The Advantage

A Newsletter for Providers

Medicare Diabetes Prevention Program (MDPP)

The MDPP is a structured intervention aimed to help prevent or delay the onset of type 2 diabetes among Medicare beneficiaries who have an indication of prediabetes. MDPP services were made available to eligible beneficiaries nationwide beginning April 1, 2018, under a performance-based payment model through the Centers for Medicare & Medicaid Services (CMS).

Why is the MDPP an important program?

- Currently, 25 percent of Americans age 65 and older live with diabetes.
- If current trends continue, by 2050, this percentage will double.
- Only 14 percent of adults age 65 and older are aware they have prediabetes.
- Medical care for older Americans (age 65+ years) with diabetes costs Medicare $104 billion annually, and this cost is growing.
- In 2016, Medicare spent $42 billion more on beneficiaries with diabetes than on those without.
- Of beneficiaries with diabetes vs. those without diabetes, Medicare spent an estimated (per beneficiary):
  - $1,500 more on Part D drugs.
  - $3,100 more on hospital and facility services.
  - $2,700 more on physician and other clinical services.

What are the goals of the MDPP?

- To reduce or delay the onset of diabetes in persons with a prediabetes diagnosis.
- To provide healthy eating, exercise, and living education that promotes healthier behaviors.
- To decrease health care costs associated with diabetes.

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Summer 2018

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AmeriHealth Caritas VIP Care Plus

www.amerihealthcaritasvipcareplus.com

Research shows that people with prediabetes who take part in a structured lifestyle change program can:

- Cut their risk of developing type 2 diabetes by 58 percent (71 percent for people over age 60).
- Reduce their risk of developing type 2 diabetes by 58 percent if they are at high risk for the disease and achieve weight loss of 5 percent to 7 percent by eating healthier and participating in 150 minutes of physical activity per week.
- Experience long-lasting results — even after 10 years, they are one-third less likely to develop type 2 diabetes.

Per CMS, eligible MDPP participants are those who:

- Are enrolled in Medicare Part B.
- Have no previous diagnosis of type 1 or type 2 diabetes (other than gestational diabetes).
- Meet one of the following three blood test requirements in the 12 months prior to the first core session:
  - A hemoglobin A1C test with a value between 5.7 and 6.4 percent.
  - A fasting plasma glucose of 110 – 125 mg/dL.
  - A two-hour plasma glucose of 140 – 199 mg/dL (oral glucose tolerance test).
- Have a body mass index (BMI) of at least 25 (BMI of 23 or greater if self-identified as Asian).
- Do not have end-stage renal disease (ESRD).
- Have never previously received any MDPP services (once-per-lifetime limit).

Organizations that wish to furnish MDPP services to beneficiaries and bill Medicare for those services must enroll in Medicare as an MDPP supplier. To enroll as an MDPP supplier, organizations must:

- Have MDPP preliminary recognition or have full recognition of the Centers for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program.
- Have an active and valid tax identification number (TIN) and National Provider Identifier (NPI).
- Pass enrollment screening at the high categorical risk level.
- On the MDPP enrollment application, submit a list of MDPP coaches who will lead sessions, including full names, dates of birth, Social Security numbers (SSNs), active and valid NPIs, and coach eligibility end dates (if applicable).
- Meet MDPP supplier standards and requirements, as well as other requirements of existing Medicare providers or suppliers.
- Revalidate enrollment every five years.

Source: "Medicare Diabetes Prevention Program (MDPP) Expanded Model," Centers for Medicare & Medicaid Services website, June 15, 2018, **https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program**.

Care for older adults

AmeriHealth Caritas VIP Care Plus wants to partner with you to improve the health of our members. Many of our plan's members are over age 65, which can present many challenges. Our older members face many unique issues that can affect their well-being.

Providers treating our members age 65 and older should annually complete the following components of the Healthcare Effectiveness Data and Information Set (HEDIS®) Care for Older Adults (COA) measure:

- Advanced care planning.
- Functional status assessment.
- Pain assessment.
- Medication review.

