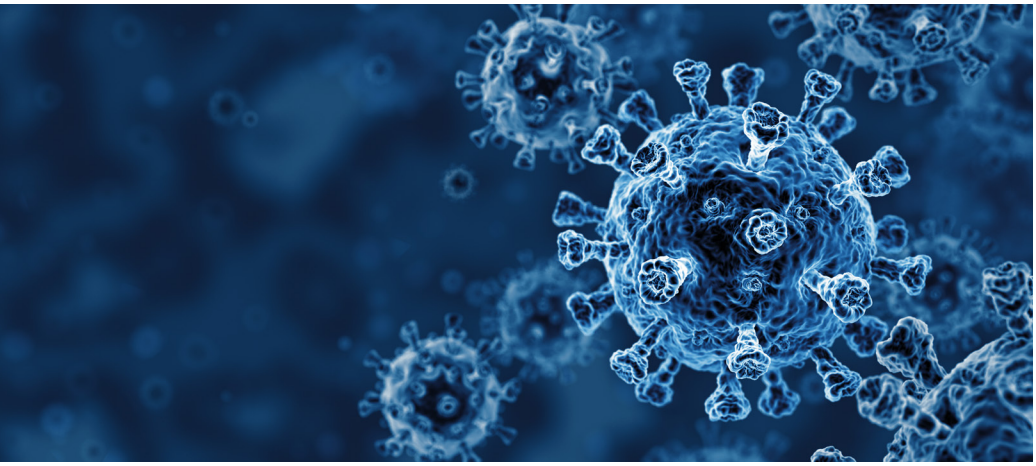
The Advantage

A Newsletter for Providers



COVID-19 billing information

In response to the Centers for Medicare & Medicaid Services (CMS) and other federal COVID-19 guidance, First Choice VIP Care Plus will be taking the following measures:

1. **Testing and claims reporting for COVID-19** — Use of CPT code 87635 or HCPCS code U0002 for the non-Centers for Disease Control and Prevention (CDC) diagnostic lab test, depending on the method used, or HCPCS code U0001 for the CDC diagnostic lab test, will be allowed. For tests performed with high throughput technologies, use HCPCS code U0003 for infectious agent detected by nucleic acid, amplified technique, or HCPCS code U0004 for any technique, multiple types, non-CDC. Labs, physician offices, hospitals, and other settings can bill for tests ordered that they perform. There will be no member cost-sharing for these tests. For specimen collection, use HCPCS codes G2023 or G2024 (for an individual in a skilled nursing facility or a lab on behalf of a home health agency).
2. **Diagnosis codes for COVID19** — Effective with services performed on and after April 1, 2020, a confirmed diagnosis (positive and presumptive positive test results) of COVID-19 should be reported with diagnosis code U07.1, COVID-19. Some additional ICD-10-CM codes that may be helpful for reporting encounters related to possible COVID-19 exposure as described in the ICD-10-CM Official Coding and Reporting Guidelines are:
   - Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out.
   - Z20.828 Contact with and (suspected) exposure to other viral communicable diseases.
   - Z11.59 Encounter for screening for other viral diseases.

Summer 2020

Table of contents

3. **Telehealth visits** — As of March 6, 2020, First Choice VIP Care Plus has expanded telehealth in compliance with new CMS guidance, to include coverage in all areas (not just rural), in all settings; the use of popular video chat applications; and the increase of allowed services. Please note: When billing professional claims for nontraditional telehealth services, bill with the place of service (POS) equal to what it would have been in the absence of the COVID-19 public health emergency (PHE), along with a modifier 95, which indicates the service rendered was actually performed via telehealth. There are also options for virtual check-ins and e-services.

4. **Waiving of deductible and coinsurance for COVID-19 services** — Cost-sharing does not apply for Part B COVID-19 testing-related services, which are medical visits that: (a) are furnished between March 18, 2020, and the end of the COVID-19 PHE; (b) result in an order for or administration of a COVID-19 test; (c) are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and (d) are in any of the following categories of HCPCS evaluation and management codes:

   - Office and other outpatient services.
   - Hospital observation services.
   - Emergency department services.
   - Urgent care centers.
   - Nursing facility services.
   - Domiciliary, rest home, or custodial care services.
   - Home services.
   - Online digital evaluation and management services.
   - Telehealth visits.

   Providers should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services.

5. **Sequestration** — Effective May 1, 2020 – December 31, 2020, the 2% sequestration reduction will not be deducted from claim payments when applicable.

6. **Prior authorization** — No prior authorization is needed for our members to see out-of-network providers during the COVID-19 PHE. Please note, however, that prior authorization is still required for services that typically require authorization, such as inpatient admissions, certain durable medical equipment (DME), and magnetic resonance imaging (MRI) scans.

7. **Prescription drugs** — To help ensure your patients, our members, have the medications they need, First Choice VIP Care Plus has taken the following actions as they relate to Part D prescription drugs:

   - Removed the "refill too soon" edits — This will allow our enrollees to refill medications early to ensure they have an appropriate supply of medication.
   - Allowed the maximum extended days' supply of 90 days.
   - Allowed retail pharmacies or other pharmacies to provide home delivery/mail order.
   - Allowed non-contracted pharmacies to fill prescriptions or reimburse members if they pay for a prescription out of pocket.

8. **Accelerated/advanced payment** — First Choice VIP Care Plus does not have an accelerated/ advanced payment program.

