FLORIDA
ProviderNews
2013 • Quarter 4

Recent and upcoming changes

to our precertification, utilization management and clinical practice guidelines

We already faxed or mailed and posted notices on our website about important changes* to some of our processes and guidelines as a result of the recent Amerigroup Corporation (Amerigroup) acquisition by WellPoint, Inc. (WellPoint). But there's a lot to remember – so it bears repeating.

If you have questions about these changes, contact your local Provider Relations representative or call our Provider Services team. Not sure who your local Provider Relations representative is? Visit our provider self-service website > select the grey **Contact Us** link at the top of the page > click the PDF link or tout titled **Your Local Provider Relations Representatives.** Or call the local phone number shown on the page to get help.

Process area	Clinical Utilization Management (UM) guidelines	Pharmacy policies	Precertification	
Effective date of change	May 1, 2013	May 1, 2013	August 1, 2013	January 1, 2014
What's changing	WellPoint medical policies, publicly accessible at www.unicare.com, became the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive. McKesson Interqual criteria are used when no specific UniCare medical policies exist. In the absence of licensed McKesson Interqual criteria, we use a list of specific UniCare Clinical UM Guidelines posted and maintained on the Amerigroup provider self-service website. These can be obtained in hard copy by written request. The policies support precertification requirements, clinical-appropriateness, claims edits and retrospective review.	In relation to the Clinical UM guidelines change outlined at left, our pharmacy policies have also changed to match WellPoint's guidelines. Check our provider self-service website for updated policies. Click on Pharmacy Tools > Clinical Pharmacy Policies under our Quick Tools menu. **Exceptions apply.** See the exclusions language within each posted policy. These policies do not apply to programs for which Amerigroup does not manage the pharmacy benefit or to Medicare.	For a list of all CPT codes affected, log in to our secure provider self-service website and select Precertification Lookup from the orange Tools menu. **Requirements were added to specific services in the following categories:** ■ Integumentary ■ Musculoskeletal ■ Respiratory ■ Cardiovascular ■ Digestive ■ Urinary ■ Male/female genital ■ Nervous ■ Eye ■ Auditory ■ Radiology ■ Genetic testing ■ Durable medical equipment ■ Radiation therapy **Requirements were removed from specific services in the following categories:** ■ Outpatient rehabilitation ■ Enteral and parenteral therapy ■ Many prosthetics and orthotics	Amerigroup stops using McKesson InterQual Care Planning and Behavioral Health criteria to determine medical necessity for nonbehavioral health and behavioral health inpatient and outpatient precertification reviews. **McKesson InterQual will still be used for nonbehavioral health concurrent review determinations.**

* Except in cases where superseded by state Medicaid or Centers for Medicare & Medicaid Services (CMS) requirements, all nonbehavioral health, behavioral health inpatient and outpatient precertification requests and behavioral health concurrent reviews will be determined using WellPoint's UniCare medical policies and clinical utilization management guidelines.

Amerigroup RealSolutions® in healthcare

Flu prevention and treatment saves lives

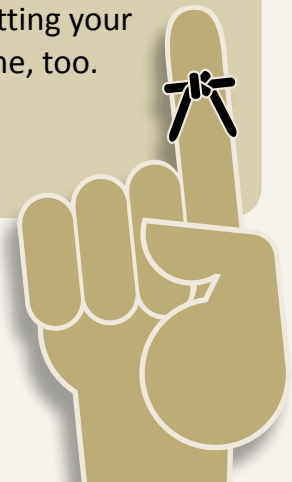
Antiviral drugs

If patients do get sick, antiviral drugs not only lessen flu duration and symptoms but decrease the risk for flu-related complications. Antiviral drugs, as well as many cough and cold products, are on our formulary posted to providers. amerigroup.com > Quick Tools > Pharmacy Tools > Medicaid or Medicare Formularies. Restrictions apply.

Stay informed

Find the latest flu updates, health care recommendations and printable patient education materials at www.cdc.gov/flu.

Remember to **protect yourself** and your patients by getting your vaccine, too.



Flu season is upon us, and patients with certain chronic conditions, including asthma, diabetes and chronic heart disease, are at increased risk for illnesses and hospitalizations caused by seasonal flu. The Centers for Disease Control and Prevention (CDC) estimates **more than 200,000 people are hospitalized from flu complications** annually, and between 3,000 and 49,000 die each year from flu-related causes.

An ounce of prevention

While the CDC recommends everyone 6 months of age and older receives the vaccine, flu shots are especially important for your high-risk patients. Encourage them to be vaccinated as soon as possible – a flu shot is still the best prevention method.

To support your proactive efforts to contact patients with flu shot reminders, **we sent you a list of your high-risk Amerigroup panel members.**

Those at highest risk include:

- Children 6 months to 5 years old
- Adults 65 and older
- Women who are pregnant or expect to become pregnant
- Patients with certain chronic diseases

Adult members with Amerigroup pharmacy benefits can get a **free flu shot.**

They just need to show their member IDs at participating pharmacies during flu shot clinic hours. Coverage for children's vaccines varies, so contact your local Provider Relations representative to learn more.

