The Advantage

A Newsletter for Providers

Meet our new Medical Director

We are happy to introduce our new Medical Director, Dr. Gregory Busch.

Dr. Busch is a graduate of Philadelphia College of Osteopathic Medicine and is board certified in family medicine and geriatrics.

Dr. Busch started serving a diverse patient population at Philadelphia College of Osteopathic Medicine. As a physician, he focused on delivering patient-centered care before this became a recognized need in senior care. His emphasis on practical care of patients allowed him to achieve the best outcomes possible based on individual situations. He changed his career path 10 years ago focusing on health plans.

He began overseeing patient activities and ensuring that providers met their patients' needs in the community. Dr. Busch collaborated with faith- and community-based organizations to ensure that members were able to receive care where they lived and spent their time. Accessibility to health care was greatly increased due to these strategies.

Dr. Busch brings a wealth of knowledge ranging from having been a provider himself, through understanding how health plans and their communities can best serve their members.

www.keystonefirstvipchoice.com

Spring 2022

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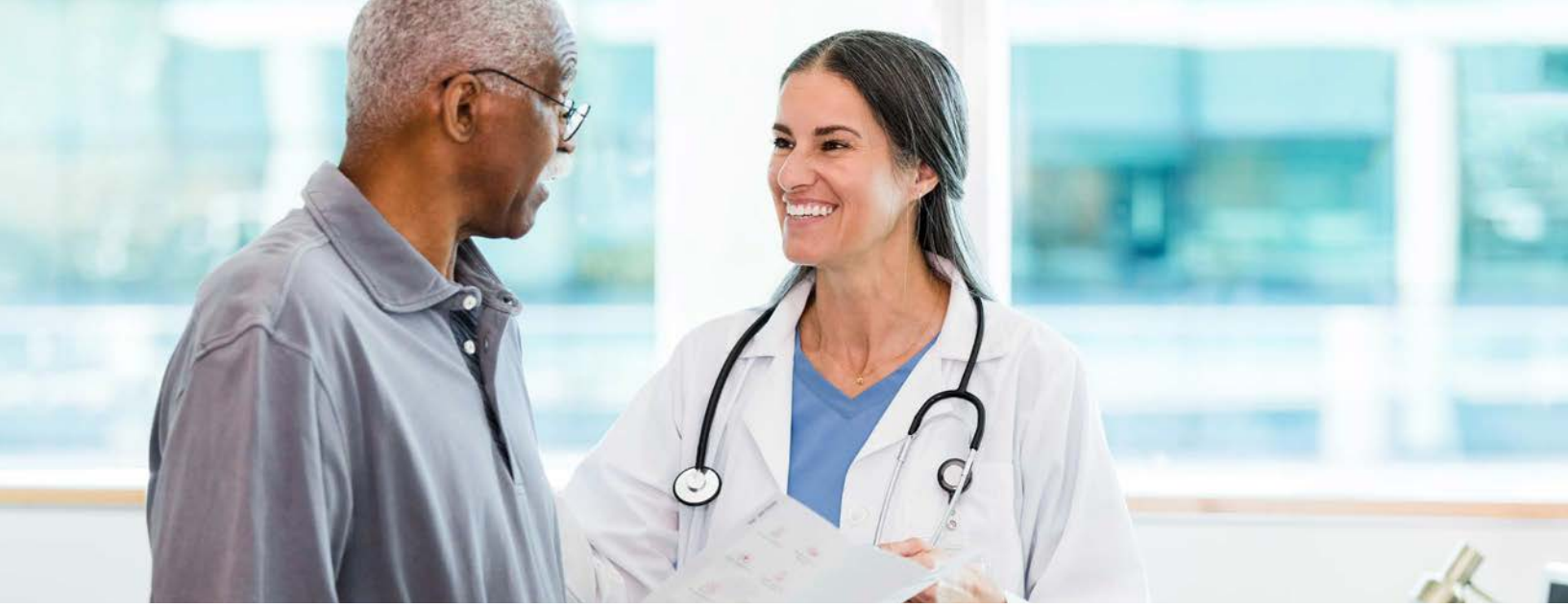
Keystone First VIP Choice®



Keystone First VIP Choice Nationally Recognized for Exceptional Commitment to Quality

Keystone First VIP Choice Medicare Advantage dual eligible special needs (HMO D-SNP) plan would like to announce that it has earned an overall 4.5 Star Rating (out of a possible five Stars) from the Centers for Medicare & Medicaid Services (CMS) for 2022. Keystone First VIP Choice earned this achievement through our commitment to providing quality benefits and services while focusing on social determinants of health.