9. **Inpatient add-on payment** — The 20% inpatient add-on will be applied to the weighting factor (operating portion only) of the assigned diagnosis-related group (DRG) for discharges of individuals diagnosed with COVID-19. Discharges of individuals diagnosed with COVID-19 will be identified by the presence of the following ICD-10-CM diagnosis codes:

   - **B97.29** (Other Coronavirus as the Cause of Diseases Classified Elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
   - **U07.1** (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 PHE period.

It's flu vaccine time again

We ask for your help, as a provider, in ensuring your patients receive flu vaccines, especially as we are also facing COVID-19. Your role in this effort is critical to help avert the considerable toll that influenza takes on the public's health each year.

Per the CDC, although people age 65 and older can get any injectable flu vaccine, there are two vaccines specifically designed for people age 65 and older:

- The "high-dose vaccine" contains four times the amount of antigen as the regular flu shot. It is associated with a stronger immune response following vaccination (higher antibody production).
- The adjuvanted flu vaccine, Fluad™, is made with MF59 adjuvant, which is designed to help create a stronger immune response to vaccination.

Please be reminded that participating providers will be reimbursed 100% of the Medicare-allowable amount for influenza vaccines, along with the administration code G0008 for your Medicare patients in our plan.

Medical record documentation for risk adjustment

Medical record documentation plays a critical role in risk adjustment. That's why CMS requires that all diagnosis codes reported for risk adjustment be based on clinical medical record documentation from a face-to-face encounter.

This means the provider must document and report all diagnoses that affect the patient's evaluation, care, and treatment, including chronic or coexisting conditions.

ICD-10-CM Documentation and Coding Guidelines

CMS ICD-10-CM Official Guidelines in the ICD-10 Manual

Coding Must Mirror Medical Record

Under ICD-10 Official Coding Guidelines, a diagnosis can only be coded if it is stated explicitly in the documentation. Coders cannot presume a given condition exists based on symptoms or lab results. For example, abnormal GFR levels cannot be interpreted to be CKD unless confirmed and documented by the provider. A clinician is the only one who can interpret results and assign a final diagnosis.

Documentation Must Be Specific

Documentation should be thorough and specific so that the appropriate diagnosis code can be assigned.

Include descriptors such as:

- Acuity
- Stage/Severity
- Underlying cause
- Complications/Associated conditions
- Anatomic site/Laterality
- Episode of care

Active Conditions

The CMS-HCC Risk Adjustment process requires the documentation and reporting of active conditions at least once per year.

In practice, co-existing conditions should be documented and reported each time they affect care, treatment decisions, etc.

"History of"

History of means the patient no longer has the condition. Frequent documentation errors regarding "history of" conditions:

- Coding a past condition as active
- Coding history of when the condition is still active:
  - H/O CHF, meds Lasix vs. Compensated CHF, stable on Lasix
  - H/O COPD, meds Advair vs. COPD, controlled w/Advair
  - H/O HIV vs. HIV positive, asymptomatic

Health Status Codes

Frequently overlooked, but significant, conditions may include:

- Ostomies – Colostomy, Gastrostomy, Ileostomy, etc.
- Amputation status – Lower Extremities (AKA, BKA, Feet/Toes)
- Renal dialysis status – Including presence of or fitting of dialysis catheter
- Organ Transplant – Heart, Lung, Liver, Pancreas, Bone Marrow
- HIV - Asymptomatic HIV Status
- BMI- Morbid Obesity-BMI >40 Height and weight must be documented

It is important to assess, document and code these conditions, when present, at least once annually.

ICD-10-CM Documentation and Coding Guidelines

CMS ICD-10-CM Official Guidelines in the ICD-10 Manual

Cancer Coding Reminders

Active Cancer — Cancer should be documented and coded as active when:

- The patient is undergoing treatment directed at the malignancy for curative or palliative purposes
- The patient has failed all treatment options and no other options remain
- Patient has elected to waive treatment

Personal History of Cancer — After cancer has been excised/eradicated, all active treatment has ceased, and there is no evidence of current disease, a "history of" Z code is appropriate.

Metastatic Cancer — Clearly document the primary site and the metastatic site to avoid reporting multiple primary sites.

Additional Tips

- Use standard medical abbreviations.
- Incorporate and document lab and diagnostic results into progress note.
- Link medications to the condition(s) they treat to show ongoing care/management.
- Review/update medication and problem lists.

CMS Signature Requirements:

Don't forget to sign the visit note!

- **Electronic** - Authentication, provider name, credential and date signed.
- **Manual signature** - Legible signature with credential, or signature with provider name and credential preprinted on note.
- **Stamped/Typed signatures** are not acceptable.

EMR Considerations

When using copy/paste feature in EMR, ensure any information brought forward is valid, current and applicable to the current visit. Records from one date of service (DOS) should not be cloned from another DOS.

Final Reminders

The two most important things for providers to know regarding Risk Adjustment coding are:

1. See the patient at least once a year to determine health status.
   - Evaluate and document ALL active conditions.
   - Simply listing every diagnosis in the medical record is not acceptable and does not support reporting a risk adjustment code.
2. Be as specific as possible in the documentation.
   - This will allow for the most accurate ICD-10 codes to be reported. Documentation should include additional manifestations/ complications related to a chronic condition.

