Provider Reference Guide

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

Your Provider Network Management Account Executive: _____

Phone number: _____ Fax number: _____

Email: _____

First Choice VIP Care Plus website: www.firstchoicevipcareplus.com

Visit us online for more detailed information, which can be found in the Provider Manual. Other available information includes training modules, prior authorization forms, quality resources, provider directory, searchable formulary, NaviNet link, claims resources, newsletters, plan updates, and other notifications.

Provider information

Provider Services **1-888-978-0862**
Hours ..... **8 a.m. – 8 p.m., 7 days a week**

When dialing Provider Services, it's critical you get to the correct main menu. When you dial the Provider Services number, you will hear:

Thank you for calling First Choice VIP Care Plus, a Healthy Connections Prime Medicare-Medicaid plan. If you are a doctor, hospital, or provider of care, **press 9** now.

- Prior authorizations for medical services, **press 1.**
- Questions about Part D prescription drugs, **press 2.**
- For detailed questions regarding finalized claims, payment, redetermination, or adjustment, **press 3.**
- Prior authorizations for behavioral health services, **press 4.**
- All others, please hold while we transfer you to a Provider Services Specialist.

Fraud and Abuse Hotline **1-866-833-9718**

Prior authorizations **1-888-244-5410**
Fax **1-888-257-7960**

Laboratory services ..... **LabCorp** (and contracted hospitals)

Pharmacy services **1-855-327-0512**

Transportation services ..... **www.modivcare.com**
SC Region 1 ..... **1-866-910-7688**
SC Region 2 ..... **1-866-445-6860**
SC Region 3 ..... **1-866-445-9954**

Providers may also contact First Choice VIP Care Plus for assistance in scheduling transportation for a First Choice VIP Care Plus member.

NaviNet (provider portal) ..... **connect.NaviNet.net**
NaviNet Customer Care **1-888-482-8057**
The free NaviNet provider portal is for key systems and patient information such as member eligibility, member primary care provider (PCP) rosters, electronic copies of remittances, claim status and updates, online prior authorization, care gaps, and more.

Additional government resources

Centers for Medicare & Medicaid Services (CMS) ..... **1-800-MEDICARE (1-800-633-4227)**
TTY **1-877-486-2048**
Website ..... **www.medicare.gov** and **www.cms.gov**

South Carolina Department of Health and Human Services ..... **www.scdhhs.gov**

Member information

Member Services **1-888-978-0862**
TTY 711
Hours ..... **8 a.m. – 8 p.m., 7 days a week**

Member enrollment **1-800-726-8774**
TTY 711
Website ..... **www.scthrive.org**
Hours ..... **8:30 a.m. – 5 p.m., Monday – Friday**

Member Pharmacy Services **1-855-327-0511**
Hours ..... **24 hours a day, 7 days a week**

Nurse Call Line **1-855-843-1147**
Hours ..... **24 hours a day, 7 days a week**
A confidential line for members to ask health-related questions.

Care Management **1-888-244-5440**
Fax **1-888-257-7950**
Hours ..... **8 a.m. – 5 p.m., Monday – Friday**
The Care Management Team has Care Coordinators (registered nurses and social workers), Community Health Navigators, and Care Connectors ready to assist members with their most urgent needs. Staff can assist members with a wide array of clinical and nonclinical services; answer questions regarding health conditions and medications; help schedule physician appointments and arrange transportation; and help members locate community resources for housing, food, and clothing.

Claims submission, electronic funds transfer, and electronic remittance advice

Electronic claims submission:

- Use First Choice VIP Care Plus payer ID **77009**.
- Contact your practice management system vendor or clearinghouse to initiate electronic claims submission through Change Healthcare.
- Direct claim entry is also available through Change Healthcare Office.
- Electronic billing questions ..... **1-877-363-3666**.

Paper claims submission:

First Choice VIP Care Plus
Claims Processing Department
P.O. Box 7106
London, KY 40742-7106

Electronic funds transfer (EFT) or electronic remittance advice (ERA) enrollment through Change Healthcare:

- Visit **www.changehealthcare.com** > Support > Enrollment Services.
- EFT enrollment: ..... **1-866-506-2830**.
- ERA enrollment: ..... **1-877-363-3666**.

Filing information

- Claims must be filed within 365 days from the date of service (or the date of discharge for inpatient admissions).
- This plan covers both Medicare and Medicaid, but should only be listed as a primary plan and not listed as primary and secondary in your billing system. Therefore, file only one claim to the plan, and it will be processed under both Medicare and Medicaid benefits. Only one payment will be remitted for both benefits.

Provider claim dispute process

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' payment amount. Examples of circumstances that may give rise to a provider dispute:

- The amount paid for a Medicare-covered service is less than the amount that would have been paid under Original Medicare.
- 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 claim disputes 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 available on our website. If you do not use the form, you must include the following:

1. Submitter contact information (name and phone number).
2. Provider information (name, phone number, NPI, and Tax ID number).
3. Member information (name, date of birth, and member ID number).
4. Claim information (claim number, date of service, and billed amount).
5. Reason for dispute.
6. Any documentation which supports your position that the plan's reimbursement is not correct.

