hours of quitting, the carbon monoxide levels in the bloodstream return to normal. One year after quitting, the risk of heart disease is decreased to half of a smoker's risk. Five years after quitting, the risk of mouth, throat, and other cancers is also cut in half. Our plan covers both prescription and non-prescription options when it comes to quitting. Whether it is prescription medication like Chantix[™], nicotine nasal spray, or even gum, we have our members covered. Let's help them quit together!



Charging for prescriptions

Did you know? Medicare does not allow doctors to charge for writing a prescription. A typical doctor's visit involves a review of medical history, discussion of a condition or symptom, examination, and/or treatment. A prescription is part of treatment and is included in the cost of the doctor's office visit.

Culturally and Linguistically Appropriate Services (CLAS) and cultural competency training

Our plan works to provide culturally competent health care through its CLAS program. Several of the plans in our family of companies have been recognized for culturally competent care by the National Committee for Quality Assurance (NCQA). NCQA is the nation's most trusted independent source for driving health care quality improvement. The goal of our cultural competency program is to ensure all of our members, regardless of culture, country of origin, language, race, or ethnicity, are able to access quality health care services. We recognize that it is our responsibility, and our participating providers', to ensure health-related information and services are tailored to meet the unique needs of our diverse membership.

To earn this distinction, NCQA examines how we implement the 15 national CLAS standards, including race, ethnicity, and language data collection; access to and availability of language services; provider network cultural responsiveness; CLAS program; and work reducing health care disparities. We foster cultural awareness both in our staff and in our provider community by leveraging ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. We routinely examine the access to care standards for both the general population and the population who speaks a threshold language, defined as a language spoken by at least 5 percent of our plan's population.

To support this effort, First Choice VIP Care Plus offers interpretation services at no cost for our members. Language Services Associates' (LSA) INTERPRETALK® program provides a fast and easy way to communicate with our limited English proficiency (LEP) members. LSA has interpreters in more than 200 languages available 24 hours a day, seven days a week.

Connecting with an interpreter

Call Member Services at **1-888-978-0862** (8 a.m. – 8 p.m.) to access this service at no cost to our members. After hours, contact the 24-Hour Nurse Call Line at **1-877-693-8275** to connect to an interpreter. Be prepared to:

- Provide the member's name.
- Provide the member's preferred language.
- Provide the member's Medicare ID number.
- Ask for a medical interpreter.

After you provide this information to our Member Services department or the Nurse Call Line, you will be connected to an interpreter. Explain the objective of the call to the interpreter and then proceed by speaking to the member in the first person. In addition to language services, we also provide free TTY/TDD services for our hearing-impaired members. To connect to a TTY/TDD operator, members may call **1-866-428-7583**.

As a participating provider, you must do your part by participating in annual cultural competency training. Below are some links to resources and trainings to help you achieve this requirement:

1. Video series: What is Health Equity, and Why Does it Matter? Found under Activities > Video Library at www.ihl.org/education/ihipenschool/Pages/default.aspx.
2. United States Department of Health and Human Services (USDHHS) Office of Minority Health at www.thinkculturalhealth.hhs.gov/Content/clas.asp.
3. USDHHS Health Resources and Services Administration at www.hrsa.gov/culturalcompetence/index.html.

Just for fun

Find out where you are on the health literacy scale

Do your patients always go away completely understanding what you've told them and knowing exactly what to do next, or do you sometimes baffle them with science? Take the quiz to find out!

1. What is your first step when you are talking to someone about their health or medication?
 - a) Find out what they already know.
 - b) Make sure you have their name and address correct.
 - c) Ask what is wrong with them.
2. Which of these are key steps for building people's health literacy?
 - a) Link all new information back to what the person knows.
 - b) Use the person's own words and build on them.
 - c) Give information in logical steps.
 - d) All of the above.
3. What is a good way to draw attention to key points in written material?
 - a) Tear out the particular page and give it to them.
 - b) Highlight the information in some way.
 - c) Try to avoid giving people written information at all.
4. The best way to give people information is:
 - a) Refer them to an appropriate website.
 - b) In manageable chunks.
 - c) All at once, so they get the whole picture.
5. Rather than overload people with too much information at one time:
 - a) Give them a pamphlet.
 - b) Ask them to make another appointment later.
 - c) Agree with them on the best way to get more information.
6. A picture is worth:
 - a) A thousand words.
 - b) Not a lot, unless it includes explanatory words.
 - c) Quite a bit if it is a Rembrandt.
7. When reinforcing information, you should (choose all that apply):
 - a) Ask the person to give you a written summary of what you have told them.
 - b) Check for understanding (ask them to tell you what they understood about what you said).
 - c) Use pictures and diagrams.
 - d) Link the information back to what the person knows.
 - e) Use prompts, e.g., "Do you remember what we said about..."
 - f) Bring in another health professional to discuss the same information with the person.
8. When checking with someone that you have been clear, you should use:
 - a) Open-ended questions.
 - b) Closed questions.
9. When reviewing medicines, you should (choose all that apply):
 - a) Use the person's actual medicines.
 - b) Find out what the person already knows about their medicines.
 - c) Ask the person which medicine they want to start with.
 - d) Consider using medicine cards.
10. People with low health literacy:
 - a) Understand everything health professionals tell them.
 - b) Are less likely to ask questions of their health professionals.
 - c) Have fewer problems with their medicines than others.