Coding and documenting diabetes

Diabetes categories for coding

Health plan claims analysis reveals that diabetes mellitus is a frequently miscoded diagnosis. It's important that accurate coding and correct documentation, per ICD-10-CM guidelines, is used for reporting diabetes mellitus. As you know, complete and correct coding is important for many reasons, including:

- It helps reduce future medical record inquiries for audits to support the reporting of chronic conditions.
- Adherence to **ICD-10-CM** coding conventions for diagnosis reporting is required under Health Insurance Portability and Accountability Act (HIPAA) regulations[1].
- It is vital for managed care organizations, such as First Choice VIP Care Plus, to have accurate and complete diagnosis data on file to provide optimum care management for health plan members.

Guidelines

Accurate coding of diabetes mellitus requires understanding of the CMS ICD-10-CM **Official Guidelines in the ICD-10 Manual**. Please follow the quick reference guide and examples below when coding for diabetes mellitus:

In ICD-10-CM, diabetes is classified in categories E8 – E13. The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting the body system.

ICD-10-CM presumes a causal relationship between diabetes and several acute and chronic conditions.

The term "with" means "associated with" or "due to" when it appears in a code title, the alphabetic index, or an instructional note in the tabular list. However, if the physician documentation specifies that diabetes is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication. **Note:** Medical record documentation should indicate whether the two conditions are related.

[1]HIPAA administrative simplification: modifications to medical data code set standards to adopt ID-10-CM and ICD-10-PCS. Final rule," Federal Registry, January 16, 2009, 74(11):3328 – 62, https://www.ncbi.nlm.nih.gov/pubmed/19385111.

ICD-10-CM Documentation and Coding Guidelines

CMS ICD-10 CM Official Guidelines in the ICD-10 Manual

ICD-10-CM diabetes categories:

- E08 Diabetes mellitus due to an underlying condition
- E09 Drug or chemical induced diabetes mellitus
- E10 Type 1 diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus

Other manifestations of diabetes mellitus:
Common chronic complications of diabetes, besides renal, ophthalmic, neurological or circulatory, are classified to E08-E13 with the following:

- E08 - E13 with .61 diabetic arthropathy
- E08 - E13 with .62 diabetic skin complications
- E08 - E13 with .63 diabetic oral complications

Diabetic neurological complications
Peripheral, cranial and autonomic neuropathy are chronic manifestations of diabetes mellitus. The sub-classification for neurological complication is the following:

- E08 - E13 with .40 unspecified diabetic neuropathy
- E08 - E13 with .41 diabetic mononeuropathy
- E08 - E13 with .42 diabetic polyneuropathy
- E08 - E13 with .43 diabetic autonomic (poly)neuropathy
- E08 - E13 with .44 diabetic amyotrophy
- E08 - E13 with .49 other diabetic neurological complication

Include status codes for DM manifestations
Frequently overlooked, but significant, conditions may include:

- Ostomies/Artificial Openings – Colostomy, Gastrostomy, Ileostomy, etc.
- Amputation status – Lower Extremities (AKA, BKA, Feet/Toes)
- Long Term Insulin Use

Diabetes and skin ulcers
When a patient has diabetes with skin ulcer, the ICD-10-CM classification presumes a causal relationship between the conditions unless the documentation clearly states that the two conditions are not related.

The code for the diabetic foot ulcer complication (E08-E13 with .621) is assigned first with an additional code of L97.4-, L97.5- indicating the specific site of the ulcer.

If gangrene is present, code E08-E13 with .52 should be assigned as an additional code.

Other diabetic skin ulcers are coded to E08-E13 with .622 and an additional code to identify the site of the ulcer (L97.1-L97.9, L98.41-L98.49).

Diabetic circulatory complications

- Diabetic peripheral vascular disease without gangrene is coded as E08-E13 with .51.
- Diabetic peripheral vascular disease with gangrene is coded as E08-E13 with .52.
- Diabetes with other circulatory complications is coded to E08-E13 with .59.

Complications due to insulin pump malfunction
Failure or malfunction of the pump may result in under-dosing or overdosing of insulin. Both of these situations are mechanical complications and are assigned a code from subcategory T85.6 mechanical complication of other specified internal and external prosthetic devices, implants and grafts. The appropriate T85.6- code is selected depending on the type of malfunction as the following:

- T85.614 Breakdown (mechanical) of insulin pump
- T85.624 Displacement of insulin pump
- T85.633 Leakage of insulin pump

ICD-10-CM Documentation and Coding Guidelines

CMS ICD-10 CM Official Guidelines in the ICD-10 Manual

Uncontrolled Diabetes
There is no default code for uncontrolled diabetes in ICD-10-CM. Uncontrolled diabetes is classified by type and whether it is hyperglycemia or hypoglycemia.

Type 2 diabetic ketoacidosis
Codes E11.10 type 2 diabetes mellitus with ketoacidosis without coma and E11.11 type 2 diabetes mellitus with ketoacidosis with coma were created to identify ketoacidosis in patients with type 2 diabetes.

Diabetes complicating pregnancy
Diabetes mellitus complicating pregnancy, delivery or the puerperium is classified in chapter 15 of ICD-10-CM. Pregnant women who have diabetes mellitus should first be assigned a code from category O24 diabetes mellitus in pregnancy, childbirth and puerperium followed by an appropriate diabetes code(s) (E08-E13) from chapter 4 of ICD-10-CM to indicate the type of diabetes.

Gestational diabetes
Subcategory O24.4 gestational diabetes is assigned for this condition. No other code from category O24 should be assigned with a code from category O24.4. Subcategory O24.4 is subdivided as to whether the gestational diabetes is controlled by diet, insulin or oral hypoglycemic drugs and whether it occurs in pregnancy, childbirth or the puerperium.