"Keeping our members well can't happen without maintaining a robust provider network whose health care professionals care deeply for our members and stress the importance of regular exams," said Robert J. Smith, Keystone First VIP Choice's President. "Having our care managers and providers focus on the socioeconomic factors affecting our members has yielded exemplary results. The fact that our Star Rating increased even in the midst of a pandemic makes this accomplishment stand out even more."

"Star Ratings tell us about the quality of service we are providing and our plan responsiveness," said Tonya Moody, Keystone First VIP Choice's Vice President. "While the pandemic has been challenging for all of us, earning this score means we are excelling at helping our members get care and stay well, and that we are building healthy communities. Our integrated care model, quality management initiatives, and the relationships we have built in the communities we serve all contributed to our increased ratings."

CMS' nationally recognized quality rating system looks at Medicare Part C (health plan services) and Part D (drug plan services). CMS uses information from member satisfaction surveys, health plans, and health care providers to give overall performance Star Ratings to plans. The Star Ratings program emphasizes areas such as preventive medicine, early disease detection, customer service and benefits supporting chronic condition management. The program's goal is to raise the quality of care and strengthen protections for Medicare beneficiaries.

Keystone First VIP Choice Medicare Advantage dual eligible special needs plan scored four or five out of five Stars in 33 of 39 categories. Highlights include:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores were a particular area of strength in the areas of both Customer Service and Rating of the Health Plan, each earning five stars.
- Significant improvement was noted in the following additional areas:
  - Members' medication adherence for hypertension, cholesterol and diabetes
  - Call Center performance
  - The plans helped members stay healthy through increased colorectal screenings and flu vaccinations
  - Members' chronic conditions for rheumatoid arthritis and statin therapy for cardiovascular disease were better managed
  - Members got better quality care more quickly

Note: Every year, Medicare evaluates plans based on a 5-star rating system. Information in this notice is based on 2022 Star Ratings data published by CMS on October 8, 2021. Star Ratings are calculated each year and may change from one year to the next.

Balance Billing

Members of our plan are classified as Qualified Medicare Beneficiaries (QMBs), and therefore cannot be balance billed per Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This law prohibits Medicare providers from collecting Medicare Parts A and B deductibles, coinsurance, or copays from QMBs. 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.

To help providers better understand the coordination between Medicare and Medicaid payments and the balances that cannot be collected from a QMB, we have provided three example payment scenarios:

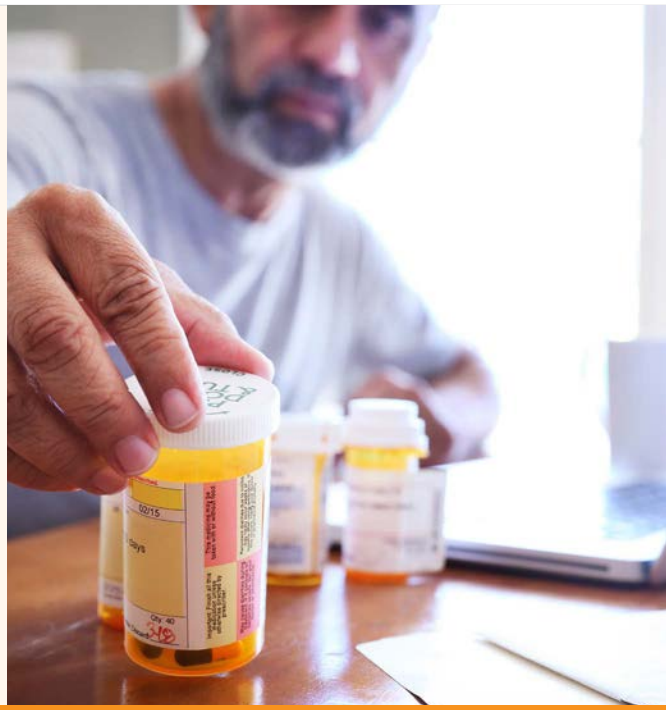
	Scenario # 1	Scenario # 2	Scenario # 3
Provider Charges	$150.00	$150.00	$150.00
Medicare Allowable	$100.00	$100.00	$100.00
Medicare Payable Amount	$80.00 (80%)	$80.00 (80%)	$80.00 (80%)
Medicare Cost-share	$20.00 (20%) sent to Medicaid for possible reimbursement	$20.00 (20%) sent to Medicaid for possible reimbursement	$20.00 (20%) sent to Medicaid for possible reimbursement
Medicaid Allowable	$75.00	$95.00	$110.00
Medicaid Payable Amount	$0.00 (Medicare paid more than Medicaid allowed so no additional payment can be made.)	$15.00 (Medicaid allowed more than the Medicare payable amount, so an additional payment may be made.)	$20.00 (Medicaid allowed more than the Medicare payable amount, so an additional payment may be made, but shall not exceed the Medicare allowable.)
Total Payable Amount between Medicare and Medicaid	$80.00	$95.00	$100.00
Provider Write-off	$70.00	$55.00	$50.00
Member owes	**$0.00**	**$0.00**	**$0.00**