We understand you may not always have the opportunity to complete these components, so AmeriHealth Caritas VIP Care Plus wants to help. Our plan has created a form which includes all the required COA components. We then reach out to our members to discuss advance care planning and to perform the functional status and pain assessments with them. The medication review requirement is completed by our clinical pharmacist.

We provide a copy of the completed COA form to each member's primary care provider (PCP). If your office receives a COA form, we ask you to file it in the respective member's chart. We hope it will assist providers in addressing any health issues our members may have, while helping us to ensure our members' needs are addressed.

Transitional care management with post-discharge medication reconciliation

AmeriHealth Caritas VIP Care Plus values both its providers and members. We want to remind you to provide transitional care management (TCM) with post-discharge medication reconciliation services for your patients. CMS understands the importance of this service in providing quality care for your patients and has adopted the post-discharge medication reconciliation (MRP) HEDIS measure and designated it a star rating measure. Medication reconciliation is a review in which discharge medications are reconciled with the most recent medication list in the outpatient record. Documentation must be in the outpatient medical record and include evidence of medication reconciliation; the date when it was performed by the prescribing physician, registered nurse, or clinical pharmacist; and the provider's signature.

If coding guidelines are met, MRP is reimbursed through TCM service codes 99495 and 99496; otherwise, it can be reported with the non-reimbursable CPT Category II code 1111F. The two TCM codes generally have the same requirements; the primary difference is the level of decision-making involved (either moderate or high complexity). To report these services, the following milestones must be met:

1. The initial direct contact with the patient and/or caregiver (including telephone or electronic contact) must occur within two days of discharge.
2. Moderate-complexity patients must be seen within 14 days of discharge (99495), and high-complexity patients must be seen within seven days of discharge (99496).
3. Medication reconciliation must be performed and documented within 30 days of discharge. Other necessary follow-up, such as reviewing lab work and scheduling additional services, should also be performed within that 30 days.

We realize not all patients discharged from the hospital require the complex decision-making required by TCM services, but it is still important to complete MRP within 30 days. If you perform MRP without TCM, please document this service and submit claims using the appropriate CPT codes.

We are here to help both you and our members. Our team of nurses, social workers, and non-clinical support staff are available to assist members with scheduling post-discharge visits with your office as needed.

Controlling high blood pressure

Before providers can begin to control high blood pressure, they must first obtain an accurate blood pressure reading. Even small inaccuracies of 5 – 10 mm Hg can have considerable consequences. For example, overestimating true blood pressure by 5 mm Hg may lead to inappropriate treatment with antihypertension medications in almost 30 million Americans, with attendant exposure to adverse drug effects, the psychological effects of misdiagnosis, and unnecessary cost. Below are some factors that can affect the accuracy of a blood pressure reading and the magnitude of the discrepancies.

Factor	Magnitude of systolic/diastolic blood pressure discrepancy (mm Hg)
Talking or active listening	10/10
Distended bladder	15/10
Cuff over clothing	5 – 50/
Cuff too small	10/2 – 8
Smoking within 30 minutes of measurement	6 – 20/
Paralyzed arm	2 – 5/
Back unsupported	6 – 10/
Arm unsupported, sitting	1 – 7/5 – 11
Arm unsupported, standing	6 – 8/

Other common issues:

- Terminal digital preference — rounding off of numbers to the nearest zero.
- Forearm blood pressure — generally a higher reading than upper arm measurements.
- Improper technique — Is the member standing or sitting? For some patients, standing blood pressure measurement is more appropriate. For example, some patients who are age ≥70 and taking antihypertension medications may benefit from a standing measurement.
- White-coat effect — Who is taking the blood pressure measurement? Doctors tend to instill more anxiety in patients than a nurse or medical assistant.

