AdventHealth Provider Network

2019 Provider Information Booklet

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Network Services

Section 1: Network Services

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Health Management

Health Management is a no-cost program designed to assist your value-based contract lives and Accountable Care Organization (ACO) members who have ongoing medical needs related to chronic illness. Our team of skilled professionals includes registered nurse health advisors, LPN health coordinators, and social workers who work together to support patients with education in managing chronic illness and assistance in coordinating care between visits.

Physician Benefits

- Increased patient compliance with physician orders.
- Reduced costs due to prevention of avoidable visits.
- Improved continuity of care.
- Increased patient satisfaction.
- Customized patient care plan.

Referral Process

To refer your high- and rising-risk patients to the Health Management program, submit a referral form via FAX to 407-303-0926 or by email at PHSO.HealthMgmt@AdventHealth.com.

Referral forms are available on the Health Management page on the provider portal MyAHPN.com, under the resources tab.

Health Management Works

"Nurse health advisors have been effective in helping my most challenging patients stay compliant with their medications and more. Nurses have the time to connect and follow-up with the patients. It's resulted in fewer visits to the emergency rooms. Health Management is a valuable service for me and my patients."

Robert Rodgers, MD

Health Management Gets Results

Patients who participate in health management are more likely to close care gaps and experience lower cost of care.

88%

of participants have A1c<9.

88%

decrease in hospital admissions.

36%

reduction in total cost of care.

Provider Operations and Engagement

The Provider Operations and Engagement team supports clinically integrated network (CIN) and AdventHealth Accountable Care Organization (ACO) physicians by working to enhance the physician experience while improving patient outcomes, quality and reducing the overall cost of healthcare.

The team is dedicated to assisting with removing barriers to patient care through education, implementation, and support of Population Health technologies.

Population Management Advisor

Your Provider Network Relations Specialist or Population Management Advisor (PMA) is a single point of contact for your practice to access all the services provided to you. For many physicians, caring for patients within the context of population health is a new and unfamiliar concept in the changing world of healthcare. Your Specialist/PMA will provide CIN and ACO quality measure and care gap information specific to your attributed members. Specialists/PMAs can also engage coding experts and other resources to assist as needed to achieve high performance for population health programs. Some of the services offered are:

- Understanding specific population health payer/plan physician requirements.
- Educating and supporting physicians and office staff to improve performance on specific quality measures and reduce care gaps for attributed members.
- Implementing and optimizing population health technology solutions.

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HealtheRegistries

HealtheRegistries is an online tool that leverages clinical and claims information that allows you to manage quality measures to improve population health outcomes.

With single-sign on access through the AdventHealth Provider Network portal, MyAHPN.com, HealtheRegisteries will be your most comprehensive source of actionable data for your patient population.

Benefits

ACTIONABLE INFORMATION

Use the information specific to your patient panel to close care gaps

IDENTIFY AT-RISK PATIENTS

Accurately predict the health risks of patients to allow for targeted interventions

DATA ON DEMAND

No more waiting for reports to be delivered to your offices

For more information, contact the Experience Center at 877-850-5438

or via email at AHS.ExperienceCenter@AdventHealth.com.

Note: You will need an OPID to access HealtheRegistreries.
For more information, contact the Experience Center at 877-850-5438 or via email at AHS.ExperienceCenter@AdventHealth.com.

Pharmacy Program

The pharmacy program ensures clinical safety, effective treatments, and pharmacy cost management specific to your clinically integrated network (CIN) and the AdventHealth Accountable Care Organization (ACO). Our pharmacist is your resource for medication management.

The pharmacy team works with providers on formulary education for clinical, evidence-based prescribing.

Provider Benefits

- Pharmacist resource for medication treatments
- Formulary education for preferred medications
- Brand to generic options
- Specialty medication therapies
- Medication alternative treatments
- Clinically cost-effective disease state options
- Drug optimization to improve member compliance

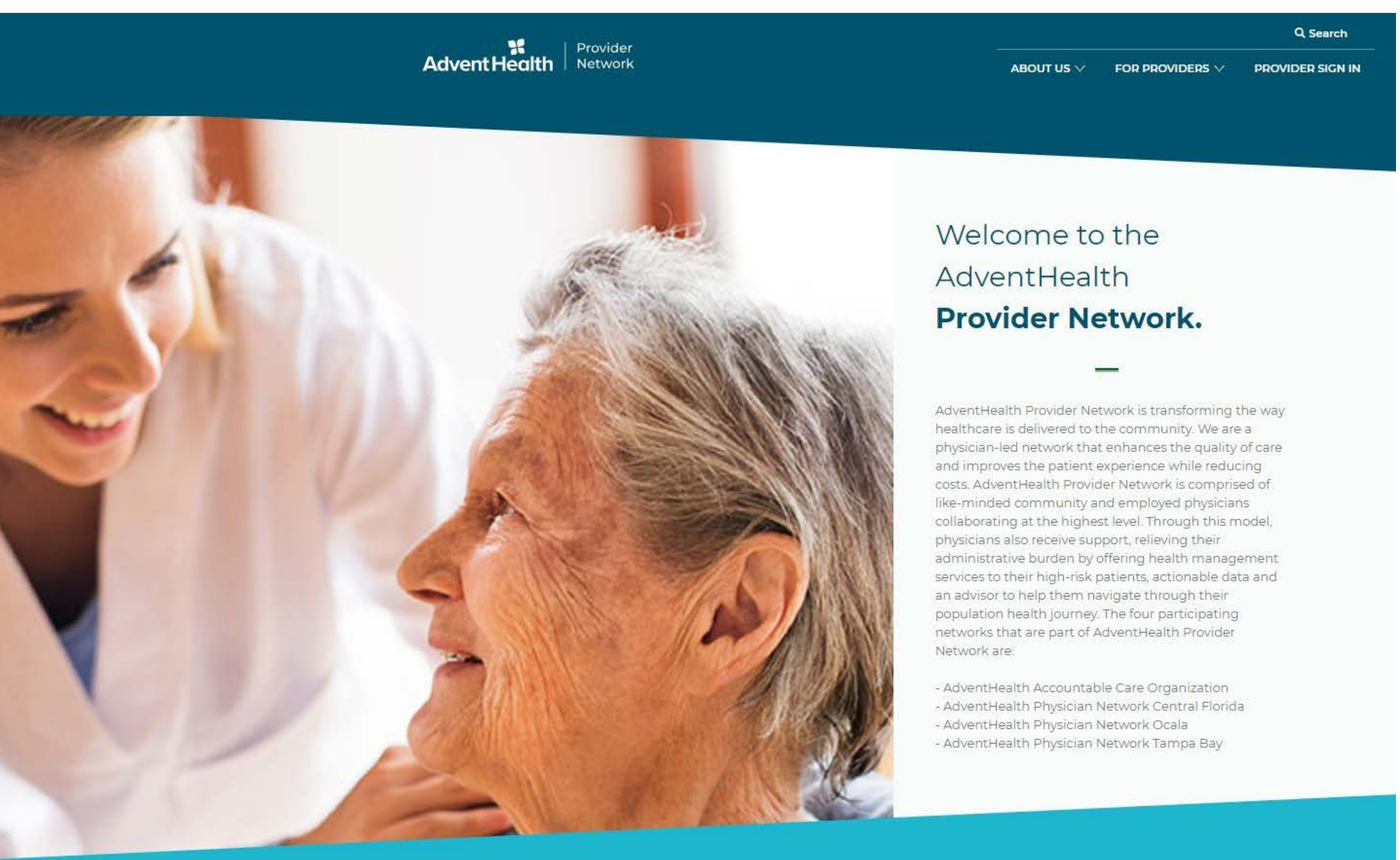
Member Benefits

- Medication therapy management
- Medication education and safety

Provider Portal

myAHPN.com is a secure portal that allows you to view content that is specific to your clinically integrated network (CIN) and the AdventHealth Accountable Care Organization (ACO), if applicable.

The portal has a directory of your network colleagues, information about the populations in your network, and free resources available to you.



LOGIN

1. Navigate to myAHPN.com.
2. Click provider sign in.
3. Enter your AdventHealth OPID/ username and password.

Note: To access the portal outside of the AdventHealth network, you will be prompted to enter a 6-digit security code from the SecureAuth Authenticate App.

The portal will “remember” you and the security code for 90 days.

NAVIGATION

ABOUT US

AdventHealth Provider Network physician directory

POPULATIONS

Helpful information on network populations

QUICKLINKS

Single sign-on access to HealtheRegistries

RESOURCES

Information specific to your patient panel and care gap closure (coming soon)

NEWS & MEDIA

Latest news and events in one location

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Clinical Mission Integration

Spiritual Care in the Outpatient Setting

Grounded in AdventHealth's legacy of wholistic care, AdventHealth Physician Network Central Florida is enhancing how we care for the needs of the whole person, including spiritual health. In the hospital setting, spiritual care has traditionally been provided by chaplains and trained volunteers. However, 20 times as many patients are treated outside the hospital setting.

As part of the AdventHealth Clinical Mission Integration program, three key spiritual indicators—love, joy, and peace—were identified to screen for spiritual wholeness.

Spiritual Wholeness Screening Process

Practice Responsibilities

SCREEN

At registration, patients complete the following spiritual wholeness screening:

- Do you have religious beliefs that influence your medical decisions?
- Do you have someone who loves and cares about you?
- Do you have a source of joy in your life?
- Do you have a sense of peace today?

Note: This can be a paper form or part of your EHR.

DISCUSS

Talk to patients about spiritual wholness.

- Add conversational notes to patient record
- If a patient responds with no/not sure, generate a refferal to the e-spiritual care center

For more information, contact the Experience Center at 877-850-5438 or via email at AHS.ExperienceCenter@AdventHealth.com.

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Spiritual Care Support

Provided by the E-Spiritual Care Center

ASSESSMENT

Upon receiving a referral, the e-spiritual care center:

- Contacts patient and develops a relationship
- Conducts spiritual assessment
- Listens to the concerns of the patient
- Addresses spiritual concerns by developing a spiritual care plan

SPIRITUAL SUPPORT

After the the assessment, the e-spiritual care center:

- Provides spiritual support and/or spiritual counseling
- Prays with patient
- Reads holy scriptures
- Provides religious resources
- Mobilizes patient's faith community for support

FOLLOW-UP

Once the support is complete, the e-spiritual care center provides a summary to the referring physician outlining:

- Outcomes of intervention
- Concerns on spiritual health
- Recommendations for addressing the patient's spiritual care
- Spiritual Care Support
- Provided by the E-Spiritual Care Center

For more information, contact the Experience Center at 877-850-5438 or via email at AHS.ExperienceCenter@AdventHealth.com.

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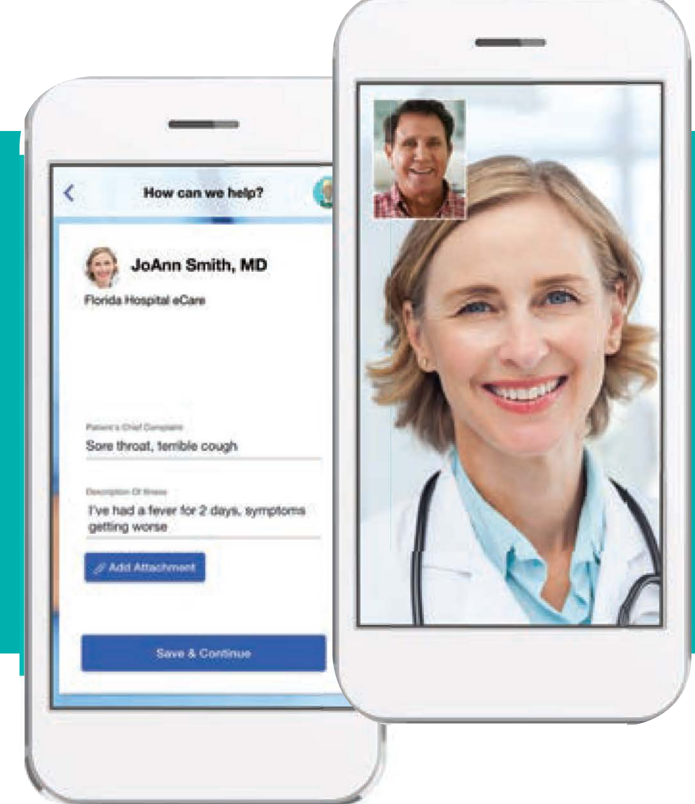
24/7 eCare

eCare is an Urgent Care Telehealth via video chat on the computer or mobile device for a one-on-one doctor's appointment with our AdventHealth Physician Network providers. After the provider diagnoses the condition, they can submit a prescription to the patient's preferred pharmacy.

- Visits available 24/7 on demand
- Download the eCare app in the Apple Store or Google Play
- Uses secure video and audio to protect your health information
- Disney HMO Plan: $0 co-pay
- AHEP: $25 co-pay Traditional PPO only
- Community Access: $49 co-pay

Common eCare Treatments

- Conjunctivitis/pink eye
- Coughs, cold, bronchitis and flu
- Lower back pain
- Seasonal allergies
- Sinus and upper respiratory infections
- Skin conditions
- Urinary tract infections



Learn more For more information, contact the Experience Center at 877-850-5438 Monday through Friday from 8 am to 5 pm or via email at AHS.ExperienceCenter@AdventHealth.com.

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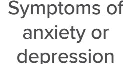
Mindoula

24/7 Behavioral Health Support for Tier 1 PCPs and their Value-Based Life Patients

Mindoula is a behavioral health support service that is free for Tier 1 PCPs and their value-based life patients. Mindoula has the power to help PCPs close the depression screening care gap and reduce inappropriate ED utilization, admissions and readmissions by providing patients easy access behavioral health services.

Patients with behavioral health issues combined with a chronic condition are more likely to use the ED for care instead of visiting the appropriate care provider to address their needs.

Which patients should use Mindoula?


Symptoms of anxiety or depression

Currently taking psychotropic medications

Diagnosed with two or more chronic medical problems

Current or historical psychiatric diagnosis

Taking four or more of any medication

Multiple hospital or ED visits in a year

PCP Partnership

Mindoula works in partnership with PCPs and makes it easy to refer a patient and continue to stay informed on the patients' progress.

Here is how it works:

- PCP completes PHQ2/9 screening with patient at visit.
- PCP refers value-based lives who screen positive to Mindoula.
- Mindoula care manager engages and enrolls patient with chart review and intake.
- Mindoula psychiatrist reviews and develops diagnosis and treatment recommendations.
- Mindoula care manager delivers intake report and makes additional care recommendations back to the PCP.
- PCP reviews Mindoula report and follows up with patient.
- Mindoula care manager provides ongoing remote support and provides monthly summaries.
- Mindoula psychiatrist performs monthly case review, assessments and discharge when target is achieved.

Learn more For more information, contact the Experience Center at 877-850-5438 Monday through Friday from 8 am to 5 pm or via email at AHS.ExperienceCenter@AdventHealth.com.

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Section 2: Quality and Utilization Information

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Introduction

We are committed to communicating clearly and effectively with our aligned provider networks. Managing population health requires executing strategies to provide the quality care that members deserve and meet the metrics for the quality measures set forth by the accountable care organization (ACO) and clinically integrated network (CIN) to prove exceptional clinical care has been delivered.

This section is designed to provide basic information on each measure selected by physician leaders for 2019. This user friendly guide is divided into two parts, Preventive Care and Chronic Disease Management, and will make clinical documentation easier for you throughout the year.

In order to shift the culture from a focus on acute care to one of wellness across all our populations, everyone must begin to think differently. Using this section brings you one step closer to reaching the goal, engaging the member to have greater involvement in their own care, and providing the continuum of care they need within your practice.

Suggested codes are available in the 2019 Quality Measures Quick Reference Guide handout and on the provider portal.

Preventive Care

ACO 13 Fall Screening for Future Fall Risk

Purpose

Each year, millions of seniors—those 65 and older—fall. In fact, more than one out of four older people fall each year, but less than half tell their doctor. Falling once doubles your chances of falling again.

Measure Details

Description:

Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Numerator:

Patients who were screened for future fall risk at least once within the measurement period.

Denominator:

Equals Initial Population.

Exclusions:

Exclude patients who were assessed to be non-ambulatory during the measurement period.

Exceptions:

Not Applicable.

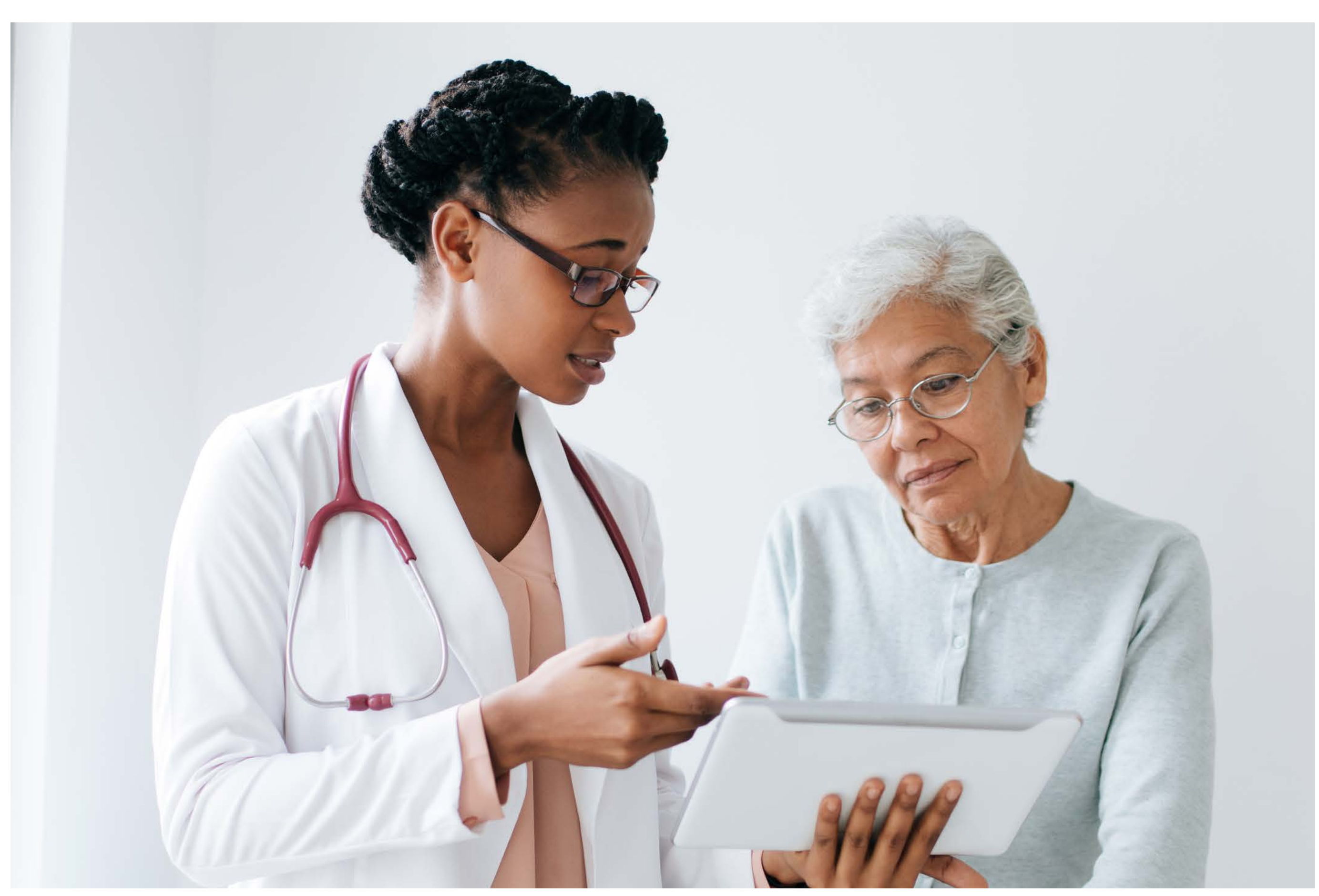
Patient is not ambulatory - count as non-ambulatory only if non-ambulatory at the most recent encounter during the measurement period (i.e., patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair).

Applicable Plans for the Measure

- Identifying members > 65 years who have not seen their PCP in the last 12 months
- Developing protocols for office visit and calls
- Provide patient education
- Provide a list of community resources to the patient
- Refer patient to Health Management team

How To Satisfy the Measure

- Screening must be performed by a clinician with appropriate skills and experience
- Setting of the screening is not restricted to an office and can be inpatient or at home by a health care professional
- Screening for falls must be done at least once a year
- Screening tools are not needed to satisfy this measure
- Documenting NO FALLS is sufficient
- Assessing gait or balance meets the intent of the measure
- Screening for future fall risk may be completed during a telehealth encounter



HEDIS Body Mass Index Screening

Purpose

Obesity is a complex, multifaceted, chronic disease. Environmental, genetic, physiological, metabolic, behavioral, and psychological factors can all affect obesity. Obesity's impact on an individual's overall health increases both morbidity and mortality rates. It also increases the risk of chronic diseases like diabetes, CHD, and cancer. BMI is a common and reliable measurement to identify overweight and obese individuals who may be at risk of increased morbidity.

Measure Details

Description:

The percentage of patients 18 to 74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.

Numerator:

Patients with a documented BMI during the encounter or during the previous year.

Denominator:

All patients aged 18 years and older at the beginning of the measurement period.

Exclusions:

Patients who are pregnant during the current measurement year, or the previous year.

Exceptions:

Not Applicable.

Applicable Plans for the Measure

- Measure weight and BMI for patients who are over 18 years of age
- Identify members who have not seen the PCP in the last 12 months
- Develop protocols for office visit and calls
- Provide patient education
- Provide a list of community resources to the patient

How To Satisfy the Measure

- Documenting BMI during the measurement year or the year prior to the measurement year including:
  - BMI: date and result
  - Weight: date and result
- Including ranges and thresholds do NOT meet criteria, a distinct BMI value or percentile is required
- Note: For patients age 18 to 19 on date of visit, a height, weight and BMI percentile must be recorded.

