



AmeriHealth Mercy Participating Provider Orientation

Leading America
in health care solutions
for the underserved



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Mission Statement

We help people:

Get care

Stay well

Build healthy communities

We have a special concern for those who are poor.

I. Who We Are

- **AmeriHealth Mercy Health Plan is a Medical Assistance (Medicaid) managed care health plan serving more than 100,000 Medical Assistance recipients in 15 counties. The counties in the Lehigh/Capital area and Northeastern Pennsylvania served by AmeriHealth Mercy are Adams, Berks, Carbon, Cumberland, Dauphin, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Monroe, Northampton, Perry, Pike and York Counties.**
- **Headquartered in Harrisburg, Pennsylvania, AmeriHealth Mercy Health Plan is a mission driven health care ministry of the Sisters of Mercy. Our corporate parent partners are Mercy Health System and AmeriHealth First.**
- **Our plan offers members an extensive provider network of physicians, specialists, pharmacies and hospitals. In addition, members receive many benefits and services.**
- **AmeriHealth Mercy Health Plan is a member of the AmeriHealth Mercy Family of Companies, the largest organization of Medicaid managed care plans in the United States. Touching the lives of 6.5 million members, the AmeriHealth Mercy Family of Companies is an industry leader in Medicaid, State Children's Health Insurance Programs (SCHIP), and other publicly funded insurance programs.**

AmeriHealth Family of Companies



The AmeriHealth Mercy Family of Companies

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II. Member Information

Enrollment

Eligibility is determined by the Pennsylvania State Department of Public Welfare (DPW)

- **Benefit Consultants**

 - **Lehigh Capital Zone 1-800-440-3989**

 - Assist recipients in the selection of an HMO and PCP

 - Educate recipients on plan benefits, referral system, and provider network

 - Notifies DPW of plan selection

 - DPW notifies AMHP of member's plan and PCP selection

Rights & Responsibilities

Member Rights and Responsibilities/Complaints, Grievances and Appeals

- Refer to the Provider Manual and to the Member Handbook for detailed instructions
- The Provider Manual is available on the Provider Center at www.amerihealthmercyhp.com

Cultural Competency

DPW defines Cultural Competency as:

The ability of individuals to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations

- Communication is the first step in establishing a physician-patient relationship
- If an AmeriHealth Mercy member requires or requests translation services because they are either non-English or limited English speaking, or the member has some other sensory impairment, the provider has a responsibility to make arrangement to procure translation services for those members, and to facilitate the provision of health care services
- Providers who are unable to arrange for translation services contact Member Service (1-888-991-7200)

Cultural Competency

Title III of the American with Disabilities Act (ADA) states that public accommodations, including healthcare provider sites must comply with basic non-discrimination requirements that prohibit exclusion, segregation, an unequal treatment of any person with a disability

Health Literacy

- Health literacy is the ability to communicate with members in a way that is easy for them to understand and act upon
- Members with both high and low reading levels can have limited knowledge of health care resulting in low health literacy
- Low health literacy is a growing problem and difficult to detect with no outward signs
- Members with low health literacy tend to be less compliant, which leads to lower quality of life and higher health care costs
- Low health literacy leads to problems with understanding:
 - ✓ Physician instructions
 - ✓ Consent forms
 - ✓ Medical brochures
 - ✓ Instructions for medications

Health Literacy

Strategies to improve health literacy:

- Build Relationships
 - ✓ Take patient's values and preferences into account
- Ensure Understanding
 - ✓ Use plain, everyday words or pictures that are clear
 - ✓ Provide easy-to-read health materials
 - ✓ Encourage dialogue about diagnosis or medications to determine comprehension

Eligibility

Verify eligibility in 8 ways:

1. Member's ID card and PA Access card

2. Panel Listing

3. NAVINET

Internet address is <https://navinet.navimedix.com/Main.asp> - complete the sign in fields (username and password)

4. PROMISe Online

Internet address is <http://promise.dpw.state.pa.us/> and click on PROMISe Online

5. EVS Software

MA HIPAA-Compliant PROMISe Ready Software is available free-of-charge by downloading from the OMAP PROMISe website at: <http://www.dpw.state.pa.us/omap/> Select Provider Information from the available links and then select Eligibility Verification Information. To order on CD-ROM, call 1-717-975-4100--there will be a \$19.95 shipping & handling charge.

