Keystone First
VIP Choice®

Provider Reference Guide

Your Provider Network Management Account Executive Information

Phone number:

Fax number:

Email address:

Website: **www.keystonefirstvipchoice.com**

Visit us online for more detailed information, which can be found in the Provider Manual. Other available information includes training modules, prior authorization forms, quality resources, provider directory, searchable formulary, NaviNet link, claims resources, newsletters, plan updates, and other notifications.

Provider Information

Provider Services:
1-800-521-6007

Fraud and Abuse Hotline:
1-866-833-9718

Supplemental benefits:
Refer to website

NaviNet:
www.navinet.net
1-888-482-8057

The free NaviNet provider portal provides patient information such as member eligibility, member primary care provider (PCP) rosters, electronic copies of remittances, claim status and updates, care gaps, and more.

Providers can also submit medical prior authorization requests and claims investigations. To initiate a claims investigation, locate the ***Investigate*** icon in the Claim Inquiry function. This allows you to request an adjustment and track responses on claims that were previously finalized. For each submitted transaction, you will receive an electronic response to the claim investigation. The response will indicate if the claim was adjusted, or other details are provided explaining why the claim was not considered for an adjustment.

Member Information

Member Services:
1-800-450-1166
TTY 711

Care Management:
1-800-450-1166

The Care Management team has care managers (registered nurses and social workers), Concierge Services Coordinators, and Care Connectors ready to assist members with their most urgent needs. Staff can assist members with a wide array of clinical and nonclinical services, answer questions regarding health conditions and medications, help schedule provider appointments and arrange transportation, and help members locate community resources for housing, food, and clothing.

Claims

Claims must be filed within 365 days from the date of service (or the date of discharge from inpatient admissions).

Payer ID Number: **77741**

Contact your practice management system vendor or clearinghouse to initiate electronic claims submission through Change Healthcare

To submit claims through Change Healthcare:

Electronic billing:
1-877-363-3666

Electronic Funds Transfer (EFT) or Electronic Remittance Advice (ERA) through ECHO:

EFT/ERA enrollment:
1-888-834-3511

ECHO ERA Payer ID: **58379**

Visit ECHO at **www.enrollments.echohealthinc.com/efteradirect/enroll**

Direct entry claims submission through Change Healthcare's Connect Center: **https://physician.connectcenter.changehealthcare.com/#/site/home**

Paper Claim Submission:
P.O. Box 7143
London, KY 40742-7143

Claim Disputes:
Providers may dispute the way a claim was paid or processed. **Claim disputes must be submitted within 180 days of the initial remittance advice date.** Providers may use the Claims Dispute form located on our website or a written request, which must include the following information:

- ✓ Submitter contact information (name, phone number)
- ✓ Provider information (name, phone number, NPI number, Tax ID number)
- ✓ Member information (name, Date of Birth, member ID number)
- ✓ Claim information (claim number, Date of Service, billed amount)
- ✓ Reason for dispute
- ✓ Any documentation which supports your position that the plan's reimbursement is not correct

Claims Disputes may be submitted via:

Fax: **1-888-599-1476**

NaviNet using the Claims Investigation function:
www.navinet.net

Provider Services: **1-800-521-6007**

Mail using the Paper Claims Submission address above.

Balance Billing

Under the requirements of the Social Security Act, all payments from our plan to participating plan providers must be accepted as payment in full for services rendered. In the event of a balance from deductible, copayment, or coinsurance, providers should submit appropriate claims to Medicaid payer. Members may not be balance billed for medically necessary covered services under any circumstances.

Model of Care

The Model of Care (MOC) is an integrated care management approach to health care delivery and coordination for dual-eligible (Medicare and Medicaid) individuals. The MOC is a program that includes multiple disciplines coming together to provide input and expertise for a member's individualized plan of care. This plan is designed to maintain the member's health and encourage the member's involvement in their health care.

The Centers for Medicare & Medicaid Services requires providers who care for our beneficiaries to annually participate in and attest to completing our MOC training. Providers may receive training in the following ways:

- Via an online interactive or a PDF version of the MOC training module on our website.
- In person at a training seminar.
- With printed/faxed MOC materials.

Providers may find information on the MOC and the annual training requirement in the provider manual.

Prior Authorization

Authorization is not a guarantee of payment. Payment is subject to benefit coverage rules, including member eligibility and any contractual limitations in effect at the time of service. All requests for services are subject to Medicare coverage guidelines and limitations.

Providers are responsible for obtaining prior authorization for services prior to scheduling. Please submit clinical information to support medical necessity. Requests will not be processed if clinical information, CPT, or ICD-10 codes are missing.

Except for emergency services, prior authorization is required for all services listed below and referrals to out of network providers. Participating providers are not required to obtain prior authorization for an emergent short procedure unit (SPU) or emergent 23-hour observation stay.

Standard requests are reviewed within 14 calendar days. Urgent requests are reviewed within 72 hours. For a request to be considered urgent, the following criteria must be met:

1. Applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function; or
2. If a physician (contracted or noncontracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision.

The most up-to-date listing of services requiring prior authorization will be maintained on our website:

Prior Authorization Lookup Tool:
www.keystonefirstvipchoice.com

Prior Authorization Submissions:
NaviNet: **www.navinet.net**

Item?	Phone	Fax	Website
Medical*	**1-855-294-7046**	**1-855-809-9202**	
Behavioral health:	**1-866-688-1137**	**1-855-396-5740**	
*Radiology (Outpatient Only - CT/CTA, CCTA, MIR/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan) contact NIA:	**1-866-272-4086**		**www.radmd.com**
*DME, Medical Oncology, Physical Therapy, Genetic Testing, Occupational Therapy, Radiation Oncology, Joint and Spine Surgery, Pain Management, and Diagnostic Sleep Testing contact eviCore:	**1-877-506-5193**		**www.evicore.com/pages/ProviderLogin.aspx** (preferred)
Pharmacy:	Complete the Request for Medical Prescription Drug Coverage Determination Form found on our website.		

Peer-to-peer process:

- Preservice requests – Must be requested during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer to peer must occur before the whole or partial denial determination is rendered.
- Inpatient requests –
  - ✓ Anytime during the inpatient stay.
  - ✓ Within five business days of the verbal/faxed denial notification or up to five business days after the member's discharge date, whichever is later.
- Retrospective requests – Up to five business after a determination has been rendered.

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