An abnormal glucose tolerance in pregnancy, without a diagnosis of gestational diabetes, is assigned a code from subcategory O99.81 abnormal glucose complicating pregnancy, childbirth and the puerperium.

Did You Know? Approach to treatment of type 2 diabetes

Lifestyle

- Weight management.
- Healthy food choices.
- Portion control.
- Physical activity: 150 minutes total per week (three to five days) of aerobics, plus two to three sessions of resistance exercises, flexibility, stretching, and balance.

Medications are on formulary as of Sept. 2019. Always refer to the plan website for current formulary.

Metformin

- Always first-line therapy.
- Try extended release (ER) formulation for fewer gastrointestinal (GI) side effects.
- OK to use if glomerular filtration rate (GFR) is greater than 30 ml/minute.
- May need to hold temporarily for dehydration or for dye study.
- Continue as long as tolerated or not contraindicated, even if adding other medications.
- May develop B12 deficiency with long-term use.

Metformin: 500 mg, 850 mg, and 1,000 mg dosages; ER dosages of 500 mg and 750 mg.

If your goals have not been achieved, please consider the following:

Medications to avoid hypoglycemia

DPP-4:

- Moderate efficacy.
- May need real dose adjustment.
- Weight loss neutral.
- Potential risk for acute pancreatitis.
- May cause joint pain.

Do not use GLP-1.

On VIP formulary

- **Alogliptin** 12.5 mg, 25 mg, 6.25 mg; renal dosing.
- **Januvia® (sitagliptin)** 100 mg, 25 mg, 50 mg; renal dosing.
- **Tradjenta® (linagliptin)** 5 mg; no renal dosing.
- **Combo:**
  - **Alogliptin-metformin** 12.5/1,000 mg and 12.5/500 mg.
  - **Janumet® XR** 100/1000 mg, 50/1000 mg, 50/500 mg.

SGLT-2:

- Moderate efficacy.
- Cardiovascular benefits.
- Avoid if estimated GFR is less than 45 ml/minute.
- Can cause genitourinary infections.
- Can cause volume depletion.

On VIP formulary

- **Jardiance® (empagliflozin)** 10 mg and 25 mg.
- **Invokana® (canagliflozin)** 100 mg and 300 mg (risk of bone fractures).

GLP-1:

- High efficacy.
- Weight loss.
- GI side effects; usually improve over time.
- Injectable.
- May be associated with pancreatitis.
- Risk of thyroid C cell tumors.
- Some protect the cardiovascular system.

Do not use DPP-4.

On VIP formulary

Trulicity® (dulaglutide)
0.75 mg and 1.5 mg; once weekly.

Ozempic® (semaglutide)
0.25 mg, 0.5 mg, and 1 mg; once weekly.

Victoza® (liraglutide)
0.6 mg; once daily.

Medications to promote weight loss	Medications with cardiovascular protection	Medications beneficial with chronic kidney disease	Medications for step therapy
GLP-1: Refer to VIP formulary. **SGLT-2:** Refer to VIP formulary.	**GLP-1:** Refer to VIP formulary. **SGLT-2:** Refer to VIP formulary if GFR is greater than 45 ml/minute.	**SGLT-2:** Hold for GFR < 30 **GLP-1**	**GLP-1:** Refer to VIP formulary. **SGLT-2:** Refer to VIP formulary. **DPP-4:** Refer to VIP formulary. To get approval for second-line therapy, record must indicate metformin was tried and was not tolerated, was contraindicated, or did not achieve full control of diabetes.

If patient still needs better control, please consider the following:

- **Add basal insulin — start at 10 units/day or 0.1 – 0.2 IU/kg a day.**
- **Titrate every three to five days by 2 units to reach fasting plasma goal.**
- **If patient develops hypoglycemia, lower dose by 10 – 20 percent.**

- **Lantus® SoloStar® U-100.**
- **Levemir® Flextouch® pen U-100.**
- **Toujeo® SoloStar® U-300.**

Information based on 2019 American Diabetic Association guidelines.

Controlling blood pressure claims coding chart

As a reminder, the HEDIS measure for Controlling Blood Pressure (CBP) can now be reported using CPT II codes. Below are the CPT II codes that correspond to particular systolic and diastolic blood pressure measurements. Please note, correct coding and submission of claims is the responsibility of the submitting provider.

Code	Type	Measure	Description
3074F	CPT II	Controlling Blood Pressure	Most recent systolic blood pressure less than 130 mm Hg
3075F	CPT II	Controlling Blood Pressure	Most recent systolic blood pressure 130 – 139 mm Hg
3077F	CPT II	Controlling Blood Pressure	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	CPT II	Controlling Blood Pressure	Most recent diastolic blood pressure less than 80 mm Hg
3079F	CPT II	Controlling Blood Pressure	Most recent diastolic blood pressure 80 – 89 mm Hg
3080F	CPT II	Controlling Blood Pressure	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Opioid treatment programs

Beginning January 1, 2020, Medicare will pay Medicare-enrolled opioid treatment programs (OTPs) to deliver opioid use disorder (OUD) treatment services to Medicare beneficiaries. Covered opioid use disorder treatment services include:

- U.S. Food and Drug Administration-approved opioid agonist and antagonist treatment medications.
- Dispensing and administering medications (if applicable).
- Substance use disorder counseling.
- Individual and group therapy.
- Toxicology testing.
- Intake activities.
- Periodic assessments.