New Long-Term Care for Broward, Miami-Dade and Monroe counties

The Florida Agency of Health Care Administration recently selected us to be a provider for Long-Term Care (LTC) Statewide Medicaid Managed Care (SMMC) in Broward, Miami-Dade and Monroe counties. Implementation dates are November 1, 2013, in Broward County and December 1, 2013, in Miami-Dade and Monroe counties. Learn more on our provider self-service website.

Primary care provider **rate increase reminder**

In compliance with the Patient Protection and Affordable Care Act (ACA) as amended by Section 1202 of the Health Care and Education Reconciliation Act, state Medicaid agencies and Medicaid managed care organizations will pay eligible providers increased rates for eligible services rendered between January 1, 2013, and December 31, 2014.

Each state determines its own procedures for attestation of eligibility and payments of the rate increase pending approval of state plan amendments filed with the Centers for Medicare & Medicaid Services (CMS).

Check our provider self-service site **News & Announcements** box for updates to the progress of this initiative in your state.

Our site gives you updated information as we hear it and links to previous communications, required forms, and state announcements or websites for further information.

HIPAA final rule – protect your patients' health information

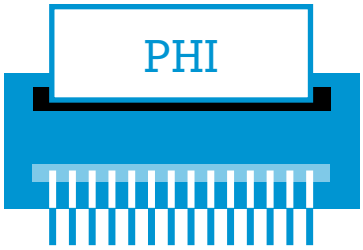
Newly expanded regulations about protected health information (PHI) strengthened the privacy and security protections for patients' health information established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

What changed as of September 23, 2013

The final ruling broadens the definition of business associates who must comply with HIPAA laws, enhances patients' privacy protections and provides individuals new rights to their health information. Under this mandate, the Office for Civil Rights will perform regular audits of health plans, health care providers and business associates to ensure compliance with all applicable laws. Penalties and fines for violations of HIPAA regulations have also increased significantly.

Definition of a business associate

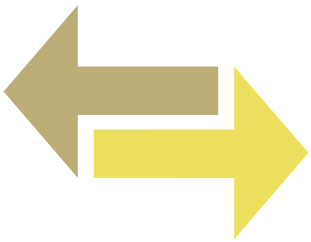
The ruling expands the previous definition of a business associate to include patient safety organizations, health information organizations, e-prescribing gateways, vendors of personal health records who provide services on behalf of a covered entity, and subcontractors who create, receive, maintain or transmit PHI on behalf of the business associate. Some business associates and vendors that were previously excluded from HIPAA compliance must now sign a business associate agreement.



Patient medical records

Under the new regulations:

- Patients can ask for copies of their medical records in an electronic format
- When individuals pay for services by cash, they can instruct their providers not to share information about their treatments with the health plans in which they might be enrolled
- New limits are imposed on how information is used and disclosed for marketing and fundraising purposes
- The sale of an individual's health information without his or her permission is prohibited



Misrouted protected health information

Providers and facilities are required to review all member information received from Amerigroup to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice.

Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Provider Services team at 1-800-454-3730 for help.

For more information,
visit hhs.gov/ocr/privacy/hipaa/administrative/omnibus/index.html and review the complete HIPAA omnibus final rule.

HELPING YOU...

Get a better **online experience**

Throughout the year, we added new features and enhanced some existing features of our provider self-service website to make your experience with us even easier.

With our suite of online tools, you can:

- **Request** precertifications[1] and view the current status of any submitted request
- **Submit** appeals for denied claims
- **Request** general pharmacy[2] and onsite infusion or administration of medical injectables for up to five medications at once for the same medical condition
- **Check** medication precertification status
- **Appeal** medication denials and check status
- **Upload** supporting documents

1 Not available in Tennessee or Texas
2 Not available in Texas

To learn more about our new tools and features, click on **Tutorials** in our online Provider Resources and Documents library on our home page.

Get language assistance for patients

Our members count on you. They may have questions, but language barriers prevent them from communicating with you and your staff.

We are committed to communicating with our members about their health plan and our services, regardless of their language.

Members can receive help anytime, even when in your office, by calling our Member Services phone number printed on the back of their Amerigroup ID cards.

Translation of written materials about benefits can also be requested by calling our Member Services team at 1-800-600-4441. TTY/TDD services are available by dialing 1-800-855-2880.

Prepare for **ICD-10 compliance**

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. This transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

Now is the time to talk to your payer partners, practice management systems vendors and clinical information systems vendors about this implementation. Doing so will help to ensure a smooth transition to the new code sets and minimize business interruption to your practice.

The implementation plan for your practice's transition to ICD-10 is a long-term effort where periodic checkups can help to keep you on target for the October 1, 2014, compliance deadline.

Ask yourself these questions as you and your staff prepare:

How will the update affect processes/workflows?
Once you answer this question, you can devise a plan to address the changes that need to occur to incorporate ICD-10.

What systems changes are needed?
You should have a comprehensive list of all necessary system changes, upgrades and/or other adjustments, the cost of these changes, the amount of time it will take to complete these changes, and the timeline for implementation.