Our plan is assessed on how well our providers control their patients' (our members') blood pressure through the HEDIS Controlling High Blood Pressure measure. This measure determines the percentage of patients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year, based on the following criteria:

- Patients ages 18 to 59 whose blood pressure was less than 140/90 mm Hg.
- Patients ages 60 to 85 with a diagnosis of diabetes whose blood pressure was less than 140/90 mm Hg.
- Patients ages 60 to 85 without a diagnosis of diabetes whose blood pressure was less than 150/90 mm Hg.

Only about half of people with high blood pressure have it under control. This puts them at higher risk for heart disease and stroke. Another one in five adults don't even know they have high blood pressure. We want to work together with our providers to help educate our members on the importance of getting an accurate blood pressure reading, in addition to controlling their high blood pressure by taking their medications, reducing sodium in their diets, getting daily exercise, and quitting smoking.

Sources:
Joel Handler, "The Importance of Accurate Blood Pressure Measurement," *The Permanente Journal* 13, no. 3 (2009): 51 – 54, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2911816.

https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_bloodpressure.htm
http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2017-table-of-contents/controlling-high-blood-pressure

All-cause readmissions

AmeriHealth Caritas VIP Care Plus wants to work with our network providers to prevent hospital readmissions. As defined for Medicare, a hospital readmission occurs when a patient is admitted to a hospital within 30 days after being discharged from an earlier (initial) hospitalization. This includes hospital readmissions to any hospital, not just to the hospital at which the patient was originally hospitalized. Medicare uses an "all-cause" definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission.

We would you to let us know how we can help you minimize readmissions while improving care for our members. Hospitalizations can be stressful for our members, and even more so when they result in subsequent readmissions. You can help lower the rate of readmissions by engaging with the hospital, other providers, and our Care Management team.

Care Management will:

- Work with you to coordinate the member's discharge.
- Help facilitate members following up with a specialist or their PCPs by scheduling appointments, prior to discharge, with the provider within seven days of discharge.
- Complete post-discharge medication reconciliation in the member's home and provide you with the results to place in the member's medical record.
- Ensure home-based services are in place, such as durable medical equipment, home health care, and therapies.
- Update the member's Individualized Care Plan to address barriers to recovery, provide education needed to manage health, and help prevent readmissions.
- Work with hospital discharge planners to help with a smooth transition home.

Medicare annual wellness visit

Medicare covers an annual wellness visit (AWV) for members who:

- Are no longer within 12 months of the effective date of their first Medicare Part B coverage period.
- Have not received an initial preventive physical examination (IPPE) or AWV within the past 12 months.

During an AWV:

- Administer or update a Health Risk Assessment (HRA) — see details below.
- Establish or update a list of current providers and suppliers.
- Establish or update a member's medical and family history.
- Review the member's potential risk factors for depression, including current or past experiences with depression or other mood disorders.
- Review the member's functional ability and level of safety.
- Assess height, weight, BMI, and other routine measurements as deemed appropriate based on medical and family history.
- Detect any cognitive impairments the member may have.
- Establish or update a written screening schedule for the member, such as a checklist for the next five to 10 years, as appropriate.
- Establish or update a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the member.
- Furnish health advice personalized to the member and referr them appropriately to health education or preventive counseling services or programs.
- Furnish, at the discretion of the member, advance care planning services.

When completing an HRA:

- Collect self-reported information from the member. You or the member can complete the HRA before or during the AWV; this should take no more than 20 minutes.
- Account for and tailor your instruction to the communication needs of underserved populations, persons with limited English proficiency, and persons with low health literacy.
- At minimum, address the following topics:
  - Demographic data.
  - Self-assessment of health status.
  - Psychosocial risks.
  - Behavioral risks.
  - Activities of daily living (ADLs), including but not limited to dressing, bathing, and walking.
  - Instrumental ADLs, including but not limited to shopping, housekeeping, managing medications, and handling finances.

The following HCPCS codes can be used for the AWV:

- G0438 — Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
- G0439 — Annual wellness visit; includes a personalized prevention plan of service (PPS), subsequent visit.

