AmeriHealth Caritas Next

FirstChoice Next
A Product of Select Health of South Carolina, Inc.

CONNECTIONS

A Provider's Link to AmeriHealth Caritas Next and First Choice Next

Summer 2023

Table of Contents

NaviNet....2

Provider Data Intake Form (PDIF)....2

Provider credentialing rights....3

Timely filing of claims....3

Billing the member....4

Member rights and responsibilities....5

Prior authorization guidelines....6

Population Health program....7

Population Health program participation....8

Medical records requirements....9

Fraud, waste, and abuse....9

Provider Data Intake Form (PDIF)

Updating your provider information

Whether submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. When changing key provider demographic information, you are contractually required to notify us in writing with at least 30 days' advance notice.

Every 90 days, before the due date, you will be sent a reminder to verify that your provider data is accurate. You will have 30 days to attest to the accuracy of information or submit any corrections through the **Provider Data Intake Form** on NaviNet. Providers who do not respond in this time frame may be removed from our provider directory until they validate their data. This validation process is only used for our AmeriHealth Caritas Next and First Choice Next products. It does not apply to our Medicaid plans.

To review or update your provider information, follow these steps:

1. Log in to NaviNet.
2. Select the appropriate health plan.
3. Click the **Provider Data Information Form** link (in the upper left corner of the plan homepage).
4. On the **Provider Selection** screen, click the **Please Select a Provider** option. Select a provider and then submit.
5. You will be taken to the **Provider Self-Service screen**. In the bottom right portion of the page, click the box titled **Proceed to Provider Updates**.
6. Click the box titled **PDIF Update**.
7. Click **Location Selection**.
8. Click the box for the provider(s) for whom you want to attest and/or make changes. Click the **Next** box in the bottom right corner of the page.
9. Review and make changes to the provider summaries, if applicable.
10. Provide required documentation, if applicable.
11. Attest and click the **Next** box in the bottom right corner of the page.

Provider directory data changes will be reflected within the online provider directory within 14 business days. If the change is not shown in 14 business days, please contact your Provider Network Management Account Executive.

NaviNet

The NaviNet Provider Portal is an easy-to-use, secure platform that links providers to health plan members. Our Provider Portal at www.navinet.net allows you to share critical administrative, financial, and clinical information with AmeriHealth Caritas Next and First Choice Next, all in one place.

This tool can help you manage patient care through quick access to:

- Member eligibility and benefits information, including information for members in pending status
- Panel roster reports
- Care gap reports to identify needed services
- Member clinical summaries
- Social determinants of health information
- Admission and discharge reports
- Medical and pharmacy claims data
- Electronic submission of prior authorization requests

If you do not already use NaviNet to keep informed of your member accounts, you can register at www.navinet.net. All you need is a federal tax ID.

Provider credentialing rights

The criteria, verification methodology, and processes used by the plan are designed to credential and recredential providers in a nondiscriminatory manner, regardless of race, ethnic or national identity, gender, age, sexual orientation, specialty, or procedures performed.

During the review of the credentialing application, applicants are entitled to certain rights. Every applicant has the right to:

- Review the information submitted to support their credentialing application, except for recommendations and peer-protected information obtained by the plan.
- Correct erroneous information. When the Provider Services department receives information that varies substantially from the information the provider gave, the Provider Services department will notify the health care provider to correct the discrepancy.
- Make corrections in writing to the Provider Services department within 10 business days of identification. If the change is not reflected in 10 business days, please contact your Provider Network Management Account Executive. Please refer to the provider manual to learn more.
- Be updated on the status of their credentialing or recredentialing application by requesting this update from the Provider Services department. The Provider Services department will share all information with the provider, except for references, recommendations, or peer-review protected information (e.g., information received from the National Practitioner Data Bank). Applicants can ask for updates by phone, email, or writing. The Provider Services department will respond to all requests within 24 business hours of receipt. We will respond by email or phone call to the provider.
- Be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- Review all credentialing application and primary source verification policies and procedures by requesting them from the Provider Services department.

To ask for any of the above, please contact the Provider Services department.

Timely filing of claims

Providers must submit all original paper and electronic claims to the plan within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to both capitated and fee-for-service claims. Please allow for normal processing time before resubmitting a claim either through the electronic data interchange (EDI) or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: The EDI vendor must receive claims by 9 p.m. for them to be sent to the plan the next business day.

Unless otherwise agreed to by the plan and provider, failure to submit a claim within the 180-day timely filing deadline does not invalidate or reduce any claim if:

- It was not reasonably possible for the provider to file the claim within the 180-day period.
- The claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider or in the case of a force majeure, later than one year from the time of submittal of the claim. Force majeure is defined as any act of God, governmental act, act of terrorism, war, fire, flood, earthquake, hurricane or other natural disaster, explosion, civil commotion, or other event beyond the provider's reasonable control.