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

Model of Care

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. First Choice VIP Care Plus is required to train its providers on how we integrate and coordinate care and services for our members through our Model of Care. Providers may receive training on the Model of Care in the following ways:

- Through an online interactive Model of Care training module on our website at **www.firstchoicevipcareplus.com/provider/resources/model-of-care.aspx**.
- In person at a training seminar.
- With printed Model of Care training materials.

Balance billing

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 remit, as they are not members' responsibility.

This practice, known as "balance billing," is prohibited by federal law and as stipulated under your First Choice VIP Care Plus Provider Services Agreement. **Please be advised that it is unlawful for providers to balance bill any patient who is a member of Healthy Connections Prime for any covered services.**

Prior authorization

Prior authorization is required for all referrals to out-of-network physicians and providers with the exception of emergency services.

Emergency room (ER) policy: Prior authorization is not required for ER visits. Participating providers are not required to obtain prior authorization for an emergent short procedure unit (SPU) or emergent 23-hour observation stay.

The most up-to-date listing of services requiring prior authorization will be maintained in the provider section at **www.firstchoicevipcareplus.com**.

Services requiring prior authorization* include, but are not limited to, the list below:

- Elective or non-emergent air ambulance transportation.
- All out-of-network services (excluding emergency services).
- Inpatient services:
  - All inpatient hospital admissions, including medical, surgical, skilled nursing, and rehabilitation.
  - Inpatient diabetes programs and supplies.
  - Inpatient medical detoxification.
  - Elective transfers for inpatient and/or outpatient services between acute care facilities.

Services requiring prior authorization* include, but are not limited to, the list below (continued):

- Certain outpatient diagnostic tests.
- Home-health services.
- Therapy and related services:
  - Speech, occupational, and physical therapy provided in the home or in an outpatient setting, after the first visit per therapy discipline or type.
  - Cardiac and pulmonary rehabilitation.
- Transplants, including transplant evaluations.
- All durable medical equipment (DME) rentals and rent-to-purchase items.
- DME, medical supply, and prosthetic device purchases:
  - Purchase of all items in excess of $500 in allowable charges.
  - Prosthetics and orthotics in excess of $500 in allowable charges.
  - **All** wheelchairs (motorized and manual) and all wheelchair accessories (components), regardless of cost per item.
  - Nutritional supplements.
- Hyperbaric oxygen.
- Surgery (including sleep apnea or uvulopalatopharyngoplasty [UPPP]).
- Medications: Infusion or injectable medications listed on the Medicare Professional Fee Schedule. Infusion or injectable medications not listed on the Medicare Professional Fee Schedule are not covered by First Choice VIP Care Plus.
- Surgical services that may be considered cosmetic, including, but not limited to:
  - Blepharoplasty.
  - Mastectomy for gynecomastia.
  - Mastopexy.
  - Maxillofacial.
  - Panniculectomy.
  - Penile prosthesis.
  - Plastic surgery and cosmetic dermatology.
  - Reduction mammoplasty.
  - Septoplasty.
- Cochlear implantation.
- Gastric bypass and vertical band gastroplasty.
- Hysterectomy.
- Pain management — external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation, and injections and nerve blocks.
- Radiology outpatient services:
  - Computed tomography (CT) scan.
  - Positron emission tomography (PET) scan.
  - Magnetic resonance imaging (MRI).
  - Magnetic resonance angiography (MRA).
  - Magnetic resonance spectroscopy (MRS).
  - Single-photon emission computed tomography (SPECT) scan.
  - Nuclear cardiac imaging.
- All miscellaneous, unlisted, or not otherwise specified codes.
- All services that may be considered experimental and/or investigational.

For inquiries.....**1-888-244-5410**

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*All requests for services are subject to Medicare and Healthy Connections Medicaid coverage guidelines and limitations.

Prior authorization is not a guarantee of payment.

Emergency room, observation care, and inpatient imaging procedures do not require prior authorization.

Providers must meet state and CMS requirements and documentation for reimbursement. Please see requirements and documentation necessary in the First Choice VIP Care Plus Provider Manual.

Prior authorization for CT scans, MRIs, MRAs, and nuclear cardiology services are required for outpatient services only. The ordering physician is responsible for obtaining a prior authorization number for the study requested. Patient symptoms, past clinical history, and prior treatment information will be requested and should be available at the time of the call. (Outpatient studies ordered after normal business hours or on weekends should be conducted by the ordering facility as requested by the ordering physician. However, the ordering physician must contact Prior Authorization within 48 hours or the next business day to obtain proper authorization for the studies, which will be subject to medical necessity review.)

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