Top 10 most expensive chronic diseases for health care payers

According to the CDC, the following chronic diseases are the top 10 most expensive for health care payers to treat. This can be attributed not only to direct medical costs, but also to indirect causes such as lost productivity[1].

1. Cardiovascular diseases — $317 billion per year.
2. Smoking-related health issues — Over $300 billion per year.
3. Alcohol-related health issues — $249 billion per year.
4. Diabetes — $245 billion per year.
5. Alzheimer's disease — $236 billion per year (plus an estimated $223.1 billion in unpaid care).
6. Cancer — $171 billion per year.
7. Obesity — $147 billion per year.
8. Arthritis — $128 billion per year.
9. Asthma — $56 billion per year.
10. Stroke — $33 billion per year.

As a dual eligible special needs plan (D-SNP), AmeriHealth Caritas VIP Care Plus serves a membership who rely on both Medicare and Medicaid. This population is typically more sick and frail than the general Medicare population. Fifty-five percent of dual eligible members have three or more chronic conditions, among other needs, such as the need for social services[2]. Care coordination for members who must navigate the health care system to address their multiple chronic conditions is key to both improving health outcomes and reducing expenditures. To support these members, we provide:

- A Care Manager for each member to help them access needed services and ensure the integration of these services, including primary, acute, and behavioral health care.
- A comprehensive health assessment conducted on at least an annual basis.
- An individualized care plan that includes both health-related and personal goals as well as the appropriate steps to reach those goals.

Sources:

[1] https://healthpayerintelligence.com/news/top-10-most-expensive-chronic-diseases-for-healthcare-payers

[2] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, 2008

Alleviating patient fears and stress

Not all people who are anxious or worried about their health have an underlying medical condition. One study[1] categorized patients into four groups: the truly healthy (*I am healthy and I know it*), the health evaders (*I am dying and I know it*), the health illusionists (*I am dying and I deny it*), and, of course, the worried well — constituting a fifth of patients — who are well, yet worry about their health unnecessarily. The key to managing the worried well is increased patient engagement and increased patient education. Not only does improved communication with patients very reliably increase patient satisfaction, it also increases compliance and adherence to treatment[2].

For example, sometimes when a healthy patient is referred to see a specialist, they may sense or feel that there is urgency, when in fact the situation may be routine, such as a routine colonoscopy with a gastrointestinal specialist. Setting expectations by explaining the referral isn't an urgent matter and that it may take a few weeks before an appointment can be scheduled may help alleviate a patient's fear and concern. There may also be situations when assisting a patient in scheduling an appointment may help reduce their stress.

Sources:

[1] The Oxford Health Plans Workplace Wellness Survey

[2] https://www.theguardian.com/commentisfree/2013/oct/11/healthcare-anxiety-doctors-non-beneficial-treatments

Discussing diet and exercise with your patients

Exercise and healthy eating are key elements of disease prevention and health promotion. Exercise has been shown to reduce the risk of many chronic illnesses, including cardiovascular disease, hypertension, diabetes, obesity, and osteoporosis; to reduce anxiety and stress; and to improve the chances of continued independent living in later life. Research shows that communication regarding weight loss and healthy lifestyles between a provider and patient improves health outcomes, patient satisfaction, patient-provider relationships, and treatment adherence. However, one survey showed that only 38 percent of respondents reported frequently receiving advice from their providers on diet and only 42 percent on exercise[1].

This lack of communication may be due to providers having inadequate training in nutrition science or in counseling patients on healthy lifestyle changes. Despite this, providers can play an important role in helping solve their patients' weight problems by talking to them. Sometimes this can be a difficult subject to discuss, so here are some tips on how to talk to patients about their weight:

- Screen patients by calculating their BMI. Explaining to them what BMI means can often get the conversation started naturally.
- Be non-judgmental, but direct, factual, and compassionate.
- Try motivational interviewing to elicit a patient's desires and goals.
- Learn about nutrition science and how to simplify it for your patients.
- Build strong relationships with dietitians and refer patients to them for treatment that is covered by the patient's insurance.
- Be a role model by practicing a healthy lifestyle and share your personal experiences.
- If you don't already, start cooking; then you can convey how healthy meals can be delicious and easy to prepare!