90-Day Prescriptions

Studies show that patients who obtain 90-day prescriptions have a higher rate of medication adherence. In addition, wastage is comparable to patients getting 30-day prescriptions, but there is an increased savings overall for 90-day prescriptions1.

Keystone First VIP Choice 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 a 90-day supply. To confirm if a drug is covered under the 90-day benefit, please check our online **Drug List at https://www.keystonefirstvipchoice.com/apps/formulary/2022.aspx**, which indicates if a drug is not available under this benefit by displaying the following "NO MAIL" symbol:

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



HEDIS® Incentive Program

Keystone First VIP Choice would like to introduce our Healthcare Effectiveness Data and Information Set (HEDIS) Provider Incentive Program. This program provides compensation for reporting nonpayable CPT II codes, which help to satisfy HEDIS measures. Keystone First VIP Choice is excited about our provider incentive program and will work with your practice so you can maximize your revenue while providing quality and cost-effective care to our members.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your Provider Network Management Account Executive or our Quality department at **vipquality@amerihealthcaritas.com.**

HEDIS measure	Care for Older Adults (COA)		
• Medication review.	• Functional status assessment.	• Pain assessment.	
Code	**Type**	**Description**	**Payment**
1159F **1160F**	CPT II	Medication listed documented in medical record + (must be billed together) Review of all medications by a prescribing practitioner or clinical pharmacist and documented in the medical record	$25.00
1125F	CPT II	Pain severity quantified, pain present	$25.00
1126F	CPT II	Pain severity quantified, no pain present	$25.00
1170F	CPT II	Functional status assessed	$25.00

HEDIS measure	Controlling Blood Pressure (Select two, one systolic and one diastolic.)		
Code	**Type**	**Description**	**Payment**
3074F	CPT II	Most recent systolic blood pressure less than 130 mm Hg	$25.00
3075F	CPT II	Most recent systolic blood pressure 130 – 139 mm Hg	$25.00
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mm Hg	$25.00
3078F	CPT II	Most recent diastolic blood pressure less than 80 mm Hg	$25.00
3079F	CPT II	Most recent diastolic blood pressure 80-89 mm Hg	$25.00
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mm Hg	$25.00

HEDIS measure — Hemoglobin A1c Control for Patients with Diabetes

HEDIS measure	Hemoglobin A1c Control for Patients with Diabetes		
Code	**Type**	**Description**	**Payment**
3044F	CPT II	Most recent HbA1c is less than 7.0	$25.00
3046F	CPT II	Most recent HbA1c is greater than 9.0	$25.00
3051F	CPT II	Most recent HbA1c is equal to 7.0 – 7.9 (less than 8.0)	$25.00
3052F	CPT II	Most recent HbA1c is 8.0 – less than or equal to 9.0	$25.00

HEDIS measure — Medication Reconciliation Post-Discharge (after each inpatient discharge)

HEDIS measure	Medication Reconciliation Post-Discharge (after each inpatient discharge)		
Code	**Type**	**Description**	**Payment**
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record.	$25.00

How do I participate?

Provide the qualifying services to eligible members during regularly scheduled office visits.

Identify Keystone First VIP Choice members on your panel who require one or more of the eligible services. See "How can I identify eligible members?" below for instructions on completing this step. Schedule appointments with the identified members and provide the required eligible services.

Then submit a claim for the eligible services you provided with the appropriate CPT II codes by following your normal claim submission process. **It is that easy.**

How can I identify eligible members?