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ACO 14 Influenza Immunization

Purpose

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May. The flu is caused by influenza viruses and is spread mainly by coughing, sneezing and close contact. Each year thousands of people in the United States die from the flu, and many more are hospitalized.

Measure Details

Description:

Percentage of patients age six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported **previously receiving an** influenza immunization.

Numerator:

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.

Denominator:

All patients aged six months and older seen for a visit during the measurement period.

Exclusions:

None.

Exceptions:

- Documentation of MEDICAL reason: i.e. Allergy
- Documentation of PATIENT reason: i.e. Patient declined
- Documentation of SYSTEM Reasons: i.e. Vaccine not available

Previous Receipt – receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1).

Applicable Plans for the Measure

- Identify the qualified members (accurate reports)
- Contact the member to make an appointment with the PCP
- Provide communication and education for the member
- Use the appropriate vaccine for the member based on age
- Publicize a "vaccine day" in combination with education to offer influenza vaccinations
- Offer influenza vaccination education multiple times during the flu season
- Provide immunizations during annual wellness visit

How to Satisfy the Measure

- Documenting if the patient received an influenza immunization OR reported previous receipt of an influenza immunization between August 1, 2018, and March 31, 2019, for 2019 reporting.
- Documenting patient who reports previously receiving an influenza immunization during the flu season
- Documenting the date the immunization was given
- Screening for influenza immunization can be done during a telehealth encounter
- Documenting vaccination is "up-to-date"

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ACO 17 Tobacco Use: Screening and Cessation Intervention

Purpose

Tobacco use can lead to lung cancer, chronic bronchitis, and emphysema. It increases the risk of heart disease, which can lead to stroke or heart attack. All these risks apply to the use of any tobacco, including hookah and chewing tobaccos.

Measure Details

Description:

Percentage of patients age 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Three rates are reported:

1. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
2. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention
3. Percentage of patients age 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Numerator:

Population 1: Patients who were screened for tobacco use at least once within 24 months

Population 2: Patients who received tobacco cessation intervention

Population 3: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Denominator:

Population 1: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Population 2: Equals initial population who were screened for tobacco use and identified as a tobacco user

Population 3: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Exclusions:

None

Exceptions:

Population 1: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)

Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)

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Applicable Plans for the Measure

- Provide communication and education for the member
- Complete tobacco cessation. Giving brochures and/or pamphlets or complementary/alternative therapies DO NOT satisfy this measure. Tobacco cessation must include documentation of brief counseling and/or pharmacotherapy in patient's file

How to Satisfy the Measure

- Screening every adult patient at least every 24 months
- Defining "within 24 months" as the 24-month look-back from the measurement period end date (January 1, 2018 to December 31, 2019)
- Screening for all forms of tobacco use including chewing tobacco
- Using vapor tobacco is not included in this measure
- Completing tobacco cessation intervention—includes brief counseling (three-minutes or less) and/or pharmacotherapy to satisfy this measure
- Screening for tobacco use may be completed during a telehealth encounter

ACO 18 Screening for Clinical Depression and Follow Up Plan

Purpose

Depression is widespread, and statistics suggest that the percentage of depressed people throughout the country is growing. It is estimated that 19 percent of Americans suffer from depression at some point in their lives. Children, as well as the elderly, are being affected by depression. Some statistics show that almost 50 percent of children and adolescents, and 20 percent of adults have some symptoms of depression. The human cost to patients in pain and suffering is unmeasurable. It should be identified early and proactively treated.

Measure Details

Description:

Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Numerator:

Patients screened for depression on the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Denominator:

All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Exclusions:

Patients with an active diagnosis for depression or a diagnosis of bipolar disorder are excluded.

Exceptions:

- Patient reason(s), patient refuses to participate
- Medical reason(s); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient´s health status
- Situations where the patient´s functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (for example: certain court appointed cases or cases of delirium)

Applicable Plans for the Measure

- Screen patients age 12 and older for depression annually
- Identify patients who may have depression
- Develop a plan to treat patient with positive screening result
- Provide patient education on lifestyle changes and medicines prescribed
- Refer patient to psychiatry when necessary
- Refer high-risk members to Health Management team

How to Satisfy the Measure

- Using any age appropriate screening tools (PHQ2 in Athena)
- Completing a depression screening on the date of encounter
- Documenting one or more of the following in the medical record, if the screening is positive on the date of encounter:
  - Additional evaluation for depression
  - Suicide risk assessment
  - Referral to a practitioner who is qualified to diagnose and treat depression
  - Pharmacological intervention
  - Other interventions or follow-up for diagnosis or treatment of depression
- Reviewing the screening tool and document the result in the medical record to comply with the CMS requirement
- Documenting the name of the age appropriate standardized depression screening tool used in the medical record and the result of the screening (positive or negative), if a copy of the screening tool is not in the chart

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ACO 19 Colorectal Cancer Screening

Purpose

Colorectal cancer, also known as colon cancer, is the second leading cause of cancer death in the U.S (source: CDC, 2018). Early detection can save your life. Being screened for colorectal cancer is important and costs less than cancer treatment.

Measure Details

Description:

Percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer.

Numerator:

Patients with one or more screenings for colorectal cancer, during or prior to the reporting period indicating one of the following meet the criteria:

- Fecal occult blood test during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior to that year
- Colonoscopy during the measurement year or the nine years prior to the measurement year
- Cologuard fecal immunochemical DNA test, FIT-DNA test every three years

Denominator:

Patients 50 to 75 years of age with a visit during the measurement year.

Exclusions:

Exclude patients with a diagnosis of colorectal cancer or total colectomy.

Exceptions:

None.

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Applicable Plans for the Measure

- Identify the qualified members (accurate reports)
- Contact the member to make an appointment with the PCP
- Provide communication and education for the member
- Use the appropriate test for the member based on his/her history
- Follow-up communication with the member
- Partner with a GI specialist for referrals
- Encourage members to send a copy of the test result to their PCP

How to Satisfy the Measure

- Excluding digital rectal exam in the office for the FOBT
- Documenting self reporting should include date (year is enough), type of test, and result/finding in form of normal or abnormal (if possible, obtain the actual result of the test performed)
- Completing documentation of colorectal cancer screening during a telehealth encounter

ACO 20 Breast Cancer Screening

Purpose

Breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year (American Cancer Society, 2012). It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival.

Measure Details

Description:

Percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer within 27 months.

Numerator:

Women aged 50 to 74 who had one or more mammograms any time 27 months prior to December 31 of the measurement period, not to precede the patient's 50th birthday.

Denominator:

Women 50 to 74 years of age with a visit during the measurement period.

Exclusions:

Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.

Exceptions:

None.

Applicable Plans for the Measure

- Identify the member (accurate data reports)
- Contact member and make appointment with the PCP
- Communicate to and educate the member
- Use appropriate test for the member based on medical history
- Document encounter correctly
- Encourage members to send a copy of the test results to their PCP

How to Satisfy the Measure

- Completing biopsies, breast ultrasounds or MRIs do NOT count as appropriate method for primary breast cancer screening
- Timing for a mammogram includes the measurement year, the year prior to the measurement year, and a three-month grace period for a total of 27 months
- Documenting in the medical record must include both of the following:
  - Date the breast cancer screening was performed
  - Results of screening
- Documenting 'normal' or 'abnormal' is acceptable
- Findings of patient reported results must include date, type of test and results
- Screening includes: screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography
- Documenting screening for breast cancer may be completed during a telehealth encounter

ACO 28 Controlling High Blood Pressure

Purpose

Treatment for high blood pressure typically involves a combination of medication and lifestyle changes to help control the condition and prevent or delay related health problems.

High blood pressure, also known as hypertension, is present once the blood pressure is 140/90 and above.

Measure Details

Description:

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator:

Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Denominator:

Patients 18 to 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

Exclusions:

Patients with evidence of end-stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

Exceptions:

None.

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Applicable Plans for the Measure

- Assess blood pressure (BP) annually for patients who are 18 to 85 years of age
- Identify patients who have elevated BP readings
- Develop protocols for office return visits and calls
- Provide patient education on lifestyle changes and medicines prescribed
- Provide community resources list to the patient
- Refer high-risk members to Health Management team

How to Satisfy the Measure

- Bringing the patient in early in the year for the annual visit
- Missing blood pressure is assumed "NOT CONTROLLED"
- Using the lowest systolic and lowest diastolic reading, if multiple blood pressure readings are taken on the same day
- Recording the last BP of the year is used to evaluate this measure

HEDIS Well-Child Visit in the first 15 months of life (W15) - 6 visits

Purpose

The American Academy of Pediatrics recommends that each baby should visit their provider at least 6 times during the first 15 months of their lives. The benefits are as follows:

- **Prevention**: Immunizations are scheduled to prevent illnesses
- **Monitor:** Baby's growth and development is monitored closely
- **Concerns:** If parents have any concerns, they are addressed in these visits
- **Team bonding:** This will create a strong relationship and trust between the provider, parents and the child

Measure Details

Description:

The percentage of patients who turned 15 months old during the measurement year and who had at least six well-child visits with a PCP during their first 15 months of life.

Numerator:

The number of patients who received 6 or more well-child visits (Well-Care Value Set) with a PCP, on different dates of service, on or before the child's 15-month birthday.

Denominator:

All patients who are in their first 15 months of life during the measurement year.

Exclusions:

Patients who enter hospice any time during the measurement year.

Exceptions:

None.

Applicable Plans for the Measure

- Schedule appointments ahead of the time
- Contact member's parents and make appointment
- Communicate and educate the member's parents
- Provide follow-up communication with the member's parents
- Ensure encounter is documented correctly

How To Satisfy the Measure

- Completing at least six well-care visits with a PCP/pediatrician
- Including only well-care, sick visits are NOT included
- Scheduling visits at least two weeks apart
- Scheduling visits at 2, 4, 6, 9, 12 and 15 months
- Recording evidence of ALL of the following at each visit:
  - Health and developmental history
  - Physical exam
  - Health education/anticipatory guidance

Chronic Diseases

ACO 42 Statin Therapy for the Prevention & Treatment of Cardiovascular Disease

Purpose

An overwhelming number of studies have established dyslipidemia as the major risk factor for the development of atherosclerotic cardiovascular disease. Recent reductions in plasma cholesterol levels have contributed to a dramatic decrease in the incidence of premature coronary heart disease in the western world. However, atherosclerotic cardiovascular disease remains the main killer in the western world and its impact is increasing worldwide.

Measure Details

Description:

Percentage of the following patients–all considered at high-risk of cardiovascular events–who were prescribed or were on statin therapy during the measurement period:

- Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
- Adults aged ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR
- Adults aged 40 to 75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

Numerator:

Patients who are actively using or who receive an order for statin therapy at any point during the measurement period.

Denominator:

1. Patients aged ≥ 21 years at the beginning of the measurement period with clinical ASCVD diagnosis
2. Patients aged ≥ 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia
3. Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

Exclusions:

- Patients who have an active diagnosis of pregnancy
- Patients who are breastfeeding
- Patients with a diagnosis of rhabdomyolysis

Exceptions:

- Patients with adverse effect, allergy, or intolerance to statin medication
- Patients with active liver disease or hepatic disease or insufficiency
- Patients with end-stage renal disease (ESRD)
- Patients with diabetes who have the most recent fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Applicable Plans for the Measure

- Identify members at risk
- Complete annual checkup and blood work
- Clear documentation of patient's condition and exception/exclusion
- Use generic statins and not brand

How to Satisfy the Measure

- There are three populations under this measure who can be on statin therapy
- Patients who meet one or more of the following criteria are considered high-risk for cardiovascular events under ACC/AHA guideline

  1. Recording the diagnosis of clinical Atherosclerotic Cardiovascular Disease (ASCVD) must be in the medical record for patients with: Acute coronary syndromes
     - History of myocardial infarction
     - Stable or unstable angina
     - Coronary or other arterial revascularization
     - Stroke or transient ischemic attack (TIA)
     - Peripheral arterial disease of atherosclerotic origin
  2. Documenting test result for LDL in the chart for the patients with previously or currently diagnosed with familial or pure Hypercholesteremia
  3. Diagnosing Type 1 or Type 2 diabetes with fasting or direct LDL level of 70-189 mg/dL Document current statin therapy in the patient's medication list

- Prescribe ONLY statin therapy meets this measure
- Adherence to statin therapy is not calculated in this measure
- Document "samples" provided to patients as "current statin therapy" in medical record
- Document exception/exclusion in medical record
- Intensity of the statin is not calculated in this measure
- Prescription or order does not have to be linked to an encounter or visit, it may be called to pharmacy

ACO 27 DM Hemoglobin A1c Poor Control (>9%)

Purpose

The American Diabetes Association recommends that the A1c test be the primary test used to diagnose prediabetes, Type 1 diabetes and Type 2 diabetes. This also helps establish a baseline A1c level. The test may then need to be repeated later during your treatment regimen.

Measure Details

Description:

The percentage of patients 18 to 75 years of age with diabetes (Type 1 or Type 2) who had an A1c greater than 9% during the measurement period.

Numerator:

Patients whose most recent A1c level (performed during the measurement period) is > 9.0%.

Denominator:

Patients 18 to 75 years of ages with diabetes with a visit during the measurement period.

Exclusions:

None.

Exceptions:

None.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

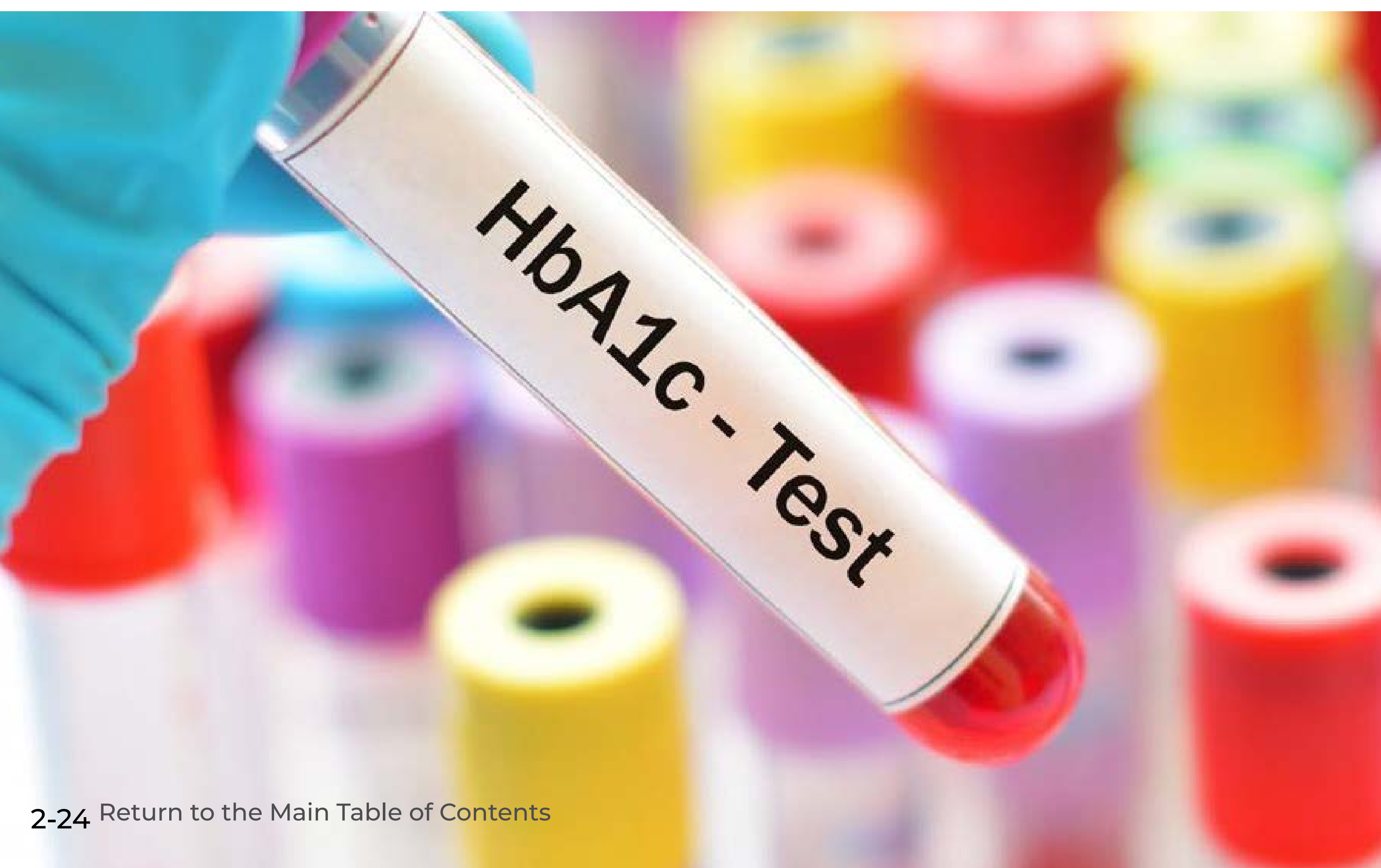
Applicable Plans for the Measure

- Screen patients annually with diabetes ages 18 to 75
- Identify patients who have an A1c>9
- Develop a plan to proactively treat patient
- Provide patient education on lifestyle changes and medicines prescribed
- Refer patient to dietician and/or endocrinologist when necessary

How to Satisfy the Measure

- Documenting results in provider's note
- Documenting the results and date that A1c performed (if the day is unknown enter 01 i.e.05/01/2018)
- Including the result and date the A1c was performed in the provider's note
- Documenting A1c finger stick at the point of care in the chart
- Including a distinct numeric result is required for compliance
- Documenting all needed information
- Documenting most recent A1c may be completed during a telehealth encounter

Note: This measure is inverted. Therefore, the lower performance score in this measure is an indication of better quality of care provided for the patients.



HEDIS Comprehensive Diabetes Care Medical Attention for Nephropathy

Purpose

Chronic kidney disease (CKD) is usually an irreversible disease that happens over many years. The progression of CKD can often be stopped and/or slowed through medication and lifestyle changes. If left untreated, it can ultimately lead to kidney failure. The only treatment options for kidney failure are dialysis and kidney transplant.

Measure Details

Description:

The percentage of patients 18 to 75 years of age with diabetes (Type 1 and Type 2) who had medical attention for nephropathy.

Numerator:

The percentage of patients 18 to 75 years of age with diabetes (Type 1 and Type 2) who had medical attention for nephropathy.

Denominator:

Patients 18 to 75 years of age by the end of the measurement year who had a diagnosis of diabetes (Type 1 or Type 2) during the measurement year or the year prior to the measurement year.

Exclusions:

Patients who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Patients 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year.

- At least two outpatient, ED, Observation visits on different dates of service with advanced illness diagnosis
- At least one acute inpatient encounter with advanced illness diagnosis
- A dispensed dementia medication

Exceptions:

None.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Applicable Plans for the Measure

- Identify the member (accurate data reports)
- Contact member and make appointment with the PCP
- Provide communication and education to the member
- Use appropriate test for the member based on medical history
- Document encounter correctly

How To Satisfy the Measure

Identifying members with diabetes in two ways:

1. Encounter claim
2. Pharmacy claim

Documenting screening or monitoring test or evidence of nephropathy includes diabetics who have one of the following:

- Urine test (24-hour urine for Albumin, times urine for Albumin or protein, spot urine for albumin, 24-hour urine for total protein, random urine for protein/creatinine ratio)
- Treatment of nephropathy or ACE/ARB therapy
- End-stage renal disease (ESRD)
- Kidney transplant
- A visit to a nephrologist
- At least one ACE inhibitor or ARB dispensing event
- Evidence of stage 4 chronic kidney disease (CKD stage 4 value set)

HEDIS Comprehensive Diabetes Care Screening Retinopathy

Purpose

Vision screening is a way of detecting retinopathy early before vision changes are noticed. Diabetic retinopathy doesn't usually cause any noticeable symptoms in the early stages. If retinopathy is detected early enough, treatment can stop it from getting worse. Otherwise, by the time symptoms become noticeable, it can be much more difficult to treat.

Measure Details

Description:

The percentage of patients 18 to 75 years of age with diabetes (Type 1 and Type 2 indicated in the measurement year or the year prior) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Numerator:

A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Denominator:

Patients 18 to 75 years of age by the end of the measurement year who had a diagnosis of diabetes (Type 1 or Type 2) during the measurement year or the year prior to the measurement year.

Exclusions:

Patients who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Patients 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year.

- At least 2 outpatient, ED, Observation visits on different dates of service with advanced illness diagnosis
- At least one acute inpatient encounter with advanced illness diagnosis
- A dispensed dementia medication

Exceptions:

None.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Applicable Plans for the Measure

- Identify the member (accurate data reports)
- Contact the member and make appointment with the optometrist
- Provide communication and education to the member
- Use appropriate test for the member based on medical history
- Ensure encounter is documented correctly

How to Satisfy the Measure

Identifying members with diabetes in two ways:

1. Encounter claim
2. Pharmacy claim

Documenting one of the following satisfies this measure:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year
- A bilateral eye enucleation anytime during the member's history through December 31 of the measurement year
- A note, by a PCP or other health care professional, indicating that an ophthalmoscopic exam was completed by an eye care professional. The date and the result (negative or positive) will meet the criteria for this measure

Section 3: Clinical Documentation Integrity and Risk Adjustment

Section 3: Clinical Documentation Integrity and Risk Adjustment

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Introduction

Evolution to Value

As we continue to move toward a value-based and patient-centered health care environment, diagnosis coding is becoming vital to physicians, health care professionals, and payers to establish the complexity of the patient's health status, medical decision making and ultimately reimbursement.

Accurately capturing each patient's health status supports the quality and optimization of patient care. The following sections provide example assessments/plans, documentation requirements, and ICD-10 diagnosis coding tips for some of the most commonly reported chronic conditions.

Why focus on documentation and coding improvement?

- Support and meet clinical quality measurement initiatives and requirements
- Improve the overall health status and continuity of care for patients
- Optimize a healthy revenue cycle and claims processing
- "If it hasn't been documented, it hasn't been done."