7 - c - 8 - a - 9 - All of the above 10 - b

1 - a - 2 - d - 3 - b - 4 - b - 5 - c - 6 - a

ANSWERS:

1 – 2 out of 10

There is definitely static on the line. Time to start using better techniques to help your patients build their health literacy.

3 – 4 out of 10

Not the best, but you have potential. While you're on the right track, there is room for improvement.

5 – 6 out of 10

Not bad. You get the message across most of the time, but some patients might not be getting the full picture.

7 – 8 out of 10

Good performance. You're a great communicator, and with a few improvements, you'll be brilliant!

9 – 10 out of 10

Crystal clear with five-bar signal. Congratulations! You are an excellent communicator — clear and direct. Well done; keep up the good work and lead by example.



Source — www.hqsc.govt.nz.



June 15 — World Elder Abuse Awareness Day

The International Network for the Prevention of Elder Abuse and the World Health Organization at the United Nations (UN) annually observes World Elder Abuse Awareness Day (WEAAD) on June 15th. On that day, communities in the United States and all over the world sponsor events to highlight the growing tragic issue of elder abuse.

Every year, an estimated 5 million, or 1 in 10, older Americans are victims of elder abuse, neglect, or exploitation. And that's only part of the picture: experts believe that for every case of elder abuse or neglect reported, as many as 23.5 cases go unreported. Older adults are contributing members of American society, and their abuse or neglect diminishes all of us. America has confronted and addressed the issues of child abuse and domestic violence, but for too long we have ignored the issue of elder abuse.

Elder abuse can be physical, emotional, financial, and sexual. It includes people who are neglected and those who neglect themselves (self-neglect). Elders who are abused are twice as likely to be hospitalized, four times as likely to go into nursing homes, and three times as likely to die. While most abusers are family members, trusted professionals and complete strangers may also target older adults. Abuse can happen in any setting: in the older adult's own home, nursing homes, or assisted living facilities.

Alliances among local entities that have regular contact with older adults, such as aging services providers, health professionals, long-term care and nursing home staff, and law enforcement officers, can help improve the health, safety, and financial security of older adults. Consider starting an elder justice coalition or multidisciplinary team in your community as a way to launch WEAAD. This type of multidisciplinary effort can contribute richly to your community efforts to prevent and intervene in cases of elder abuse for years to come. Contact the National Center on Elder Abuse at www.ncea.aoa.gov for more information about starting or reinvigorating your own local elder justice community coalition.

Red flags of elder abuse:

Neglect

- Lack of basic hygiene, adequate food, or clean and appropriate clothing.
- Lack of medical aids (glasses, walker, dentures, hearing aid, and medications).
- Person with dementia left unsupervised.
- Person confined to bed left without care.
- Home cluttered, filthy, in disrepair, or having fire and safety hazards.
- Home without adequate facilities (stove, refrigerator, heat, cooling, working plumbing, and electricity).
- Untreated bedsores (pressure ulcers).

Financial abuse and exploitation

- Lack of amenities victim could afford.
- Vulnerable elder or adult “voluntarily” giving uncharacteristically excessive financial reimbursement or gifts for needed care and companionship.
- Caregiver having control of elder’s money but failing to provide for elder’s needs.
- Vulnerable elder or adult signing property transfers (power of attorney or new will) but being unable to comprehend the transaction or what it means.

Psychological and emotional abuse

- Unexplained or uncharacteristic changes in behavior, such as withdrawal from normal activities and unexplained changes in alertness.
- Caregiver isolating elder (not letting anyone come into the home or speak to the elder).
- Caregiver being verbally aggressive or demeaning, controlling, overly concerned about spending money, or uncaring.