Eligible members are easy to identify. Members due for eligible services may be identified in NaviNet by going to **www.navinet.net** and following the steps below:

Primary care providers (PCPs)

- Care gap reports: Highlight the Report Inquiry option, then choose "Clinical Reports." Select the care gap report option available in the drop-down menu that best suits your needs.
- PCP performance report card: Highlight the Report Inquiry option, then choose "Administrative Reports." Select "PCP Performance Report Card" from the drop-down menu.

PCPs and other providers

- Member clinical summary: Highlight the Report Inquiry option, then choose "Member Clinical Summary Reports." Select "Member Clinical Summary."
- Under the Eligibility and Benefits option, search for a member. If the member has a missing care gap, you will get a pop-up alert. That member's clinical summary report is also accessible here.

Alternatively, PCPs may receive monthly quality score cards in the mail, or providers can request a list from our Quality Improvement department by email at **qualityahcvipcareplus@amerihealthcaritas.com.**

How are the supplements paid out?

Incentive payments are based on each eligible service submitted on a claim. Payments will be remitted just like any other claim you submit.

Are there other benefits?

Yes. Submitting the correct CPT II code helps inform us that you have provided the service, and may decrease the need for us to request medical records to review for this information to satisfy HEDIS measures.

How are members engaged to seek these services?

Keystone First VIP Choice members who need one or more of the eligible services may receive letters, recorded and live phone calls, and text reminders from the health plan encouraging them to contact their provider offices and schedule needed services.

Questions

If you have questions about this program, please contact your Provider Network Management Account Executive, Provider Services at **1-800-521-6007**, or Quality Improvement at **1-215-937-8115**.

Please note, correct coding and submission of claims is the responsibility of the submitting provider. Keystone First VIP Choice reserves the right to make changes to this program at any time and shall provide written notification of any changes.

www.keystonefirstvipchoice.com
Provider Services: 1-800-521-6007

HEDIS Diabetes Measure Changes

The HEDIS Diabetes Measure will no longer be bundled under the "Comprehensive Diabetes Care" measure. The Diabetes HEDIS measure is now comprised of four individual measures and can be reported using CPT or CPT II codes. Below are the codes that correspond to the results of each measurement.

Measure	HBD - Hemoglobin A1c Control for Patients with Diabetes	
Code	**Type**	**Description**
3044F	CPT II	Most recent HbA1c level < than 7.0%
3051F	CPT II	Most recent HbA1c level ≥ 7.0% and < 8.0%
3052F	CPT II	Most recent HbA1c level ≥ 8.0% and ≤ 9.0%
3046F	CPT II	Most recent HbA1c level > than 9.0%

Measure	KED - Kidney Health Evaluation for Patients with Diabetes – One code from each group (eGFR test and both uACR tests).		
Code	**Type**	**Description**	
80047	CPT	eGFR (blood test)	Basic metabolic panel (Calcium, ionized)
80048			Basic metabolic panel (Calcium, total)
80050			General health panel
80053			Comprehensive metabolic panel
80069			Renal function panel
82565			Creatinine; blood
82043	CPT +	uACR	Albumin; urine (eg, microalbumin), quantitative
82570	CPT	uACR	Creatinine; other source

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

Measure	EED - Eye Exam for Patients with Diabetes	
Code	**Type**	**Description**
2022F, 2024F, 2026F	CPT II	Primary care Physician Positive exam
3072F, 2023F, 2025F, 2033	CPT II	Primary care Physician Positive exam
S0620, S0621, S3000, 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218,67220, 67221, 67227, 67228 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242, 99245, 92201, 92202, 99243, 99244	CPT	Eye care professional only exam

Americans with Disabilities Act - Access to Medical Facilities

In 1990, President George H.W. Bush signed the Americans with Disabilities Act (ADA), which prohibited discrimination against individuals with disabilities in everyday activities. Title II and Title III of the ADA require hospitals and medical offices provide "full and equal access" to all health care services and places and make "reasonable modifications to policies, practices and procedures when necessary to make health care services fully available to individuals with disabilities."

Easy access to medical facilities is especially important for people with disabilities. Given that people with disabilities often have complex medical conditions that require more frequent visits to medical facilities, it is important for hospitals and medical offices to improve their accessibility. Medical facilities should offer some unique accommodations to make the practice and office ADA-compliant.