Eligibility (cont'd)

6. POS Card Swipe Devices

Consult DPW website (<http://www.dpw.state.pa.us/>) for approved PROMISe compliant POS boxes under Approved 270/271 Eligibility Software and Service Vendors. Please contact these vendors for pricing and availability

7. PA State Medical Assistance EVS Telephone Line

1-800-766-5387 (Must use new 13-digit provider number)

8. AMHP Provider Services Eligibility Hotline

1-800-521-6007 24 hours/7 days

Available Benefits

Members are eligible for the benefits covered under their Program under the Pennsylvania Department of Public Welfare's Medical Assistance Program subject to the limitations set in the AMHP Co-Pay Schedule.

Description of Benefits

Self-referred Benefits

- All OB and GYN visits
- Ambulance - Emergency use only
- Dental –Members receive dental benefits (benefits based on DPW eligibility) through DentaQuest
- Vision –Members receive routine eye exams through Davis Vision
 - Eyeglasses and contact lenses are covered for members

Benefits (Continued)

- Family Planning Covered by AmeriHealth Family Planning. All family planning claims should be mailed to:

AmeriHealth Mercy Family Planning
P.O. Box 8369
Philadelphia, PA 19101

For questions, call 1-800-541-4560

- County-specific Mental Health/Substance Abuse
- Durable Medical Equipment (DME)
 - Less than \$500 billed – prescription only
 - Over \$500 billed – authorization required
1-877-693-8271, ext 83465 to Prior Auth DME

•Benefits (Continued)

- Hospitalization
- Home Health, Skilled Nursing, Rehab and Hospice Care
 - Covered with an authorization
- Laboratory Services
- Specialty Care Services
- Rehabilitation Services

Benefits (Continued)

- Pharmacy

- Formulary

- Generic – NO COPAY!

- Brand Name – \$3 copay (requires Letter of Medical Necessity when generic is available)

- Non Formulary – requires Prior Authorization

- Over-the-Counter Medications (OTC)

- List of covered OTC medications is provided in the drug formulary

- Vitamins (some restrictions)

- Up to \$10/month per member

- Prior Authorization Form and Formulary may be found at

- <http://www.amerihealthmercyhp.com/pharmacy>

Benefits (Continued)

Injectable Medications (Member)

- Multi-source branded products, member injectables and non-formulary medications require prior authorization through AMHP pharmacy Direct line (215) 937-5015
- Formulary insulin products, EpiPen, haloperidol injection and fluphenazine injection do not require authorization

AMHP Pharmacy Hotline

- 1-866-610-2774, ask for Injectable Medicine Department
- Specific Prior Authorization forms for injectable products may be found at <http://www.amerihealthmercyhp.com/pharmacy>

III. Key Departments

Provider Services

1-800-521-6007

- 24 Hours/7 Days
- Request forms or literature
- Ask questions regarding policy and procedure

Patient Care Management

1-800-521-6622

- Monday to Friday, 8:00 am to 5:30 pm
- Prior Authorization
- Admission Notification
- Special Needs
- WeeCare

Prior Authorization

Procedures requiring prior authorization include, but are not limited to*:

- DME over \$500 billed per item
- Any services/products not listed on the MA fee schedule
- Elective hospital admissions
- Elective SPU services
- Home Health Care
- Skilled Nursing Facility
- Ambulance transportation (non-emergent)
- CAT Scans, MRI/MRA, PET Scans, Nuclear Medicine **contact NIA at 1-800-642-2602**

*Refer to the Provider Manual for complete listing

Provider Contracting

- AmeriHealth Mercy prides itself on having a provider representative available to you
- Provide on-site education, issue resolution, assists with credentialing
- AMHP uses the Council for Affordable Quality Health Care (CAQH) to streamline the data collection process for credentialing and recredentialing
- Access CAQH online at <http://www.caqh.org/> for fast and easy credentialing

If you prefer a paper credentialing process, send PA Standard Application credentialing information to:

AmeriHealth Mercy
ATTN: Credentialing
8040 Carlson Rd., Ste. 500 Park Drive
Harrisburg, PA 17112

Quality Management

- Insures that members receive the highest standard of care from providers
- Conducts periodic audits and surveys to ensure these standards are met (HEDIS)
- QI Program Evaluation available on the Provider Center of our website and is also available upon request

Special Needs

- Case Managers assist members identified as having special needs
- Anyone can be special needs
- Resolves problems/issues that members have while navigating the healthcare system
- Ensures each member's medical needs are met
- Referrals – Call: 1-877-693-8271, option 2