Physical or sexual abuse

- Inadequately explained fractures, bruises, welts, cuts, sores, or burns.
- Unexplained sexually transmitted diseases.

Provider directory outreach

CMS has revised its requirements for Medicare plans’ provider and pharmacy directories. The new requirements include conducting quarterly outreach to contracted providers to ensure the accuracy of all provider directory data, as well as collecting additional provider directory data from providers participating in dual eligible special needs plans.

To verify the accuracy of our directory data and to gather the additional information, we are furnishing each provider organization with a data sheet for the practice or facility along with one for each of the providers in the practice, if applicable. We will be sending these out quarterly and ask you to please review each data sheet and indicate any corrections which should be made directly on the sheets provided, such as address, phone number, hours of operation, missing data, or the addition or termination of a provider. In addition, please answer the questions pertaining to the additional data we are collecting. We will include information on where to return the completed data sheets. If we do not hear from you within 30 days, we will assume your information is correct.

Prohibition on balance billing qualified dual eligible members

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 our plan to participating plan providers must be accepted as payment in full for services rendered. Members may not be balance billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims inquiry processes to resolve any outstanding claims payment issues. Providers may reference CMS Medicare Learning Network® (MLN) Matters number SE1128 for further details.

Partner with us to prevent health care fraud, waste, and abuse

First Choice VIP Care Plus recognizes the importance of the detection, investigation, and prevention of fraud, waste, and abuse.

First Choice VIP Care Plus's Fraud, Waste, and Abuse Program is dedicated to preventing any form of suspicious activity related to potential health care fraud, waste, and abuse. The program includes investigation of any reasonable belief that fraud, waste, and/or abuse may be, is being, or has been committed. If you become concerned about or identify potential fraud, waste, or abuse, we encourage you to contact us by:

- Calling us on our toll-free Fraud, Waste, and Abuse Hotline at **1-866-833-9718**.
- Writing to us at: Special Investigations Unit, AmeriHealth Caritas, 200 Stevens Drive, Philadelphia, PA 19113.
- Emailing us at **fraudtip@amerihealthcaritas.com**.

Some examples of fraud, waste, or abuse include:

- Billing for services not furnished.
- A member using another member's ID card to receive care.
- Submitting false information to obtain authorization to furnish services or items to Medicare and Medicaid recipients.
- Accepting kickbacks for patient referrals.
- Violating physician self-referral prohibitions.
- Billing for a more costly service than performed.
- Providing, referring, or prescribing services or items that are not medically necessary.
- Providing services that do not meet professionally recognized standards.

We look forward to partnering with you to prevent fraud, waste, and abuse.

Advanced beneficiary notices (ABNs) — Not for use with Medicare Advantage members

Per a CMS memo dated May 5, 2014, providers may not use an ABN with patients who are on a Medicare Advantage plan. Medicare-Medicaid Plans (MMPs) are considered Medicare Advantage plans, and we must properly notify members regarding matters of non-coverage; this is done through the prior authorization process. Circumventing this process diminishes member protections that are part of the prior authorization process. In circumstances where there is a question whether or not the plan will cover an item or service, the member has the right to request a prior authorization. If coverage is denied, the plan must provide the member with a standardized written denial notice that states the specific reasons for the denial and informs the member of his or her appeal rights. This means that the member is not liable for services provided by a contracted provider if the Medicare Advantage plan failed to provide a compliant denial notice.

For more details on this requirement, please refer to chapter 4 of the "Medicare Managed Care Manual."

Emdeon change

Emdeon, the revenue and payment cycle management provider for our plan, has rebranded as Change Healthcare. Emdeon announced the change in September 2015. It has begun migration of its website, offices, and communications to the new brand. You will continue to have access to the important information you need. To help keep things simple, here are a few things that may help:

- Change Healthcare has not closed the existing Emdeon website. All existing Emdeon bookmarks will continue to work.
- The login button on the new (Change Healthcare) site will redirect you to legacy (Emdeon) sites and product lists.
- Contact Change Healthcare (Emdeon) at **1-877-363-3666** or visit **www.changehealthcare.com** and select Resources for:
 - Enrollment.
 - Product support.
 - Payer lists.
 - Electronic funds transfer (EFT)/e-payment.
 - Payer electronic remittance advice (ERA).