Standard Requirements:

- Designated handicapped parking spaces near facility
- Pull-up areas for vans and buses for drop-off
- Curb cuts in sidewalks and entrances
- Ramps, if needed
- Elevators, if needed
- Widened doorways for wheelchair or stretcher access
- Hallways with 36 inches of clear width
- Handrails along wall
- Toilet stalls with grab bars, raised toilet seat, and space to maneuver wheelchairs or other mobility aids
- Furniture arrangements to provide clearance for wheelchairs and other mobility aids

Exam Rooms: Not all exam rooms need to accommodate wheelchairs/stretchers/mobility aids, but at least one should meet the following requirements:

- Door width – 32 inches wide when door opened to 90 degrees
- 60 x 60 inch space for wheelchairs to turn around
- Exam table that can be to the height of a wheelchair seat (17- 19 inches) and has straps, handrails or cushions to provide support and safety
- 30 x 48 inch space next to exam table to allow patients to move from wheelchair to table
- Lift to move patients from chair to exam table
- Floor scale for wheelchairs

Disabilities not associated with mobility – vision, hearing

- TDD phone – Telecommunication for patients who are deaf
- Assistance by staff or other technology for reading and completing forms – patients who are blind or have low-vision:
  - Large print option available for forms, educational material, etc.
  - Audio tools for assistance with forms and educational materials
- "Accessible" or adaptive websites:
  - Add text to images
  - Allow for adjustment in font size
  - Allow for adjustment in contrast
  - Use audio descriptions if possible

According to the Centers for Disease Control and Prevention, approximately 61 million Americans (25%) have a disability that affects their day-to-day life.
These disabilities include:

- Mobility
- Cognition
- Hearing
- Vision
- Independent living
- Self-care (difficulty dressing, bathing, etc.)

As health care providers, these disabilities must be recognized and addressed. People with disabilities have a unique set of challenges that can significantly impact their health. Studies show that people with disabilities report:

- Poorer overall health
- Reduced access to adequate health care
- Health behaviors that impact their health, including smoking and physical inactivity

The medical profession is devoted to care for the ill, but often people with disabilities do not receive the same level of care as nondisabled people. Often, the health care system is not equipped to optimally care for people with disabilities or recognize the stigma associated with people with disabilities. Making medical facilities and practices more accessible to disabled people, and increasing awareness and understanding of this population at all levels of the health care system, will help remove some of the barriers and thus improve the health outcomes of this population.

Care for patients with disabilities is often more complex, requiring additional resources and increased coordination. Providing a higher level of care for this group will require improving training of providers, conducting more health research on people with disabilities, developing best practices, advancing technology, especially in the communication realm, and designing models of care for practices to develop the skills and capacity to meet the special needs of this population.

Healthy People 2020, a set of goals and objectives released by the U.S. Department of Health and Human Services every decade, has defined one of its goals: "to maximize health, prevent chronic disease, improve social and environmental living conditions, and promote full community participation, choice, health equity, and quality of life among individuals with disabilities of all ages." This is an ambitious, but important goal, as improving the health of individuals with disabilities will result in healthier communities with long-term and widespread benefits. Health care organizations and health care providers must lead the way by removing barriers and implementing practices that improve the health and wellbeing of people with disabilities.

For additional training resources, please visit the ADA.gov document "Access To Medical Care For Individuals With Mobility Disabilities" found at **https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm**. You may also visit our plan website at **www.keystonefirstvipchoice.com** under Training Modules, to access a module on Disability Competency.

https://www.cdc.gov/media/releases/2018/p0816-disability.html

https://www.cdc.gov/ncbddd/disabilityandhealth/people.html

https://www.cdc.gov/ncbddd/.../features/key-findings-community-prevalence.html

https://www.healthypeople.gov/2020/topics-objectives

https://www.ada.gov/medicare_mobility_ta/medcare_ta.htm

www.eeoc.gov/facts/heath_care_workder.html

https://www.ncbi.nih./gov/books/NBK11429

Medicare Advantage Risk Adjustment

What is risk adjustment?

Risk adjustment is an essential mechanism used in health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan.

Accounting for the health status of beneficiaries for payment purposes is called risk adjustment and is intended to ensure Medicare Advantage (MA) plans have adequate resources to reimburse providers treating MA beneficiaries, including individuals with complex chronic diseases.

In turn, MA plans rely on risk adjustment to maintain predictable and actuarially sound payments from the Centers for Medicare & Medicaid Services (CMS) in order to provide benefits to all enrollees.