OTP providers must be:

- Enrolled in Medicare.
- Fully certified by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Accredited by an accrediting body approved by SAMHSA.
- Able to meet additional conditions to ensure the health and safety of individuals being furnished services under these programs and the effective and efficient furnishing of such services.

If you interested in enrolling as an OTP provider, please visit **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Enrollment**.

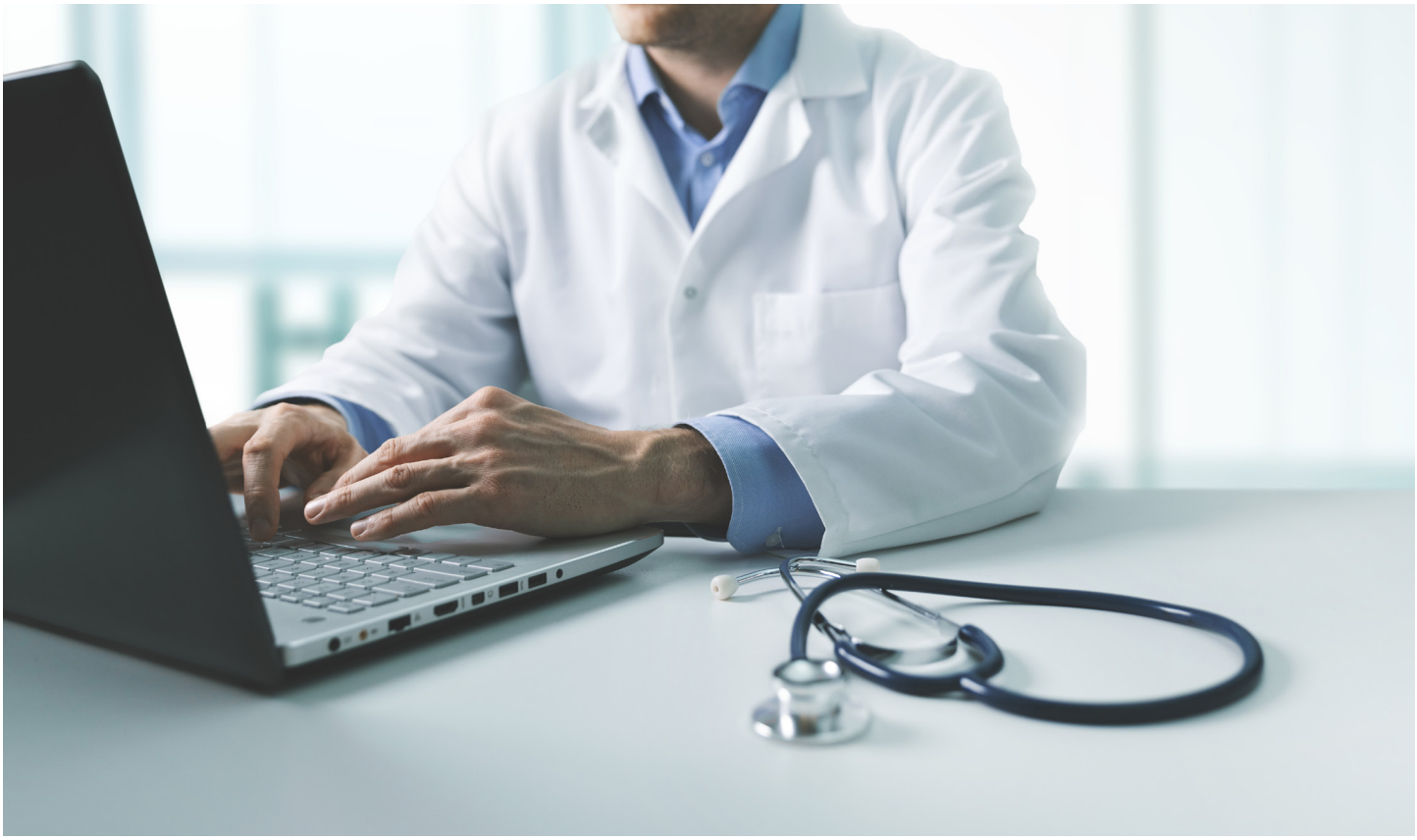
As part of our health plan's efforts to combat the opioid epidemic, we have safety requirements in place for opioid prescriptions. These safety edits have all been reviewed and approved by a panel of doctors and pharmacists, and are intended to improve member safety and well-being:

- Limiting prescriptions containing acetaminophen to 4 grams per day.
- A hard safety edit limiting initial opioid prescription fills to seven days for opioid-naïve patients (those who have taken no opioids in the last 108 days).
- Requests for more than seven days will be subject to a coverage determination.
- A 90-morphine milligram equivalent (MME) cumulative-dose soft point of sale (POS) edit for all opioids from two or more prescribers.
- A 200-MME cumulative-dose hard edit for all opioids from two or more prescribers.
- A soft POS edit for concurrently used opioids and benzodiazepines.
- A soft POS edit for concurrently used opioids and buprenorphine. The soft edit will only reject if the opioid claim follows the buprenorphine claim, so as not to impede access to buprenorphine.
- A reporting-only flag for concurrently used opioids and gabapentin/pregabalin. This combination is starting to present concerns of abuse, so although claims will not stop we are reviewing profiles with these combinations.

Beneficiaries who are residents of a long-term care facility, in hospice care or receiving palliative or end-of-life care, or being treated for active cancer-related pain will be excluded from these limits and edits.