Sources:

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2278358/
https://www.hsph.harvard.edu/ecpe/teaching-patients-about-healthy-lifestyle-behaviors-communication-is-the-first-step/

Nationwide scam involving faxed prescriptions

Be aware of a nationwide scam in which fraudulent prescriptions are faxed to providers for authorization. Read on for steps you can take to identify and report suspicious authorization requests for new or refill prescriptions.

Background:

Telemarketing companies are calling patients and asking for the names of their PCPs. They use this information to generate unnecessary prescriptions for the patient. Then, posing as a pharmacy, they fax these fraudulent prescriptions to PCPs. The prescriptions appear to come from a legitimate pharmacy and may appear to be requests for patients to receive new medications or refills. The provider is asked to authorize the prescription by signing and returning it. This can result in patients actually receiving unnecessary medication.

Certain medications and medication types tend to be targeted. Common requests include:

- Topical pain-relief creams, especially for quantities greater than 300 grams (e.g., lidocaine or diclofenac sodium gel).
- Over-the-counter topical pain creams repackaged in kits (e.g., a livixil pak: lidocaine 2.5 percent, prilocaine 2.5 percent, and bandages).
- Diabetic supplies, often in quantities of 100 (e.g., test strips, ultrathin lancets, or alcohol prep pads).

However, because the list of targeted products changes frequently, it is not enough to focus only on certain types of medication. Instead, examine requests you receive for telltale signs that they could be fraudulent.

Red flags:

Be especially on guard when you receive prescriptions:

- By paper fax.
- From a pharmacy in a different state from where the patient lives.
- Written for just below the threshold requiring prior authorization.
- For new medication for a patient.

Action needed:

- Pay special attention to prescription requests you receive by fax, as well as requests you have not initiated.
- Before signing and returning any prescription requests, reconcile the request with the patient's medical record to ensure the medication is appropriate and necessary.
- Share this information with the appropriate staff at your practice or in your organization.
- Reinforce to your patients the message we are sharing with our members: discouraging them from sharing personal health information if someone they don't know contacts them by phone.
- Report questionable prescriptions you have received to our Fraud Tip Hotline at **1-866-833-9718**, or by email to **fraudtip@amerihealthcaritas.com.**

90-day prescriptions

Studies show that patients who obtain 90-day prescriptions have higher rates of medication adherence. In addition, waste is comparable to patients getting 30-day prescriptions, but there is an increased savings overall for 90-day prescriptions[1].

AmeriHealth Caritas VIP Care Plus offers a 90-day prescription benefit for both mail-order and retail prescriptions and encourages you to write prescriptions for chronic and long-term conditions for 90-day supplys. To confirm if a drug is covered under the 90-day benefit, please check our online formulary, which indicates the drugs available under this benefit.

Source:

[1] CMS MMRR2012_002_03_A04 - Medication Days' Supply, Adherence, Wastage, and Cost Among Chronic Patients in Medicaid

Reminder to use claims modifiers 25 and 59 appropriately

As a reminder, append the appropriate modifiers to the HCPCS/CPT code when performing a service or separate, distinct, or independent procedure on the same day that a procedure or other service is performed.

- **Modifier 25 is used to indicate that, on the day of a procedure or other service identified by a CPT code, the patient's condition required a significant, separately identifiable evaluation and management service aside from the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.**
- **Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day.**

CMS has adopted modifiers and guidelines for documenting and billing multiple services or procedures performed on the same dates of service. AmeriHealth Caritas VIP Care Plus has created a provider reference manual with guidance, examples, and modifiers to assist your practice in correctly billing for services where modifiers 25 or 59 are used. The AmeriHealth Caritas VIP Care Plus guide to appropriate use of claims modifiers can be found at **www.amerihealthcaritasvipcareplus.com** under Provider Resources. Additional resources from CMS and the American Medical Association (AMA) on the appropriate use of modifiers are found below.