Risk adjustment accounts for beneficiary differences by adjusting payments to the MA plan. Payments reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status.

What methodology is used for risk adjustment?

CMS pays MA plans on a per enrollee capitated basis for medical care and separately for prescription drug benefits. MA benchmark base rates are determined for each county and then are risk-adjusted by CMS for each enrollee to account for the cost differences associated with various diseases and demographic factors. In other words, CMS modifies the payments to MA plans to reflect the health of each beneficiary.

CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into **Hierarchical Condition Categories (HCCs)**. HCCs, together with demographic factors such as age and gender, are used to predict beneficiaries' total care costs.

Each January starts a "clean slate" for HCCs. A nonresolving chronic condition diagnosis (such as diabetes) must be reported on a claim denoting a face-to-face visit with an acceptable type of provider, in an acceptable setting, at least once during the calendar year. If it is not reported this is called "falling off" and the MA plan's payments from CMS would not accurately reflect the member's actual condition.

This system is prospective, which means it uses a beneficiary's diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.

How can this help beneficiaries?

Risk adjustment is much more than a regulatory requirement. It actually improves quality of care in several ways. Accurate identification of patient health status allows us to:

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

How can providers help?

- Providers should become familiar with the principles of risk adjustment and the impact it has on the health care system.
- Because risk adjustment is dependent on diagnosis coding, it is very important that all chronic, acute, and stable conditions are documented during each face-to-face encounter.
- All encounters should be submitted to the health plan and all diagnosis codes should be coded to the highest specificity.
- Document clearly and concisely how the conditions coded were assessed, monitored, or treated, or how they affected the patient's care or your medical decision-making during the visit.
- Make sure all medical record entries have a valid signature with credentials (e.g., "M.D.,") and dates for each encounter per CMS guidelines.
- Become familiar with standard coding principles for your specialty and make sure that all reported diagnosis codes are clearly supported in the medical record to survive audit scrutiny and avoid concerns of potential fraud.
- **Be prepared to quickly provide medical records to the MA plan when CMS does a Risk Adjustment Data Validation (RADV) audit. This is the process of verifying that diagnosis codes submitted for payment are supported by medical record documentation.**

Learn the advantages of using NaviNet

Did you know your office can check on the status of a claim, submit a claim investigation, access all our 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 on 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
- Submit a claim investigation request – **see details below**
- Access clinical and administrative reports, including care gaps and PCP panel reports – **see new Rollup Report feature below**
- Request prior authorizations
- Access links to provider tools and resources, including the provider directory and direct claims entry

If your practice is not registered with NaviNet, please consider registering. To register, please visit **http://www.navinet.net/** and sign up or contact your Provider Account Executive. Once registered you will automatically have access to all of the group/practice locations that fall under one Tax ID Number (TIN).

Claim Investigation Function

The ***Investigate*** icon located in the Claim Inquiry function lets you request an adjustment and track responses on claims that were previously finalized. For each submitted transaction, you will receive an electronic response to the claim investigation. The response will indicate if the claim was adjusted or details are provided explaining why the claim was not considered for an adjustment. We encourage you to utilize this claim investigation option; however, if you do not have NaviNet access, you can still contact Provider Services at **1-800-521-6007**.

A few **important** things to note before you submit your claim investigation:

- ✓ The claim investigation submission feature is only for finalized claims.
- ✓ Claim investigations are for individual claims.
- ✓ To receive notification of the status of your submitted investigation, ***Notifications*** in NaviNet must be enabled. Enabling notifications allows you the option to select how often and when you want to be notified.

After you complete and submit your claim investigation, you will receive a message in NaviNet that the transaction was received, indicating it was successfully submitted. Once the claim review has been completed, you will be notified through NaviNet that a claim response is available. Responses can be expected within 10 business days.

Step-by-step video instructions, called Claims Investigation, can be found on NaviNet Plan Central.

New RollUp Reports

We have enhanced NaviNet to give providers the capability to run certain reports on a "RollUp" basis. Instead of having to run a report for each of the Provider ID numbers that may exist for your group, you can now run **ONE** report with data consolidated for the practice at the TIN level. The specific reports that can be run at the RollUp TIN-level are:

Administrative Reports

- Claims Status Summary RollUp
- Panel Roster Report RollUp

Clinical Reports

- Admit Report RollUp
- Care Gap Query RollUp
- Discharge Report RollUp

To create a RollUp report in NaviNet:

1. Under **Workflows for this Plan** on Plan Central, select **Report Inquiry**.
2. Select either *Administrative Reports* or *Clinical Reports*.
3. Select the specific report you would like to run.
4. Select ANY of the "Group Name – PIN" options available in the **"* Choose a Provider Group"** drop down menu.
5. Click **Search**.

