The Advantage

A Newsletter for Providers

Winter 2016/2017

Model of Care annual training requirement

First Choice VIP Care Plus's Model of Care is an Integrated Care Management approach to health care delivery and coordination for dual eligible (Medicare and Medicaid) individuals. The Model of Care is a program that involves multiple disciplines coming together to provide input and expertise for a member's individualized plan of care. This plan is designed to maintain the member's health and encourage the member's involvement in his or her health care.

The Centers for Medicare & Medicaid Services (CMS) requires providers who care for our beneficiaries to annually participate in and attest to completing our Model of Care training. Annual Model of Care training is also a contractual requirement for all participating providers. This required training can be accessed in any of the following ways:

- Via an online interactive Model of Care training module on our website: **amerihealthcaritas.adobeconnect.com/_a1050101005/firstchoicemoc/**.
- In person from a First Choice VIP Care Plus Account Executive or training seminar. Account Executive contact information is available online at **www.firstchoicevipcareplus.com**, and information on training seminars will be faxed to you when one is available in your area.
- By requesting electronic Model of Care training materials from Provider Services at **1-888-978-0862** or calling your First Choice VIP Care Plus Account Executive.

Providers may find information on the Model of Care and the annual training requirement in the Provider Manual at **www.firstchoicevipcareplus.com/provider/communications/index.aspx**.

Other required Medicare annual training, which should completed on your own:

- Compliance.
- Fraud, Waste, and Abuse.
- Cultural Competency.

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

www.firstchoicevipcareplus.com

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We have a winner!

The past two years we have incentivized providers to participate in the Model of Care training by offering a chance to win a lunch for their office by completing and submitting an attestation of training. We are pleased to announce this year's winner is Golden Corner Family Practice in Walhalla, SC. Thank you to all providers who complied with this requirement.

Provider manual updates

From time to time, we make updates to our provider manual. Since the provider manual is an integral part of your contract with our plan, we want to inform you of the following 2017 updates:

- Updated the image of the plan identification card.
- Added language regarding not accepting new patients.
- Expanded the language on the annual Model of Care training requirement.
- Expanded the language on balance billing.
- Added a section on prospective claims editing policy.
- Included additional information on refunds and recoveries.

If you have any questions about these updates, please contact your Provider Network Account Executive.

Removal of referral requirement

We are pleased to announce the following change to the First Choice VIP Care Plus plan effective January 1, 2017:

- First Choice VIP Care Plus will no longer require referrals, either paper or electronic, for members needing to access specialty care providers and services through participating providers. We are pleased to reduce the administrative burden for our network providers by removing the referral requirement. Please note there is no change to the prior authorization requirement for members needing services through non-participating providers.

We hope this enhancement is positive for your practice and you find it easier to provide quality health care services to our members. Please contact your First Choice VIP Care Plus Account Executive with any questions or concerns you may have. As always, thank you for your participation in the First Choice VIP Care Plus network and for your continued commitment to our members.

ER usage — Working together to encourage the right care in the right setting

One of the drivers of health care costs is the inappropriate use of the emergency room (ER). Too often, ERs have become places where patients go with problems that are not emergencies. These simple medical concerns that end up being treated in the ER can lead to escalating costs when they could have been easily treated by a primary care provider (PCP) or at an urgent care center.

What we are doing

We consistently stress the following messages in every member contact:

- Consult with your PCP first.
- Go to an urgent care center for non-emergency care. For common problems, urgent care is efficient and far less costly than an ER.
- Use the 24/7 Nurse Call Line (**1-877-693-8275**). It can help members determine if they really need to go to the ER.

How you can help

- If you receive notification that one of your First Choice VIP Care Plus patients went to the ER, contact the patient to schedule a follow-up visit.
- Reinforce the importance of patients calling your office before going to the ER.
- Suggest the alternative of using urgent care if needed.
- Consider same-day appointments and/or the extension of evening or weekend hours.

How we can help you

- Let us know if you need assistance with contacting or scheduling a follow-up appointment with a member. Our Integrated Health Care Management team will work to contact the member and address barriers that may be influencing him or her to use the ER.