Why is clinical documentation integrity (CDI) needed?

- Ensure that patients are treated at least once a year for all chronic conditions
- Improve care coordination by making sure all conditions are tracked by the primary care physician and treated by the appropriate specialist
- Ensure complete and accurate registries to be used in case management programs for Population Health
- Improve the accuracy of value-based payments to providers by appropriately capturing disease burden of populations

Why is documenting conditions every year necessary?

A patient's risk adjustment factor (RAF) is based on the health conditions they have, as well as demographic factors. An accurate RAF score and expected level of risk depend on complete documentation and correct coding of the patient's medical record.

The Center for Medicare & Medicaid Services (CMS) requires that health care providers identify all conditions the patient may have (specifically, those that may fall within a Hierarchical Condition Category or HCC) at least once per calendar year to support an accurate RAF score for the patient.

Diabetes Mellitus

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

- Diabetes Mellitus Type II, unspecified (E11.9_)
- DMII with renal complications (E11.2_)
- DMII with ophthalmic complications (E11.3_)
- DMII with neurologic complications (E11.4_)
- DMII with periph. circulatory complications (E11.5_)
- DMII with other specified complications (E11.6_)

Example | Diabetes with Hyperglycemia

Assessment & Plan

Diabetes not controlled. Patient unable to keep blood sugar (BS) low enough. Will adjust insulin and see patient for follow-up in two weeks. Asked patient to keep log of daily BS during this time.

ICD-10 CM Codes

- E11.65 – Type 2 Diabetes Mellitus with Hyperglycemia
- Z79.4 – Long-term (current) use of insulin

Documentation & Coding Tips

- E11 (Type 2 Diabetes Mellitus) – if type of diabetes is not documented or documentation states patient uses insulin.
- Hyperglycemia – not controlled/uncontrolled diabetes; patient with elevated BS or elevated A1c should be coded Type 2 Diabetes with Hyperglycemia, E11.65.
- Z79.4 – code to indicate patient uses insulin. Note: if patient has Type 1 Diabetes, Z79.4 is not utilized as insulin use is presumed.
- All diabetic complications are weighted with a roughly 3x greater RAF score than Diabetes without complications. To code conditions as being diabetic complications/manifestations, the medical record documentation must present a specific causal relationship between the two conditions. Examples of such a causal relationship include: with, in relation to, related with, diabetic, due to, etc.
- Exceptions to the causal relationship rule in ICD-10 are any conditions listed under the sub term with. The following is an excerpt from the ICD-10-CM codebook index.

Note this list is not all-inclusive. Please refer to the ICD-10-CM codebook for the complete list.

- Diabetes, diabetic (mellitus) (sugar) – E11.9 with:
  - Amyotrophy – E11.44
  - Arthropathy – NEC E11.618
  - Autonomic (poly) neuropathy – E11.43
  - Cataract – E11.36
  - Charcot's joints – E11.610
  - Chronic kidney disease (CKD) – E11.22
  - Circulatory complication – NEC E11.59
  - Complication – E11.8
    - Specified – NEC E11.69
  - Dermatitis – E11.620
  - Foot ulcer – E11.621
  - Gangrene – E11.52
  - Gastroparesis – E11.43
  - Glomerulonephrosis, intracapillary – E11.21
  - Gomerulosclerosis, intercapillary – E11.21
  - Hyperglycemia – E11.65
    - Coma – E11.641
  - Hyperosmolarity – E11.00
    - Coma – E11.01
  - Kidney complications – NEC E11.29
  - Kimmelsteil-Wilson disease – E11.21

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Cancer

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare Patients:

- Secondary malignant neoplasm of brain (C79.31)
- Acute myeloblastic leukemia, not having achieved remission (C92.00)
- Acute promyelocytic leukemia, not having achieved remission (C92.40)
- Acute myelomonocytic leukemia, not having achieved remission (C92.50)
- Secondary malignant neoplasm of bone (C79.51)
- Secondary malignant neoplasm of bone marrow (C79.52)
- Malignant neoplasm of unspecified part of unspecified bronchus or lung (C34.90)
- Multiple myeloma not having achieved remission (C90.00)
- Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites (C85.88)
- Other specified types of non-Hodgkin lymphoma, unspecified site (C85.80)
- Malignant neoplasm of colon, unspecified (C18.9)
- Malignant neoplasm of bladder, unspecified (C67.9)
- Malignant neoplasm of rectum (C20)
- Malignant neoplasm of unspecified site of unspecified female breast (C50.919)
- Malignant neoplasm of prostate (C61)
- Malignant neoplasm of thyroid gland (C73)

Example | Secondary Malignant Neoplasm of Bone

Assessment & Plan

Metastatic bone cancer originating from breast cancer. Breast cancer was eradicated four years ago. Doing well with current pain management regimen. Follow up with patient after the next round of radiation.

ICD-10 CM Codes

- C79.51 – Secondary malignant neoplasm of bone
- Z85.3 – Personal history of malignant neoplasm of breast

Documentation & Coding Tips

- When a secondary cancer is coded and the primary cancer is still present, the primary cancer should be coded as well; if the primary cancer has been completely eradicated, it should not be coded.
- Cancer (except those coded to categories [C80-C95] for which treatment is no longer received) would be coded with a Z code for History of malignant neoplasm. Likewise, any cancer stated to have been completely eradicated would be coded to a Z code.

Pulmonary

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

- COPD, unspecified (J44.9)
- COPD w acute lower respiratory infection (J44.0)
- COPD w (acute) exacerbation (J44.1)
- Emphysema, unspecified (J43.9)
- Unspecified chronic bronchitis (J42)

Example | COPD With Acute Exacerbation

Assessment & Plan

Acute exacerbation of COPD with acute bronchitis due to patient smoking. Advised on smoking cessation. Increased prednisone, prescribed antibiotic and increased nebulizer treatments to every two to four hours. Follow-up in five days or sooner if symptoms worsen.

ICD-10 CM Codes

- J44.0 – COPD with acute lower respiratory infection
- J44.1 – COPD with (acute) exacerbation
- J20.9 – Acute bronchitis, unspecified
- F17.218 – Nicotine dependence, cigarettes, with other nicotine induced disorders

Documentation & Coding Tips

Four codes are required for the scenarios above:

1. COPD with acute exacerbation
2. COPD with acute bronchitis
3. Acute bronchitis
   - J20.9 and J44.0 – are necessary to correctly code acute bronchitis with COPD
   - J44.0 – note: use additional code to identify the infection
   - J20.9 – added to identify the infection, acute
   - J44.1 – additional code to identify the COPD exacerbation
4. A cause and effect relationship must be documented to assign code F17.218. If cause and effect relationship is not documented, code F17.210 (nicotine dependence, unspecified, uncomplicated).

If causative organism is known and documented, code specified organism code under J20, acute bronchitis.

Congestive Heart Failure

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

- Heart failure, unspecified (I50.9)
- Other restrictive cardiomyopathy (I42.5)
- Other cardiomyopathies (I42.8)
- Other secondary pulmonary hypertension (I27.2)
- Other specified pulmonary heart diseases (I27.89)

NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

Example | Congestive Heart Failure

Assessment & Plan

The primary care physician can code for CHF if they are coordinating care with the cardiologist. The assessment and plan can be related to Care Coordination.

ICD-10 CM Codes

- I50 – Heart failure
- I50.1 – Left ventricular failure
- I50.2 – Systolic (congestive) heart failure
- I50.3 – Diastolic (congestive) heart failure
- I50.4 – Combined systolic and diastolic heart failure
- I50.9 – Heart failure, unspecified

Documentation & Coding Tips

- First code whether heart failure is due to an underlying condition such as:
  - Hypertension
  - Hypertension with chronic kidney disease
  - Rheumatic heart failure
  - Heart failure following surgery
  - Complication abortion or ectopic or molar pregnancy
  - Obstetric surgery and procedures
- The type of heart failure should be documented as:
  - Diastolic
  - Systolic
  - Combined/mixed diastolic/systolic
  - Left ventricular

Rheumatoid Arthritis & Infectious Connective Tissue Disease

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

- Rheumatoid arthritis, unspecified (M06.9)
- Inflammatory polyarthropathy (M06.4)
- Sacroiliitis, not elsewhere classified (M46.1)
- Sicca syndrome, unspecified (M35.00)
- Sicca syndrome with keratoconjunctivitis (M35.01)
- Polymyalgia rheumatica (M35.3)
- Progressive systemic sclerosis (M34.0)
- CR(E)ST syndrome (M34.1)
- Systemic sclerosis, unspecified (M34.9)
- Psoriatic juvenile arthropathy (L40.54)
- Other psoriatic arthropathy (L40.59)
- Systemic lupus erythematosus, organ or system involvement unspecified (M32.10)
- Polymyositis, organ involvement unspecified (M33.20)

Example | Rheumatoid Arthritis

Assessment & Plan

Patient presents with pain, swelling and stiffness of joints in the hand which is found to be a flare of their rheumatoid arthritis. Reviewed patient's Disease-Modifying Antirheumatic Drug medication routine and sending patient for Disease Activity Score 28 (DAS28).

ICD-10 CM Codes

- M05 Code Category – Rheumatoid arthritis with rheumatoid factor
- M06 Code Category – Other rheumatoid arthritis

Documentation & Coding Tips

Over 400 ICD-10 Codes that allow for greater detail including:

- Type: RA with rheumatoid factor, other rheumatoid arthritis, enteropathic, arthropathies, juvenile arthritis
- Subtype: Felty's syndrome, rheumatoid lung disease, vasculitis, heart disease, myopathy, polyneuropathy, other organs, etc.
- Anatomic Location: Shoulder, elbow, wrist, hand, hip, etc.
- Laterality: Right, left, unspecified

Morbid Obesity

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

- Morbid Obesity (BMI ≥ 40.2) (E66.01)
- BMI Ranges (Z68.41 - Z68.45)
- Morbid (severe) obesity with alveolar hypoventilation (E66.2)

Example | Body Mass Index (BMI)

Assessment & Plan

Morbid obesity recorded BMI ≥ 40.2 – patient admits to overeating. Discussed dietary changes and reduced caloric intake at length. Will schedule consult appointment with our registered dietician. Type 2 diabetes without complications, A1c within normal limits. Continue current medication.

ICD-10 CM Codes

- E66.01 – Morbid (severe) obesity due to excess calories
- Z68.41 – BMI 40.0 - 44.9, adult
- E11.9 – Type 2 diabetes mellitus without complications
- Z71.3 – Dietary counseling and surveillance

Documentation & Coding Tips

- Any clinician can document BMI in the patient's medical record
- Physicians and other health care professionals must document the condition and its medical significance (i.e., overweight/morbid obesity)
- Two codes should be reported for conditions coded to E66, overweight and obesity, along with code for documented BMI

Mental Health

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

- Bipolar disorder, unspecified (F31.9)
- Major depressive disorder, single episode, unspecified (PHQ-9: 10 - 27) (F32.9)
- Major depressive disorder, recurrent, unspecified (PHQ-9: 10 - 27) (F33.9)

Example | Major Depression

Assessment & Plan

A comprehensive medication reconciliation, including documentation of each medications: indication, length of treatment, benefits, side effects and plan for continued treatment is sufficient documentation of M.E.A.T. (monitor, evaluate, assess, treat) to support coding it on a claim.

ICD-10 CM Codes

- F32 – Major depressive disorder, single episode
- F33 – Major depressive disorder, recurrent

Documentation & Coding Tips

- Major Depression can be coded when a patient scores between a 10-27 on the PHQ-9 Tool.
- Depression & Anxiety do not risk adjust, but Major Depression does, even a single episode.
- Documentation for depression must include:
  - Episode (single or recurrent)
  - Severity (mild, moderate, severe)
  - Presence of any associated symptoms (with or without psychotic features)
  - Clinical status of current episode (in partial or full remission)

Major Depression ICD-10 Codes:

F32.0 Major depressive disorder, single episode, mild

F32.1 Major depressive disorder, single episode, moderate

F32.2 Major depressive disorder, single episode, severe without psychotic features

F32.3 Major depressive disorder, single episode, severe with psychotic features

F32.4 Major depressive disorder, single episode, in partial remission

F32.5 Major depressive disorder, single episode, in full remission

F32.8 Other depressive episodes

F32.9 Major depressive disorder, single episode, unspecified

F33.0 Major depressive disorder, recurrent, mild

F33.1 Major depressive disorder, recurrent, moderate

F33.2 Major depressive disorder, recurrent severe without psychotic features

F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms

F33.4 Major depressive disorder, recurrent, in remission

F33.40 Major depressive disorder, recurrent, in remission, unspecified

F33.41 Major depressive disorder, recurrent, in partial remission

F33.42 Major depressive disorder, recurrent, in full remission

F33.8 Other recurrent depressive disorders

F33.9 Major depressive disorder, recurrent, unspecified

Heart Arrhythmia

Consider the following common, risk-adjusted ICD diagnoses for Medicare patients:

- Unspecified atrial fibrillation (I48.91)
- Sick sinus syndrome (I49.5)
- Bradycardia, unspecified (R00.1)
- Ventricular tachycardia (I47.2)
- Unspecified atrial flutter (I48.92)
- Supraventricular tachycardia (I47.1)
- Atrioventricular block, complete (I44.2)

Example | Atrial Fibrillations/Atrial Flutter

Assessment & Plan

Patient has intermittent episodes of irregular heartbeat over the past year causing shortness of breath. Paroxysmal atrial fibrillation (PAF) recorded on Holter monitor. Patient is also being treated for hypertension. Patient admits to non-compliance with taking medicines. Stressed importance of compliance with patient. Follow up in one week. Patient had Myocardial Infarction (MI) 6 months ago.

ICD-10 CM Codes

- I48.0 – PAF
- I10 – Essential (primary) hypertension
- T46.5X6D – Under dosing of other antihypertensive drugs, subsequent encounter
- Z91.12 – Patient's intentional under dosing of medicine regimen
- I25.2 – History of MI

Documentation & Coding Tips

- Atrial Fibrillation (AF) is broken down into four categories:
  1. Paroxysmal – Terminates within seven days
  2. Persistent – Sustained > seven days and is subject to rhythm control to maintain normal sinus rhythm (NSR) via medication
  3. Permanent (Chronic) – NSR cannot be sustained and physicians and other health care professionals or patient cease further attempts to maintain NSR
  4. History AF – AF in the past but now NSR and the patient is not taking medicine to maintain NSR
- Atrial flutter (AFL) is broken down into two categories:
  1. Type I (Typical)
  2. Type II (Atypical)
- If sick sinus syndrome or another cardiac arrhythmia has been successfully treated by implantation of a pace-making device (which is not malfunctioning), the arrhythmia diagnosis should not be captured, as it is considered to be a historical condition, which has now been resolved.
- AF and AFL can specifically be captured when not specified as controlled, resolved or compensated, or when being controlled by medicine as long as that medicine is noted in the visit documentation by the physician or other health care professional. As assessment of the condition, e.g. stable, EKG results or Physical Exam findings, may also serve as M.E.A.T. (monitor, evaluate, assess, treat).
- If non-compliance with medication is documented, it should be coded to category (T36-T50) for under dosing (taking less medicine than prescribed by a physician or other health care professional), along with a code from (Z91.12-Z91.13) for non-compliance or complications of care (Y63.6-Y63.9).

Vascular Diseases

Consider the following common, risk-adjusted ICD diagnoses for Medicare patients:

- Peripheral vascular disease, unspecified (I73.9)
- Other P.E. w/o acute cor pulmonale (I26.99)
- Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (I82.409)
- Abdominal aortic aneurysm, without rupture (I71.4)
- Unspecified atherosclerosis of native arteries of extremities, unspecified extremity (I70.209)
- Atherosclerosis of aorta (I70.0)

Example | Peripheral Vascular Disease

Assessment & Plan

Patient had intermittent claudication and was sent for ankle-brachial index test (ABI). ABI came back abnormal, diagnostic of peripheral vascular disease (PVD). Patient will begin taking aspirin and smoking cessation was discussed, as that can make it worse.

ICD-10 CM Codes

- I73 Code Category – Other peripheral vascular diseases

Documentation & Coding Tips

In order to document most specifically for PVD, include these components in documentation:

- Location of vein/artery
- Whether the vein/artery is native or a graft (and type of graft if known)
- Complications such as intermittent claudication, ulceration or rest pain
- Laterality (left, right or bilateral) and specify if one or both sides are affected by complicating conditions of atherosclerosis

ICD-10 I73 Code Category:

- I73 Other peripheral vascular diseases
- I73.0 Raynaud's syndrome
  - I73.00……without gangrene
  - I73.01……with gangrene
- I73.1 Thromboangiitis obliterans [Buerger's disease]
- I73.8 Other specified peripheral vascular diseases
  - I73.81 Erythromelalgia
  - I73.89 Other specified peripheral vascular diseases
- I73.9 Peripheral vascular disease, unspecified

NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

Chronic Kidney Disease

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

Diabetes and high blood pressure are the two main causes of chronic kidney disease (CKD). Diabetes causes damage to many organs, including the kidneys and heart, as well as blood vessels, nerves and eyes. High blood pressure, or hypertension, if poorly controlled, is a leading cause of heart attacks, strokes and CKD. Also, CKD can cause high blood pressure.

Example | Chronic Kidney Disease

Assessment & Plan

Bloodwork completed on April 8, 2019. Patient eGFR 19=CKD IV due to HTN and DMII. Albuminuria 260. Refer to nephrology for persistent hyperkalemia/metabolic acidosis and recurrent kidney stones. Assess for future kidney dialysis.

ICD-10 CM Codes

- I73 Code Category – Other peripheral vascular diseases

Documentation & Coding Tips

Based on severity, CKD is designated by Stages 1-5.

- N18.2, Stage 2 – Mild CKD
- N18.3, Stage 3 – Moderate CKD
- N18.4, Stage 4 – Severe CKD
- N18.6, Stage 5 – End-stage renal disease (ESRD) or end-stage renal failure

Typically, ESRD patients will have kidney function between 10 to 15%. If the provider documents both a stage of CKD and ESRD, only code N18.6 should be assigned.

- Document any underlying cause of CKD such as diabetes or hypertension
- Document if the patient is dependent on dialysis HCC Z99.2
- Chronic renal failure without a documented stage will be assigned to chronic kidney disease, unspecified N18.9
- Document any associated diagnoses/conditions

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Risk Adjustment Factor Tip Sheet

1. Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients:

DIABETES MELLITUS

- Diabetes Mellitus Type II, unspecified (E11.9_)
- DMII with renal complications (E11.2_)
- DMII with ophthalmic complications (E11.3_)
- DMII with neurologic complications (E11.4_)
- DMII with periph. circulatory complications (E11.5_)
- DMII with other specified complications (E11.6_)

CANCER

- Secondary malignant neoplasm of brain (C79.31)
- Acute myeloblastic leukemia, not having achieved remission (C92.00)
- Acute promyelocytic leukemia, not having achieved remission (C92.40)
- Acute myelomonocytic leukemia, not having achieved remission (C92.50)
- Secondary malignant neoplasm of bone (C79.51)
- Secondary malignant neoplasm of bone marrow (C79.52)
- Malignant neoplasm of unspecified part of unspecified bronchus or lung (C34.90)
- Multiple myeloma not having achieved remission (C90.00)
- Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites (C85.88)
- Other specified types of non-Hodgkin lymphoma, unspecified site (C85.80)
- Malignant neoplasm of colon, unspecified (C18.9)
- Malignant neoplasm of bladder, unspecified (C67.9)
- Malignant neoplasm of rectum (C20)
- Malignant neoplasm of unspecified site of unspecified female breast (C50.919)
- Malignant neoplasm of prostate (C61)
- Malignant neoplasm of thyroid gland (C73)

PULMONARY

- COPD, unspecified (J44.9)
- COPD w acute lower respiratory infection (J44.0)
- COPD w (acute) exacerbation (J44.1)
- Emphysema, unspecified (J43.9)
- Unspecified chronic bronchitis (J42)

CONGESTIVE HEART FAILURE

- Heart failure, unspecified (I50.9)
- Cardiomyopathy, unspecified (I42.9)
- Other restrictive cardiomyopathy (I42.5)
- Other cardiomyopathies (I42.8)
- Other secondary pulmonary hypertension (I27.2)
- Other specified pulmonary heart diseases (I27.89)

RHEUMATOID ARTHRITIS & INFECTIOUS CONNECTIVE TISSUE DISEASE

- Rheumatoid arthritis, unspecified (M06.9)
- Inflammatory polyarthropathy (M06.4)
- Sacroiliitis, not elsewhere classified (M46.1)
- Sicca syndrome, unspecified (M35.00)
- Sicca syndrome with keratoconjunctivitis (M35.01)
- Polymyalgia rheumatica (M35.3)
- Progressive systemic sclerosis (M34.0)
- CR(E)ST syndrome (M34.1)
- Systemic sclerosis, unspecified (M34.9)
- Psoriatic juvenile arthropathy (L40.54)
- Other psoriatic arthropathy (L40.59)
- Systemic lupus erythematosus, organ or system involvement unspecified (M32.10)
- Polymyositis, organ involvement unspecified (M33.20)

MORBID OBESITY

- Morbid Obesity (BMI >=40) (E66.01)
- BMI Ranges (Z68.41 - Z68.45)
- Morbid (severe) obesity with alveolar hypoventilation (E66.2)

MENTAL HEALTH

- Bipolar disorder, unspecified (F31.9)
- Major depressive disorder, recurrent, unspecified (PHQ- 9: 10 - 27) (F33.9)
- Major depressive disorder, single episode, unspecified (PHQ-9: 10 - 27) (F32.9)

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NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

HEART ARRHYTHMIA

- Unspecified atrial fibrillation (I48.91)
- Sick sinus syndrome (I49.5)
- Ventricular tachycardia (I47.2)
- Unspecified atrial flutter (I48.92)
- Supraventricular tachycardia (I47.1)
- Atrioventricular block, complete (I44.2)

- Other P.E. w/o acute cor pulmonale (I26.99)
- Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (I82.409)
- Abdominal aortic aneurysm, without rupture (I71.4)
- Unspecified atherosclerosis of native arteries of extremities, unspecified extremity (I70.209)
- Atherosclerosis of aorta (I70.0)

2. Bill all active diagnoses by attaching ICD-10 codes to the claim for the encounter.

3. Document an assessment and plan for each of the active diagnoses from step 1. Review info with the patient.

Valid Examples of an Assessment and Plan

- Diabetes not controlled – patient unable to keep blood sugar (BS) low enough. Will adjust insulin and see patient for follow up in two weeks. Asked patient to keep log of daily BS during this time.
- Morbid obesity recorded BMI is 40.2 – patient admits to overeating. Discussed dietary changes and reduced caloric intake at length. Will schedule consult appointment with our registered dietitian.