Prior Authorization Tips

- **Need to know if a procedure requires prior authorization or not?** Use our new CPT lookup tool found in the Provider>Resources>Prior Authorization section of our website.
- **Faxing an authorization?** Use our new Optical Character Recognition Prior Authorization Form found in the Provider>Resources>Prior Authorization section of our website.
- **Using NaviNet to request authorizations?** Remember to include your contact information in the **"Notes"** section in case we need to get in touch with you.
- **Need a peer-to-peer review?** Be sure to let the Clinical Care Reviewer know during their initial outreach. During that outreach, the Reviewer will notify you the request does not meet medical necessity criteria and will be pended to the Medical Director for determination. The peer-to-peer must occur before the decision is rendered by the Medical Director.

Are you receiving faxes from us?

Faxing, it is how we communicate with our provider community. Our plan sends faxes regarding plan/contractual updates and changes, new or updated billing guidance, general information, and quality/bonus initiatives. If you are not receiving faxes from us, you may miss something important that you need to know, so please reach out to your Account Executive or use the secure contact form found on our website under Contact Us to provide us your fax number.

Results from the 2021 Provider Satisfaction survey

We would like to extend a sincere thank you to all the practices that participated in the 2021 Provider Satisfaction survey. We value your insight and appreciate the time you took to participate in the survey. The results are being analyzed. We will reinforce areas where you identified that we do well, and we will develop action plans to address areas that were identified as needing improvement.

While we are still delving into the data, we are pleased that our continued collaboration and partnership with our providers is reflected in the percent of providers that felt we were achieving good-to-excellent ratings in the following categories:

- 82 percent in overall Satisfaction
- 73 percent in overall Provider Relations/Network Management satisfaction.
- 68 percent in overall Claims Reimbursement/Issue Resolution Process.
- 77 percent in overall Care Management process
- 79 percent in overall Utilization Management process.
- 72 percent in takes physician input and recommendations seriously.
- 75 percent would recommend our plan to other providers.
- 77 percent would recommend our plan to other members.

While we rate closely to other Medicare Advantage Dual Special Needs plans, we certainly want to continue to reinforce that we are here to support you in the care of our members. We will strive to improve in all individual areas. We look forward to working with you to address these issues and welcome your ideas and comments. We encourage you to share them through the secure form found under Contact Us on our website or with your Account Executive.

Secure Protected Health Information (PHI)

Protecting confidential and proprietary information is the responsibility of every provider, his or her staff, and our plan. In order to help minimize the risk of inadvertent disclosure when sending personal health information (PHI) to our plan, consider the following guidelines:

1. Send all electronic communication through a secure connection.
2. If your office does not have a way to send secure emails:
   - ✓ Opt not to send an email, but instead contact Provider Services or your Account Executive.
   - ✓ Use the ***"Secure Form"*** found under the ***Contact Us*** section of our website to reach out to us.
   - ✓ Consider signing up with a secure email service. There are both free and pay options available.
   - ✓ If you have to email, do not transmit any PHI. For example, if you are checking on a claim, all we need to look up a claim is the claim number. There is no need to send any member identifying information. We will reply to you securely and this will then allow you to reply to us securely.

And let us know if you receive PHI from the plan in an unsecured manner so that we can follow up as necessary.

Help us keep the Keystone First VIP Choice provider information updated

Accurate provider information is critical to ensuring member access to their health care services. ***Members rely on provider directories to locate in-network providers and we rely on you to inform us of changes***.

Keystone First VIP Choice is committed to removing access to care barriers. Inaccurate information, such as the following can prevent members from accessing care:

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

Other consequences of inaccurate provider information include:

- Payment made to the wrong provider.
- Misstatement of provider network access and availability.