Type of claim	Description and time frame
Original claim	Must be submitted to the plan within 180 calendar days from the date services were rendered or compensable items were provided.
Rejected claim	Is not registered to the claims processing system and can be resubmitted as a new claim. They may be corrected and resubmitted within 180 calendar days from the date of services.
Denied claim	Has been processed in the claims system. It may have a payment attached or may have been denied. A corrected claim can be reprocessed if submitted within 365 calendar days of the original date of service.
Out-of-network provider claim	Must be submitted to the plan within 180 calendar days from the date services were rendered or compensable items were provided.

Billing the member

Providers may collect copayments, coinsurance, and any unpaid portion of the deductible at the time of service.

Balance or surprise billing

Members are protected from balance billing for the following services:

Emergency services

If a member has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most the provider or facility may bill the member is the plan's in-network cost-sharing amount (such as copayments and coinsurance). A provider cannot balance bill a member for these emergency services. This includes services the member may get after they are in stable condition, unless they give written consent and give up their protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a member gets services from an in-network hospital or ambulatory surgical center, certain providers within such facilities may be out of network. In these cases, the most those providers may bill the member is the plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers can't balance bill the member and may not ask the member to give up their protections not to be balance billed.

Out-of-network providers

Out-of-network providers may need to bill the member for an unpaid balance after the time of service. It is the out-of-network provider's responsibility to advise the member and obtain the member's acknowledgment in writing if products or services extend beyond the plan's coverage so that the member understands that they are liable for any costs beyond what the plan will pay.

Member rights and responsibilities

Member rights

A member has the right to:

- Receive information about the health plan, its benefits and services that are included or excluded from coverage policies, and network providers' and members' rights and responsibilities. Written and web-based information provided to the member must be readable and easily understood.
- Be treated with respect and recognized for their dignity and right to privacy.
- Participate in decision-making with providers about their health care. This right includes candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. The member has a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations about the plan's member rights and responsibilities policies by contacting Member Services.
- Choose providers, within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information. The member also has the right to have access to their medical record per applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The plan will provide information about advance directives to members and providers and will support members through our medical record-keeping policies.
- Obtain a current directory of network providers, on request. The directory includes addresses, phone numbers, and a listing of providers who speak languages other than English.
- File a complaint or appeal about the health plan or care provided with the applicable regulatory agency and receive an answer from the health benefit plan to those complaints within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. The member also has the right to know that their provider cannot be penalized for filing a complaint or appeal on the member's behalf.
- Members with chronic disabilities have the right to get help and referrals to providers who are experienced in treating their disabilities.
- Have candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage, in terms the member understands. This includes an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the member is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the member's medical record. The plan does not direct providers to restrict information regarding treatment options.
- Have available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency medical conditions.
- Call 911 in a potentially life-threatening situation without prior approval from the plan, and to have the plan pay for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger the member, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands.
- Receive prompt notification of terminations or changes in benefits, services, or the provider network.

- Have a choice of specialists among network providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Member responsibilities

A member has the responsibility to:

- Communicate, to the extent possible, information that the plan and network providers need for the member's health care.
- Follow the plans and instructions for care that they have agreed on with their providers. This responsibility includes considering the possible consequences of not adhering to recommended treatment.
- Understand their health problems and participate in developing mutually agreed-on treatment goals to the degree possible.
- Review all benefits and membership materials carefully and follow health plan rules.
- Ask questions to ensure understanding of the provided explanations and instructions.
- Treat others with the respect and courtesy they expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

Prior authorization guidelines

Prior authorization is required to evaluate the medical necessity of certain health care products and services. When referring members to a hospital, the PCP only needs to refer to the admitting/performing physician, who is then responsible for obtaining prior authorization for the hospital admission.

Responsibilities of the admitting/performing physician for hospital admissions:

- Make hospital admission arrangements.
- Acquire the following required information:
  - Member name and date of birth
  - Member ID number
  - Admission date
  - Place of admission
  - Diagnosis
  - Planned procedure
- Provide medical information to support the prior authorization review request.
- Notify the member's PCP of the diagnosis, planned procedure, and hospital arrangements.
- Contact the hospital with the prior authorization code.

Criteria used for utilization management determinations are available on request to all AmeriHealth Caritas Next and First Choice Next providers and members free of charge. Members and providers can learn more about the availability of review criteria and how to obtain clinical criteria used for a utilization management determination through the provider manual, Member Handbook, and written utilization management determination letters.

Population Health program

The plan's Population Health program is a holistic solution to provide comprehensive care management services. This fully integrated model allows members to transition seamlessly from one level of care to another for their unique needs. From this integrated solution, the plan delivers and coordinates care across all programs. We offer this program to all plan members.

The Population Health program includes:

- Assessment
- Screening for social determinants of health
- Care planning
- Health and wellness education to encourage self-management
- Service coordination
- Treatment
- Reassessing and adjusting the person-centered care plan and its goals as needed

The Population Health program uses evidence-based practice guidelines and is structured around a member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management.