4. Reconcile the problem list based on all active conditions from this evaluation.

Risk Adjustment Factor Tip Sheet

The Following 83 Disease/Categories Impact Risk Adjustment Factor Scores

Code	Name
HCC1	HIV/AIDS
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
HCC6	Opportunistic Infections
HCC8	Metastatic Cancer and Acute Leukemia
HCC9	Lung and Other Severe Cancers
HCC10	Lymphoma and Other Cancers
HCC11	Colorectal, Bladder, and Other Cancers
HCC12	Breast, Prostate, and Other Cancers and Tumors
HCC17	Diabetes with Acute Complications
HCC18	Diabetes with Chronic Complications
HCC19	Diabetes without Complication
HCC21	Protein-Calorie Malnutrition
HCC22	Morbid Obesity
HCC23	Other Significant Endocrine and Metabolic Disorders
HCC27	End-Stage Liver Disease
HCC28	Cirrhosis of Liver
HCC29	Chronic Hepatitis
HCC33	Intestinal Obstruction/Perforation
HCC34	Chronic Pancreatitis
HCC35	Inflammatory Bowel Disease
HCC39	Bone/Joint/Muscle Infections/Necrosis
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
HCC46	Severe Hematological Disorders
HCC47	Disorders of Immunity
HCC48	Coagulation Defects and Other Specified Hematological Disorders
HCC51	Dementia with Complications
HCC52	Dementia Without Complications
HCC54	Substance Use with Psychotic Complications
HCC55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications
HCC56	Substance Use Disorder, Mild, Except Alcohol and Cannabis
HCC57	Schizophrenia
HCC58	Reactive and Unspecified Psychosis
HCC59	Major Depressive, Bipolar, and Paranoid Disorders
HCC70	Quadriplegia
HCC71	Paraplegia
HCC72	Spinal Cord Disorders/Injuries
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
HCC74	Cerebral Palsy
HCC75	Myasthenia Gravis/Myoneural Disorders, Inflammatory and Toxic Neuropathy
HCC76	Muscular Dystrophy
HCC77	Multiple Sclerosis

Code	Name
HCC78	Parkinson's and Huntington's Diseases
HCC79	Seizure Disorders and Convulsions
HCC80	Coma, Brain Compression/Anoxic Damage
HCC82	Respirator Dependence/Tracheostomy Status
HCC83	Respiratory Arrest
HCC84	Cardio-Respiratory Failure and Shock
HCC85	Congestive Heart Failure
HCC86	Acute Myocardial Infarction
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease
HCC88	Angina Pectoris
HCC96	Specified Heart Arrhythmias
HCC99	Intracranial Hemorrhage
HCC100	Ischemic or Unspecified Stroke
HCC103	Hemiplegia/Hemiparesis
HCC104	Monoplegia, Other Paralytic Syndromes
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene
HCC107	Vascular Disease with Complications
HCC108	Vascular Disease
HCC110	Cystic Fibrosis
HCC111	Chronic Obstructive Pulmonary Disease
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders
HCC114	Aspiration and Specified Bacterial Pneumonias
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
HCC124	Exudative Macular Degeneration
HCC134	Dialysis Status
HCC135	Acute Renal Failure
HCC136	Chronic Kidney Disease, Stage 5
HCC137	Chronic Kidney Disease, Severe (Stage 4)
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss
HCC161	Chronic Ulcer of Skin, Except Pressure
HCC162	Severe Skin Burn or Condition
HCC166	Severe Head Injury
HCC167	Major Head Injury
HCC169	Vertebral Fractures without Spinal Cord Injury
HCC170	Hip Fracture/Dislocation
HCC173	Traumatic Amputations and Complications
HCC176	Complications of Specified Implanted Device or Graft
HCC186	Major Organ Transplant or Replacement Status
HCC188	Artificial Openings for Feeding or Elimination
HCC189	Amputation Status, Lower Limb/Amputation Complications

Section 4: Populations

Section 4: Populations

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Florida Hospital Care Advantage (FHCA)

Florida Hospital Care Advantage (FHCA)

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- Individual
- Group
- AdventHealth Employee Plan
- Rosen Hospitality Employee Plan

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Florida Hospital Care Advantage and Health First Health Plans

COUNTIES:

Brevard, Flagler, Hardee, Hernando, Hillsborough, Highlands, Indian River, Lake, Marion, Seminole, Sumter, Orange, Pasco, Pinellas, Polk, Volusia

PLANS AND ESTIMATED NUMBER OF LIVES:

- Medicare Advantage 8,600
- Individual and Group 7,700
- Self-funded 68,100

At-a-Glance Glossary

AdventHealth: Hospital system with 46 hospital facilities in nine states. In Florida, AdventHealth includes over 30 hospitals and emergency rooms, 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities.

AdventHealth Employee Health Plan: The benefit plan name for AdventHealth employees and their dependents is a Florida Hospital Care Advantage product and administered by Health First Health Plans.

AdventHealth Physician Network Central Florida: A physician-led CIN spanning Flagler, Lake, Orange, Osceola, Seminole and Volusia counties.

AdventHealth Physician Network Ocala: A physician-led CIN spanning Marion and Sumter counties.

AdventHealth Physician Network Tampa Bay: A physician-led CIN spanning Hillsborough, Pasco and Pinellas counties.

Clinically Integrated Network (CIN): Brings a hospital system, physicians and other dedicated healthcare providers together for one common goal: to bring quality, performance, efficiency and value to the patient. The AdventHealth Clinically Integrated Networks include: AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala and AdventHealth Physician Network Tampa Bay.

Florida Hospital Care Advantage (FHCA): The brand name of health insurance created in partnership between AdventHealth and Health First Health Plans (HFHP) and supported by the Florida Hospital Healthcare System (FHHS) networks. AdventHealth employees, Medicare Advantage, Group and Individual members are covered as a part of FHCA.

FHCA Commercial Plans: Includes FHCA Individual plans for individuals and families as well as Group plans for small (<50 employees) and large (50+ employees) employers.

FHCA Medicare Advantage (MA): FHCA's plan that includes everything Original Medicare offers, plus additional benefits, like allowances for dental care, vision and a fitness program.

Florida Hospital Healthcare System (FHHS): A fee-for-service provider network and network services team affiliated with AdventHealth.

Health First Health Plans (HFHP): The third-party administrator of medical coverage under the FHCA brand name, providing claims, customer service and medical management. Providers who are contracted for FHCA are also contracted for Health First products.

Population Health Services Organization (PHSO): The professional management arm for AdventHealth Population Health efforts. In Florida, this includes FHHS, AdventHealth Clinically Integrated Networks and AdventHealth ACO. It exists to guide and support AdventHealth in its adoption of transformative, value-based, integrated healthcare models.

SunSaver: This is the FHCA Medicare Advantage plan. This plan has no monthly premium, and no referrals are required. Part D drug benefits are included.

Health First Health Plans, Inc. and Health First Commercial Plans, Inc. are both doing business under the name of Florida Hospital Care Advantage. Florida Hospital Care Advantage does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Contact Reference Guide

Provider Service (Claims, Benefits & Eligibility)

All Plans .... Tel 844-522-5278

Provider Portal

http://myfhca.org/

All Plans Setup .... Tel 407-200-4838
844-522-5279

All Plans Support .... Tel 844-522-5279

Network Services (Provider Outreach and Engagement, Contracting & Demographic Updates)

Central, East and West Regions .... Tel 844-700-7476

Authorizations

Medical

All Plans .... FAX 855-328-0059

Pharmacy

AdventHealth Employee Health Plan - RX Plus Pharmacy .... Tel 866-943-4535
FAX 407-805-8545

Medicare Advantage, Individual and Group .... Tel 844-522-5278
FAX 855-328-0061

Rosen Employees........ Tel 800-311-3446
FAX 248-948-9904

Behavioral Health

AdventHealth Employee Health Plan - Orlando Behavioral Administrators........ Tel 855-847-9419
FAX 407-637-8060

Rosen Employees........ Tel 844-522-5278

All Other Plans - Magellan Behavioral Health........ Tel 800-424-4347

AIM Radiology Program

http://aimspecialtyhealth.com/

All Plans .... Tel 800-694-1005
FAX 800-610-0050

Pain Management (Injections/Spinal Surgeries)

http://palladianhealth.com/

Palladian Health........ Tel 888-658-8181

Health Management

PHSO.HealthMgmt@AdventHealth.com .... Tel 844-700-7476

Claimsnet (Electronic Claims Clearinghouse)

http://health-first.claimsnet.com/

Customer Service..Tel 800-356-0092

Sales/Marketing..Tel 800-356-1511

Change Healthcare (Electronic Remittance Advice-ERA/835 and Electronic Funds Transfer-EFT)

http://changehealthcare.com/

Customer Service..Tel 866-858-8938

Compliance, Fraud/Waste/Abuse Hotline

CCO (Chief Compliance Office)..Tel 321-434-7496

FAX 321-434-7545

Report Abuse..Tel 888-400-4512

FAX 321-434-7545

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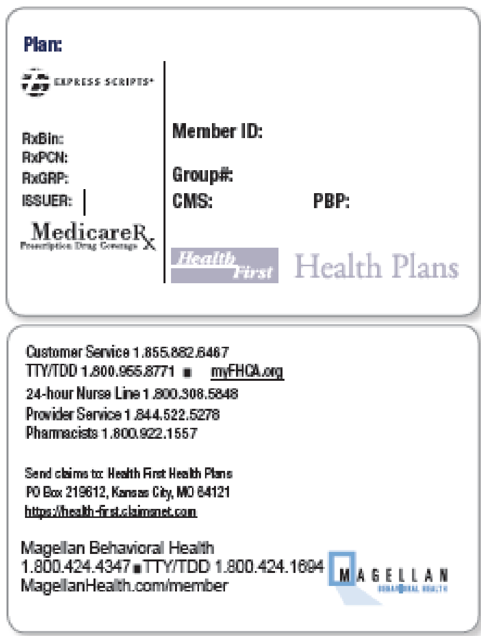
Plan Participation and ID Cards

How do you recognize a Florida Hospital Care Advantage member?

FHHS providers are contracted to accept all FHCA and HFHP products, including Medicare Advantage, Individual and Group plans and self-funded plans such as AdventHealth, Rosen and Health First employees. All FHHS providers accept these contracts unless expressly excluded from your FHHS contract. Examples of the various ID cards are provided to assist you in identifying the plans in which your contract participates.

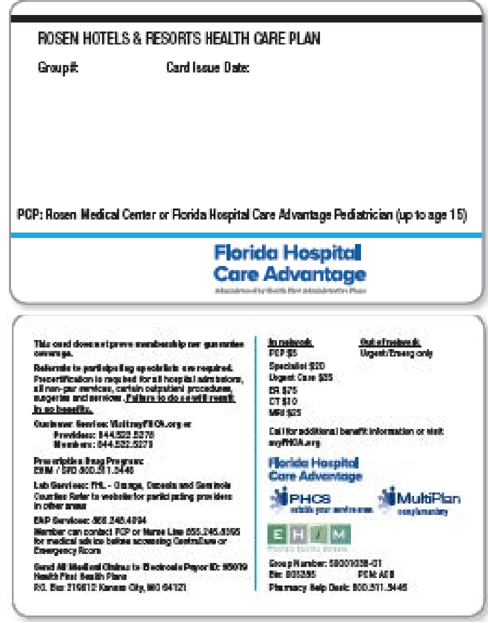
FHCA Plan ID Cards

Medicare Advantage (SunSaver Plan)



AdventHealth Employee Health Plan

Rosen Hotels & Resorts



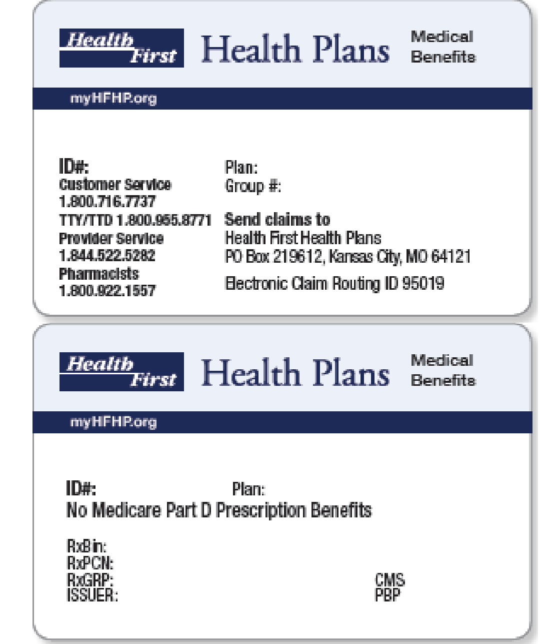
Group and Individual Plans

Health First Health Plans ID Cards

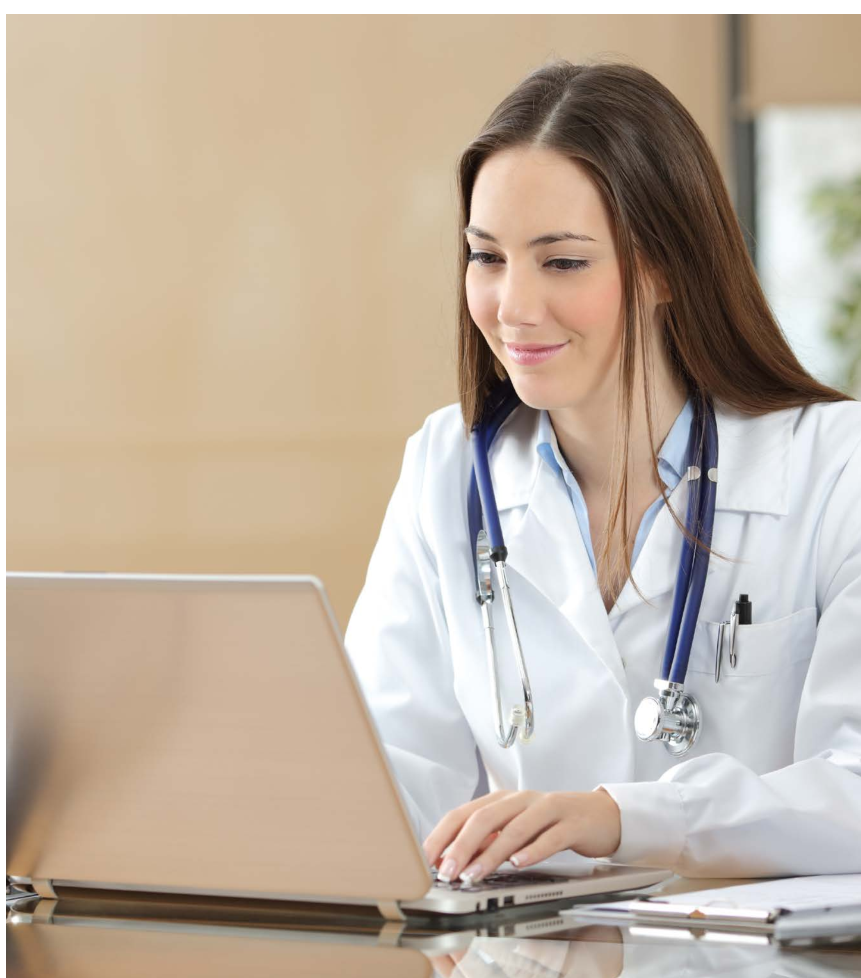
Members of Health First Health Plans (HFHP) are covered as part of your FHHS provider contract.

HFHP Medicare Advantage (with Pharmacy Benefit)

HFHP Medicare Advantage (without Pharmacy Benefit)



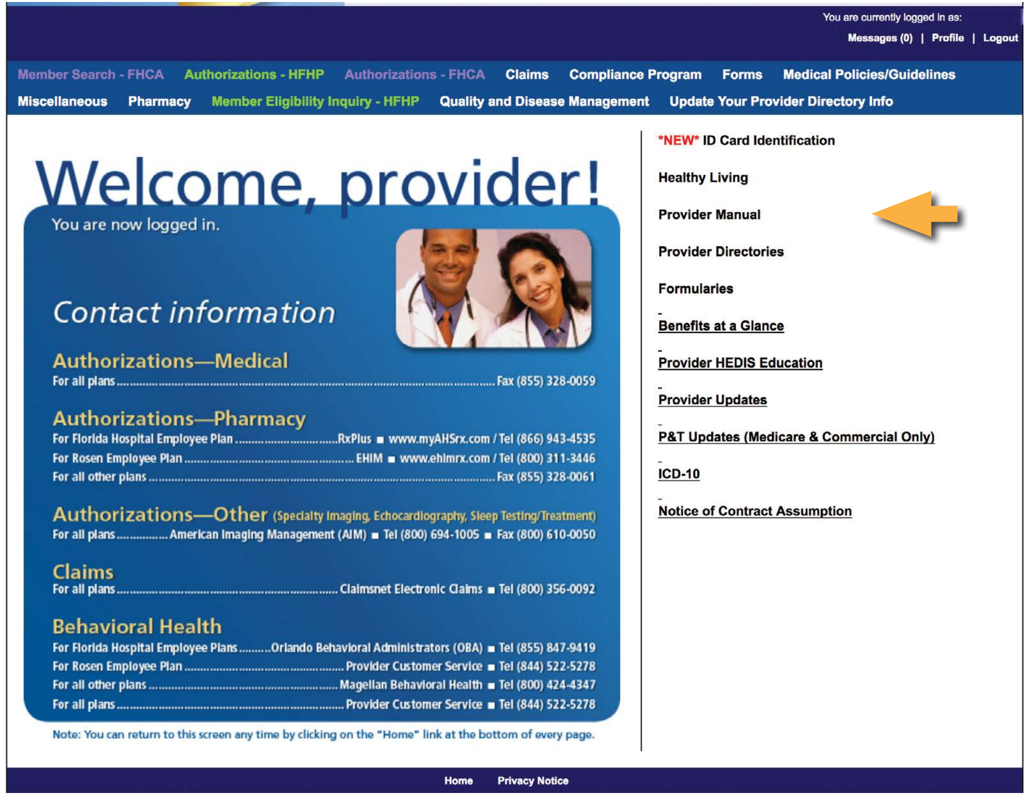
HFHP Individual HMO POS



24/7 Access

For 24/7 access to information please visit myFHCA.org. The complete Provider Manual is available online through the Provider Web Portal. Please see the following page for detailed instructions regarding registration for the Provider Web Portal.

Displayed below is the home page, where the Provider Manual can be located on the right side panel.



After-Hours Access to Information

For after-hours access to information, providers may also utilize the Telephone Self-Service Interactive Voice Response (IVR) System for cost-share information, deductibles and maximum amounts. Simply call the Provider Service line at 844-522-5278.

Telephone Self-Service Instructions: Interactive Voice Response (IVR)

FHCA Provider Service Line 844-522-5278

Enter the Member ID OR last four digits of the Social Security number and the Member's DOB in MMDDYYYY format.

Select Option #1 to speak to a customer service representative (CSR) during normal business hours: Monday through Friday from 8 a.m. to 6 p.m.

Select Option #1 to verify co-pay and co-insurance information.

Select Option #2 for Specialist Cost Share

Select Option #3 for Urgent Care Cost Share

Select Option #4 for Emergency Room Cost Share

Select Option #5 for All Cost Shares

Select Option #2 to verify deductible and out-of-pocket information.

What if I don't have the member's information or the call doesn't pertain to a specific member?

Don't worry. Your call will transfer to the next available CSR within 45 seconds during normal business hours.

CSRs are available to assist you Monday through Friday from 8 a.m. to 6 p.m.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Provider Web Portal

Registration Required

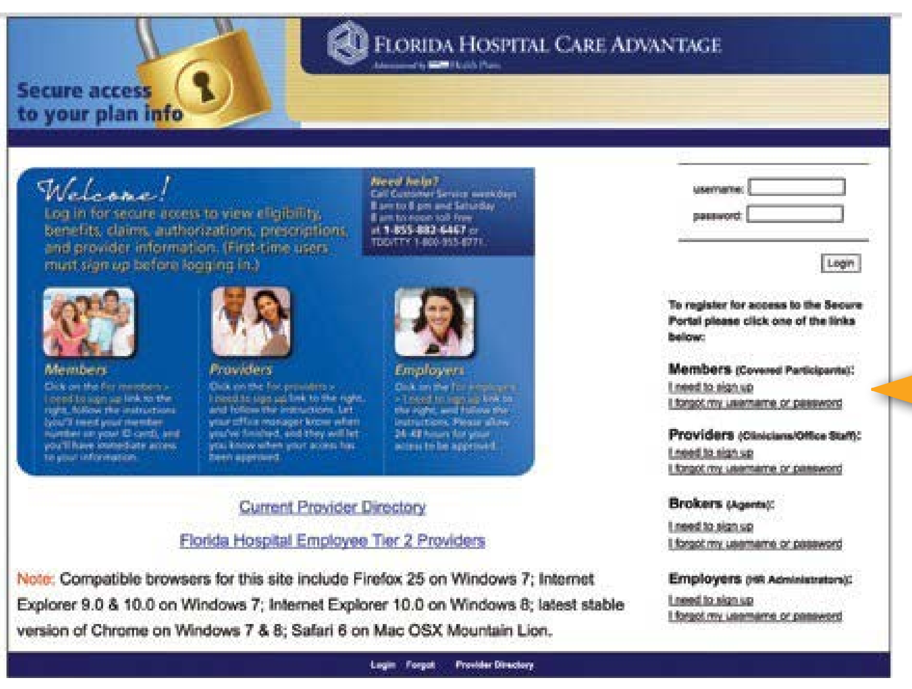
If you do not yet have a provider portal account and would like to sign up for access, please contact your Provider Outreach team.