Assessing usage of appropriate modifiers

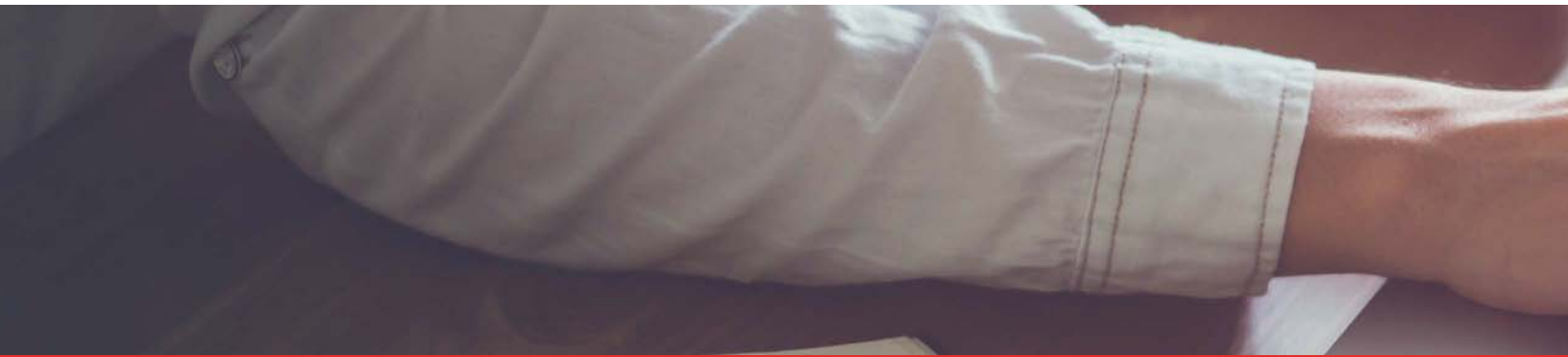
- AmeriHealth Caritas VIP Care Plus follows CMS guidelines on the appropriate use of modifiers, and is therefore conducting an assessment of claims containing modifiers 25 and 59 for appropriate use.
- Claims reviews may occur when high use of modifiers 25 and 59 by individual providers, groups, or facilities is detected. Providers will be notified and educated if inappropriate use of modifiers is found.

Action needed:

- Share this notice and training manual with your billing or practice management staff.

Reminders and resources:

- Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers.
- Providers should familiarize themselves with CMS guidance on the use of appropriate modifiers:
  - Modifier 59 article: **www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf.**
  - The Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.6, regarding the use of CPT modifiers, pages 36 and 49: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.**
  - Chapter 1: General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services: **www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.**
  - HCPCS Level II Coding Procedures: **www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/HCPCSLevelIICodingProcedures7-2011.pdf.**



Using your CLIA ID when filing claims

To ensure the accuracy, reliability, and timeliness of patients' test results, CMS requires that virtually all laboratories, including provider office laboratories, meet applicable federal requirements and have a Clinical Laboratory Improvement Amendments (CLIA) certificate to operate.

As a reminder, providers that perform laboratory testing must indicate their CLIA ID number when submitting claims.

For electronic and paper claims, please enter your CLIA ID numbers in the fields indicated below:

- For the 837 professional electronic claim submission, please enter your CLIA ID number in Loop ID 2300, segment/data element REF2.
- For the CMS 1500 paper form, please enter your CLIA ID in field 23 (titled "prior authorization number").
- You do not need to indicate your CLIA ID number on institutional claims.

Please note that providers must ensure laboratory tests performed are within the scope of their certification and that they have a valid current CLIA number.