The plan's Population Health team works proactively to meet our members' needs at all levels to maximize health outcomes. The team includes:

- Nurses
- Licensed mental health and substance use disorder professionals
- Care Connectors
- Clinical pharmacists
- Plan medical directors
- PCPs
- Specialists
- Community agencies
- Members and their caregivers, parents, or guardians

Population Health program participation

We offer all plan members the chance to participate in Population Health programs. Members can opt out on request. Providers may also contact the plan to enroll members in a program, and members may contact the plan to self-refer into a program.

For specific Population Health-related needs, members are identified when they enroll in the plan through systematic risk stratification. We include a new member assessment in the member's welcome packet to help identify current health conditions and health care services. Based on their responses to this initial health assessment, we identify members for participation in the appropriate care management program. We also identify members for participation through telephonic outreach.

The plan systematically restratifies members quarterly. Members are encouraged to let the plan know if they have a chronic health condition or special health need, or if they are receiving ongoing care.

Let Us Know program

We encourage providers to refer members to Population Health Management as needs arise or are identified. If you recognize a member with a special, chronic, or complex health condition who may need the support of one of our programs, including Complex Care Management, Care Coordination, or the Bright Start® program, please contact our Rapid Response and Outreach Team. Providers can also complete our Let Us Know member intervention request form and fax it to our Rapid Response Outreach Team for members who have missed appointments or who may need transportation services or further education on their treatment plan or chronic condition. You can download this form from our website at www.amerihealthcaritasnext.com.

Members are also referred to the Population Health programs through internal plan processes. Identified issues and diagnoses that result in a referral to the Population Health program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members with substance use disorder-related conditions
- Members who are developmentally or cognitively challenged
- Members with a special health care need
- Members with polypharmacy use
- Pregnant members
- Members with high trauma exposure
- Members who need long-term services and supports to avoid hospital or institutional admission

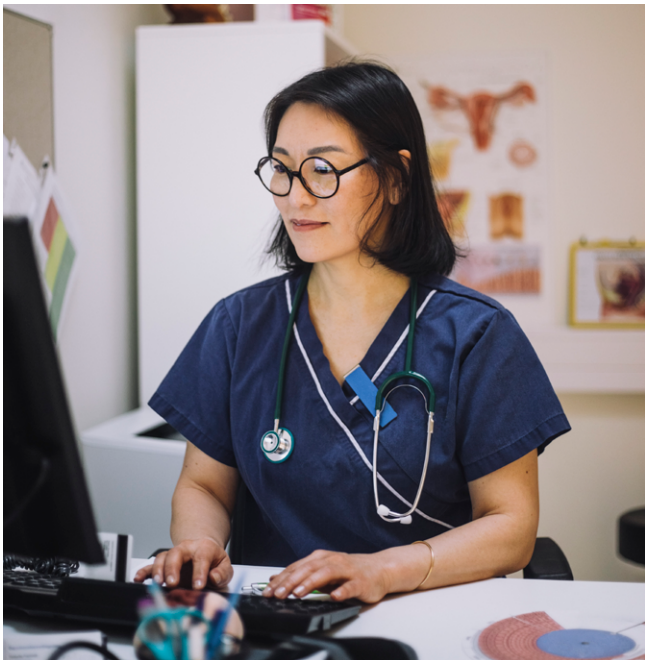
Medical records requirements

Participating providers must maintain medical records in a manner that is current and detailed and allows for effective and confidential patient care and quality review. Provider office medical record filing systems should facilitate access, availability, confidentiality, and organization of records at all times.

Providers must retain all medical records, whether electronic or paper, for a period of no less than 10 years after the rendering of covered services to the member.

Providers are required to make medical records accessible to all appropriate government agencies, including but not limited to the Department of Insurance and their respective designees for quality assurance, investigation of complaints or grievances, enforcement, or other activities related to compliance with applicable laws.

Providers must follow the medical record standards outlined in the provider manual for each member's medical record, as appropriate.



Fraud, waste, and abuse

The plan has an established enterprise-wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Local AmeriHealth Caritas Next and First Choice Next staff, including a Special Investigation Unit Manager and Investigator, will be supported by the Program Integrity department.

As a network provider, you are responsible for reporting suspected fraud, waste, and abuse.

Reporting issues to AmeriHealth Caritas Next and First Choice Next

If you are aware of potential or actual fraud, waste, or abuse, we encourage you to report the issue to the Special Investigations Unit by:

- Calling the toll-free Fraud, Waste, and Abuse Hotline at **1-866-833-9718**. The hotline is available 24/7 and allows anonymous reporting of issues.
- Emailing **fraudtip@amerihealthcaritas.com**
- Completing the anonymous online fraud intake form found at **www.amerihealthcaritasnext.com**
- Mailing a written statement to:
  Special Investigations Unit
  AmeriHealth Caritas Next/First Choice Next
  P.O. Box 7318
  London, KY 40742