Dental-related ER visits

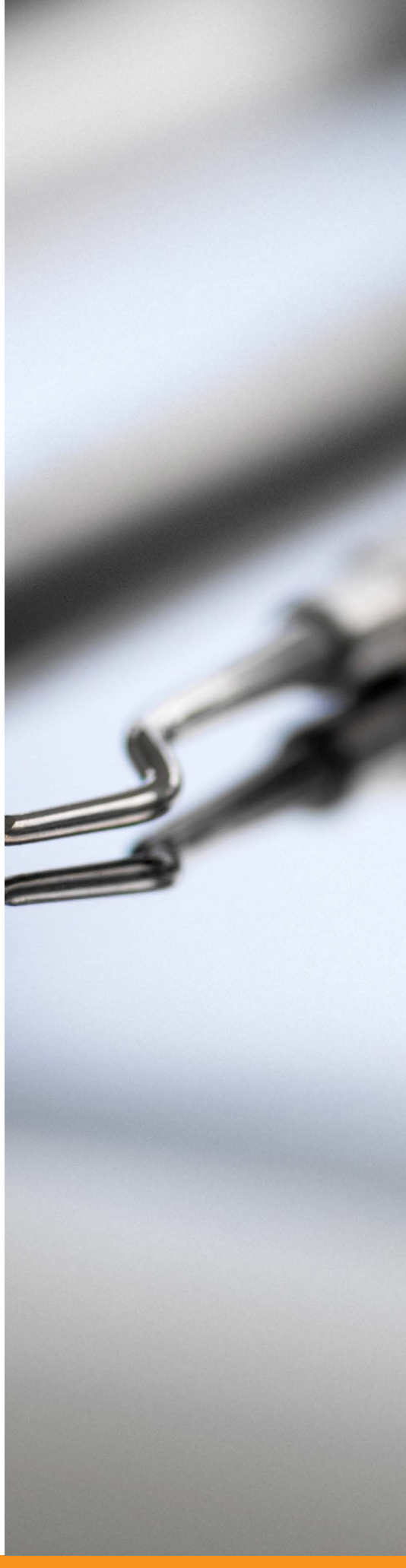
The number of ER visits for dental conditions in the United States continues to rise. In 2012, ER dental visits cost the U.S. health care system $1.6 billion, with an average cost of $749 per visit[1]. It is estimated that up to 79 percent of dental ER visits could be diverted to a dental office setting[2]. As the majority of ERs do not employ a dental professional, most often a patient is discharged with an antibiotic, pain medication, and the suggestion to follow up with a dentist.

Help us stop the cycle of dental-related ER visits. Our goal is to ensure that our members receive the routine, foundational dental care they need to avoid ER visits for dental issues.

Access to preventive care, effective recall systems, expanded office hours, patient education, and helping members establish a dental home are all crucial in addressing this issue. While we need your help to reduce these drastic numbers, remember that we are here to assist you as well!

- South Carolina Department of Health and Human Services (SCDHHS) offers an annual adult dental benefit of $750.00 for preventive and simple restoration services.
- First Choice VIP Care Plus can assist in locating social services, which can provide members with dental services at little to no cost to them.

[1,2] Wall T, Vujicic M. Emergency department use for dental conditions continues to increase. Health Policy Institute Research Brief. American Dental Association. April 2015. Available at: **www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_2.ashx**.



Opioid abuse prevention, identification, and treatment

According to the Centers for Disease Control and Prevention (CDC), an estimated 20 percent of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription. In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills. Opioid prescriptions per capita increased 7.3 percent from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties. Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States. In the past decade, while the death rates for the top leading causes of death, such as heart disease and cancer, have decreased substantially, the death rate associated with opioid pain medication has increased markedly. Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths.

Per CMS, dual eligible beneficiaries as a group are at increased risk for opioid addiction or misuse as they have a higher prevalence of both substance use disorder and chronic pain compared to beneficiaries with Medicare only or Medicaid-only adults with disabilities. Medicare-Medicaid plans (MMPs) are in a prime position to prevent, identify, and treat opioid addiction or misuse. Given the scope of their coverage, MMPs have a tremendous opportunity to impact the current opioid crisis by supporting evidence-based interventions and approaches such as:

- Conducting assessments and reassessments of our members to uncover any abuse or potential opioid abuse.
- Identifying each enrollee's goals; unmet needs; pain self-management practices; past successes and challenges; current medications; history of substance use disorder, opioid overdose, suicide attempts, and mental health conditions; concomitant use of benzodiazepines; and any respiratory disease or other comorbidities that increase susceptibility to opioid toxicity, respiratory distress, or overdose.
- Training Care Coordinators and direct care staff on behavioral change techniques, such as motivational interviewing, to help with conversations about substance use.
- Ensuring that providers are knowledgeable about unsafe or inappropriate prescribing associated with opioid misuse. Resources include federal guidelines and evidence-based practices for assessing and treating opioid misuse and abuse (**www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**).
- Ensuring that providers are knowledgeable about evidence-based treatments for substance use disorders for dual eligible beneficiaries, including the Food and Drug Administration (FDA)-approved medications that are currently available to treat opioid dependence: buprenorphine (or buprenorphine and naloxone combination drug), naltrexone, and methadone. These drugs are frequently used in combination with behavior therapy such as motivational interviewing, as they have been shown to effectively treat opioid dependence (**store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP**).
- Examining data from CMS' Overutilization Monitoring System (OMS) and implementing the guidance for Part D sponsors, including MMPs, to identify and address potential opioid overutilization and misuse.

In addition to the measures MMPs can take, the Drug Enforcement Agency (DEA) will be reducing the production of Schedule II opioid controlled substances to be manufactured in 2017 by 25 percent or more. It will be very important for providers to heed the CDC's recommendations (**www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**) to reduce the prescribing of opioids for chronic pain. Providers should also strongly consider other drug options when treating new patients with chronic pain and the weaning of Schedule II opioid drugs with existing patients. Together we can help prevent, identify, and treat opioid abuse.

Important vaccines for members 65 and older

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 young, healthy 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 71 and 85 percent of seasonal flu-related deaths have occurred in people 65 years old and older, and between 54 and 70 percent of seasonal flu-related hospitalizations have occurred among people in that age group[1]. So influenza is often quite serious for people 65 years old and older. Per the CDC, although people 65 years old and older can get any injectable vaccine, there are two vaccines specifically designed for people 65 years old and older:

- The "high-dose vaccine" is designed specifically for people 65 years old and older and 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). Results from a clinical trial of more than 30,000 participants showed that adults 65 years old and older who received the high-dose vaccine had 24 percent fewer influenza infections as compared to those who received the standard-dose flu vaccine. The high-dose vaccine has been approved for use in the United States since 2009[1].
- The adjuvanted flu vaccine, Fluad™, is made with MF59 adjuvant, which is designed to help create a stronger immune response to vaccination. In a Canadian observational study of 282 persons aged 65 years old and older conducted during the 2011 – 12 season, Fluad was 63 percent more effective than regular-dose unadjuvanted flu shots. There are no randomized studies comparing Fluad with Fluzone® High-Dose. This vaccine will be available for the first time in the United States during the 2016 – 2017 season[1].

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 Advisory Committee on Immunization Practices (ACIP). CMS has aligned Medicare coverage to meet the ACIP recommendations:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B.
- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a beneficiary who is 65 years old or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the two recommended pneumococcal vaccinations[2].

Medicare benefit

Medicare covers the costs of both the vaccine and its administration by recognized providers. Both the pneumococcal and influenza vaccines are covered at 100 percent[3] for Medicare beneficiaries.

[1] www.cdc.gov
[2] MLN Matters MM9051
[3] Of the Medicare Fee Schedule

Fall prevention and safety for older adults

As adults age, their muscles become weaker, and it can be harder for them to keep their balance. This can cause a risk of falling, even while doing everyday activities. Certain conditions or medicines can also increase the risk of falling.

Know their risk

The risk of falling can increase if older adults:

- Have trouble walking, standing up, or going up and down a curb or step.
- Have fallen within the past year.
- Have had a stroke.
- Have a condition like diabetes that can affect the feeling in their feet.
- Take medicines that make them feel sleepy, relaxed, or loopy.
- Have poor vision.
- Have certain eye conditions like cataracts or glaucoma.

First Choice VIP Care Plus would like to work together with our providers to help protect our members from falls. As a Medicare-Medicaid Plan, we are required to visit our members' homes to do assessments. An element of the assessment is to review the environment in which the members live. We can determine if the member is safe in their home and, if not, determine what we can implement to make the home safer. Our plan is unique in that we are able to refer qualified members into waiver programs which provide services to keep them safe in their homes and out of nursing facilities; we can also offer similar services to those who are not eligible for waivers. These services can include home modifications which can help prevent members from falling. We also develop care plans for each member, which will include any safety concerns. This care plan will be shared with the member's providers and will allow us to better partner with you to reduce fall risks. You can help reinforce the importance of fall prevention by sharing some of these tips with your older adult patients:

To reduce the risk of falling inside their homes

People feel most comfortable in their homes. This makes it easier to overlook common obstacles that can lead to falls. Use these tips to help your patients reduce the risk of falling in their homes.