How do your external partners plan to handle the implementation? How will their plans affect your practice?

What are the new documentation requirements?
With the new level of specificity of each code, having the right documentation available for your medical coders will lessen the potential for decreased productivity associated with using the new code set.

Who needs training and what type of training do they need?
You should have a comprehensive list of the education and training needs, including type and timeline for your staff members.

Need to better understand HEDIS coding requirements for specific patient conditions or measures?

Contact your local Provider Relations representative for help. We offer resource materials specific to coding guidelines and tips to help you with compliance and outreach for better health and quality outcomes.

Risk adjustment 101

Providing the best care possible to your patients, our members, is a shared goal. To better understand the severity of the illnesses of our members, we review claims histories and medical records to make sure our members' diagnoses are fully and accurately reported.

This gives us a complete understanding of the health status of our member population.

As a result, we can better anticipate the needs of our members and help you deliver quality care.

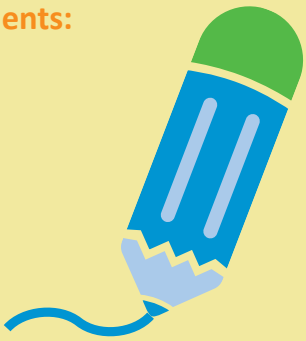
What is risk adjustment?

Risk adjustment was implemented by the Centers for Medicare & Medicaid Services (CMS) to pay Medicare Advantage (MA) health plans more accurately for the expected health cost expenditures of members by adjusting payments based on demographic and clinical information. Each year, CMS requires all MA health plans to submit detailed documentation of each member's diagnoses and attest the diagnosis codes are supported by valid documentation within the medical record. To meet this requirement, MA health plans conduct regular risk adjustment medical record reviews. We continually conduct these reviews to verify the accuracy of coding and identify additional conditions not captured through claims or encounters.

Your role in the process

You play a vital role in risk adjustment by helping us meet our data reporting and submission obligations to CMS. Complete and accurate medical records help us quantify each member's full illness burden, including disease complexity and severity.

Tips to help us meet risk adjustment requirements:



- Document coexisting conditions at least annually
- Ensure your documentation is clear, concise, complete and consistent
- Document the patient's full name and service date on each page of the medical record
- Ensure all diagnosis codes submitted on claims are supported in the medical records
- Ensure each diagnosis code in the medical record is submitted on a claim

How to learn more

For general information,
visit the CMS Medicare website on risk adjustment at www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk_adjustment.html.

For training and tools on risk adjustment,
visit the Customer Service and Support Center (CSSC) for Medicare Prescription Drug Organization website at www.csscoperations.com and select Risk Adjustment Processing System > Training.

Our Special Needs Plan Model of Care

We know Special Needs Plan (SNP) members need lots of care to address their often severe and disabling conditions. You don't have to do it alone! Our SNP Model of Care for dually eligible Medicaid and Medicare beneficiaries is truly a collaboration between you, the member and our staff – giving you the tools and resources to improve access to care, care coordination, and transitions with medical and behavioral health and social services.

Key features of the model of care include:

- **Assigning** an Interdisciplinary Care Team (ICT) to each member to review care plans, discuss specific cases, collaborate with providers and give recommendations to best manage care – you are a key part of the ICT
- **Arranging** an ICT meeting and inviting you to participate
- **Working** with you to determine best care options for the special needs member
- **Delivering** training for all providers, employees and contractors to ensure universal understanding of SNP members' complex conditions and care options
- **Employing** care management staff who specialize in helping SNP members
- **Assessing** members' physical, behavioral, psychosocial and functional needs when they enroll and at every year after
- **Creating** an individualized care plan based on a health risk assessment and the member's needs
- **Reviewing** clinical practice guidelines and current standards of care
- **Analyzing** and reporting results to help you improve performance and health outcomes

The case manager assigned to the member may reach out to you to request feedback on the care plan. We are continuing to create tools to provide you access to the important information gathered during the assessment process and the care plan.

Get more support

Take our Model of Care provider training at providers.amerigroup.com > Office Support > Model of Care Training (Medicare).

Call our Medicare Provider Dedicated Services Unit (DSU) at 1-866-805-4589 if you need more information about our SNP program or help coordinating care and tools to improve members' health.

Call our Case Management team at 1-866-805-4589 to discuss a specific patient and get detailed answers to your questions.

Amerigroup RealSolutions in healthcare

P.O. Box 62509
Virginia Beach, VA 23466-2509

ProviderNews

Questions?
Medicaid providers call 1-800-454-3730
Medicare providers call 1-866-805-4589

Abortion/sterilization/hysterectomy consent form reminder

Each time you submit a claim for abortion, sterilization or hysterectomy services and related procedures, you must include one of the following completed and signed consent forms for reimbursement:

- Abortion Certification
- Consent for Sterilization
- Hysterectomy Acknowledgment
- Exception to Hysterectomy Acknowledgment Requirement

You can easily download or print these forms from our provider self-service website.

Just log in and click on the **Find and Download Forms** link in the **Help and Reference** menu.

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