All individuals requiring access to the provider web portal must register online and create their own login name and password. Account sharing is not permitted.

With your Office Manager's permission, you can register for Online Portal Access at your convenience online by visiting myFHCA.org/myPortal.

The term "Office Manager" in the portal refers to the individual at the providers' practice who is responsible for submitting the User Change Forms to request new user account activation and to request removal of users who have left the practice.

As the portal "Office Manager" please have new employees who need access complete the online registration at myFHCA.org/myPortal and follow these instructions:



- The home screen appears; save this link in your Favorites (or Bookmarks). You will log in here
  each time.
- From the home screen, under Providers (Clinicians/Office Staff) click I need to sign up.

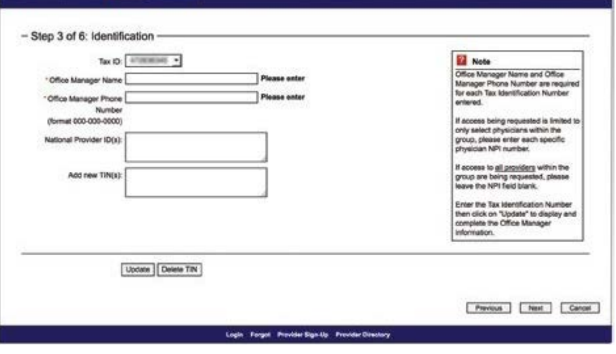
NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

- **Step 1 of 6:** Read and click Agree to the License Agreement and complete the requested information on the next screen. All information pertains to the office. Do not submit personal information.

- **Step 2 of 6:** Click Next to navigate through the screens. Enter personal information as indicated.

- **Step 3 of 6:** Enter your Tax ID number on the next screen.



- **Step 3 of 6 continued:** Enter your office manager name and phone number on the next screen. Important: If user needs the Authorizations function, the NPI numbers for the group and each provider in the group must be listed.

NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

Provider Web Portal

- **Step 4 of 6:** Select User Type (only Office Manager type will receive an option to send an access request to Provider Outreach once a user ID is created. All other user types will be prompted to contact their manager for system access).

- **Step 5 of 6:** Create a User ID and password.
- **Step 6 of 6:** Verify your information and click Finish. Registration is complete when you reach the message to contact your Office Manager to request access. Give only the login name you created to your office manager and ask that he/she submit an activation request. Passwords are confidential. Do not share your password with anyone.

- Office Managers will receive a message that includes a link to click for the Change Request Form.
- A previously registered/existing Office Manager logs in to his/her provider portal account and completes the Change Request Form found on the User Access Permission tab.
- Complete the Change Request Form, listing all Tax ID numbers the user will need to access.
  - When submitting for multiple users, submit all users with the same security level on one request. Choose either Eligibility Only or ALL (includes eligibility, claims and authorizations).
- List each associate for whom you are requesting access, including yourself if you are also a new user. Include first and last names, as well as the login name the associate created during registration. Please remember that passwords are confidential. Do not ask your associates for their passwords.
- Upon completing the form and clicking Submit, the form is automatically sent to the Florida Hospital Care Advantage provider outreach representative via an express request email within the portal.
- Once the request is received, an FHCA provider outreach representative will set up the access and send a message back to the Office Manager's express web portal email.
  - The Office Manager will know there is a reply when the Messages (1) link on their provider web portal account turns red. This link is at the top right corner of your screen.

Turn-around time for portal access is two or three business days from the time the Office Manager submits the request. Requests received without registrations must be returned as denied.

Provider Portal Password Reset Directions

Users who do not remember the password created during registration should follow the below steps:

- Go to the myFHCA.org home page (where you would normally log in)
- Under Providers, click on I forgot my username or password
- Click on Password and then Next
- Input your Username and click Next
- Answer the Secret Question and click Next
- Click Finish. An email with the new temporary password is sent to the email address on record for the user.

Users wanting to update their email address, create a new password, and/or change their security question should follow the below steps:

- Log in to your myFHCA.org account
- Click on Profile at the top right corner of the screen (you may have to expand the window to see the entire screen)
- From the Account Info tab, you can add or change your email address. Click Update to complete the change
- From the Security Info tab, you can create a new password (if you know your current one) and change your security question and answer. Click Update to complete the change

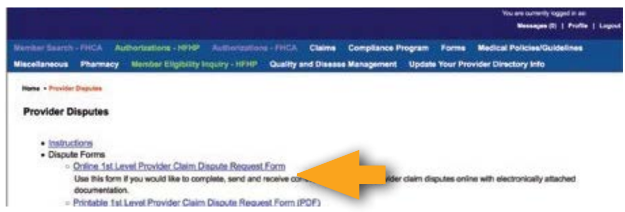
In addition, the Comments section has been added to the bottom of the User Change Request Form. Use this space for name changes, access updates, etc.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Submit Claims Disputes Online

Florida Hospital Care Advantage accepts provider disputes submitted electronically through our online provider web portal. The portal is available 24 hours a day, seven days a week.

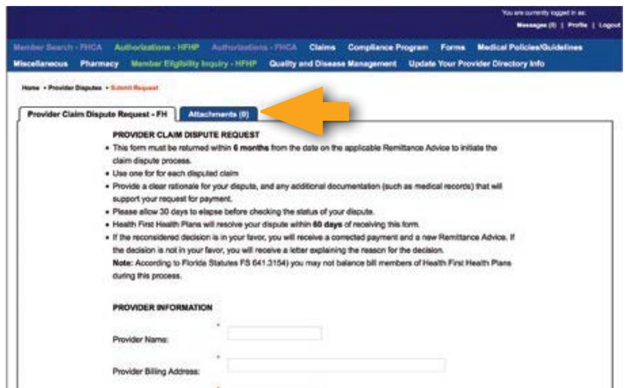
Simply log into the provider portal,
click on Claims > Provider Disputes > Online 1st Level Provider Claim Dispute Request Form and fill in the simple form with all the required information.



Click on the Attachments tab to upload supporting documentation (files must be 10 MB or less, and can be Microsoft Word, Excel, or Adobe Acrobat—for example .doc, .docx, .xls, .xlsx, or .pdf). You can also save your dispute if you need to finish it later.

Other options for submitting disputes are:

- By phone: For a single issue/single member, our CSRs can enter most disputes over the phone. Call toll-free 844-522-5278 on weekdays from 8 a.m. to 6 p.m.
- By mail: If you have several disputes, please mail them to us at Florida Hospital Care Advantage, Attn: Claims Resolution Unit, 6450 US Highway 1, Rockledge, FL 32955, or submit them online.



We hope you will find this process makes it easier for you to work with us. Our goal is to be your partner of choice. For questions about the dispute process, please review your Provider Manual, talk to your provider outreach representative, or contact our Customer Service Department.

NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

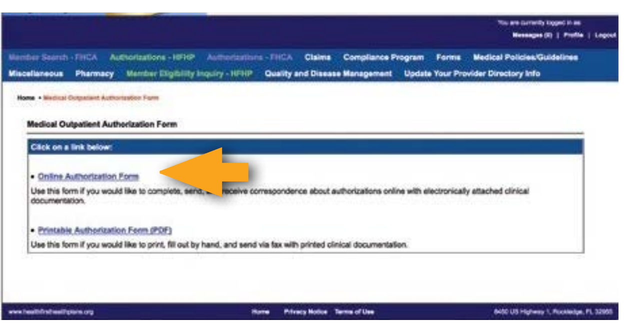
NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Submitting a Medical Outpatient Authorization Request on the Web Portal

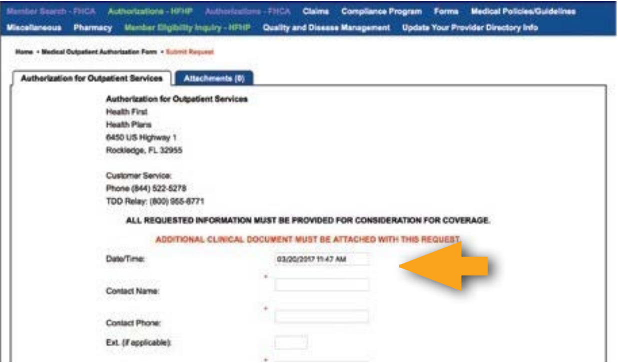
Please follow these steps to request a medical outpatient authorization on our secure online provider portal.

1. Under the Authorizations – FHCA tab, click on Medical Outpatient Authorization Form.

2. Click on the Online Authorization Form link.



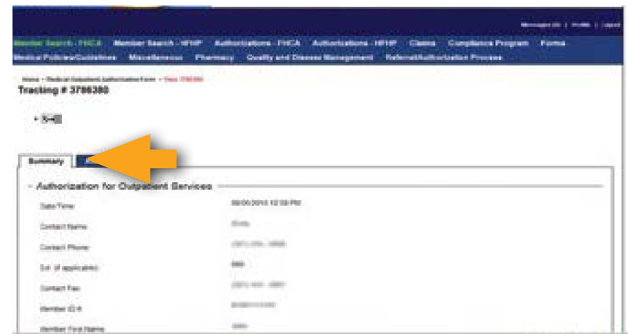
3. Fill in all required fields. Anything with a red asterisk is required for processing.



4. Once complete, click on the Attachments tab at the top.

5. When all fields are complete and clinicals are attached, under the Authorization for Outpatient Services tab, click Submit.

6. When submission is complete you will be provided with a summary of what was submitted and a tracking number for confirmation.



Once the authorization review is complete, you will receive the answer in written form by FAX or mail.

NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Reviewing Authorization Status

1. Under Member Search – FHCA tab, click on View Patient Information.

2. Then click on the Authorization tab.

3. Enter in the patient's Member ID Number and date of birth.

NOTE: For pharmacy and drug authorizations, repeat step #1, selecting the "Pharmacy/Medical Drugs Authorization Form" from the drop-down menu.

Self-Service Option

What do I need?	Where do I go?
Verify Benefits	Self-Service IVR myFHCA.org Online Portal Eligibility Inquiry (HIPAA 270/271 EDI Transaction)
Verify Deductible or Out-of-Pocket	Self-Service IVR myFHCA.org Online Portal
Verify Claim Status	myFHCA.org Online Portal Claim Status Inquiry (HIPAA 276/277 EDI Transaction)
Verify Member Eligibility	myFHCA.org Online Portal Eligibility Inquiry (HIPAA 270)
Obtain Member ID Number	myFHCA.org Online Portal
Review Authorization Status	myFHCA.org Online Portal

Authorizations

General Information

- Authorization requirements are administered by Health First Health Plans ("Health First").
- Benefits are determined by the member's plan type. Items on the authorization list may have limited coverage or may not be covered at all.
- All items and services on the authorization list require prior authorization, regardless of the service location, plan type or provider participation status. Please note there are different authorization lists depending on the member's plan type. Please visit myFHCA.org for detailed listings.
- Referrals are not required for network specialist care for the AdventHealth Employee Plan, Medicare Advantage, or Commercial Health Plans. Refer to the current Provider Directory or visit our website for a list of network providers.
  - Rosen Employee Plan – please fill out Referral to Specialist form found online at myFHCA.org.
- Authorization is not a guarantee of payment. Coverage is subject to member eligibility, as well as applicable benefit and provider contract provisions on the date of service. Contract limitations may apply and supersede any authorization provided.
- The authorization list is updated periodically but may change at any time. Please refer to the current version by visiting our website at myFHCA.org.
- See the Authorization Code List/Medical Authorization List for potentially-applicable procedure codes. The list is available on our website. Codes are for reference only, are not all-inclusive, and are subject to change.
- If waiting for a decision in the standard timeframe could seriously harm the member's life, health or ability to regain maximum function, an expedited process is available.

How to Request Authorization

With the exceptions noted below, authorization requests should be submitted directly to the Health Plan by faxing the appropriate "Authorization Request" form to 855-328-0059 or requesting authorization online. Include applicable codes, patient identification and clinical information to support the request.

Pharmacy

AdventHealth Employee Benefit Plan: Authorization is provided by Rx Vendor (RX Plus/MedImpact). Rx Plus authorizations can be made via phone at 866-943-4535 or online at MyAHSRx.com. For the most up to date Pharmacy Drug List, visit MyAHSRx.com/helpfultips/forms/formularydruglist.

Rosen Employee Plan: Contact EHIM at 800-311-3446 for authorizations.

All other plans: Authorization by Rx Vendor (Express Scripts). Submit the appropriate pharmacy (drug) "Authorization Request" form or request authorization online by visiting myFHCA.org/myPortal or FAX drug authorization requests to 855-328-0061. You can access formularies through your secure web portal account by visiting myFHCA.org/myPortal. Contact customer service via phone at 844-522-5278.

Behavioral Health/Substance Abuse Services

AdventHealth Employee Benefit Plan: Services are authorized by Orlando Behavioral Administrator (OBA). OBA authorizations may be requested by phone at 855-847-9419.

Rosen Employee Plan: Authorizations may be requested by phone at 844-522-5278.

All other plans: Services are authorized by Magellan Behavioral Health, Inc. (Magellan). Authorization may be requested by phone at 800-424-4347 or online at MagellanProvider.com.

AIM's Preauthorization (Precertification) Process

To request authorization for radiology services through AIM, you must first register online

- Register at http://aimspecialtyhealth.com/goweb.html
- Open the Start Here selection box and select "Health First Health Plans."
- For assistance, see instructions on AIM's portal.

AIM Procedures

- The ordering practitioner must contact AIM to obtain authorization before scheduling services. Radiology providers/freestanding centers should confirm that an authorization was obtained prior to service delivery.
- Most authorizations are completed immediately or within just a few days. Only a qualified physician may deny coverage for lack of medical necessity.
  - AIM's prior authorization numbers are valid for thirty (30) days from the issue date.
- If the initial facility changes due to scheduling issues, it is important to call AIM with the facility that will perform the services. However, as long as it remains a FHCA contracted facility, the claim will still be paid.

Required Information

Please use the checklist below as a guide to ensure you have all the information necessary:

- Member identification number, name, date of birth and health plan
- Ordering physician information
- Imaging provider information
- Imaging exam(s) being requested (body part, right, left or bilateral)
- Patient Diagnosis (suspected or confirmed)
- Clinical symptoms/indications (intensity/duration)

For most situations, the above will suffice. For complex cases, more information may be necessary, including:

- Results of past treatment history (previous tests, duration of previous therapy, relevant clinical medical history, etc.) AIM will accept a copy of an electronic medical record (e.g., Logician) that includes dates of present illness, medications and recent previous treatment/studies.
- Ordering physicians may also contact AIM's physician reviewer at any time during the precertification process. If the request is approved, AIM will contact the ordering physician with an order number, which will be valid for 30 days from the date issued.

If the request cannot be approved at intake, the order will remain open for up to five business days to allow opportunity for a peer-to-peer discussion and additional clinical information to be submitted.

If the request cannot be certified based on available information and evidence-based criteria, a denial will be issued by AIM. A denial notice will be sent to the ordering physician as well as the patient. For a complete listing of imaging CPT codes that require precertification from AIM, please log into the Provider Portal at MyFHCA.org.

Reviews of Non-Certified Procedures

If certification has been denied, FHCA members have the right to appeal by following the detailed instructions contained in their denial notice.

AIM Radiology Program

All plans: Authorizations are processed by AIM Specialty Health (AIM) for all lines of business. Under this program, authorization is required for outpatient non-emergency CT scans, MRIs, MRAs and PET scans. Submit requests to AIM and access clinical guidelines through their website at AimSpecialtyHealth.com. Authorization requests may also be submitted by phone at 800-694-1005. See below for additional information about AIM processes.

Spinal Procedures (surgeries, injections)

AdventHealth and Rosen Employee Benefit Plans: Spinal surgeries are authorized by the Health Plan. Pain injections do not require prior authorization for these members.

All other plans: Authorizations are processed by Palladian Health. Submit requests to Palladian or access clinical guidelines through their website at PalladianHealth.com. To submit requests to Palladian online, you must register using your Group Tax ID# and the Access Code of HFIRSTPROVIDER.

Echocardiograms, Sleep Studies and Positive Airway Pressure (PAP) Devices

AdventHealth and Rosen Employee Benefit Plans: Authorization is not required for echocardiograms or sleep testing; PAP devices are authorized by the Health Plan for these members.

All other plans: Authorizations are processed by AIM Specialty Health (AIM). Submit requests to AIM or access clinical guidelines through their website at AimSpecialtyHealth.com or call 800-694-1005.

Claim Submission

Electronic Claims

Note: First, contact the clearinghouse that you use to submit electronic claims and confirm that claims are being received by Claimsnet. If they are not going through your chosen clearinghouse, Claimsnet will be unable to assist.

1. Contact Claimsnet, the clearinghouse vendor used by Health First Health Plans, to confirm that you or your claims clearinghouse are able to submit electronic claims files to them. Claimsnet can be reached by calling 800-356-0092 or via email at HelpDesk@Claimsnet.com. Please reference Health First Health Plans Claimsnet Payer ID Number 95019.
2. After confirming your ability to submit claims electronically via Claimsnet, you will need to contact Change Healthcare (formerly known as Emdeon), the vendor used by Health First Health Plans to deliver electronic remittance advice (ERA) and electronic funds transfer (EFT) ePayment Services, to enroll.

ePayment Services

The Change Healthcare enrollment forms for EFT and ERA ePayment Services can be found online at ChangeHealthcare.com or you may contact them by calling 866-858-8938. Please reference Health First Health Plans Change Healthcare Payer ID 15064.

To view Health First Health Plans requirements for ERA and EFT, please go online to: ChangeHealthcare.com/Legacy/Support.

1. At the top right of the screen, under Menu, select Resources, then choose Payer Lists
2. At the top left of the screen, under Payer Lists, click on Medical/Hospital/Dental Payers
3. In the Payer ID field, enter 1506
4. Click the View List button

Please allow two weeks for delivery of ERA and EFT, once you have completed your enrollment with Change Healthcare for ePayment services. In the interim, you will receive paper explanation of payment (EOP) and paper checks for processed claims.

Paper Claims

All claims that are submitted on paper should be submitted to the following address:

Health First Health Plans
PO Box 219612
Kansas City, MO 64121

Provider Disputes and Corrected Claims

Disputes

Providers can submit disputes online or via the telephone. Providers can go to http://myfhca.org/myPortal to submit a dispute online or they can contact the Florida Hospital Care Advantage Customer Service Department at 844-522-5278 to submit a dispute over the telephone. Providers may submit disputes on paper by sending them to the following address:

Florida Hospital Care Advantage
Attention: Claims Dispute Unit
6450 US Highway 1
Rockledge, FL 32955

FAX: 321-434-5655

All disputes must be submitted to Florida Hospital Care Advantage within the dispute filing guidelines outlined in Policy CL-124 Provider Dispute Policy. Here are some examples of when a provider might submit a dispute for timely filing:

- Provider was given incorrect insurance information and does not have any claims history with Florida Hospital Care Advantage for that member.
- Provider was given incorrect insurance information and the claim was initially paid by the other carrier but later refunded due to the error.

Timely Filing Disputes

When submitting a dispute for timely filing, the provider must submit an acceptable form of documentation to support the claim from a timely filing perspective.

While frequently sent as proof, the following items are NOT acceptable forms of timely filing for disputes:

1. Screen prints of billing systems indicating a bill was dropped
2. A claims acknowledgement report from the provider's clearing house
3. An error/reject report from Claimsnet

Acceptable Proof of Timely Filing

Paper Claims: FAX confirmation or receipt from certified mail, FedEx, UPS, etc.

Electronic Claims: Acceptance report from Claimsnet. Please note that confirmation of receipt from the provider's clearing house and/or a rejection report from Claimsnet would not be acceptable.

Lack of Insurance Information: Documentation that demonstrates the provider did not receive correct insurance information from the member at the time of service. Please note that Florida Hospital Care Advantage will utilize claims history from the provider to determine if prior claims were submitted by the provider.

Other Insurance (Coordination of Benefits/ Subrogation): Documentation that demonstrates that another insurance company made payment and then recouped the payment. The claim must be submitted to Florida Hospital Care Advantage within three (3) months of the primary carrier's payment/ determination.

Unlisted Codes

Unlisted Procedure Codes: When submitting a claim with an unlisted procedure code, these claims should be submitted on paper and the description of the unlisted code should be written or stamped in black or blue ink in Box 24D of the 1500 form. DO NOT USE RED INK. Please submit all relevant documentation to support billing the unlisted procedure code, i.e., operative report lab report, etc.

Examples of supporting documentation might be a Medicare RA showing payment, a letter from the physician indicating medical necessity, a letter from the coding manager or supervisor justifying the amount being billed, or any listed CPT codes to which the unlisted code might be compared.

By following this process for unlisted codes, providers will avoid unnecessary denials for duplicate claims, ensure that the most accurate and timely claim edits are applied, and ensure the most accurate payment.

Unlisted J-codes: When submitting a claim with an unlisted J-code, these claims should be submitted on paper and the description of the unlisted J-code should be written or stamped in black or blue ink in Box 24D of the 1500 form. DO NOT USE RED INK. Please attach the appropriate invoice to this claim.

Corrected Claims

Corrected claims are considered a replacement of the original claim and must be submitted in their original form. Therefore, the corrected claim should include all services that were on the original claim that are to be considered for payment, even if the service(s) is paid. The only difference that should exist between the original claim and the corrected claim is the data that the provider wants to have corrected.

Electronic Corrected Claims: To submit a corrected claim electronically providers will need to add a type of bill that contains a frequency type code of 5, 7, or 8, as well as the original Florida Hospital Care Advantage claim ID number in their 837 file.