On the floors

- Be sure they know to have a clear path through each room in their homes. If they need to move furniture or other large items, have them ask a friend or family member for help.
- If they have throw rugs on the floor, tell them to use non-slip pads or adhesive to hold them in place. Otherwise, the rugs could slide and cause them to lose balance.
- Advise them to place wires and cords near the walls and away from walking areas. They may choose to coil the wires or tape them along the bottoms of the walls.

On the steps

- Make sure they know not to store shoes, books, or other items on the stairs.
- Ensure they use a handrail each time they go up and down the steps. If the handrail is loose or broken, have them ask a friend or family member to help fix it.
- Tell them to make sure their stairways are well lit and that there are light switches at the tops and bottoms of the steps. If they need help adding light switches in their homes, suggest they call an electrician for help.
- Ask them to fix any steps that are uneven, rotted, or broken or that have loose or torn carpeting.
- If possible, suggest using some brightly colored tape or paint on the edge of each step so they can easily tell where each step ends.

In the bathroom

- Recommend they put non-slip mats on the floors of their tubs or showers.
- If needed, propose they have grab bars installed inside and next to the tub and also next to the toilet.
- If they have throw rugs on their bathroom floors, suggest using non-slip pads or adhesive to hold them in place.

In the bedroom

- Advise them to check, each night before bed, that there is a clear path through their rooms and to their bathrooms.
- Recommend the use of nightlights in their bedrooms, bathrooms, and hallways.
- Have them place lamps within arms' reach of their beds.

In the kitchen and other storage areas

- Suggest they store items they use often on shelves about waist high.
- Mention having a friend or family member to help them get items from high shelves. If they must use a stool, recommend they use one with a bar to keep themselves steady.

Other things they can do to reduce the risk of falling

Stay fit

- Tai chi, a form of martial arts, is a great way to increase strength and balance. They can take classes or search online for videos to do at home with friends and family.
- Recommend other exercises that are right for them.

Take it easy

- Advise them not to stand up too fast after sitting. Tell them to take it slow and hold on to something steady for support.
- Explain that after lying down, they should sit up first, and then stand up slowly.

Encourage them to talk to you or other providers

- Have them make appointments with their eye doctors every year and remind them to always wear their glasses or contacts, if prescribed.
- Review medications they take which can increase their risk of falling.
- If they are at high risk of falling, talk to them about safety alarms.
- Recommend canes or walkers if those are right for them.

Sources: Centers for Disease Control and Prevention and www.healthfinder.gov.

Ground ambulance transport coverage

The following Medicare coverage requirements apply to ground ambulance transports*:

1. The transport is medically reasonable and necessary — Due to the beneficiary's condition, the use of any other method of transportation is contraindicated, and the purpose of the transport is to obtain a Medicare-covered service or to return from obtaining such service.
2. A Medicare beneficiary is transported — The transport of a Medicare beneficiary must occur for an ambulance transport to be payable under the Medicare program.
3. The destination is local — As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered.
4. The facility is appropriate — An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury.

When all other program requirements for coverage are met, ground ambulance transports are covered by Medicare only to and from the following destinations*:

- Hospitals.
- Beneficiaries' homes.
- Critical access hospitals (CAHs).
- Dialysis facilities for end-stage renal disease (ESRD) beneficiaries who require dialysis.
- Skilled nursing facilities (SNFs).
- Physicians' offices only as follows:
  - The transport is en route to a Medicare-covered destination.
  - The ambulance stops because of the beneficiary's dire need for professional attention.
  - Immediately thereafter, the ambulance continues to the covered destination.