Utilization management (UM) tips

- Did you know that you can submit your requests and supporting clinical documentation electronically via NaviNet? This is a great time saver for your office staff and decreases the turnaround time for receiving determinations.
- It is best practice to utilize the prior authorization form (located on the First Choice VIP Care Plus website under Provider Resources > Prior Authorization) along with the supporting clinical documentation. This decreases the turnaround time for determinations and eliminates denials secondary to failure to submit supporting documentation.
- The plan offers expedited determinations for situations where the member's health would be in serious jeopardy or their condition could rapidly deteriorate if a determination was not rendered sooner than the standard 14-day time frame. If you need a fast determination that does not meet the requirements of an expedited determination — for example, if the member already has a non-urgent procedure scheduled — please alert the plan representative, and we will do our best to get the request reviewed promptly. In addition, if the member is already in the office or facility for the procedure, please give us a call before canceling their appointment.
- Home care agencies — Please remember to submit your start-of-care documentation to obtain prior authorization for home care visits.
- The clinical documentation/update requirements for inpatient admissions are as follows:
  - Once First Choice VIP Care Plus has approved the initial request for an acute inpatient admission, additional clinical updates or documents are required only in the following circumstances:
    - » There is a change in admitting diagnosis.
    - » The member has been discharged.
    - » The UM department requests them.
    - » Approvals are based on DRG; therefore, sending clinical documentation daily can make it challenging to determine which documents actually contain relevant updated or required information.
- The reason for sending the updated clinical documentation should be noted in the documentation as it relates to the circumstances above (e.g., "discharge plan attached" or "change in diagnosis"). This will help the UM Department focus its review.



Corrected claims

In an effort to be consistent across paper and electronically submitted claims, please follow the guidelines below regarding rejected and corrected claims.

Rejected claims:

Rejected claims are those returned to the provider without being processed or adjudicated, due to a billing issue.

- Rebilling of a previously rejected claim should be done as an original claim.
- If the claim was previously rejected, it is as if the claim never existed and does not appear on any remittance advice.
- Since rejected claims are considered original claims once resubmitted, timely filing limits must be followed. Claims must be received within 365 days from the date of service.
- Note: Rejected claims are assigned a document control number (DCN); however, a DCN is not the same as a First Choice VIP Care Plus claim number.

Corrected or replacement claims:

Corrected claims are provider-submitted replacements for previously submitted claims. There are various reasons that a provider may submit a corrected claim, including, but not limited to, the provider wants to update or correct submitted charges, procedure codes, or number of units.

- In cases where resubmission serves to correct a claim that has already been denied/paid, the claim must be clearly identified as a corrected claim and resubmitted within 365 days from the date of service.
- If there is an identified overpayment beyond 365 days from date of service, please contact Provider Services to arrange repayment. You may either send a refund check with documentation directly to First Choice VIP Care Plus, P.O. Box 853914, Richardson, TX 75085-3914, or arrange to have the repayment withheld from future payments.
- Corrected claims may be submitted electronically through Change Healthcare or via paper submission to First Choice VIP Care Plus, P.O. Box 853914, Richardson, TX 75085-3914.
- Any resubmitted claim must be billed as a corrected or replacement claim and must include the original claim number.
  - You can find the claim number on the 835 ERA, on the paper remittance advice, or from the claim status search in NaviNet.
  - If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to get the claim number.

How to submit corrected or replacement claims:

- Corrected/replacement and voided claims may be sent electronically or on paper.
  - If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values ”7” for the replacement (correction) of a prior claim or ”8” for the voiding of a prior claim. The value ”6” should no longer be used.
  - In addition, you must also provide the original claim number in payer claim control number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the plan but rather a requirement of the mandated HIPAA Version 5010 Implementation Guide.
  - If the corrected claim is submitted on paper, the claim must have the following to be processed:
    - » On a professional CMS 1500 claim, the resubmission code of “7” or “8” and the plan’s original claim number must be in Field 22.
    - » On an institutional UB04 claim, bill type should end in “7” or “8” in Form Locator 4, and the plan’s original claim number must be in Form Locator 64A DCN.

Reminders:

- You may only resubmit as a corrected or replacement claim when you have received an original First Choice VIP Care Plus claim number.
- Billing of a previously rejected claim is not considered a resubmission or replacement, but an original claim.

Clinical practice guidelines

First Choice VIP Care Plus has adopted clinical practice guidelines for use in guiding the treatment of plan members, with the goal of reducing unnecessary variations in care. The following clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, a provider's clinical judgment. The provider remains responsible for determining applicable treatment for each individual.

- Asthma.
- Behavioral health.
- Cholesterol.
- Chronic obstructive pulmonary disease (COPD).
- Diabetes.
- Heart failure.
- HIV/AIDS.
- Hypertension.
- Lower back pain.
- Obesity.
- Preventive health.
- Sickle cell disease.

These guidelines are available on our website under **Provider > Resources > Clinical Resources**.