> **Frequency Type Codes Accepted:**
> 5 - Late Charges (Institutional Claim use)
> 7 - Replacement (replacement of prior claim)
> 8 - Void (void/cancel of prior claim)

The type of bill should be submitted in the 2300 loop; CLM05-1 thru CLM05-3 (CLM05-3 is the frequency type code). The original Florida Hospital Care Advantage claim ID number should be submitted in 2300 loop; REF*F8 segment.

Please note that when the frequency code is 5, 7 or 8, the original claim ID should be the Florida Hospital Care Advantage claim ID number.

Paper Corrected Claims: All corrected claims submitted on paper should be clearly marked “corrected” in blue or black ink in Box 19 of the 1500 form. DO NOT USE RED INK. Corrected claims must be signed by the provider. This includes any corrections made by the provider or requested by Florida Hospital Care Advantage.

Corrected Claims for 25/59 Modifiers: Corrected claims adding the 25 or 59 modifier should be submitted on paper. These claims must be submitted with the “25/59 Corrected Claim Cover Sheet” along with all relevant documentation that supports the addition of these modifiers.

All corrected claims that are submitted on paper should be submitted to the following address:

> **Florida Hospital Care Advantage**
> **Health First Health Plans**
> **PO Box 219612**
> **Kansas City, MO 64121**

If you have questions or concerns about any of this information, please do not hesitate to contact your provider outreach representative.

Florida Hospital Care Advantage (FHCA) Medicare Advantage

Medicare Advantage (MA) is one of the available FHCA plans. As an FHHS provider, you accept this plan unless it was specifically omitted from your FHHS contract. Occasionally, CMS conducts audits of participating physicians; therefore, it is important that you tell your patients that you accept FHCA MA products.

Clinical Documentation Integrity (CDI) Program

FHCA providers who see more than one Medicare Advantage patient have an opportunity to participate in the Clinical Documentation Integrity (CDI) program in 2019. This program compensates physicians for providing and documenting appropriate treatment and coordinating care for Medicare Advantage patients. Providers can earn up to $225 per member per year by participating in the FHCA CDI Program. The program activities include diagnosis validation opportunities, referring members for a Comprehensive Health Assessment (CHA) and closing nine care gaps.

Participation in the program is simple. There are two components – the Comprehensive Health Assessment (CHA) referral and the CDI form completion. Providers can start earning incentive dollars at any time by referring your patients for a CHA using the dedicated referral line with the FHCA CHA vendor. FHCA CDI program providers will receive forms for each MA patient where there are open care gaps. These forms will be available via paper or access through a web-based tool. To receive credit, after patients are seen in the office and appropriate information is gathered at the point of care, CDI forms will need to be completed in the web-based tool or returned to FHCA. Incentive payments will be mailed quarterly to the group on your Employer Tax ID Number. For the highest reimbursement, program requirements must be completed for each patient by September 30, 2019. Forms submitted by the end of 2019 will qualify for reduced incentive payments. For providers new to the program, some initial training is required.

Some frequently asked questions about the CDI program are available below. If you have additional questions about the CDI program or would like to participate, please contact the Provider Experience Center by calling 877-850-5438 or via email at AHS.ExperienceCenter@AdventHealth.com.

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Clinical Documentation Integrity (CDI) Program

Frequently Asked Questions (FAQs)

Program Goals

- Provide quality health care and support to Florida Hospital Care Advantage (FHCA) members to help them maintain their quality of life.
- Utilize nationally recognized best practices that focus on prevention and early disease detection, leading to better outcomes for FHCA members.
- Reward participating providers for giving appropriate care and documenting it to the highest level of specificity.
- To create an environment of data transparency that improves care coordination among concurrent providers.
- Receive accurate and proper payment to care for our members based on the expected cost of their health care by submitting accurate data to the Centers for Medicare and Medicaid Services (CMS).

Q: Why is the CDI program important to Florida Hospital Care Advantage (FHCA)?

- CMS calculates our Medicare Advantage (MA) payment annually based on the current conditions of our enrolled membership. Accurate payment helps us ensure that we have sufficient resources to provide effective treatment for high-cost patients.
- CMS requires us to submit accurate information on all FHCA MA members annually.
- The National Committee for Quality Assurance (NCQA) establishes the Healthcare Effectiveness Data and Information Set (HEDIS) measures to benchmark performance and compares health plans nationwide. CMS uses the benchmarks to determine how our network is performing compared to other health plans in the country.

Q: How do I participate?

- Sign the 2019 CDI program amendment to your Florida Hospital Health System (FHHS) contract and submit to PHSO.Provider.Outreach@AdventHealth.com.

Q: How is a CDI form generated?

- **Risk Adjustment Factor (RAF) Recapture:** Diagnosis data reported from claims or chart review – which includes hospital inpatient, hospital outpatient, in-home assessments and physician office settings – captured in the last two years.
- **HEDIS Care Gaps:** NCQA determines measures based on best clinical practices proven to deliver better outcomes. Opportunities exist when a member has not completed the required screenings or had appropriate medications prescribed.

Q: How much of a bonus am I eligible to earn?

- The bonus amount that you are eligible to earn is based on the number of attributed Medicare Advantage (MA) members with opportunities.
- All submitted reports must be completed and include supporting documentation where indicated.
- Opportunity reports that are received and noted as non-compliant can be corrected and resubmitted at any time before the end of the program year.
- The amount you can earn for closing all opportunities on each report is listed below.
  - Coding recapture opportunities:
    - Submitted before October 1, 2019: **$150 per member**
    - Submitted after October 1, 2019: **$75 per member**
  - Quality Performance Measures:
    - **$50 per member**
  - Referral for completed Comprehensive Health Assessment:
    - **$25 per member** (tracked through dedicated referral phone number)

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Q: Which members are attributed to me?

- Attribution is determined through claims by the number of office visits and/or most recent visit that a member has had with a provider. You will receive a list of all members attributed to you, along with an opportunity report for each member. The member report outlines all diagnoses that need to be assessed in 2019 and/or the care gaps of your attributed members.

Q: What if I have seen the member already?

- If you have existing documentation or results that support a care gap closure, or you assessed the diagnoses listed on the member report in 2019, you can close the opportunity. Simply complete the required information documentation, including supporting dates of service or results as needed.

Q: How do I earn a bonus for referring an attributed member to complete a Comprehensive Health Assessment (CHA)?

- Discuss the importance of a Comprehensive Health Assessment with your patients.
- Give your patients the flyer explaining the CHA program that has the phone number to schedule a CHA appointment.
- Have your staff schedule the CHA appointment through the dedicated phone number on the flyer for the member as they are checking out from an appointment.

NOTE: The CHA visit must be scheduled through the dedicated line and completed to receive the bonus.

Q: How do I earn a bonus for an attributed member with "quality performance measures?"

- To close a care gap, you often need to order a diagnostic study and obtain results before you can "close a gap in care." Ordering diagnostic studies and discussing preventive care with members will not close care gaps. The needed results and required documentation will close care gaps.
  - After you complete documentation or results to support "closure" of all care gaps indicated, you will need to provide documentation of the results.

Q: How do I earn a bonus for an attributed member with "documentation recapture opportunities?"

- Conduct an office visit in 2019 to assess diagnoses listed on the member's report in the CDI web-based tool.
  - ✓ "**Yes**" if you determine the diagnosis listed is current and document in the assessment of the office visit.
  - ✓ "**No**" on the member report if you determine a diagnosis is not active.
- Provide the date of service for all encounters associated with the diagnoses listed.
- Provide a copy of the office visit with supporting documentation of the listed diagnosis.

Q: Why do I need to validate diagnoses that resulted from other providers?

- As the primary care provider, you are viewed as the manager for the overall health of the patient; thereby, you should be aware of active and existing conditions and all medications. The member report gives you a snapshot of the patient's health and helps you to overcome gaps in knowledge that commonly arise through concurrent providers. The report supports care coordination and communication among providers to prevent adverse events.

Q: Whom do I contact for CDI program questions?

- Call the Provider Experience Center at 877-850-5438.
- Email PHSOCDI.RAF@AdventHealth.com.
  - Contact your provider outreach representative to request an office visit.

Things to Know:

- Face-to-face office visits must be completed in 2019 to validate diagnosis. An easy way to determine whether a condition is active: Do you TAMPER? = **T**reat, **A**ssess, **M**onitor or **M**edicate, **P**lan and **E**valuate or **R**efer for the condition listed.
- Based on the member's medical history and experience, you have the flexibility to decide which option is best to close the care gap(s) marked "**X**." Refer to your FHCA HEDIS quick-reference guide for a list of options if you have questions.
- All mammograms, diabetic eye exams and some labs (e.g., FIT), require actual results to close care gaps.
- Member reports must be submitted no later than January 31, 2020.

Oscar

Oscar

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Contract Details

- **Counties:** Lake, Orange, Osceola and Seminole
- **Estimate number of lives:** 34,000
- **TPA contact information:**

  https://www.hioscar.com/providers
  855-672-2755

- Fee-for-service and shared savings

At-a-Glance Glossary

AdventHealth: Hospital system with 46 hospital facilities in nine states. In Florida, AdventHealth includes over 30 hospitals and emergency rooms, more than 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities.

AdventHealth Physician Network (AHPN) Central Florida: A physician-led CIN spanning Flagler, Lake, Orange, Osceola, Seminole and Volusia counties.

Clinically Integrated Network (CIN): Brings a hospital system, physicians and other dedicated health care providers together for one common goal: to bring quality, performance, efficiency, and value to the patient. The AdventHealth Clinically Integrated Networks in Florida are AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, and AdventHealth Physician Network Tampa Bay.

Oscar Health: A health insurance company that engages members and guides them to the right care, helping over 250,000 individuals and businesses.

Population Health Services Organization (PHSO): The professional management arm for AdventHealth Population Health efforts. In Florida, this includes, Florida Hospital Healthcare System (FHHS), AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, AdventHealth Physician Network Tampa Bay, and AdventHealth ACO. It exists to guide and support AdventHealth in its adoption of transformative, value-based, integrated health care models.

Contact Reference Guide

Provider Customer Service Monday through Friday: 8am to 6pm .... Tel 855-672-2755

Authorizations .... Tel 855-672-2755

Pharmacy .... Tel 855-796-7227

Overview

Effective January 1, 2019, Oscar Health, a new health plan to Central Florida, will be offering individual and commercial group plans in Orange, Osceola, Seminole and Lake Counties. This is an upside-only shared savings agreement.

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ID Cards

Melissa Franklin

SAMPLE

oscar

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Oscar Preferred Vendors

Ensure your patient does not receive a surprise bill by routing them to one of Oscar's preferred vendors:

- Behavioral Health and Substance Abuse - Optum
- Pharmacy - CVS Caremark
- Laboratory - Guest Diagnostics
- Pediatric Dental - LIBERTY Dental
- Pediatric Vision - Davis Vision

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NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Oscar Claim Submission

To allow for fast resolution, submit your claims electronically by selecting OSCAR as your electronic payor.

Payor ID	Electronic Submission (Clearinghouse)	Paper Submission (Mailing Address)
OSCAR	Change Healthcare	Oscar Insurance P.O. Box 52146 Phoenix, AZ 85072-2146

Oscar Prior Authorization

Oscar requires prior authorization on high-level services including:

- Non-emergent inpatient procedures and ambulance services
- Home health services
- Durable medical equipment (DME), prosthetics, and orthotics with an annual cost of $500 or more
- Select outpatient procedures

For a full list of services that require authorizations, please refer to Oscar's provider manual available at Resources.HiOscar.com.

To request a prior authorization, log in to Oscar's provider portal, Provider.HiOscar.com, or contact Oscar at 855-672-2555.

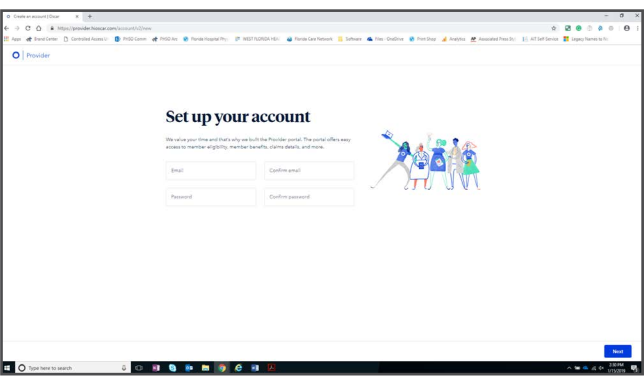
Oscar Provider Web Portal

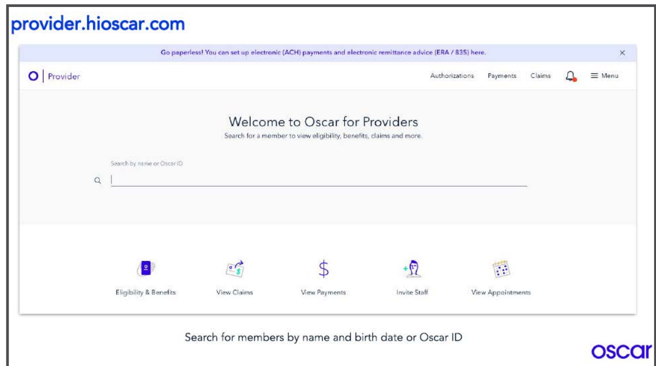
The Oscar provider portal offers easy to access member eligibility, member benefits, claims details, and more.

CREATE AN ACCOUNT

Go to Provider.HiOscar.com and click 'Go to Portal' to create an Oscar provider portal account. To create an account, you will need your TIN and basic information about your practice.

Once your account is created, you can easily navigate Oscar's site to find information on authorizations, payments, claims and more.





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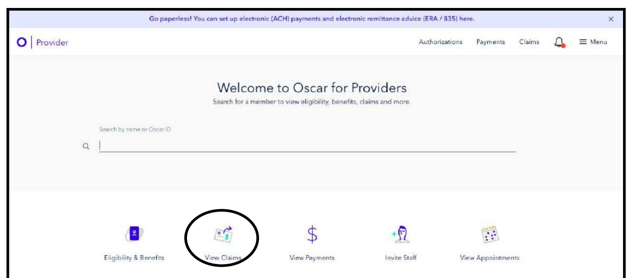
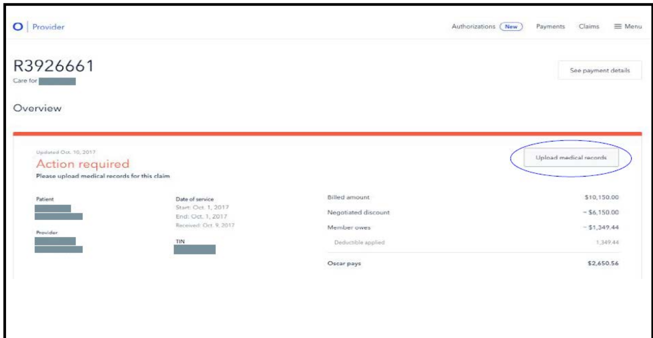
CLAIMS VIEW

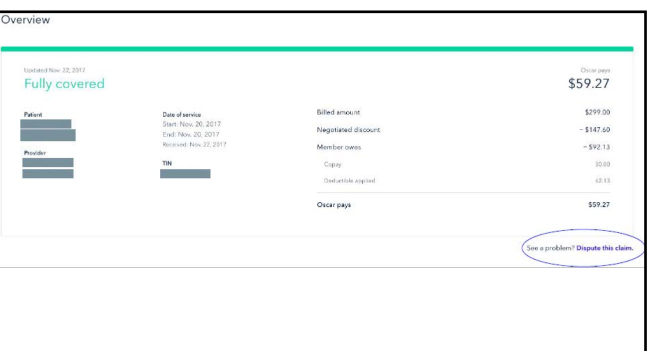


After logging in, select View Claims from the home page.

On the **Claims** page, you will see a listing of all claims. Use the drop down in the top right corner to filter your view.



Click the claim ID number to see the claim's overview including any potential required action for that claim.



To dispute a claim, click **Dispute this claim** and complete any necessary information.

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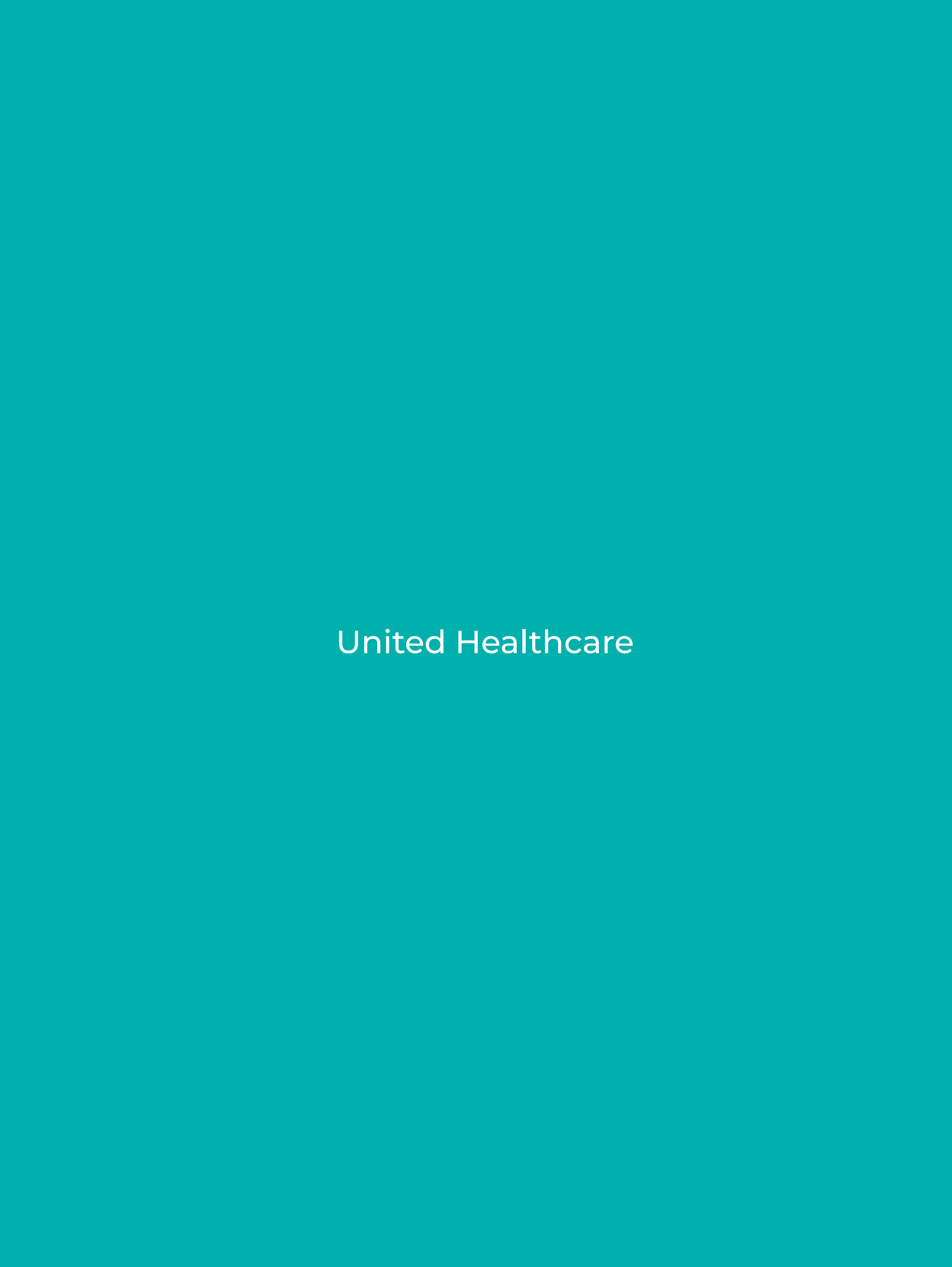
United Healthcare

United Healthcare

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Contract Details

UNITED HEALTHCARE ACO

- **Counties:** Lake, Orange, Osceola and Seminole
- **Estimate number of lives:** 50,000
- **TPA contact information:**
  - UHCprovider.com
  - 877-842-3210
- Shared savings

UNITED HEALTHCARE NEXUSACO

- **Counties:** Lake, Orange, Osceola and Seminole
- **Estimate number of lives:** 500
- **TPA contact information:**
  - UHCprovider.com
  - 877-842-3210
- Shared savings

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

At-a-Glance Glossary

AdventHealth: Hospital system with 46 hospital facilities in nine states. In Florida, AdventHealth includes over 30 hospitals and emergency rooms, more than 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities.

AdventHealth Physician Network (AHPN) Central Florida: A physician-led CIN spanning Flagler, Lake, Orange, Osceola, Seminole and Volusia counties.

Clinically Integrated Network (CIN): Brings a hospital system, physicians and other dedicated health care providers together for one common goal: to bring quality, performance, efficiency, and value to the patient. The AdventHealth Clinically Integrated Networks in Florida are AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, and AdventHealth Physician Network Tampa Bay.

Population Health Services Organization (PHSO): The professional management arm for AdventHealth Population Health efforts. In Florida, this includes, Florida Hospital Healthcare System (FHHS), AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, AdventHealth Physician Network Tampa Bay, and AdventHealth ACO. It exists to guide and support AdventHealth in its adoption of transformative, value-based, integrated health care models.

United Healthcare Accountable Care Organization (ACO): United Healthcare's network of care providers working to provide more affordable, quality health care.

United Healthcare NexusACO: Is a benefit plan that helps achieve the Triple Aim of improved quality, better health outcomes and better cost for our members.