SCDHHS Medicaid covered non-emergency ground transportation benefit:

If a First Choice VIP Care Plus beneficiary does not meet the criteria for emergency transportation, he or she should be instructed to call the non-emergency transportation broker in the county in which he or she resides. For appropriate phone numbers, please refer to **www.scdhhs.gov/site-page/transportation-beneficiary-information** or to Logisticare at **memberinfo.logisticare.com/scmember/Home.aspx**. The broker will provide Medicaid transportation services for the following:

- All non-emergency ambulance transportation to medical appointments and non-emergency transports which are planned or scheduled trips.
- Transports from a nursing home to a provider's office, a nursing home to a dialysis center, or a hospital to a residence.
- Non-emergency transportation for beneficiaries requiring stretcher or wheelchair service.
- Non-emergency transportation services to beneficiaries traveling out of state for prior authorized medical services, (e.g., lodging, meals, etc.).
- Non-emergency air transports for both rotary and fixed-wing air flights.
- Transportation for beneficiaries who receive retroactive eligibility.

The non-emergency transportation broker for SCDHHS is Logisticare. Arrangements for transportation should be made at least three days in advance of the appointment. If needed, First Choice VIP Care Plus can assist providers with making these arrangements for our members to help ensure they attend their scheduled appointments.

* Please refer to Medicare ambulance transportation coverage guidelines for an all-inclusive list and details, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1249521.html.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Balance billing

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 First Choice VIP Care Plus to participating plan providers must be accepted as payment in full for services rendered. This means for First Choice VIP Care Plus Healthy Connections Prime members, providers may not bill and/or collect any Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments that may be represented on the remittance advice, as they are not the member's responsibility. Please be advised that it is unlawful for providers to "balance bill" any patient who is a member of First Choice VIP Care Plus for any covered services.

First Choice VIP Care Plus members can be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copays for Medicaid-only covered durable medical equipment (DME) items.

How First Choice VIP Care Plus resolves balance billing issues with the provider:

- First Choice VIP Care Plus informs the provider that the member has been inappropriately balance billed and educates the provider on balance billing.
- If First Choice VIP Care Plus reimbursed the member for an inappropriately balance billed amount, the plan will notify the provider and request reimbursement be made to the plan.
- If, after outreach and education efforts to the provider, First Choice VIP Care Plus identifies ongoing inappropriate balance billing activities, First Choice VIP Care Plus may take disciplinary action up to and including termination of the Provider Agreement.

All providers are encouraged to use the claims inquiry processes to resolve any outstanding claims payment issues.

First Choice VIP Care Plus
Attn: Claims
P.O. Box 853914
Richardson, TX 75085-3914

For more information regarding balance billing, please refer to CMS' balance billing prohibition notice at **msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing-healthy-connections-prime-members-0** on the Healthy Connections Prime website.

Eligibility

Verifying eligibility is especially important for dual eligible (Medicare-Medicaid) members. Per the Medicare Managed Care Manual, Chapter 2, Section 30.4.4, dual eligible individuals meet the qualifications for using a Special Election Period (SEP), which gives them the option to request a plan change on a monthly basis. The effective date of the new plan will either be the first of the following month or the first of the next month depending on when the request was made. This SEP continues as long as the beneficiary remains dually eligible, so you must verify eligibility before each encounter at your office or facility. Here are some ways you can verify eligibility for our plan:

- Contact Provider Services at **1-888-978-0862**.
- Consult NaviNet at **navinet.secure.force.com** (for more information on NaviNet, please see page 13).

Using the member's identification card is not always a guarantee the member is still enrolled in our plan; however, we are providing you a copy of the 2017 identification card:

CMS outreach requirement for clinical documentation to support coverage decisions

Per CMS, Medicare Advantage plans must conduct a full and meaningful review of an organization determination (prior authorization) or reconsideration request (retrospective review). The plan is expected to make reasonable efforts to gather all of the information needed to make substantive and accurate decisions as early in the coverage process as possible. The plan must document all requests for information and maintain that documentation within the case file. The plan must clearly identify the records, information, and documents it needs when requesting information from a provider.

For all requests, reasonable and diligent efforts to obtain missing information include a minimum of three attempts with requests made, when possible, during normal business hours. Methods for requesting information can include:

- Telephone.
- Fax.
- Email.
- Standard or overnight mail with certified return receipt.

CMS specifies different intervals for the attempts based on whether the request is a Standard Organizational Determination (14 calendar day turnaround time), Expedited Organizational Determination (72-hour turnaround time), Standard Reconsideration (30 calendar day turnaround time), or Expedited Reconsideration (72-hour turnaround time).