Please confirm the accuracy of your information in our online provider directory, so our members have up-to-date resources. Please note:

- Providers must submit written notice of changes to Keystone First VIP Choice.
- Changes should be submitted on the ***Keystone First VIP Choice Provider Change Form*** located:
  - On our website: **www.keystonefirstvipchoice.com** under ***Provider>Resources***

  or

  - Directly at this link: **Provider** Change Form

Completed change forms may be submitted by the any of the following methods:

Fax: **1-215-937-5343**

Mail: Keystone First VIP Choice
Provider Network Management
200 Stevens Drive
Philadelphia, PA 19113

If you have any other questions, contact your Keystone First VIP Choice provider account executive.

CMS guidelines for Medicare Claims Processing and Benefits

Providers often ask us how they should submit claims to us or if we cover a certain service. As a general rule, we follow CMS claims processing guidelines, so you should submit claims to our plan just like you would to Medicare Fee for Service. As far as Medicare benefits are concerned, if Medicare Fee for Service covers a service, then we also cover it. We also offer additional services that original Medicare doesn't cover, so if you have a question about a benefit please reach out to our Plan.

Medicare Annual Wellness Visit (AWV)

We wanted to remind you that the Medicare Annual Wellness Visit (AWV) is not your typical physical exam; rather it is an opportunity for the primary care provider and health care team to perform screenings and immunizations, manage chronic conditions, and provide education and counseling about preventive services on an annual basis. The visit allows the health care team to talk about issues that are not part of a problem-focused visit and learn about social determinants of health that may be affecting your patient's well-being.

Since it is not a typical physical exam, it should not be coded as one. Please remember to use the appropriate coding for AWVs (Initial - G0438 or Subsequent – G0439). Reporting AWVs is not only in helping our plan to meet certain quality metrics – it has the added benefit to our members of qualifying them to be rewarded with a gift card for completing their AWV.

Claim Disputes vs Appeals

Claim Disputes

A claim dispute is a request from a provider for Keystone First VIP Choice to review and reconsider a payment amount made by Keystone First VIP Choice. Providers may dispute full or partial payments made by Keystone First VIP Choice if the provider disagrees with Keystone First VIP Choice's payment amount. Examples of circumstances that may giverise 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 Keystone First VIP Choice 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 the payment. Requests for a claims dispute may be submitted by calling Provider Services at **1-800-521-6007** or **in writing within 180 calendar days from the date of the initial remittance advice** from Keystone First VIP Choice using the Provider Claims Dispute form, which is available on our website. If the form is not used you must include the following:

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

Mail your claims dispute to:
Keystone First VIP Choice
Claims Processing Department
P.O. Box 7143
London, KY 40742-7143

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.

Claim Appeals

Contracted providers may only appeal claim denials as the member's authorized representative. Participating providers appealing on the member's behalf must complete the Appointment of Representative form found in the Member section under Appeals and Grievance at **www.keystonefirstvipchoice.com**. See section VI of the Provider Manual, Member Grievances and Appeals, for more information.

Model of Care Annual Training Requirement

Keystone First VIP Choice'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 their 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. All participating providers are also required to undergo annual Model of Care training and attest the training was completed. This required training can be accessed in any of the following ways:

- In person from a training seminar or a Network Management Account Executive.
- Access an online interactive Model of Care training or PDF module on our website, **www.keystonefirstvipchoice.com**, under the Provider Training and Education link.
- Review printed or faxed Model of Care materials.

Providers can attest to receiving the training by completing the **Online Survey Attestation**.

Important Contact Information

Provider Services:	**1-800-521-6007**
Prior Authorizations:	**1-855-294-7046**
	1-855-809-9202 (Fax)
National Imaging Associates, Inc. (NIA)	**1-866-272-4086**
	www.radmd.com
Quality Department:	**1-215-937-8115**
Fraud and Abuse Hotline:	**1-866-833-9718**
NaviNet:	**1-888-482-8057**
Change Healthcare Electronic Services:	**1-877-363-3666**
Electronic Claims Payer ID Number:	**77741**

Claim Correspondence (paper claims/disputes):

Keystone First VIP Choice
Claims Processing Department
P.O. Box 7143
London, KY 40742-7143

24-hour Nurse Call Line

Your Keystone First VIP Choice 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 for urgent care needs and arrange transportation. The phone number is also listed on the back of each member's ID card. Please remind your patients about this free service.

The Advantage

A Newsletter for Providers

Spring 2022

COVERAGE BY **VISTA HEALTH PLAN, INC.**
Independent Licensee of the Blue Cross and Blue Shield Association

www.keystonefirstvipchoice.com

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