Contact Reference Guide

Network Management .... Tel 877-842-3210

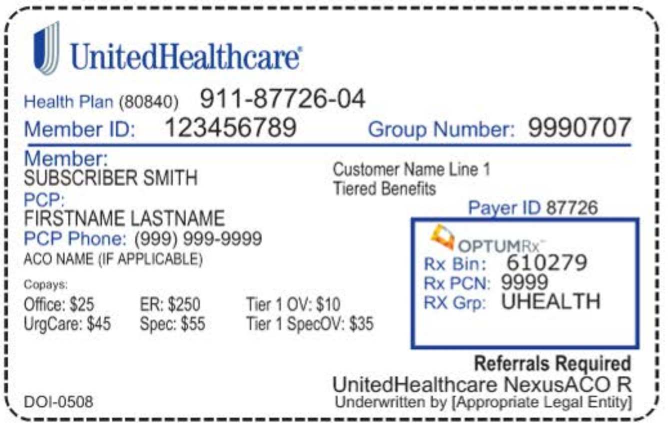
Overview

Effective January 1, 2019, an upside-only, shared savings agreement with United Healthcare was added for providers in Orange, Osceola, Seminole and Lake Counties. This agreement has two components—United Healthcare ACO and United Healthcare NexusACO products. This will be the first United Healthcare NexusACO in Florida and is a commercial product that is more highly managed with a tiered provider arrangement. As part of this agreement, our physicians will be the most preferred providers; meaning that members who see our providers will have the lowest out-of-pocket cost.

ID Cards

Both the United Healthcare ACO and United Healthcare NexusACO products have similar cards. Look for key differences on the member's ID card to identify:

- Plan type: Plan name in the lower, right corner.
- Benefit features: Referrals are required for NexusACO R, NexusACO RB and NexusACO RP plans.



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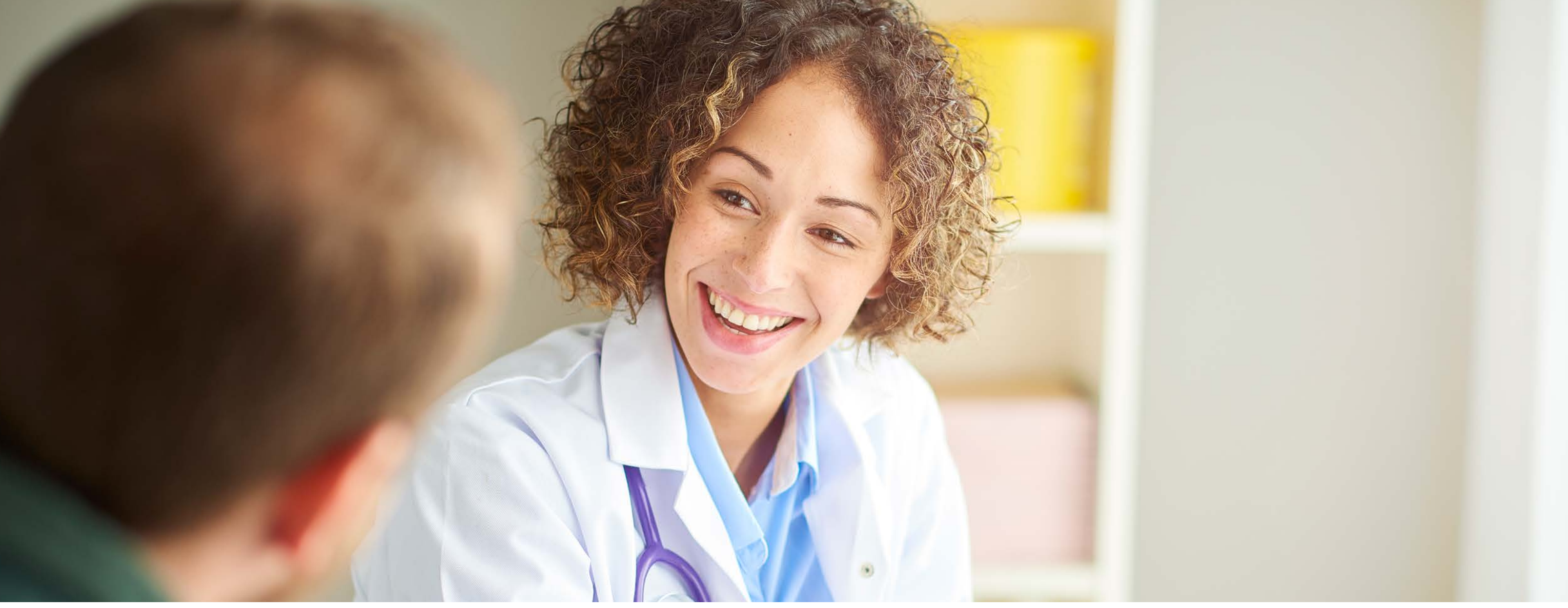
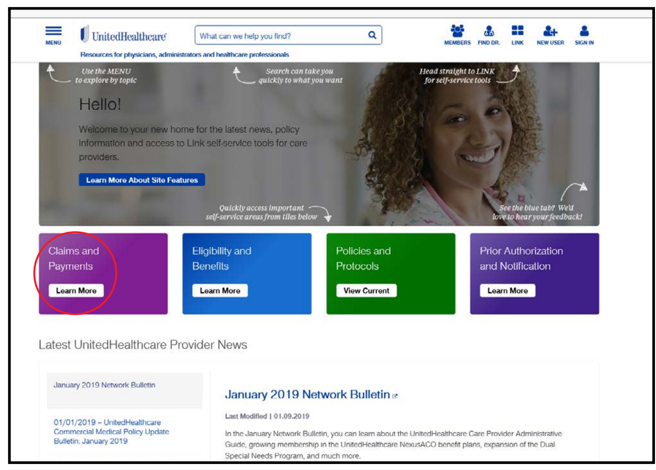


Claim Submission

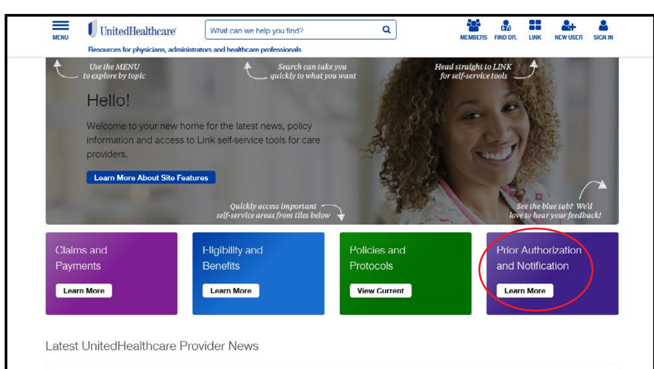
For claims submission, use United Healthcare's self-service resources available at UHCprovider.com/claims. From this site you can:

- Submit claims for all UnitedHealthcare plan members.
- See which fields are required based on the information you enter.
- View tips that allow you to correct certain errors before you hit submit.



Prior Authorization

To determine if a service is covered, prior authorizations are required for certain planned services. A prior authorization is granted only for services determined to be medically necessary. A list of services that require prior authorizations is available at UHCprovider.com and select **Prior Authorization and Notification Resources**.



Aetna

Aetna

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Contract Details

Counties: Lake, Orange, Osceola and Seminole

- **Estimate number of lives:** 12,000
- **TPA contact information:**
  - Aetna.com/health-Care-Professionals.html
    888-632-3862
- Shared Savings

At-a-Glance Glossary

AdventHealth: Hospital system with 46 hospital facilities in nine states. In Florida, AdventHealth includes over 30 hospitals and emergency rooms, more than 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities.

Aetna Accountable Care Organization (ACO): A collaborative relationship between Aetna Inc. and a healthcare delivery system, hospital, or integrated delivery network designed to improve quality, efficiency and the patient experience, and to control costs.

AdventHealth Physician Network (AHPN) Central Florida: A physician-led CIN spanning Flagler, Lake, Orange, Osceola, Seminole and Volusia counties.

Clinically Integrated Network (CIN): Brings a hospital system, physicians and other dedicated health care providers together for one common goal: to bring quality, performance, efficiency, and value to the patient. The AdventHealth Clinically Integrated Networks in Florida are AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, and AdventHealth Physician Network Tampa Bay.

Population Health Services Organization (PHSO): The professional management arm for AdventHealth Population Health efforts. In Florida, this includes, Florida Hospital Healthcare System (FHHS), AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, AdventHealth Physician Network Tampa Bay, and AdventHealth ACO. It exists to guide and support AdventHealth in its adoption of transformative, value-based, integrated health care models.

Contact Reference Guide

Provider Customer Service.......... Tel 888-632-3862

Pharmacy Management.......... Tel 800-238-6279

NaviNet (Help with portal registration and password and/or username issues)..........Tel 888-482-8057

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Overview

Aetna ACO provides care to approximately 12,000 members across Orange, Osceola, Seminole and Lake counties. AHPN Central Florida supports providers in meeting the program requirements to improve care coordination, identify and close care gaps and address other opportunities for quality and cost improvement for these Aetna patients.

ID Cards

ID cards will vary by member.

Note: To view all applicable Aetna cards, visit www.MyAHPN.com.

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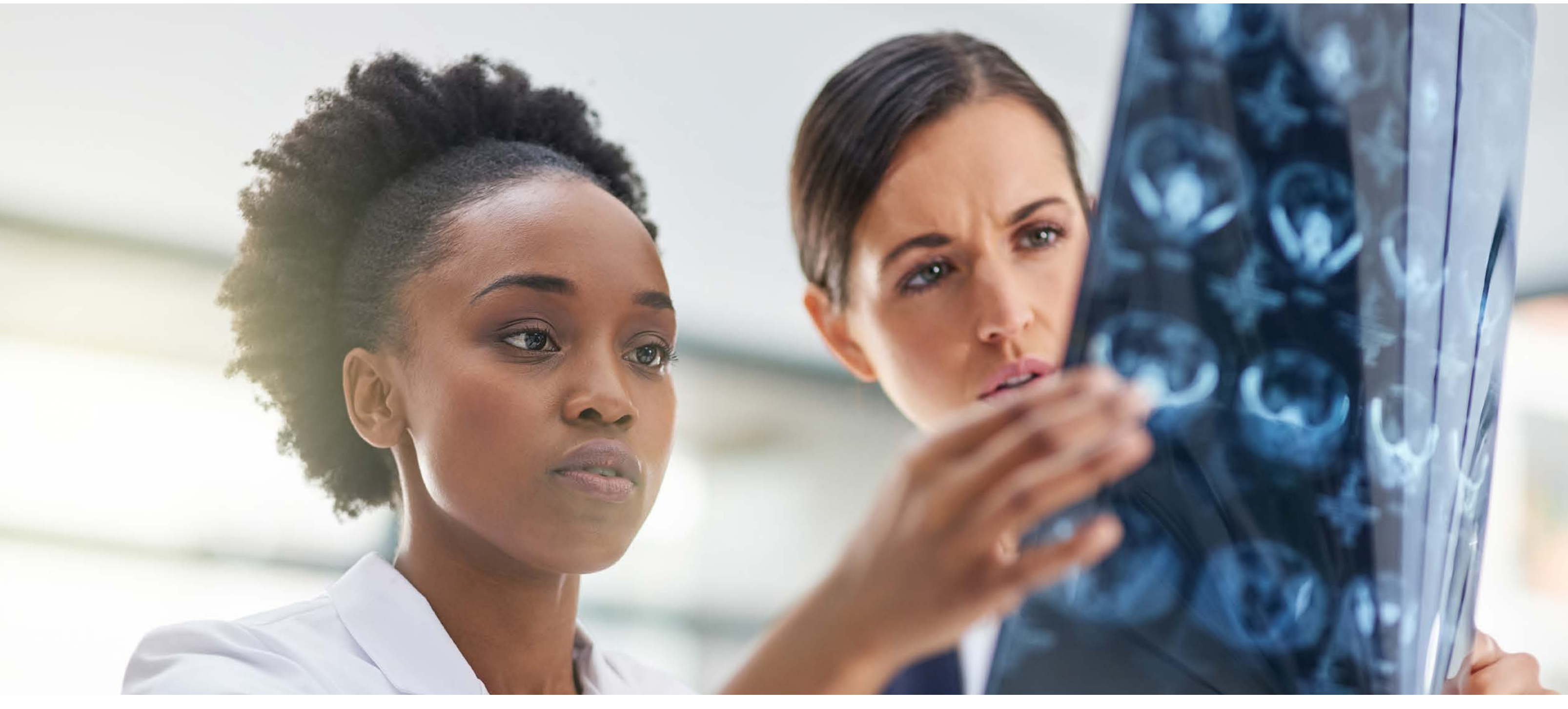
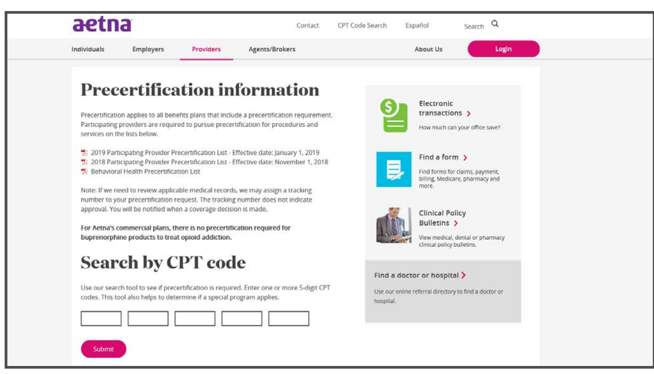


NAVIGATION TIP: Click the grey footer at the bottom of any page to jump back to the main table of contents.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Prior Authorization

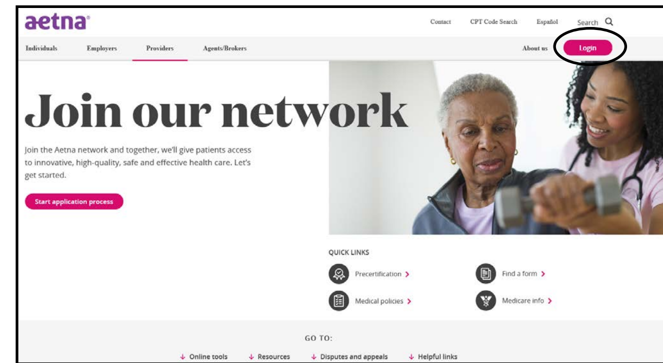
Before a procedure, verify a patient's benefits and submit a precertification request electronically via Aetna's secure provider portal. For precertification lists, along with a tool you can use to search by CPT code, visit Aetna's website at Aetna.com/Health-Care-Professionals/Precertification/Precertification-Lists.html.



Aetna Provider Web Portal

Aetna's provider website, https://www.aetna.com/health-care-professionals.html, provides helpful information including fee schedules, precertification list, drug formularies and more.

For information specific to your practice, login to Aetna's secure portal to verify benefits, check claims status, and more. To access Aetna's secure portal, select Login in the top right corner.



Disney

Disney

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Allegiance Claim Submission....4-51

Allegiance Provider Web Portal....4-52

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Contract Details

- **Counties:** Lake, Orange, Osceola and Seminole
- **Estimate number of lives:** 19,000
- **TPA contact information:**

  https://www.askallegiance.com/DisneyFH
  855-999-1522

- Shared risk

At-a-Glance Glossary

AdventHealth: Hospital System with 46 hospital facilities in nine states. In Florida, AdventHealth includes over 30 hospitals and emergency rooms, more than 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities. Allegiance: The Third-Party Administrator (TPA) for AdventHealth Physician Network Central Florida Disney Members. Allegiance is a wholly owned subsidiary
of Cigna.

AdventHealth Physician Network (AHPN) Central Florida: A physician-led CIN spanning Flagler, Lake, Orange, Osceola, Seminole and Volusia.

Clinically Integrated Network (CIN): Brings a hospital system, physicians and other dedicated health care providers together for one common goal: to bring quality, performance, efficiency, and value to the patient. The AdventHealth Clinically Integrated Networks in Florida are AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, and AdventHealth Physician Network Tampa Bay.

Florida Hospital Total Care Connect with iPad: The brand name of health insurance created in partnership between Disney and AdventHealth and supported by Allegiance, a wholly-owned subsidiary of Cigna. Disney employees and cast members are covered as a part of FH Total Care Connect with iPad.

Population Health Services Organization (PHSO): The professional management arm for AdventHealth Population Health efforts. In Florida, this includes, Florida Hospital Healthcare System (FHHS), AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, AdventHealth Physician Network Tampa Bay and AdventHealth ACO. It exists to guide and support AdventHealth in its adoption of transformative, value-based, integrated health care models.

Contact Reference Guide

Provider Customer Service

Allegiance Customer Service is available from 8 am to 8 pm Eastern, Monday through Friday............ Tel 855-999-1522

Provider Portal Issues

Allegiance technical support............ Tel 855-999-1522

Medical Authorizations

Precertification and pretreatment, contact Allegiance Care Management............ Tel 800-342-6510

Pharmacy Authorizations

Formulary list, contact ESI............ Tel 800-375-0596

Behavioral Health & Substance Abuse Authorizations

Behavioral health related inquiries, call Cigna............ Tel 800-952-6676

AHPN Provider Experience Center

AHS.ExperienceCenter@AdventHealth.com .... Tel 877-850-5438

Tel 407-200-4838

Health Management

PHSO.HealthMgmt@AdventHealth.com .... Tel 844-700-7476

FAX 407-303-0926

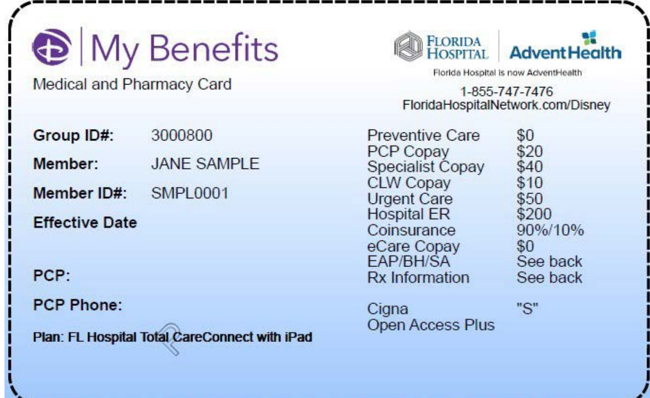
NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Allegiance Overview

The Disney HMO Plans are administered by Allegiance. Allegiance has administered self-funded health plans for more than three decades. With over 100 clients across the country representing more than 166,000 lives, Allegiance clients include hospital systems, school districts and government organizations, insurance trusts, and multiple employer welfare arrangements (MEWAs). Claims processing, customer service, enrollment, and all other services are coordinated at their corporate office in Missoula, MT.

Allegiance is a wholly-owned subsidiary of Cigna enabling them to have access to Cigna's extensive network and analytic products.

ID Card



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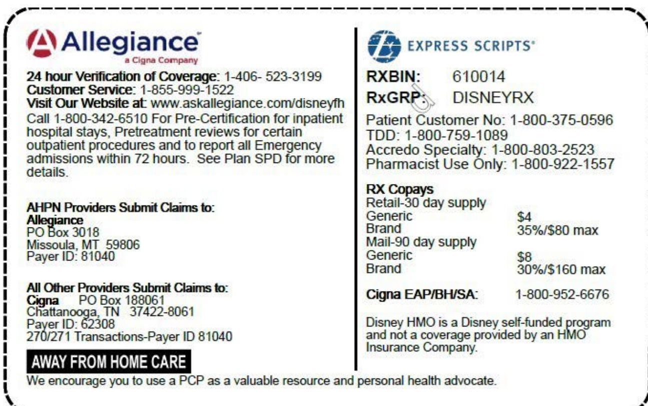

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AHPN Central Florida In-Network Providers and Facilities

Disney members must stay within the AHPN Central Florida network and selected wrap-around services for all their medical care. If they use out-of-network services, the member must pay 100% of the charge for the service. It is critically important that providers assist Disney members and their dependents on where they can obtain in-network services.

AHPN Central Florida In-Network Providers

Providers and ancillary services within AHPN Central Florida are in-network providers for Disney members. It will be much easier for AHPN Central Florida physicians to provide coordinated care for Disney members if their care remains in the network. In addition to AHPN Central Florida in-network providers and ancillary services, Disney has provided several wrap-around networks for specific services that members will also have access to that are not a part of AHPN Central Florida. To assist you in guiding Disney members to in-network resources, we have listed some resources below that were accurate at the time of printing. You can find the most up-to-date provider and ancillary service directory for Disney members at Disney.AdventHealth.com.

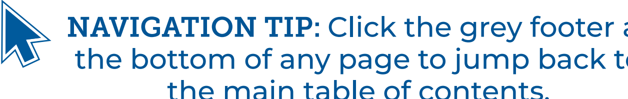
Physicians - Primary Care and Specialists	Locations and Contact Information
AHPN Central Florida Physicians	Disney.AdventHealth.com

AHPN Ancillary Services

There are a wide variety of AHPN ancillary services that are available to Florida Hospital Total CareConnect Disney members. Below we have listed out some of the most frequently used services and contact information as a quick reference. There are other ancillary services available to members such as ambulance, anesthesiology, birthing center and oncology. You can find more information on all the ancillary services for Disney members at Disney.AdventHealth.com.