Over the coming months, Change Healthcare will continue to update the provider community about its new identity.

For more information on the rebrand, please visit **emdeon.mediaroom.com**. If you have questions, please contact your Provider Account Executive. You may also contact our Provider Services department at **1-888-978-0862**.

NaviNet has a new look

NaviNet has upgraded its Plan Central, Eligibility and Benefits, and Claims Status Inquiry transactions for easier navigation. You will see the following enhanced features:

Plan Central: Easily view the latest updates and get quick access to:

- Frequently asked questions.
- Hours of availability and contact information for the plan.
- Quick links to provider tools.

Eligibility and Benefits: View eligibility status and date, benefit information for different services, and patient details.

- **Screen header:** The patient's name, gender, and date of birth are displayed prominently at the top of the screen to confirm you are viewing details for the correct patient.
- **Patient details window:** You can view more details about the patient by choosing "View Patient Details" at the top of the screen. This link opens the patient details window, which displays patient demographic information and subscriber details.
- **Eligibility status bar:** The overall coverage status of the patient appears in large font for quick confirmation. The eligibility date (start date or range) is shown to the right of the eligibility status.
- **Services menu:** A list of services supported by the health plan is displayed. Services are listed alphabetically, and the currently selected service is always highlighted in the services menu. You can choose a service to see benefit details for the patient in the details section to the right of the menu.
- **Details section:** When you select a service in the services menu, the details section shows benefit details for the patient. The header displays the name of the service selected.

Claim Status Inquiry: Access real-time, detailed claim status information, which can eliminate the need to make phone inquiries. You can check claim status at any time following a claim submission, for all claims, regardless of submission method.

- **Screen header:** The patient's name and date of birth are displayed prominently at the top of the screen to confirm you are viewing details for the correct patient.
- **Claim status bar:** Current claim status, overall claim status, and status details are displayed.
- **Claims summary section:** The most important details of the claim, including the total charge from the provider and the amount paid by the health plan, are prominently displayed.
- **Service line details section:** Details of the individual claim service line are displayed.
- **Additional payment details:** The allowed amount, amount applied to member responsibility, and explanation of benefits description are displayed for each line item.

Questions? You can find additional information on NaviNet Plan Central in the "NaviNet Enhancements Training Guide," which gives you detailed previews of the new screens. As always, feel free to contact your Provider Account Executive with any questions.



Risk adjustment: A key component in quality patient care

Risk adjustment is a methodology used by CMS for Medicare Advantage, and by SCDHHS for commercial plans, to predict health care needs and costs based on the overall health of patients. Annually, all Medicare Advantage plans are required to submit information on patient health status to help estimate the costs of patient care for the next year and establish reimbursement to the health plan.

But risk adjustment is much more than a regulatory requirement. It actually improves quality of care in several ways.

Accurate identification of patient health status allows us to:

- Understand patient needs so new programs and interventions can be developed.
- Identify high-risk patients for disease and intervention management programs.
- Integrate clinical efforts with clinics and provide more robust data.

How does risk adjustment work? Patients are given a risk score based on:

1. Demographic status (age, gender, and other factors).
2. Health status — reported ICD-10 diagnosis codes (acute, chronic, and status conditions).

Risk adjustment methodology groups diagnosis codes into hierarchical condition categories (HCC) based on health conditions that require similar health care needs.

Why are documentation and coding so important?

Patient health status (acute, chronic, and status conditions) must be addressed, documented, and coded during a face-to-face visit each year based on CMS guidelines. The information to support health status of patients is collected through diagnosis codes submitted on claims or captured in medical record review. This detailed and accurate documentation of the patient's health status is critical and affects patient care, treatment, and management.

How can I ensure my documentation supports the diagnosis codes I select?

Document clearly and concisely how the conditions coded were assessed, monitored, or treated, or how they affected the patient's care or your medical decision-making during the visit. Every encounter with a patient is an opportunity to assess overall health and comprehensively document chronic conditions, coexisting acute conditions, and active status conditions, as well as pertinent past conditions.



Important phone numbers

Provider Services:	1-888-978-0862
Prior authorizations:	1-888-244-5410 1-888-257-7960 (Fax)
Pharmacy Services:	1-866-828-0023
Fraud and Abuse Hotline:	1-866-833-9718
NaviNet:	1-888-482-8057
Change Healthcare:	
• Electronic billing and ERA:	1-877-363-3666
• EFT enrollment:	1-866-506-2830

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The Advantage

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