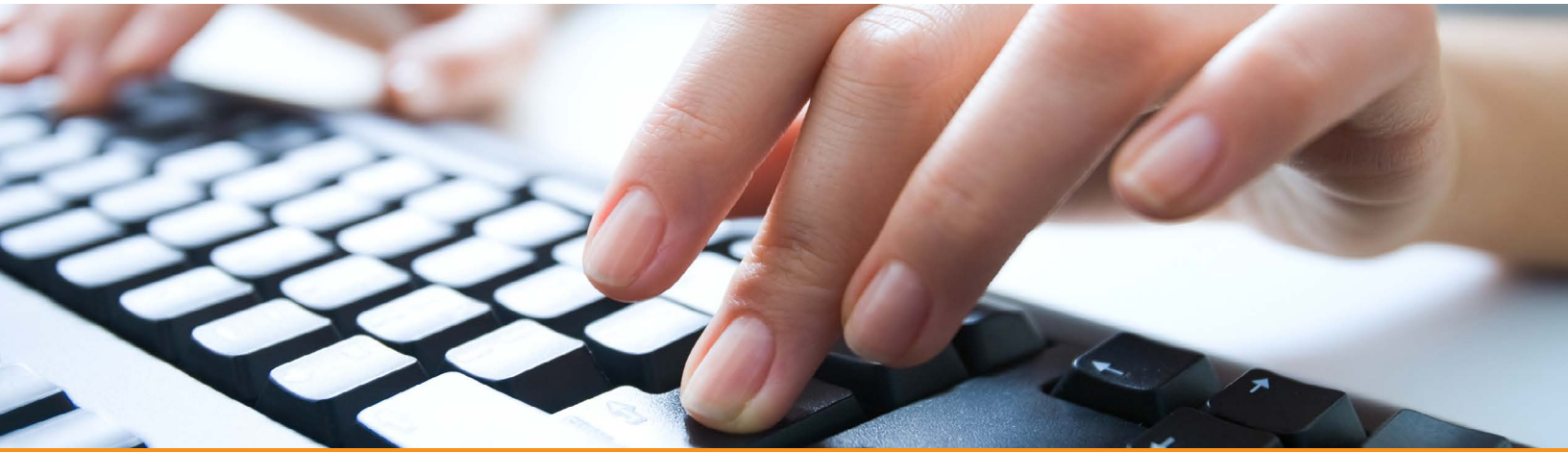
If a provider fails to submit the requested information after three attempts, the plan Medical Director is required to reach out to contracted providers. If the plan does not obtain the requested information, it must make a decision within the applicable time frame based on the available clinical information. Under certain circumstances, an extension may be granted. If the plan issues an adverse decision due to inability to obtain the information needed to approve coverage, the plan should clearly identify that basis and the necessary information in the written denial notice.

NaviNet provider portal

First Choice VIP Care Plus offers participating network providers real-time information through our secure provider portal, NaviNet. This free service is America's leading health care provider portal, connecting over 40 health plans and 60 percent of the nation's physicians. NaviNet is not only used by First Choice VIP Care Plus, but also by payers like Cigna and Aetna. Through NaviNet, providers can:

- Check claim status.
- Check member eligibility.
- Enter authorization requests.
- Generate reports — PCP panel rosters, claims inquiries, care gap reports, single condition care gap reports, and lab data.

To sign up for NaviNet, go to the link on our website or visit **navinet.secure.force.com**.



Just for fun — HIPAA word scramble

aaihp ___ ___ ___ ___ ___

Which is the correct spelling: HIPPA or HIPAA?

tcesiuyr ___ ___ ___ ___ ___ ___ ___ ___

Privacy and ___ is protected by HIPAA.

aisdut ___ ___ ___ ___ ___ ___

What is used to verify HIPAA compliance?

cat ___ ___ ___

What does the "A" in HIPAA stand for?

awl ___ ___ ___

HIPAA is not optional. It is the ___.

hip ___ ___ ___

What patient information is considered confidential?

aytipotibrl ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

What does the "P" in HIPAA stand for?

eernvoey ___ ___ ___ ___ ___ ___ ___ ___

Who is responsible for keeping patient information confidential?

tazairnuhoito ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

What must be completed and signed before records can be released?

rtvsoaechfeex ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

All faxes sent with PHI must have this.

Source: www.hqsc.govt.nz.

itblunyticaoac ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

What does the "A" in HIPAA stand for?

tlhaeh ___ ___ ___ ___ ___ ___

What does the "H" in HIPAA stand for?

arbehc ___ ___ ___ ___ ___ ___

A ___ of patient confidentiality will cause a breakdown of trust.

dhddeers ___ ___ ___ ___ ___ ___ ___ ___

How does confidential documentation need to be disposed of?

rdawpssos ___ ___ ___ ___ ___ ___ ___ ___ ___

Computer ___ should never be shared or posted.

sgduitoen ___ ___ ___ ___ ___ ___ ___ ___ ___

Charts must be _____ ___ whenever removed from their designated locations.

ifoirtnoamn ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

What does the "I" in HIPAA stand for?

gelilal ___ ___ ___ ___ ___ ___ ___

It is _____ to release PHI without permission.

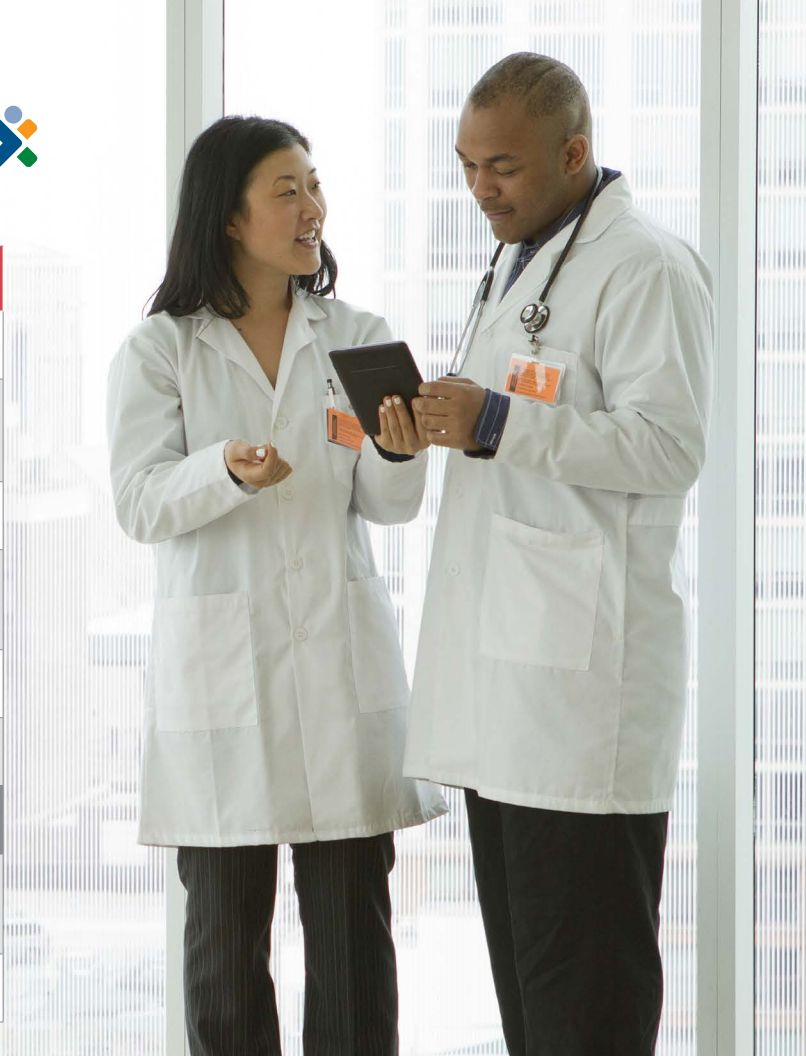
oclse ___ ___ ___ ___ ___

If you are working with a chart and have to walk away, ____ the chart.

Answers: HIPAA, security, audits, act, law, PHI, portability, everyone, authorization, fax cover sheet, accountability, health, breach, shredded, passwords, signed out, information, illegal, close

FirstChoice VIP CARE PLUS
by Select Health of South Carolina

Healthy Connections PRIME



Important phone numbers	
Provider Services	**1-888-978-0862**
Prior authorizations	**1-888-244-5410** **1-888-257-7690** (fax)
Pharmacy Services	**1-855-327-0512**
Language Line After hours	**1-888-978-0862** **1-877-693-8275**
Fraud and Abuse Hotline	**1-866-833-9718**
NaviNet	**1-888-482-8057**
Change Healthcare	
Electronic billing and electronic remittance advice	**1-877-363-3666**
EFT enrollment	**1-866-506-2830**

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