Ambulatory Surgery Centers	Phone Number
Center for Digestive Endoscopy	407-241-3221
Children's Surgery Center DBA Maitland Surgery Center	407-691-3331
Doctors Surgery Center, LLC	407-933-2448
Downtown Surgery Center	407-650-0051
Florida Eye Clinic Ambulatory Surgery Center	407-834-7776
Lakeside Surgery Center	407-206-2375
Winter Park Surgery Center DBA Physician's Surgical Care Center	407-647-5100
Diabetes Outpatient Management and Training	**Phone Number**
AdventHealth Diabetes institute	833-205-7129
Pediatric Endocrinology, Diabetes & Metabolism	407-896-2901

Durable Medical Equipment	Information	Phone	FAX for Orders
AdventHealth Respiratory & Equipment (AHRE)	FHREOnline.com	407-830-1938	407-830-0936
Home Health	**Information**	**Phone**	**FAX for Orders**
AdventHealth Home Care	AdventHealth.com/Home-Care	407-691-8202	407-691-8223
AdventHealth Home Infusion		407-865-5489	



Hospice	Information	Phone Number
AdventHealth Hospice Care Central Florida	AdventHealth.com/Hospice-Care/AdventHealth-Hospice-Care-Central-Florida	407-682-0808

Hospitals and Emergency Departments	Phone Number
AdventHealth Altamonte	407-303-2200
AdventHealth Apopka	407-609-7000
AdventHealth Celebration Health	407-303-4000
AdventHealth East Orlando	407-303-8110
AdventHealth For Children	407-303-6611
AdventHealth Kissimmee	407-846-4343
AdventHealth Lake Mary ER	321-363-0400
AdventHealth Orlando	407-303-5600
AdventHealth Waterman	352-253-3333
AdventHealth Winter Garden	407-614-0500
AdventHealth Winter Park	407-646-7000

Laboratories	Locations and Contact Information	Phone Number
AdventHealth Lab	AdventHealth.com/Lab-Services	
Quest (Genetic testing only)	QuestDiagnostics.com	866-697-8378
Counsyl Inc. (DNA Screening)	Counsyl.com	888-268-6795

Outpatient Surgery	Phone Number
Eye Surgery and Laser Center-Winter Haven	863-299-8574
Eye Surgery and Laser Center-Sebring	863-385-1074

Radiology	Locations and Contact Information
AdventHealth Imaging	Scheduling 407-303-2273

Rehabilitation	Locations and Contact Information
AdventHealth Sports Med & Rehab	Scheduling 407-303-8080

Skilled Nursing Facility	Information	Phone Number
AdventHealth Care Center		407-975-3000
East Orlando Health and Rehab Center	EastOrlandoHealth.com	407-380-3466
Consulate Health Care	ConsulateHealthcare.com Participating locations- West Altamonte, Kissimmee, Lake Mary, Plantation Bay and Rio Pinar	
Florida Living Nursing Center	FloridaLivingNursing.com	407-862-6263
AdventHealth Care Center Apopka North	www.AdventHealth.com/Skilled-Nursing/AdventHealth-Care-Center-Apopka-North	407-880-2266

Urgent Care	Locations and Contact Information
AdventHealth Centra Care	CentraCare.org
Jewett Convenient Care Center	JewettOrtho.com/Convenient-Care
AdventHealth Centra Care Kids	CentraCare.org/Centra-Care-Kids

Other In-Network Providers and Services

In addition to the AHPN network of providers and ancillary services, Disney has provided several wrap-around networks for specific services for Disney members. These networks are in addition to AHPN providers and ancillary services.

Chiropractic Care

American Specialty Health Networks Inc. (ASHN) – Contact 800-972-4226

Durable Medical Equipment/Home Health

CareCentrix – Contact 877-466-0164

Laboratory

Quest – QuestDiagnostics.com

LabCorp – LabCorp.com

Radiology

Evicore – Contact 888-693-3297

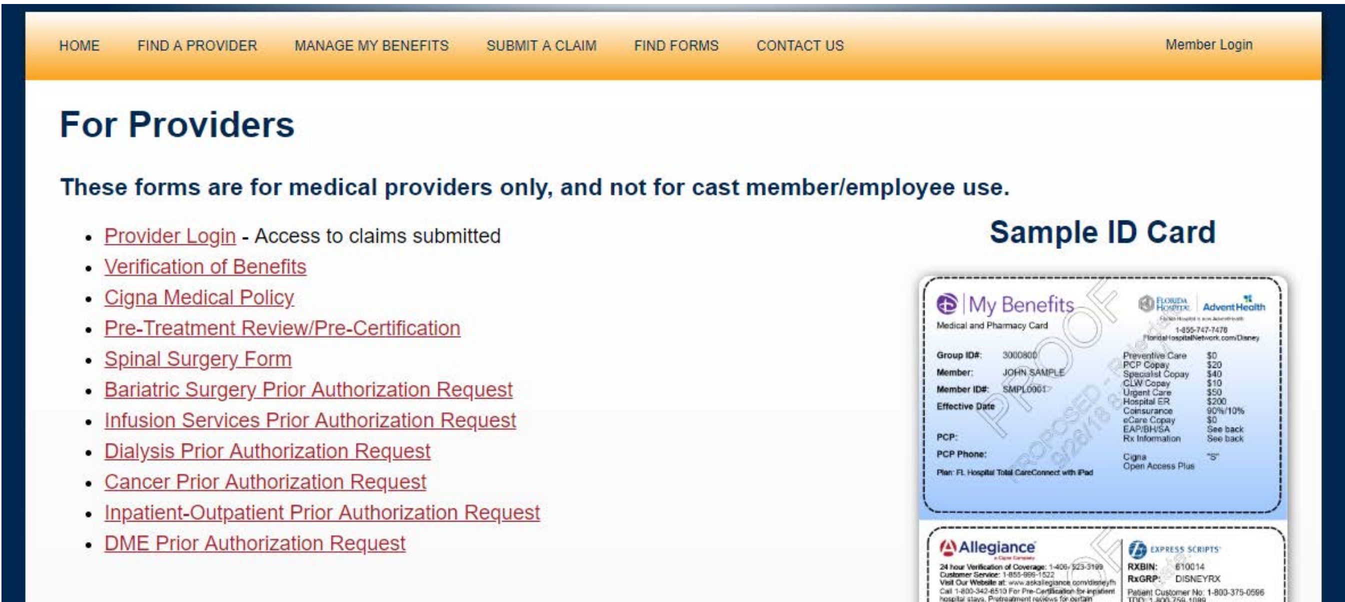
Dialysis

DaVita – DaVita.com

Fresenius – FMCNA.com

Benefits and Questions

Online verification of benefits is available at AskAllegiance.com/DisneyFH/ForProviders.



Allegiance Customer Service is available from 8 am to 8 pm Eastern, Monday through Friday at 855-999-1522. An automated voice response system (IVR) is also available 24/7/365 for claims and benefit information.

Allegiance Claim Submission

All claims will be processed by Allegiance at their facility in Missoula, MT. Checks and Explanation of Benefits (EOBs) will come from Allegiance.

Payer ID: 81040

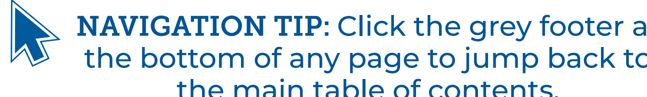
Paper Claims

All medical claims that are submitted on paper should be submitted to the following address:

Allegiance
P.O. Box 3018
Missoula, MT 59806

Electronic Claims

Providers cannot submit claims online. Claims will be fed to Allegiance via the claims file. However, status of submitted claims can be viewed at AskAllegiance.com/DisneyFH.



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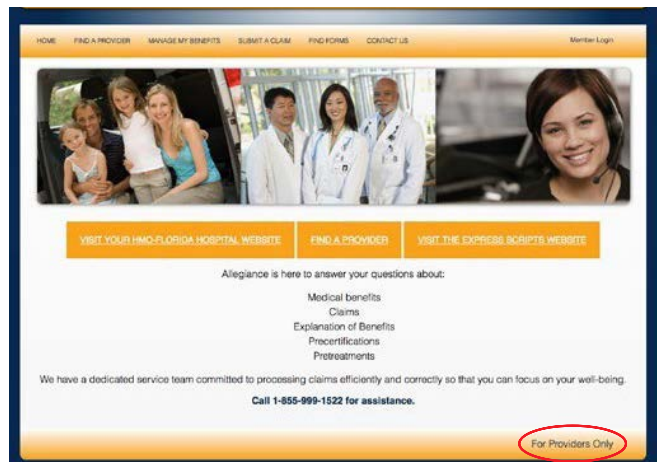
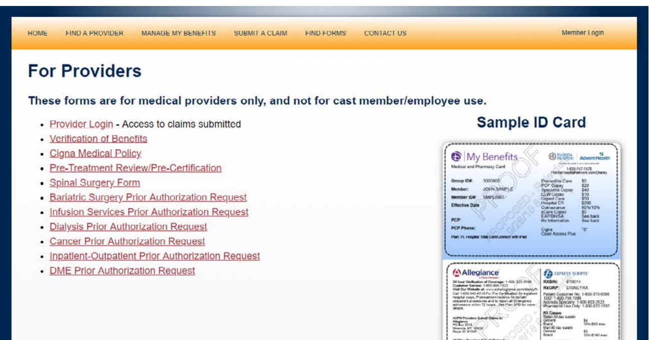
Allegiance Provider Web Portal

Registration for new user



Visit AskAllegiance.com/DisneyFH and click For Providers Only in the lower right hand corner.



Next, click the Provider Login link.

From there, select Register New User.

To create an account, you will need your billing address and tax ID number associated with your office.

Password Reset

To reset your password, select Password Help on the login page. If you need further assistance, contact Allegiance technical support at 855-999-1522.

Medical Authorizations

How to request authorization

Any precertification and pretreatment review for services should be completed at the point of service and will be coordinated through Allegiance Care Management.

Several services require preauthorization. You can see which services require preauthorization and find authorization forms at AskAllegiance.com/DisneyFH under the For Providers Only link on the bottom of the home page.

Several services require a different preauthorization process.

Pharmacy Prior Authorization and Formularies

For a formulary list, contact ESI at 800-375-0596.

Behavioral Health & Substance Abuse Prior Authorizations

For all behavioral health related inquiries, call Cigna at 800-952-6676.

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

Net Promoter Score

The Net Promoter Score (NPS) is comprised of results from a survey emailed to Disney Cast Members after the primary subscriber visits your office. Your NPS survey results are emailed to you monthly and include a summary of your results along with overall survey results of your peers within AHPN Central Florida. Your individual survey responses, including service date, score and any comments made by the patient are also included. You can use these results to increase patient satisfaction.

Patients who provide a score of 6 or below are detractors. Those who provide a score of 7 or 8 are passives, and those who provide a score 9 or 10 are promoters. To calculate your NPS, subtract the percentage of detractors from the percentage of promoters.

Begin Date: **Friday, February 1, 2019**
End Date: **Friday, March 1, 2019**

Group's Scores:

	Surveys Taken	Promoters	Detractors	Passives	Promoters	Detractors	Passives	NPS
AHPN	2538	2277	119	142	89.72 %	4.69 %	5.59 %	85.0

Scores for SMITH, SARAH - 0806899898:

Total Emails Sent: **47**
Total Emails Surveys Taken: **10**

	Surveys Taken	Promoters	Detractors	Passives	Promoters	Detractors	Passives	NPS
AHPN	10	6	2	2	60.00 %	20.00 %	20.00 %	40.0

Source	Service Date	Email Sent	Survey Completed	Score	NPS Category	Wait Time	Provider Communication	Staff Friendliness	Completeness	Scheduling	Other	Comments
AHPN	5/18/2019	5/22/2019	5/23/2019	9	Promoter							
AHPN	3/30/2019	4/3/2019	4/4/2019	10	Promoter							
AHPN	4/3/2019	4/5/2019	4/6/2019	10	Promoter							
AHPN	3/3/2019	3/7/2019	3/8/2019	0	Passive	x						
AHPN	6/14/2019	6/15/2019	6/16/2019	3	Detractor	x						
AHPN	7/12/2019	7/18/2019	7/18/2019	2	Detractor	x				x		
AHPN	2/22/2019	2/23/2019	2/24/2019	7	Passive	x					x	I saw Dr. Johnson not Dr. Smith
AHPN	6/22/2019	6/23/2019	6/24/2019	10	Promoter							
AHPN	3/27/2019	3/29/2019	3/30/2019	10	Promoter							
AHPN	2/10/2019	2/14/2019	2/18/2019	10	Promoter							

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Florida Hospital Total CareConnect with iPad Health Plan Benefits

The center of the patient's care team is the primary care provider. The relationship between a patient and PCP is important. The PCP should be the patient's first point-of-contact for non-emergency needs. PCPs help patients navigate through the health system, including referring patients into qualified health programs.

Disney's Employee Benefits

Additionally, Disney provides the following health programs to their employees and their families.

StarBaby - Allegiance Maternity Management Program

The StarBaby program is designed to provide support during pregnancy by assigning a personal maternity nurse throughout the pregnancy either by phone or through secure email. The nurse will continue to be a resource during the first few weeks after birth.

This program is available to Disney employees at no cost.

Visit: StarPointMedical.com
Call: 877-792-7827, option 1

Diabetic Medication Program

Disney Employees or Cast Members, including covered spouses, domestic partners and children, can participate in the Diabetic Medication Program. This program provides support to effectively manage diabetes – at no cost – through the Disney Healthy Pursuits Wellness Team. Members who participate also save money on the cost of diabetes medications.

Call: 800-577-7498, press 2

Employee Assistance Program

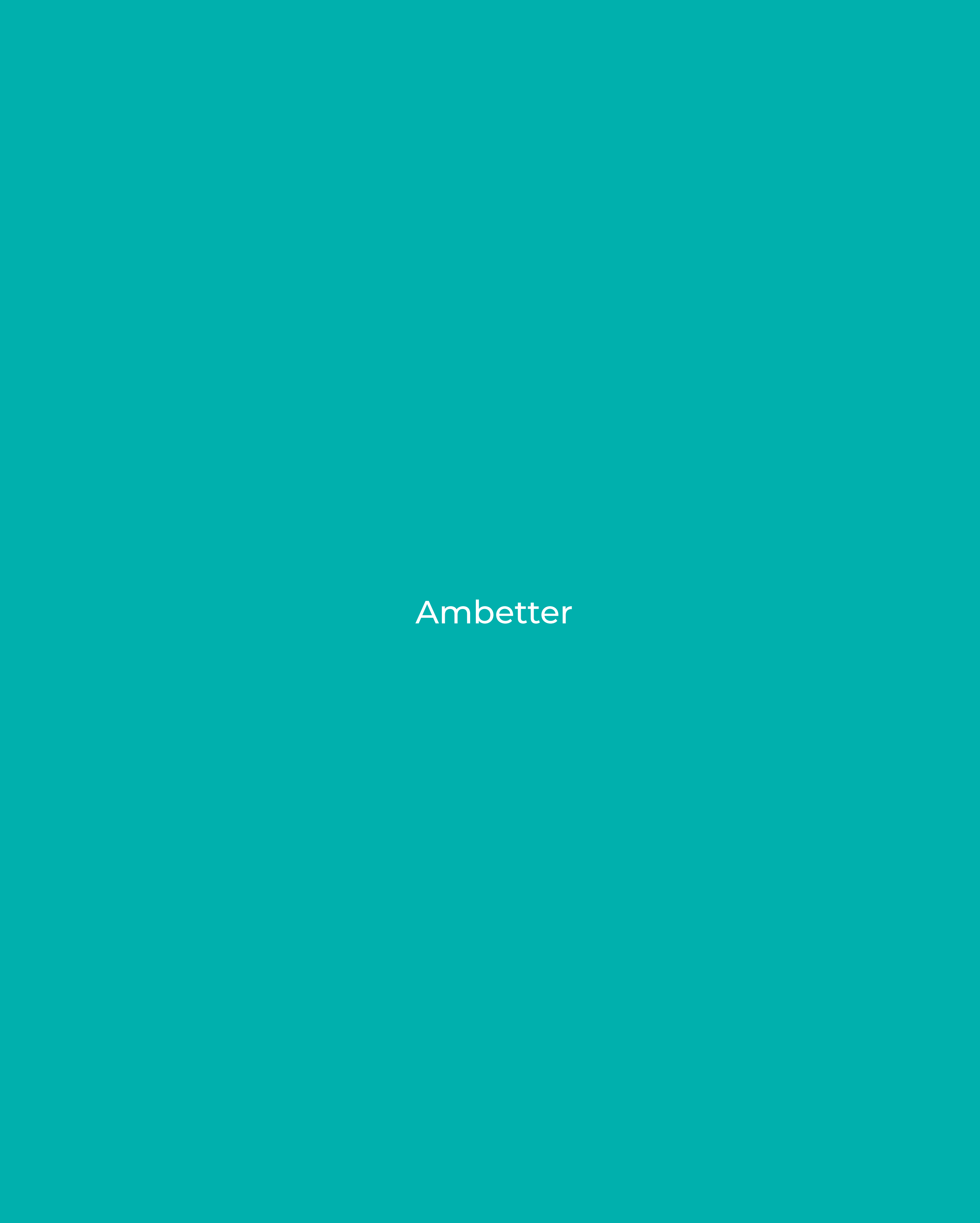
Disney Employees and Cast Members have access to five free and confidential visits with a licensed professional through Cigna Employee Assistance Program (EAP). This program is available to all employees and Cast Members—plus their dependents and household members. EAP can help with stress reduction, communication with friends and family, teens and alcohol use and issues faced by new parents. EAP professionals can also assist with eating disorders, sleep habits, relationship issues, life and job satisfaction, substance abuse and other challenges.

Call: 800-952-6676
Visit: CignaBehaviorial.com
Employee ID: Disney

Wellness Rewards Program

Disney Employees and Cast Members, along with their spouses/domestic partners, who are enrolled in a Disney medical plan option are eligible to participate in Disney's Wellness Rewards Program. Employees and Cast Members can earn up to $300. Spouses or partners can also earn up to $300 for a total of up to $600.

Visit: Benefits.Disney.com, click "Take the PHA"


Ambetter

Ambetter

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Member Benefits 4-60

Contract Details

- **Counties:** Lake, Orange, Osceola and Seminole
- **Estimated number of lives:** 20,000
- **TPA contact information:**

  Provider.SunshineHealth.com
  877-687-1169

- Fee-for-service

NAVIGATION TIP: Click the white section header to jump back to the section table of contents.

At-a-Glance Glossary

AdventHealth: Hospital System with 46 hospital facilities in nine states. In Florida, AdventHealth includes over 30 hospitals and emergency rooms, more than 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities.

Ambetter from Sunshine Health: An exchange product by Centene Corporation. Ambetter exists to improve the health of its beneficiaries through focused, compassionate and coordinated care with the core belief that quality health care is best delivered locally.

Clinically Integrated Network (CIN): Brings a hospital system, physicians and other dedicated health care providers together for one common goal: to bring quality, performance, efficiency and value to the patient. The AdventHealth Clinically Integrated Networks in Florida are AdventHealth Physician Network Central Florida, AdventHealth Physician Network Ocala, AdventHealth Physician Network Tampa Bay.

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Population Health Services Organization (PHSO): The professional management arm for AH Population Health efforts. In Florida, this includes, AdventHealth Provider Network. It exists to guide and support AH in its adoption of transformative, value-based, integrated health care models.

Sunshine Health: A Florida health plan and a wholly-owned subsidiary of Centene Corporation, a leading, multi-line, national, health care enterprise offering Medicaid, Marketplace, Medicare and specialty services.

Contact Reference Guide

Ambetter Provider Services....Tel 877-687-1169
FAX 855-678-6981

Prior Authorization....Tel 877-687-1169
FAX 855-678-6981

Ambetter 24/7 Toll-Free Interactive Voice Response (IVR) Line....Tel 877-687-1169

Overview

Ambetter has over 250,000 members throughout Florida. Locally, Ambetter has enrolled approximately 20,000 members in Orange, Seminole, Osceola and Lake counties.

Physician Resources

Secure Provider Portal

Log in at https://Provider.SunshineHealth.com/ for access to patient eligibility, patient care gaps, manage prior authorizations and more.

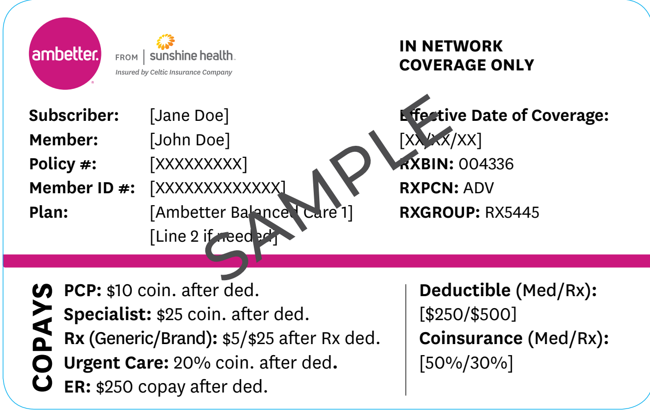
EFT & ERA Solution

Enroll in PaySpan to simplify the payment tracking and transfer process EFT & ERA. Visit PaySpanHealth.com and click Register.

Provider Relations

Ambetter's provider relations representatives deliver education and training directly to you, along with industry news updates and regular in-service meetings. Training opportunities are also available through Relias Learning Management System. You can obtain more information by logging on to https://www.sunshinehealth.com/providers/resources/provider-training.html.

ID Card



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Ambetter.SunshineHealth.com

Member/Provider Services: 1-877-687-1169
Relay FL: 1-800-955-8770
24/7 Nurse Line: 1-877-687-1169

Numbers below for providers:
Pharmacy Help Desk: 1-888-304-9081
EDI Payor ID: 68069
EDI Help Desk: Ambetter.SunshineHealth.com

Medical Claims:
Sunshine Health
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

SAMPLE

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.SunshineHealth.com.

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Claim Submission

This section provides a quick introduction to filing claims. For detailed information, call 877-687-1169.

Timely filing guidelines
180 days from date of service

Claims can be submitted via

- Secure Portal
  https://Provider.SunshineHealth.com/
- Clearinghouse
  EDI Payor ID 68069
- Mail
  P.O. Box 5010
  Farmington, MO 63640-5010

Please remember to include your Taxonomy Code of the rendering provider when submitting your Ambetter Claims.

Medical Authorizations

Pre-Auth Tool

An online form is available at https://Ambetter.SunshineHealth.com under the "Provider Resources" section. Use Pre-Auth Check to quickly determine if prior authorization is required for your patient. If a prior authorization is necessary, simply login to the secure provider portal to submit a prior authorization. You can also FAX prior authorization requests to 855-678-6981.

Member Benefits

Comprehensive Medical Care

Every Ambetter plan includes essential health benefits that your patients need, such as preventive care, maternity care and emergency services.

Prescription Coverage

Ambetter covers a wide range of prescriptions, so your patients can count on care when they need it most.

Care Management and Disease Management

Ambetter care managers work closely with you to make sure your patients have access to the care and support services they need as part of your treatment plan.

24/7 Nurse Advice Line

Your patients have nonstop access to a Nurse Advice Line for advice on all their health questions.

Rewards Program

By staying up-to-date with regular preventive care, your patients can earn dollar rewards, which can be used to help pay for out-of-pocket health care costs, health-related items and more.