Get to the H.E.A.R.T of excellent customer service:

- **Hear** — Listen intently to what the patient is saying and try not to interrupt or interject until he or she is finished talking. Take notes, so that you can repeat what you heard.
- **Empathize** — Empathy allows you to feel what the patient is experiencing from their perspective. It also shows that you're concerned about their situation and you care about the outcome. Showing empathy is saying things like, "That's awful, let me see how I can assist," or "I understand your frustration." Be upbeat, positive, and, most importantly, sincere.
- **Attitude** — Attitude is everything! Patients should feel how grateful you are that they chose you as their health care provider. Having an attitude of gratitude means making it a habit to express thankfulness and appreciation on a regular basis.
- **Respond** — Once you understand the patient's need, respond promptly. Let the patient know what your next steps are and when they can expect to hear from you, if necessary. Be sure to follow up promptly at the agreed-upon date and time.
- **Take action** — If your interaction with a patient requires you to take action, do what you said you would do when you said you would do it. Follow-through is essential to excellent customer service.

Remember, any positive or negative interaction a patient has with their provider and their office staff can alter their perception about you and First Choice VIP Care Plus as a whole. We ask providers to make every contact with our members a positive one.

The member's perception is everyone's reality.

Claim disputes

A claim dispute is a request from a provider for First Choice VIP Care Plus to review and reconsider a payment amount made by First Choice VIP Care Plus. Providers may dispute full or partial payments made by First Choice VIP Care Plus if the provider disagrees with First Choice VIP Care Plus's payment amount. Examples of circumstances that may give rise to a provider dispute are:

- Where the amount paid for a Medicare-covered service is less than the amount that would have been paid under Original Medicare.
- Where First Choice VIP Care Plus paid for a different service or more appropriate code than what was billed.

If you believe the payment amount you received for treating our member is less than the expected payment, you have the right to dispute that payment. Requests for a claims dispute may be submitted by calling Provider Services at **1-888-978-0862** or in writing within 180 calendar days of the date of the initial remittance advice from First Choice VIP Care Plus using the Provider Claims Dispute Form, which is available on our website. If the form is not used, you must include the following:

- Submitter contact information (name, phone number).
- Provider information (name, phone number, NPI number, Tax ID number).
- Member information (name, date of birth [DOB], member ID number).
- Claim information (claim number, date of service [DOS], billed amount).
- Reason for dispute.
- Any documentation that supports your position that the plan's reimbursement is not correct.

Mail your claims dispute to:
First Choice VIP Care Plus
Claims Processing Department
P.O. Box 853914
Richardson, TX 75085-3914

We will review your request and respond to you within 30 calendar days. If we agree with you, we will adjust the claims and pay any additional money that is due. We will also inform you if the decision is to uphold the original payment decision.

