Provider Newsletter

pa health & wellness | ambetter. from pa health & wellness | wellcare By allwell.

Winter 2023, Volume 14

Benefits of Positive Patient Experience

Patients that experience a positive encounter while at their provider's office are more likely to provide feedback, resulting in benefits and advantages for that office. When patients feel like their time is valued, their health is important, and they have a trusting relationship with their doctor, they are more likely to visit regularly. Here are some of the benefits of a positive experience:

Patient Loyalty & Trust – Positive experiences are predicated on patients feeling heard and trusted. Positive experiences make the patient more likely to return and ultimately lead to enhanced continuity of care.

Improved Health Outcomes – Built on loyalty and trust, continuity of care provides the doctor the opportunity to better treat the patient. Greater familiarity of specific symptoms, side effects, etc. all enable patient care and support adherence to treatments and prescribed medications that drive positive outcomes.

Potential for New Patients – When a patient has a positive experience with their doctor, they are more likely to recommend that doctor to other individuals seeking care. Word of mouth is often highly influential in helping build a practice and increasing revenue.

Patient Experience | Tips for Improvement

Getting Needed Care

- Coordinate urgent appointments with the appropriate office(s)
- Encourage patients to register and view results through the patient portal (where available)

Scheduling Appointments & Care Quickly

- Maintain a triage system and consider leaving a few appointment times available each day to ensure high risk patients are prioritized and seen quickly or provide alternate care (e.g., phone, urgent care center)
- If a patient is requesting to be seen as soon as possible but their doctor is unavailable, refer the patient to a nurse practitioner or physician assistant
- Be mindful to make every patient interaction as positive as possible
- If there is an extended wait time, actively keep patients informed and offer the patient the opportunity to reschedule

Care Coordination

- Prioritize appointments for patients who have recently been discharged from a hospital or facility
- Ask all pertinent questions to ensure awareness and obtain and review records from hospitals/other providers
- Request that patients bring in a list of their medications for each visit
- Request EMR access to allow for timely coordination of care

Rating of Health Care

- Encourage patients to schedule their routine appointments or follow up visits as soon as they can
- Train all office staff to be courteous and empathetic
- Be mindful and respectful of all patients
- Provide clear explanations for treatment and procedures – make sure to use language the patient will understand
- Spend enough time with the patient and do not rush them to ensure all concerns have been addressed

Active Listening Tips

- **Be present** in the conversation with your patients
- Utilize **good eye contact** to show your interest and attention
- Ask **open ended questions** to encourage your patients to provide further context and additional details
- **Paraphrase and read back your patients' main points** to ensure a full understanding

For additional tips and resources to improve patient experience, visit http://www.cahpsprovider.com/provider.

‹ , ‰ ŒŽ Œ‘ • „ „ Ž'• ‰

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

Physician Certification Form

This form is intended for the sole use of the individual or entity to whom it is addressed and contains protected health information (PHI) subject to provision under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). Providers may not submit false information to obtain authorization to furnish services or items under Medical Assistance.

PATIENT NAME:	
PATIENT ADDRESS:	
PATIENT SSN:	PATIENT DATE OF BIRTH:

DIAGNOSIS

Please list all diagnoses with ICD codes related to patient's need for care. Please ensure that you include diagnoses of brain injury and/or developmental disability if present.

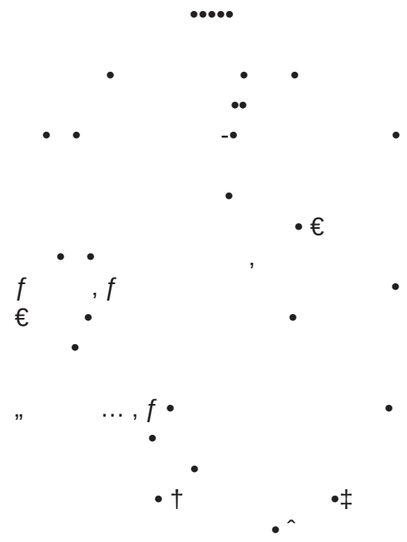
ICD 10 CODE:	PHYSICIAN DIAGNOSIS:

• •• ••• • -• € , ƒ „ … „ † ‡ˆ ‰Š

‰ŠŠ•••• • • Š Š
, Š • Š ‹Œ• ‹† ‹€ •

• •• •
• , ƒ • Ž •
‘ • ‘ •
•

‰ŠŠ•••• • • Š Š
, Š • Š ‡ ‡ €†‡' ‡ˆ •



What do I need to do now?

Community HealthChoices | pa health & wellness

PA Health & Wellness (PHW):
An authorization is not a guarantee of payment - the Participant must be eligible at the time services are rendered. PHW will not reimburse services that a Participant is not eligible to receive. This has been a requirement since the implementation of the Community HealthChoices (CHC) program, and it remains in place.

PHW Providers must verify Participant eligibility before every service is rendered. Use one of the following methods:

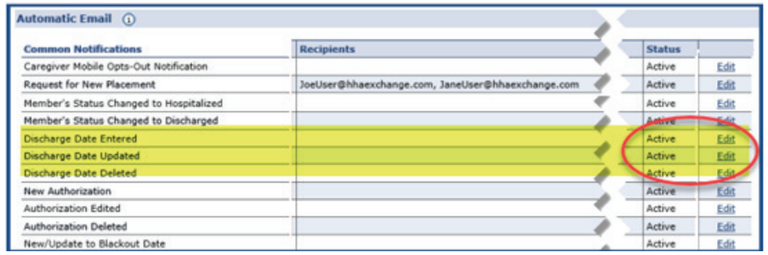
1. Pennsylvania's **PROMISe™ Eligibility Verification System (EVS).** (PROMISe™ Internet or by telephone 800-766-5387).
2. **Log on to our Secure Provider Web Portal** at www.pahealthwellness.com.
3. **Call our automated participant eligibility IVR system:** 1-844-626-6813.
4. **Call PHW Provider Services:** 1-844-626-6813.

HHAeXchange

1. **HHAeXchange:**
Be sure you're receiving PHW updates timely regarding eligibility changes, edited authorizations or added discharged dates, etc.

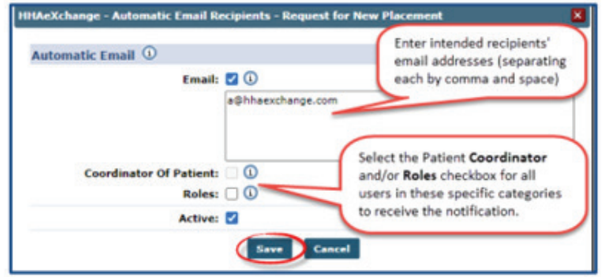
PHW will add a discharge date to the Participant's authorization(s) in HHAX upon notification of loss of Medical Assistance eligibility. Be sure to enable automatic emails to be alerted to a discharge date being entered, updated, or removed.

Automatic Email - The Automatic Email feature facilitates system-generated automatic emails triggered by specific functions performed in the system for Members. The Automatic Email library of Common Notifications includes a diverse number of notification emails created according to functionality and business needs. Notifications can be set up by those who are Administrators.



2. Verify that your automatic email notifications are set up to reach the correct individuals at your organization.

Adding and Editing Email Notification Recipients: To add specific intended recipients, click the edit link corresponding to the applicable Common Notification such as Authorization Edited (as shown in the image below). Users may select specific recipients and/or recipient groups (e.g., Member Coordinator and Roles).



HHAeXchange complete Admin Functions Process Guide can be located here: https://s3.amazonaws.com/hhaxsupport/SupportDocs/PROE+Docs/Process+Guides/Provider+Process+Guide+-+Admin+Functions.pdf

Questions?

1. Contact PHW Provider Services by calling 1-844-626-6813.
2. Send us a message securely in HHAeXchange.
3. Contact Provider Relations at phwproviderrelations@pahealthwellness.com

Stay tuned for upcoming communications and webinars on PHE Ending as well as other topics: **https://www.pahealthwellness.com/providers/provider-training.html**

To receive our latest updates by email, subscribe to our communication distribution list by emailing: **providertraining@pahealthwellness.com**

YOUR PARTNER IN BETTER HEALTHCARE

WE'RE ON A MISSION TO BE YOUR PAYER OF CHOICE.

As the #1 carrier on the Affordable Care Act's Health Insurance Marketplace, Ambetter Health plans target a consumer population of lower income, previously uninsured individuals and families who, prior to having health insurance, may have been eligible for Medicaid or were otherwise unable to access care due to financial challenges.

Partnering with Ambetter Health provides an opportunity for you to access a previously untapped consumer population by providing coverage to those who qualify for generous premium and cost-sharing subsidies.

Since launching in 2014, Ambetter Health has been very successful in attracting and retaining our target population, and we continue to focus on engaging and acquiring these subsidy-eligible consumers through:

- ✓ **Network Design**: Focusing on partners that are in our members' communities.
- ✓ **Incentive Programs**: Incentivizing healthy behaviors with rewards that members find valuable, such as allowing members to earn money toward premiums or copays by completing activities like getting their annual wellness checks.
- ✓ **Outreach and Marketing**: Performing meaningful outreach and educating consumers and providers on the covered benefits of health insurance.

Why It Matters

The Ambetter Health plan design philosophy is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own. Our products focus on various cost shares – many with low or no copay amounts – to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.

(continued)

Additionally, the emphasis on reducing barriers and improving access to care mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter Health's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service. Most importantly, Ambetter Health plans encourage members to establish relationships with their primary care providers to achieve favorable outcomes.

Targeted Population

Target Ambetter Health consumers are low income (100-250% of the federal poverty level), are currently or recently uninsured, and are typically the parents of children who are covered by the Children's Health Insurance Program (CHIP). In many cases, target Ambetter Health consumers are former Medicaid recipients whose annual income now exceeds the maximum level set for qualification.

Plan Offerings

Ambetter Health offers plans at the Bronze, Silver, and Gold tiers. This allows consumers to select plans based on what is important to them, whether it is low monthly premium payments or low out-of-pocket expenses. While Ambetter Health offers plans at all three tiers, our focus is on the Silver tier, specifically at cost share reduction (CSR) levels. At the Silver tier, members can qualify for both CSR and advanced premium tax credits (APTC) based on their annual household income.

Network Offerings

By offering increased product options for our members, Ambetter Health also benefits providers by giving them exclusive access to potential patient populations. These networks* include:

- **Gold / Silver / Bronze:** The Ambetter Health core network, our broadest network of healthcare providers and hospitals.
- **Select:** A tailored network built around exclusive agreements with health systems and their providers. PCP referrals for specialist care not required.
- **Value:** A tailored network of providers and hospitals. Members are required to get a referral from their PCP for specialist care.
- **Virtual Access:** A network of specialists and hospitals that includes virtual primary care for members over the age of 18. Members may be required to get a referral from their PCP for specialist care.

**The availability of product options varies by market.*

Healthy behavior is rewarding.

Since most of our members were previously uninsured, we've built a unique incentive program that rewards members for healthy behaviors. Members can earn rewards for:

- Completing an online well-being survey ($50)
- Getting their annual wellness exam ($50)
- Other healthy activities

Reward dollars can be used to pay out-of-pocket costs like copays, deductibles, or monthly premium payments. ***These reward dollars, combined with our low-cost-share plan designs, should greatly reduce the efforts of providers to collect Ambetter Health cost share versus our competitors.***

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Why is the IET Measure Important?

Many people living with a physical health condition also have co-occurring mental and substance use related disorders and may not realize it or are not seeking help. Together with early detection and a whole person, integrated treatment approach we can help our members stop or reduce harmful substance misuse, improve health outcomes and overall quality of life.[1]

What is the IET Measure Looking At?

This measure assesses the percentage of members ages 13 and older with a new episode of substance use disorder (SUD) who received the following:

1. Initiation of SUD Treatment. The percentage of members who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
2. Engagement of SUD Treatment. The percentage of members who initiated treatment and who were engaged in ongoing SUD treatment within 34 days of the initiation visit.

What is Included?

- Medicaid, Medicare, and Marketplace members age 13+
- New SUD Episodes between November 15 of the year prior through November 14 of the current measurement year
    - Includes episodes diagnosed by primary care providers (PCP) and other non-behavioral health providers

What is Excluded?

- SUD episodes that occurred during the 194 days prior to the new SUD episode date
- Methadone not included on the medication lists for this measure
- Members in hospice or who died during the measurement year

What Can You Do to Help?

- Provide empathic listening and nonjudgmental discussions to engage the patient and caregivers in decision making and a relapse prevention plan.
- Offer virtual, telehealth and phone visits when appropriate.
- Use evidence-based screening and treatment as recommended by SAMHSA.
- Consider Medication Assisted Treatment (MAT) options for patients with alcohol or opioid use disorder and maintain appointment availability.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships (AA, NA, etc.), or other community support groups.
- Reach out proactively within 24 hours if scheduled appointment is not kept to schedule another.
- Provide integrated/coordinated care between the physical and behavioral health providers to address any comorbidity.
- Reinforce the treatment plan and evaluate any medication regimen considering presence/absence of side effects etc.
- Partner with the health plan to address social determinants, health equity, and quality care.
- Provide timely submission of claims and code substance related diagnosis and visits correctly.

How is IET Adherence/Compliance Met?

- Initiation of SUD treatment is met when the member initiates treatment for SUD through an IP SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment event within 14-days of the SUD episode.
- Engagement is met when the member has (any combination of) two SUD visits or medication treatment events on the day after the initiation encounter through 34 days after.
    - Two visits can occur on the same day if by different providers.
    - A visit and a medication event can occur on the same day by the same provider.

***ICD-10 Diagnosis Codes**		
Substance Use Disorders: F10.XX – F19.XX (excludes remission codes)		
****CPT, HCPCS, and Rev Codes**		
Inpatient Stay: 0100-101, 0110-114, 0116-124, 0126-134, 0136-144, 0146-154, 0156-160, 0164, 0167, 0169-174, 0179, 0190-194, 0199-204, 0206-214, 0219, 1000-1002	**Observation:** 99217-99220	**Medication Assisted Treatment:** H0033, J0570-J0575, J2315, Q9991, Q9992, G2077, G2080, G2086-87 **Withdrawal Management (Detox):** H0008-H0014
Outpatient Unspecified: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99251-99255	**BH Outpatient:** 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99483, 99492-99494, 99510	**Substance Use Disorder Services:** 99408-99409, G0396-G0397, G0443, H0001, H0005, H0007, H0015-H0016, H0022, H0047, H0050, H2035-H2036, T1006, T1012
Telephone: 98966-98968, 99441-99443	**Online (virtual)Assessment:** 98969-98972, 99421-99423, 99444, 99457, G0071, G2010, G2012, G2061-G2063	**Partial Hospitalization/Intensive Outpatient:** G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484-S9485

POS Visit Codes:		
Outpatient: 03, 05, 07, 09, 11-20, 22, 33, 49-50, 71-72	**Community Mental Health Center:** 53	**Partial Hospitalization:** 52
Telehealth: 02	**Non-residential SUD Facility:** 57, 58	

Additional Support:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  www.samhsa.gov
- Provider Clinical Support Systems (PCSS)
  www.pcssnow.org

We are committed to the care and wellbeing of our members. We are also committed to working with you as a partner to develop the best possible treatment plans for all patients.

Please view the Provider section of our website <HEALTH PLAN PROVIDER WEBSITE URL> for additional tools and local resources or contact a Provider Relations or Quality Improvement Specialist for assistance.

References:

1. SAMHSA: https://www.samhsa.gov/co-occurring-disorders
2. NCQA: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment

HEDIS Every Minute...Every Day
Working Together for Better Care

HEDIS is a comprehensive set of performance measures that evaluates the quality of care provided by healthcare organizations. It helps us assess and improve the effectiveness of our services, ensuring that our members receive the highest standard of care.

During the HEDIS season, we collaborate with you, our valued providers, to collect and report the necessary data to meet these quality measures. Here's what you need to know:

1. **Importance of HEDIS:** HEDIS serves as a vital tool to assess and compare the quality of care provided by different healthcare organizations. By participating in HEDIS, we can identify areas for improvement and work together to enhance the health outcomes of our members.
2. **Focus on Preventive Care:** HEDIS places significant emphasis on preventive care, including vaccinations, cancer screenings, and annual well visits. These measures help us identify opportunities for early intervention and improve overall health outcomes.
3. **Chronic Disease Management:** HEDIS also evaluates how well chronic conditions, such as diabetes, hypertension, and asthma, are managed. By closely monitoring and managing these conditions, we can help our members lead healthier lives and prevent complications.
4. **Collaboration for Success:** Your partnership is vital to the success of HEDIS. We appreciate your efforts in ensuring accurate and timely reporting of data, which enables us to evaluate the quality of care provided and implement necessary improvements.

During the HEDIS season, you may receive communications from us regarding data collection, reporting requirements, and any additional support we can provide. We value your input and encourage open communication to address any questions or concerns you may have.

Rest assured that all data collected and reported during the HEDIS season is handled securely and in compliance with all relevant healthcare regulations. We prioritize the privacy and confidentiality of our members and providers.

Thank you for your commitment to delivering quality care to our members. Together, we can make a significant impact on improving health outcomes and ensuring an exceptional healthcare experience.

Should you require any further information or have any questions about HEDIS or any other aspect of our collaboration, please do not hesitate to contact Dawn Blake, HEDIS Operations Manager at Dawn.Blake@PAHealthWellness.com.

We appreciate your partnership and look forward to another successful HEDIS season.

HEDIS

Osteoporosis Management in Women

The HEDIS® measure, Osteoporosis Management in Women Who Had a Fracture (OMW) identifies women 67-85 years of age who suffered a fracture to determine if they had follow-up for possible osteoporosis. This measure identifies if they received one of the following services in the six months after the fracture.

- A Bone Mineral Density Test (DEXA Scan).
- A prescription for a drug to treat osteoporosis.

At PHW we recently began a program to assist you in closing the gaps for this measure. On a monthly basis we pull a report identifying any women with a new fracture. A PHW representative then contacts the involved provider office by phone and fax to notify them of the date that the patient suffered the fracture and the date when the gap is due to be closed (within 6 months of the date of the fracture). Hopefully, this program will assist you in identifying those members that need follow-up. If you have any questions or would like additional information you may contact Shannon Bedortha at sbedortha@pahealthwellness.com.

Transitions of Care

The HEDIS® measure, Transitions of Care - Medication Reconciliation Post-Discharge (TRC-MRP) is a measure that requires evidence of medication reconciliation within 30 days of discharge. PHW's HEDIS Team performs year-round review of medical records to close HEDIS gaps for TRC-MRP as well as numerous other HEDIS measures. These reviews are performed for open gaps not closed by claims data.

We want to make sure that you are aware that the Medication Reconciliation gaps can be easily closed with the appropriate claims information. When a patient is seen for hospital follow-up and medication reconciliation occurs the **CPT II code of 1111F will close the TRC-MRP gap** if the visit is within 30 days of discharge. If this gap is closed by claims information this will eliminate the need for medical record review and will reduce the burden to you and your staff.

At Wellcare by Allwell, we want to help our members get the care they need, when they need it. That means everything from routine care and screenings to dental, vision, and much more.

Depending on the member's plan, covered benefits may include:

- Dental exams, cleanings, x-rays, dentures & implants
- Vision exam & eyewear allowance
- Hearing exams & hearing aids
- Wellness & Fitness Programs with gym member-ships & home fitness kits
- Transportation Services to medical appointments
- Telehealth Visits via Teledoc available 24x7

Plus, new for 2024...

Wellcare Spendables™

New for 2024, the Wellcare Spendables™ card helps members extend their coverage where they need it most. This easy-to-use card combines benefits into one card, helping members get the most value out of their plan. Members can use the card at participating retailers, online, via mobile app, or by phone.

- Over-the-Counter (OTC) Health Products
- Healthy Foods
- Gas (pay-at-pump)
- Hearing, vision, & dental out of pocket expenses
- Rent and utilities assistance

EXPRESS SCRIPTS®

In 2024, Wellcare will partner with Express Scripts Pharmacy to bring increased value to our members by providing high-quality pharmacy benefits at the lowest cost.

- We have a large network of pharmacies. Members can save money by using a preferred pharmacy.
- Mail Order Delivery is a convenient service that delivers up to a 100-day supply of medication directly to the member. Express Scripts Pharmacy can even automatically refill and renew home-delivery prescriptions at no extra cost. Members can call 1-833-750-0201 (TTY: 711) 24 hours a day, seven days a week. Or visit express-scripts.com/rx.

We offer a range of plans that provide members with affordable access to doctors, nurses, and specialists:

Plan Types:	Dual Eligible Special Needs Plan (HMO and PPO D-SNPs)	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)
Plan Names:	H2915-002 Wellcare Dual Access H2915-007 Wellcare Dual Access H2128-005 Wellcare Dual Access Open	H2915-003 Wellcare No Premium H2915-011 Wellcare Assist H2915-013 Wellcare Patriot Giveback H2915-016 Wellcare No Premium	H2128-002 Wellcare No Premium Open H2128-004 Wellcare Giveback Open

As always, Wellcare by Allwell is committed to working with you to ensure your patients receive the best care.
If you have any questions, please visit our website www.wellcare.com/allwellPA or contact us at:
Wellcare By Allwell Medicare Provider Services
HMO, PPO: 1-800-977-7522 (TTY:711)
HMO, PPO D-SNP: 1-844-796-6811 (TTY:711)

The Medicare Health Outcomes Survey (HOS) and Provider Impact

The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure used in Medicare managed care. The objective of the HOS is to assesses member's physical and mental health status over times, as well as measuring effectiveness of care.

The HOS is administered annually to a random sample of Medicare beneficiaries drawn from each participating Medicare Advantage plan (i.e., a baseline survey is administered to a new cohort, or group, each year). Two years later, these same respondents are surveyed again (i.e., follow up measurement).

Providers can significantly impact the way that member's respond to the HOS questions. Here are some tips that can be incorporated into your practice:

HOS Measure	Questions	Tips for Success
Monitoring Physical Activity	• In the past 12 months have you discussed level of exercise or physical activity with a doctor or other health provider • In the past 12 months did a doctor or health provider advise you to start, maintain or increase physical activity	• Discuss patient's level of activity during visits and encourage patients to start, maintain or increase physical activity. • Ask your patient what types of activities they enjoy. • Recommend activities based on physical abilities and interests.
Improving Bladder Control	• In the past 6 months have you experienced leaking of urine? • In the past 6 months how much did leaking of urine change your daily activities or interfere with your sleep? • Have you ever talked with a doctor, nurse, or health provider about leaking of urine? • Have your ever talked with a doctor, nurse, or health provider about managing urine leakage problem?	• Ask patient if they experience issues with leaking of urine. • If leaking of urine is interfering with daily life, establish a plan of care and recommend options for treatment.
Reducing the Risk of Falling	• In the past 12 months did you talk to a doctor or health provider about falling, problems with balance or walking? • Have you experienced a fall in the past 12 months? • In the past 12 months, did you experience a problem with balance or walking? • Has your doctor done anything to help prevent falls?	• Conduct falls risk assessments with patients to identify recent falls and problems with balance. • Provide recommendations to help reduce falls and assess if DME items may be needed (walker, cane, etc.). • Encourage home safety to ensure items in the home will not hinder mobility. • Review medications to ensure patient is aware of medications that might cause falls.

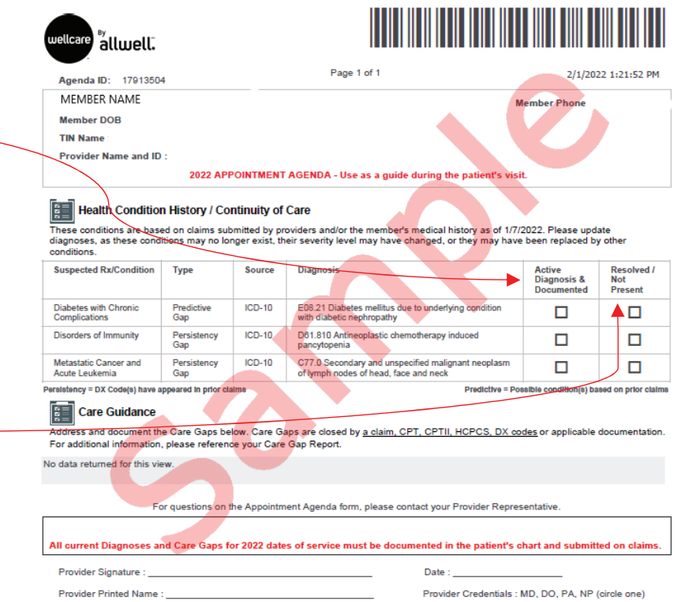
CoC (Continuity of Care)
A basic guide to reviewing and submitting appointment agendas

CoC HCC Validation

- Providers should schedule and conduct a comprehensive exam with the patient, assessing the validity of each condition on the appointment agenda.
- Submit the signed appointment agenda
  - AND submit the same diagnosis code in the medical claim
  - OR gap addressed by checked exclusion box in the dashboard

✓ 'Active Diagnosis & Documented'
- Patient is currently presenting with this condition. Provider must submit a claim with a diagnosis code that maps to this Disease Category listed on the agenda.

✓ 'Resolved/Not Present'
- Patient is not presenting with this condition. Provider must submit a claim with a 2022 face-to-face visit and should submit appropriate diagnosis codes for conditions the patient is currently presenting.


wellcare By allwell.

Agenda ID: 17913504 Page 1 of 1 2/1/2022 1:21:52 PM

MEMBER NAME Member Phone
Member DOB
TIN Name
Provider Name and ID :

2022 APPOINTMENT AGENDA - Use as a guide during the patient's visit.

Health Condition History / Continuity of Care

These conditions are based on claims submitted by providers and/or the member's medical history as of 1/7/2022. Please update diagnoses, as these conditions may no longer exist, their severity level may have changed, or they may have been replaced by other conditions.

Suspected Rx/Condition	Type	Source	Diagnosis	Active Diagnosis & Documented	Resolved / Not Present
Diabetes with Chronic Complications	Predictive Gap	ICD-10	E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy	☐	☐
Disorders of Immunity	Persistency Gap	ICD-10	D61.810 Antineoplastic chemotherapy induced pancytopenia	☐	☐
Metastatic Cancer and Acute Leukemia	Persistency Gap	ICD-10	C77.0 Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck	☐	☐

Persistency = DX Code(s) have appeared in prior claims Predictive = Possible condition(s) based on prior claims

Care Guidance

Address and document the Care Gaps below. Care Gaps are closed by a claim, CPT, CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your Care Gap Report.

No data returned for this view.

For questions on the Appointment Agenda form, please contact your Provider Representative.

All current Diagnoses and Care Gaps for 2022 dates of service must be documented in the patient's chart and submitted on claims.

Provider Signature : _____ Date : _____

Provider Printed Name : _____ Provider Credentials : MD, DO, PA, NP (circle one)

ALL conditions must be addressed for the agenda to be complete

Contact Information

- PHW will manage the bonus calculation, reconciliation, and payment processing.
- You may also email or fax paper agendas or patient charts to
  - PHWAgenda@pahealthwelleness.com
  - Fax: 1-844-918-0782 S Line: CoC

Questions?

- Want to know more information? We here at PHW have created a step-by-step guide for CoC provider portal navigation in the below link
  - https://www.pahealthwellness.com/providers/risk-adjustment.html
- At the bottom of this page, you will find Risk Adjustment tools and resources
  - Click “CONTINUITY OF CARE/HCC ACCURACY PROGRAM”
  - In this section, you will find a PDF with our Continuity of Care Provider Presentation with detailed instructions and images to aid in your agenda submissions.

Clinical Documentation Improvement (CDI) Upcoming Webinars

Learn more about: Risk Adjustment Documentation and Coding

Each webinar includes an overview of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs). ***To register,*** *please click on the link next to the webinar you would like to attend.*

2024 CMS Model and ICD-10 Updates

- Jan 16, 2024 @ 10AM | https://centene.zoom.us/meeting/register/tJ0uf-usrzgpGtx6TUrMFGlSMYm3iNc-aXsy
- Jan 17, 2024 @ 12noon | https://centene.zoom.us/meeting/register/tJEqc-qppjgsHNc1F0AlMFejQ9K_tKatjNog
- Jan 18, 2024 @ 5PM | https://centene.zoom.us/meeting/register/tJAkdeCtrTloG9UYWE4UWP2TE0YkQ_UXMwZ7
- Jan 19, 2024 @ 2PM | https://centene.zoom.us/meeting/register/tJ0sdeCuqz4uGN0BzaltbOjRRrwNAADaRjY1
- Jan 23, 2024 @ 10AM | https://centene.zoom.us/meeting/register/tJEqfuCgrD8jG93jfCHOhlRzNtQ6MGqEh4hu
- Jan 24, 2024 @ 12noon | https://centene.zoom.us/meeting/register/tJlqdO2hqDouHNzQ_I3zG4dI3CZtecvbXtTS
- Jan 25, 2024 @ 6PM | https://centene.zoom.us/meeting/register/tJMpdu-sqjorHNebSk4lUP-yUva1a-jLrKnu
- Jan 26, 2024 @ 3PM | https://centene.zoom.us/meeting/register/tJYucuCspj8jHtR9Zit-q1hnnWYIZvb21Owl
- Jan 30, 2024 @ 10AM | https://centene.zoom.us/meeting/register/tJItcOitrzIpGNzMf3O2qtXfXyABvPqFbQBO
- Jan 31, 2024 @ 1PM | https://centene.zoom.us/meeting/register/tJApcOCoqD4uGNOj-NgWh15WNWPNNO8UMilF

Provider Updates

Full Time Equivalent Form (PDF)

Physician Certification Form (MA 570) Completion Reminder (PDF)

Medicare Part B Step Therapy Provider Notification Effective January 1, 2024 (PDF)

Important Pharmacy Claims Processing Change, Effective January 1, 2024 (PDF)

Express Scripts FAQ (PDF)

Provider Notification Optum CPI AMISYS Phase 5 (PDF)

Please visit https://www.pahealthwellness.com/providers/provider-updates.html **to view all recent Provider Updates.**

Fraud, Waste and Abuse

There are several things, as a Provider, that can be done to reduce and mitigate the risk of False Claims Act liability. Making sure there is an understanding of the rules that relate to the services and good being billed. The information included in claims should always be as accurate and complete as possible. It is also important to ensure there is awareness of any potential billing problems. Below are resources related to Fraud, Wase, and Abuse:

FALSE CLAIMS ACT:

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the Government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying Government property from an unauthorized officer of the Government
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit:
https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd032207att2.pdf

STARK LAW:

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies.

For more information regarding the Stark Law, please visit:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

ANTI-KICKBACK STATUTE:

The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally-funded programs.

For more information regarding the Stark Law, please visit:
https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

Reporting Fraud, Waste and Abuse

If you suspect fraud, waste, or abuse in the healthcare system, you must report it to PA Health & Wellness and we'll investigate. Your actions may help to improve the healthcare system and reduce costs for our participants, customers, and business partners.

To report suspected fraud, waste, or abuse, you can contact PA Health & Wellness in one of these ways:

- PA Health & Wellness anonymous and confidential hotline at **1-866-685-8664**
- Pennsylvania Office of Inspector General at **1-855-FRAUD-PA (1-855-372-8372)**
- Pennsylvania Bureau of Program Integrity at **1-866-379-8477**
- Pennsylvania Department of Human Services **1-844-DHS-TIPS (1-844-347-8477)**
- Mail: Office of Inspector General, 555 Walnut Street, 7th Floor, Harrisburg, PA 17101
- Mail: Department of Human Services, Office of Administration, Bureau of Program Integrity, P.O. Box 2675, Harrisburg, PA 17105-2675

You may remain anonymous if you prefer. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, corporate law department, market medical directors or senior management).

Meeting appointment accessibility standards

Are your patients able to obtain services when they are needed?

PA Health & Wellness monitors the availability of our network practitioners. Availability is key to participant care and treatment outcomes.

PA Health & Wellness follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. We monitor compliance with these standards annually and use the results of monitoring to ensure adequate appointment availability and reduce the unnecessary use of emergency rooms.

Please review the appointment availability standards in the Provider Manual.

1. CHC & Medicare:
https://www.pahealthwellness.com/providers/resources/forms-resources.html

2. Marketplace:
https://ambetter.pahealthwellness.com/provider-resources/manuals-and-forms.html

Medical Necessity Appeal

Providers or Participants may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing:

Mail to:
PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd, Suite 200
Mechanicsburg, PA 17055

Email: PHWComplaintsandGrievances@PAHealthWellness.com

Phone: 844-626-6813 TTY: 711

NOTE: PHW will not accept data stored on external storage devices such as USB devices, CD-R/W, DVD-R/W, or flash media.

Overpayment Refund Submission

When needing to submit a refund check for claims overpayments checks should be made payable to PA Health & Wellness. The submission should also include a list of the claims that were overpaid.

Mail to:
PA Health & Wellness
P.O. Box 3765
Carol Stream, IL 60132-3765

Provider Newsletter

Winter 2023

pa health & wellness™ | ambetter. FROM pa health & wellness™ | wellcare By allwell™

1700 Bent Creek Blvd, Suite 200, Mechanicsburg, PA 17055