For additional information regarding CLIA, applying for or renewing a certificate, or assigned test complexity levels, please visit the CMS CLIA website at **www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html**.

Source:

[1] CMS.gov, August 2017, "CLIA Program and Medicare Laboratory Services" MLN Fact Sheet, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CLIABrochure.pdf.

Electronic funds transfers (EFTs)

EFTs allow you to receive your payments faster and more safely by sending them directly to a bank account you designate. We encourage providers with high claim volumes to sign up for electronic remittance advice (ERA) if they intend to receive EFTs. Utilizing both provides timely remittance information after the EFT payment arrives. Paper remittance advices will arrive via mail after the EFT payment. Please visit **www.changehealthcare.com/legacy/resources/enrollment-services/medical-hospital-enrollment** to access the EFT online enrollment forms.

New EFT enrollees: Under **Medical and Hospital Enrollment**, select **EFT Enrollment**. Select **EPayment Enrollment Authorization Form** to initiate a new enrollment process.

Existing EFT enrollees: Under **Medical and Hospital Enrollment**, select **EFT Enrollment**. Select **EFT Payer Add/Change/Delete Authorization Form** to add this plan to your existing EFT enrollment.

The phone number for online enrollment support is **1-866-506-2830**, option 1.

24-Hour Nurse Call Line

Your AmeriHealth Caritas VIP Care Plus patients can call our 24-Hour Nurse Call Line at **1-888-765-6375** to get help with urgent health concerns when your office is closed. The Nurse Call Line can help a patient find an urgent care clinic and arrange transportation. The Nurse Call Line number is also listed on the back of each member's ID card. Please remind your patients about this free service.

Social Security Number Removal Initiative (SSNRI)

The SSNRI is a CMS program to discontinue the use of SSNs from all Medicare fee for service ID cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare ID cards beginning in April 2018. Since our plan already uses a unique member ID number, there will be no change to our member's ID numbers. However, please note that if you are currently using the HICN on claims filed to our plan, after a transition period we will no longer be able to accept the HICN.

Report suspected fraud, waste, or abuse to AmeriHealth Caritas VIP Care Plus

Providers who suspect a AmeriHealth Caritas VIP Care Plus provider, employee, or member is committing fraud, waste, or abuse should notify the AmeriHealth Caritas VIP Care Plus Special Investigations Unit as follows:

- By phone at **1-866-833-9718**.
- By U.S. mail at:
  AmeriHealth Caritas VIP Care Plus
  Special Investigations Unit
  200 Stevens Drive
  Philadelphia, PA 19113

The AmeriHealth Caritas VIP Care Plus Special Investigations Unit supports the efforts of local and state authorities in the prosecution of reported cases of fraud, waste, and abuse. Reports of suspected fraud, waste, and abuse related to AmeriHealth Caritas VIP Care Plus may also be sent directly to the U.S. Department of Health and Human Services in one of the following ways:

- By calling **1-877-7SAFERX (772-3379)**.
- Online at **hhstips@oig.hhs.gov**.

Information may be left anonymously.

Important phone numbers

Provider Services: **1-888-667-0318**

Prior authorizations: **1-866-263-9011**
1-866-263-9063 (Fax)

Pharmacy Services: **1-855-327-0510**

Language Line: **1-888-667-0318**

- After hours: **1-855-843-1145**

Fraud, waste, 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**

Just for fun

Can you name nine common errors that can occur while obtaining a sitting blood pressure from a patient?

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

1)Patient's arm is unsupported; 2) Patient's back is unsupported; 3) Patient is talking; 4) Patient is engaged in active listening; 5) Wrong size cuff used ("miscuffing"); 6) Blood pressure cuff is positioned too low on the upper arm; 7) Cuff is over clothing; 8) Observer is not at eye level with the monitor; 9) Patient's legs are crossed

Source:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2911816/

Coverage by AmeriHealth First.

www.amerihealthcaritasvipcareplus.com

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A Newsletter for Providers

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