WeeCare

- Case manages pregnant members to access prenatal care and associated social services
- Referrals – Call: 1-877-364-6797
- Members may self-refer for OB care and GYN Care
- OB Care Provider must complete Obstetrical Needs Assessment Form and fax to AMHP within **5 business days** to be eligible for incentive payment
- Submit HCFA form to London, KY for incentive payment using code T1001-U9
- Diagnostic tests and pregnancy-related services, such as ultra sound, non-stress tests, childbirth education, and smoking cessation counseling, do not require a referral

WeeCare (Continued)

- Postpartum visits: Invoiced as individual visits (not included with delivery fee)
- Bill with CMS 1500 form using standard CPT codes
- Vaginal deliveries: one (1) postpartum visit
- C-section deliveries: two (2) postpartum home care visits allowed; requires no authorization

IV. Provider Information

Provider Office Standards

PCP's:

Scheduling Procedures

6 or less patients/hr/physician

Emergent Care

- Immediately or referred to ER

Urgent Care

- Within 24 hours

Routine Care

- Within 10 business days of member's call

Specialty Care Providers:

Scheduling Procedures

Emergent Care

- Immediately upon referral

Urgent Care

- Within 24 hours of referral

Routine Care

- Within 10 business days of referral

The Referral Process

- Electronic Referrals Submission and Inquiry are now available via NaviNet
- Paper Referral process is available
- Referrals are valid for 180 days
- Unlimited visits within the 180 days
- Specialty Care Provider can contact Provider Services to extend referrals past 180 days for up to 1 year by calling 1-800-521-6007

NaviNet Services

Services available on NaviNet (www.navinet.net)

- Eligibility and Benefits
 - ✓ Provides real-time past and current member eligibility information
- Claim Status
 - ✓ Check the status of submitted claims
- Referral Submission
 - ✓ PCPs can electronically submit a referral for real-time approval
- Referral Inquiry
 - ✓ PCPs, Specialists, hospitals and ancillaries can search, retrieve and print approved referrals stored in the system

NaviNet Services

- The Member Clinical Summary Report is a snapshot in time that contains the following data for a specific patient:

- ✓Demographic information (member and PCP)
- ✓Medications (filled within the past 6 months)
- ✓Chronic Conditions
- ✓Gaps in Care (based upon diagnosis compared to clinical recommendations)
- ✓ER Visits (within the past 6 months)
- ✓Inpatient Admissions (within the past 12 months)
- ✓Office Visits (within the past 12 months)

- This summary is provided either in a PDF format or as a CCD formatted file

Expanding a Referral

Specialist:

- Should call for expansion of diagnostic and treatment procedures
- Must be same specialist/group as in original referral
- Services must be related to the same episode/diagnosis of care as original referral
 - Referrals are expanded for 180 days at a time
 - May be expanded for up to 1 year

Reimbursement

- Specialists are reimbursed based on the MA fee Schedule
- The MA fee schedule is on the DPW website:
- http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/S_001967
- Access the MA Web site if you have questions regarding CPT coding

Outpatient Lab Services

- AMHP contracts with its participating hospitals and Quest Laboratory to provide outpatient laboratory services. If no lab is designated on the member's ID card, any other participating laboratory may be utilized
- Laboratory draws (36415 and associated draw codes) are not eligible
- No referral is required; only a script from requesting physician is needed
 - Includes STAT and PAT's

Emergency Care Policy

- Members have direct access to ER
- Prior auth is not required for emergent services
- Non-emergent care should be provided in the physician office, and not referred to the ER

V. Payment Process

Claims Submission and Processing

- Bill office visits and services on a CMS1500 or electronically
- Must be submitted within 180 days from date of service (or 60 days from receipt of primary EOB). Resubmissions within 365 day from date of service
- To be set up to bill electronically call EDI at 1-877-234-4272 (AmeriHealth Mercy uses Emdeon)

Resubmission of Claims

Resubmitted/Corrected Claims

- Mark claim as “Corrected Claim” using black ink
- Resubmit within 365 days of the date of service
- Mail to claims address with “Corrected Claim” clearly marked on outside of envelope
- Do not mix corrected claims with new submissions
- AMHP does not accept handwritten claims
- Both professional and institutional corrected claims can be submitted via EDI

Appeals Process

- Administrative
 - Incorrect claims payment
 - Timely filing
- Medical
 - Denials based on medical necessity
 - Prior authorization denials
 - Please refer to Appeals Policy

Coordination of Benefits

- AMHP is always the payer of last resort
- Must be submitted as a hardcopy claim
- Submit claims involving COB within 60 days of receipt of primary carrier's remittance with the following:
 - Claim form
 - Primary carrier's EOB or Denial Notification (dates and dollars must match)
- Primary Insurer
 - Must follow requirements for both plans

Closing

Questions?