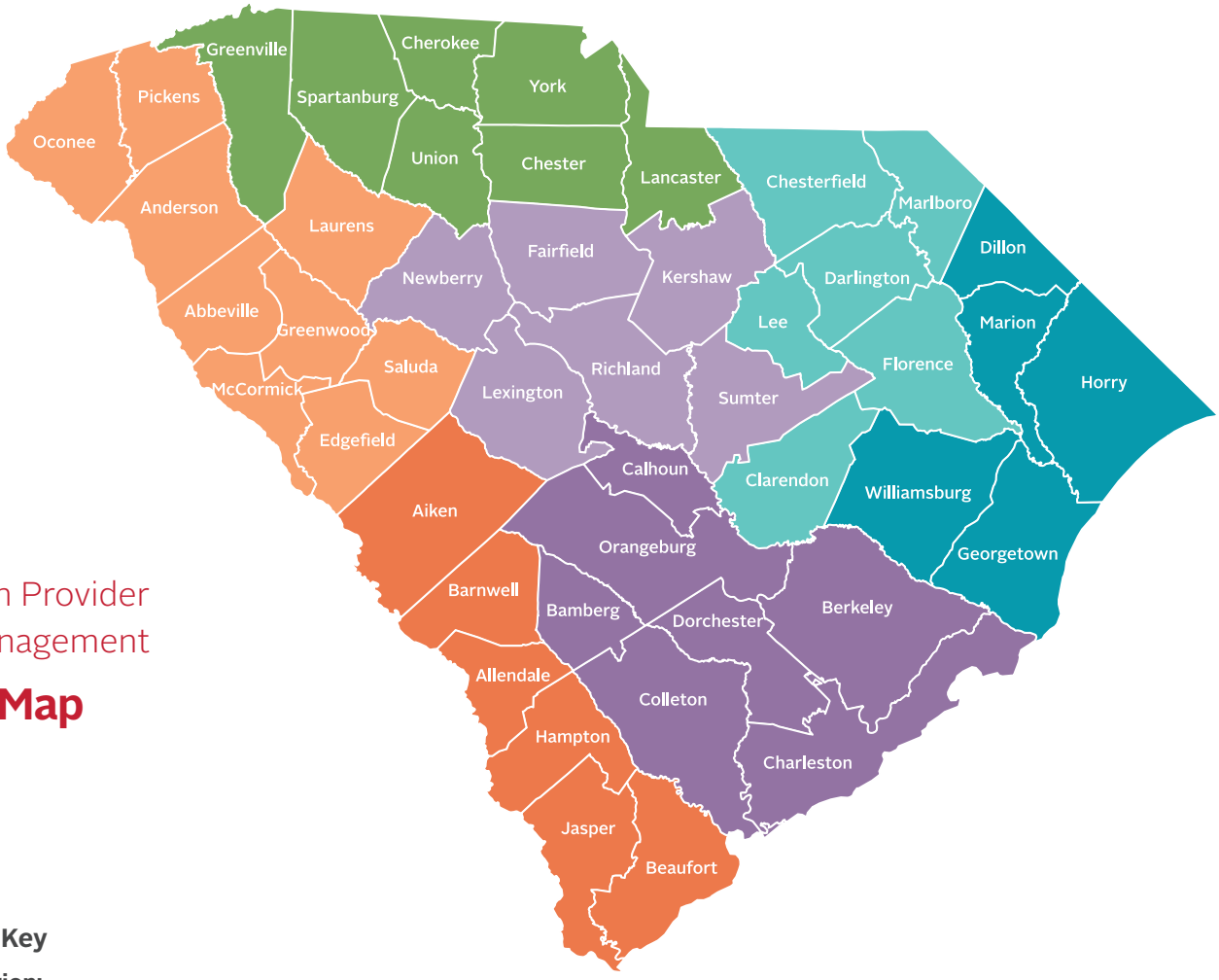
Balance billing reminder

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 process to resolve any outstanding claims payment issues. Providers may reference CMS MLN Matters number SE1128 for further details.

Do you know your First Choice VIP Care Plus Account Executive?

If you have questions about electronic funds transfer or provider data updates, or need provider orientation or training on NaviNet*, and would like to schedule a visit, email us or give us a call.

We support your efforts in providing the highest quality care to our members.



Select Health Provider Network Management

Regional Map

Region Service Key

Upstate region:
Joyce Mahon **1-864-787-0056** | jmahon@selecthealthofsc.com

Upstate western region:
Mary Wasden **1-843-666-2521** | mwasden@selecthealthofsc.com

Upstate Greenville region:
Sarah Hipps **1-843-259-0482** | shipps@selecthealthofsc.com

Midlands region:
Kaye Steele **1-803-354-1231** | ksteele@selecthealthofsc.com

Upper Pee Dee region:
Paige Watford **1-843-933-0276** | pwatford@selecthealthofsc.com

Lower Pee Dee region:
Louanne Finley **1-843-666-2331** | lfinley@selecthealthofsc.com

Lowcountry border region:
Lori Pingston **1-843-709-6532** | lpingston@selecthealthofsc.com

Lowcountry region:
Ashkia Harman **1-843-709-8922** | aharman@selecthealthofsc.com

Statewide Service

Ancillary services (DME and therapy):
Ruth Sisson **1-843-509-2894**
rsisson@selecthealthofsc.com

First Choice VIP Care Plus:
Donna Thompson **1-843-609-7873**
dthompson2@selecthealthofsc.com

Hospital Account Representative:
Nancy Carey **1-843-300-5857**
ncarey@selecthealthofsc.com

LTSS Account Representative:
Dionne Green **1-843-666-4548**
ddgreen@selecthealthofsc.com

Learn the advantages of using NaviNet

Did you know your office can check on the status of a claim, access all your First Choice VIP Care Plus members' eligibility information and gaps-in-care reports, and submit authorization requests through the payer-provider web portal NaviNet?

NaviNet makes it easier for you to get member information quickly and securely, without the hassle of making phone calls. Enrolling in the NaviNet provider portal will allow you to:

- View member eligibility status and dates.
- Check the status of a claim at any time following a submission, regardless of the submission method.
- View detailed claim status information, including ability to print remittance advices.
- Access clinical and administrative reports, including care gaps and primary care provider (PCP) panel reports.
- Request prior authorizations.
- Quickly access frequently asked questions, hours of availability, and contact information for First Choice VIP Care Plus.
- Access links to provider tools and resources, including the provider directory and direct claims entry.

We encourage your office to enroll on **www.navinet.net** to get immediate access to your First Choice VIP Care Plus member information. Go to **www.navinet.net** and click Sign Up, or contact your First Choice VIP Care Plus Account Executive.

Help us keep the First Choice VIP Care Plus provider directory updated

Accurate provider directory information is critical to ensuring member access to their health care services. Please confirm the accuracy of your information in our online provider directory, so our members have up-to-date resources. Some of the key items in the directory are:

- Provider name.
- Phone number.
- Office hours.
- Hospital affiliations.
- Address.
- Fax number.
- Open status.
- Multiple locations.

To make changes/corrections or if you have any other questions, contact your First Choice VIP Care Plus provider account executive.

HICN — MBI reminder

Effective January 1, 2020, CMS began requiring the use of the new Medicare Beneficiary Identifier (MBI) on most transactions and will reject transactions received using the Social Security number-based Health Insurance Claim Number (HICN).

As a dual eligible special needs plan, First Choice VIP Care Plus has always used unique ID numbers for our beneficiaries and not the HICN or MBI. We encourage all providers to continue to obtain and use the First Choice VIP Care Plus ID number on all transactions with our plan. This will not only help protect your patients' identities, but will also facilitate the accurate processing of your transactions. Providers can obtain a member's plan beneficiary ID number in any of the following ways:

- Checking the beneficiary's ID card.
- Accessing NaviNet at **https://navinet.navimedix.com** and verifying eligibility.
- Calling Provider Services at **1-888-978-0862** .

In the event you are unable to obtain or cannot use the member's plan ID number, please remember to use only the MBI and not the HICN.

Provider manual updates

- **Program Integrity** — Added an explanation of the Program Integrity department and how they utilize internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse.
- **Readmission review policy** — Added information about our Readmission Review Program.
- **Quality management activities** — New section added regarding how providers play a key role in helping us to measure and report the quality of care delivered to our members.
- **Claim dispute process** — Expanded information on the claim dispute process.

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

www.firstchoicevipcareplus.com

The Advantage

A Newsletter for Providers

Summer 2020

P.O. Box 40849
Charleston, SC 29423

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME