Provider Newsletter

providers.amerigroup.com

2015
Quarter 4

Medicaid

Centers for Disease Control and Prevention predicts another moderately severe flu season predominated by influenza A (H3N2)

The Centers for Disease Control and Prevention (CDC) released its report in June on influenza activity during last year's flu season and announced the composition of the 2015–16 influenza vaccine.

According to the CDC, the 2014–15 influenza season was moderately severe overall and especially severe in adults aged 65 years and older, with predominant circulation of influenza A (H3N2) viruses. Previous influenza A (H3N2)-predominant seasons have been associated with increased hospitalizations and deaths, especially among children under 5 years of age and adults 65 years of age and older.

Influenza activity peaked during late December, with influenza A (H3N2) viruses predominant early in the season. Influenza B became the predominant virus starting in late February, through the end of the flu season in May.

The Food and Drug Administration has recommended a change in the influenza A and influenza B components for the 2015–16 influenza vaccine, according to the report. Vaccine recommendations are based on several factors, including global influenza surveillance, genetic characterization, antigenic characterization, antiviral resistance and the candidate vaccine viruses available for production.

Since 2010, the CDC has recommended that everyone six months of age and older received a flu vaccine annually with rare exception.

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Amerivantage is an HMO plan with a contract with the State Medicare program. Enrollment in Amerivantage depends on contract renewal.

We are launching our annual member outreach campaign to encourage high-risk members to visit their provider for a flu vaccine. Outreach includes automated outbound telephone calls, text messages and newsletter articles. Providers can expect an increase in phone calls and early appointments for the flu vaccine.

Antiviral drugs used to lessen flu duration and symptoms, as well as many cough and cold products, are included on the formulary found on our provider website at providers.amerigroup.com/FL > Provider Resources & Documents > Pharmacy > Formulary.

Flu surveillance and patient education materials are available at the CDC website. For more information about vaccine coverage, contact Provider Services at 1-800-454-3730.

Synagis (palivizumab)

Respiratory syncytial virus (RSV) season begins as early as September and runs through April but can be longer in certain climates. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. The American Academy of Pediatrics (AAP) recommends a maximum of five (15 mg/kg) monthly doses of palivizumab during the RSV season for high-risk infants who were born before 29 weeks, 0 days gestation, have chronic lung disease (CLD) of prematurity or have hemodynamically significant heart disease. Updated indications for prophylaxis can be found in the July 2014 AAP Policy Statement and on our provider website at providers.amerigroup.com.

The Synagis prior authorization form can be found on provider website at providers.amerigroup.com/FL > Provider Resources & Documents > Pharmacy > Pharmacy Prior Authorization Form. Only one request is needed for each patient throughout the RSV season. In a case where higher dosage is necessary due to weight gain, documentation of the patient's new weight must be provided.

Accredo Specialty Pharmacy is the preferred provider for Synagis requests. Please fax prescriptions for Synagis to Accredo at 1-800-824-2642. Please check with your local Provider Services representative or our Provider Services team at 1-800-454-3730 if you have specific questions about how to obtain Synagis. You can also find additional drug information at providers.amerigroup.com/FL.

Flu prevention and treatment saves lives

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 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 six months of age and older receive 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.

Those at highest risk include:

- Children younger than age five, but especially younger than age two
  - Children between the ages of six months and eight years of age who are receiving a flu vaccine for the first time will need to have two doses, with at least four weeks between doses
- Adults age 65 and older
- Women who are pregnant or expect to become pregnant
- Patients with certain chronic diseases
- Native Americans and Alaska Natives

Encourage your patients to get a flu vaccine. Please educate your patients about the risks of the flu and provide flu vaccines as appropriate. Remember, adult members with Amerigroup Community Care pharmacy benefits can get a free flu shot. They just need to show their member ID cards at participating pharmacies during flu shot clinic hours. Coverage for children's vaccines varies, so contact your local Provider Relations representative to learn more.

Antiviral drugs

If patients do get sick, antiviral drugs not only lessen flu duration and symptoms but also decrease the risk for flu-related complications. Antiviral drugs, as well as many cough and cold products, are on our formulary posted at providers.amerigroup.com. Restrictions apply.

Stay informed

Find the latest flu updates, health care recommendations and printable patient education materials at cdc.gov/flu. Remember to protect yourself and your patients by getting your vaccine, too.

Source: Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, August 15, 2014, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2014–15 Influenza Season. http://www.cdc.gov/mmwr/mmwr_wk/wk_cvol.html (accessed September 25, 2014)

Send claims medical attachments through Availity

Amerigroup partners with Availity to offer providers the ability to check patients' eligibility and claims status, as well as submit claims and access multiple payer information with a single, secure Availity Web Portal login.

The Medical Attachments feature is now available to providers. You can now use your billing National Provider Identifier (NPI) number to register and submit attachments, with or without a claim, through the Availity Web Portal. This service enables you to submit attachments (e.g., medical records, itemized bills, etc.) prior to claims submissions, with claims submission or as requested by Amerigroup.

To access this new feature, primary access administrators (PAAs) should register today by logging in at availity.com. Click on the Amerigroup medical attachments registration link under your PAA dashboard, and you then assign access to appropriate office staff.

As an Amerigroup provider, you can also now send up to 10 unsolicited attachments through the web portal. You may submit up to 10 attachments for each claim, with a maximum file size of 10MB per attachment. This service includes attachments for secondary claims, and for attachments that are not related to a claim at all. Availity rejects any individual files larger than 10MB and requests that you split larger files into smaller files. Files can be submitted as TIFFs (.tif), JPEGs (.jpg) and PDFs (.pdf). This new feature allows your team to submit supporting medical documentation for claims without prompting by Amerigroup.

Unsolicited attachments streamline the claims process and can improve your revenue cycle by capturing required documentation needed to adjudicate a claim up front. Plus, the web portal captures, transmits, stores and retrieves your medical attachments, providing an electronic history that is easily accessible, now or in the future.

To access additional training on this new Availity feature:

1. Log in to the Availity Web Portal at availity.com.
2. Click the **Web Portal Users Login** link in the upper right corner.
3. On the Availity portal login page, enter your Availity user ID and password.
4. Click **Log in**.
5. At the top of any Availity portal page, click **Help** | **Get Trained**. *(Make sure you do not have a pop-up blocker turned on or the next page may not open.)*
6. In the new window a list of available topics will open. Locate and click **Medical Attachments**.
7. Under the **Recordings** section, click **View Recording** (next to Amerigroup Medical Attachments).

It's HEDIS season all year long

HEDIS scoring is no longer an annual event with a season lasting from January to June, but rather a year-round effort. To get the most out of our continuous improvement initiatives, we need information from you that is both current and enhanced to be actionable. We get this information directly from reports produced using your claims coding and submissions. We track and monitor data on a rolling 12 months and month-to-date basis to identify and immediately address any opportunities for improvement. Monthly updates — including administrative, supplemental and chart-based data — make identifying trends possible for us and are important in obtaining accurate lists of members who are eligible for, but haven't yet received, key preventive services required by NCQA HEDIS guidelines.

Through year-round analysis, we can provide you with lists of members who are missing important health screenings. Data collection throughout the year may also reduce your number of chart assessments during the annual HEDIS project performed in the first two quarters of a measurement year. It may even eliminate our need to visit your office at all during that span. If you would like to submit Amerigroup electronic data record feeds, let your Provider Relations representative know!

Thank you for your continued partnership to ensure that together we can achieve year-round success in meeting the measures!

Get referrals and authorizations online! Access them through *Quick Tools* at the top of our provider website.

Need to make a referral? Our online directory makes it easy to find network doctors and specialists. Click on *Find a Doctor* at the top of our website. Search by name, specialty or area, or download a PDF of our latest printed directory.

HEDIS – Help us help you

HEDIS is a set of standardized performance measures reported to NCQA by managed care plans nationally and measures compare how well a health plan performs in areas related to quality of care, access to care and member satisfaction. We use the HEDIS results to identify areas of strength and areas for improvement, measure results against our goals, and measure the effectiveness of actions we implemented to improve our results. Some of the performance measures we focus on are related to health issues such as immunizations, blood lead screening, diabetes, asthma, well-child visits, and adult access to care. Together we achieved improvement in some of our 2015 scores, but we still have work to do!

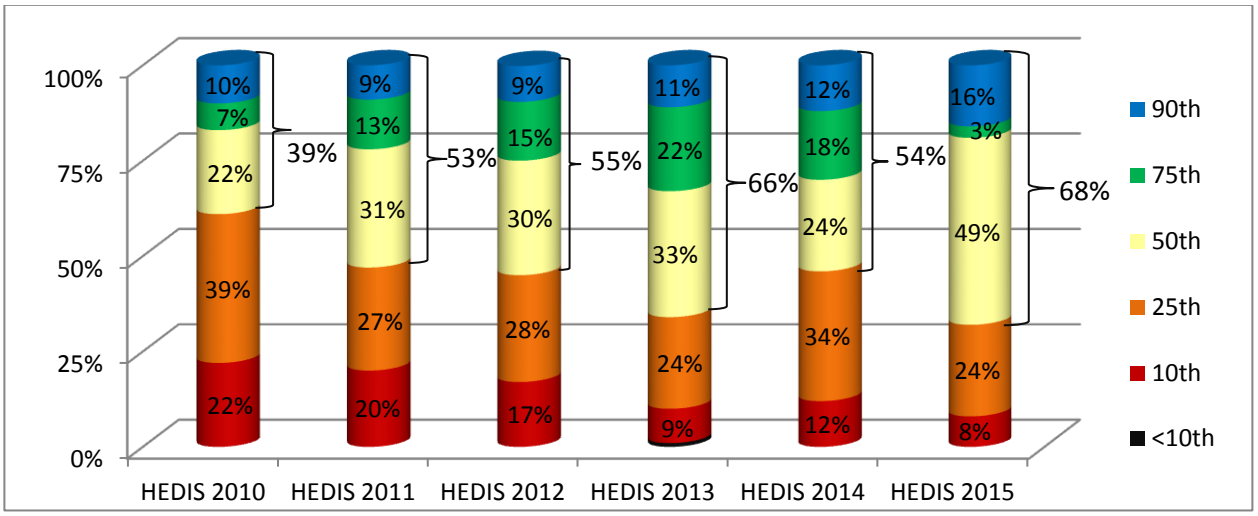
We are constantly seeking opportunities for improvement

Current Amerigroup interventions include:

- Providing members with educational resources related to a variety of health topics, including immunizations, diabetes, women's health, body mass index at health fairs, community events and clinic day events at your offices
- Improving provider and member outreach for those members due or past due for preventive services
- Providing a variety of both member and provider incentives to motivate and promote collaboration and follow-through with care recommendations
- Providing PCPs with a quality report card and member gap in care detail
- Establishing school based health clinics

HEDIS Results

The Annual HEDIS report is provided as a service and reference for you and the rest of our provider network. HEDIS 2015 measures are calculated based upon 2014 performance data. We produce this report to monitor the quality of care our membership receives and to identify opportunities to improve care delivery. The Agency for Health Care Administration requires Amerigroup to report on 38 total HEDIS measures. The Agency has set the NCQA quality compass 50th percentile as the goal Amerigroup must meet. Amerigroup was at or above the 50th percentile for 68 percent of the measures. The following graph shows our improvement over the last six years on the performance measures. Amerigroup Florida has a way to go to move all measures to the 50th percentile or above.



What are we doing to improve in 2016 and beyond?

Amerigroup has created new interventions to ensure members are receiving the care they need from their PCP. Some of the new interventions include:

- Mobile clinics to provide services in the members' community
- Working with school-based clinics
- Clinic days
- Face-to-face member outreach
- In-home labs

How can you help?

Contact your Provider Relations representative or the quality nurse assigned to your practice to:

- Develop a performance measure action plan tailored to your practice
- Call members on the care gap report and schedule them for appointments to complete the needed services
- Host clinic days specifically for Amerigroup members
- Participate as a practitioner on the mobile unit

Annual CAHPS results - Our members have a voice!

We always want feedback from you and our members, so we conduct satisfaction surveys each year. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) asks our members to rate their experiences with their providers and/or specialists and with our health plan over a six-month period. We rate our CAHPS performance against benchmarks set by the National Committee for Quality Assurance (NCQA). Our goal is to reach the 50th percentile benchmark set by the NCQA, as we are dedicated to continuous improvement of health care quality.

Comparing 2013-2015 member experience performance against NCQA benchmark

Adult member experience	2013	2014	2015	Benchmark percentile achieved
Getting care quickly	79	81	80	25th
How well doctors communicate	87	86	89	10th
Getting needed care	80	77	82	50th
Overall satisfaction with your personal doctor	73	75	81	50th
Overall satisfaction with your specialist	81	78	83	50th
Overall satisfaction with health care	62	62	77	75th
Overall satisfaction with health plan	68	68	77	50th
Child member experience				
Getting care quickly	88	91	90	50th
How well doctors communicate	91	92	93	25th
Getting needed care	82	81	81	10th
Overall satisfaction with your personal doctor	87	89	90	75th
Overall satisfaction with your specialist	85	85	84	25th
Overall satisfaction with health care	85	85	88	90th
Overall satisfaction with health plan	83	83	84	25th

How we did

Overall, our adult members are happier with our services and the services provided by our network of providers. Together, we achieved the 50th percentile or higher in eight of the 14 measures. However, we still have a lot of work to do.

How we'll do better

Our areas of focus for 2016:

- Continue to work on how well providers communicate
  - Provide more information to members and providers on covered benefits
  - Continue to encourage members to use the previsit tool prior to provider office visits to help improve member-provider communication and discussion of care needs
  - Continue to provide information to members about shared decision-making tips

- Continue to work on getting needed care
  - Continue to provide members with more information on their benefits to increase their overall knowledge of available benefits
  - Continue to educate and encourage members on the importance of seeing their assigned PCP
  - Educate members on the appropriate use of emergency care and the use of urgent care facilities when needed
  - Ensure that members and providers are aware of specialist within the network
- Continue to work on getting care quickly
  - Conduct the annual access and availability survey with providers
  - Educate members on how to access care
  - Continue to educate and encourage members on the importance of building a relationship with their PCP

What you can do to help

- Take our no-cost online cultural competency course to expand your knowledge of best communication techniques
- Attend our town hall meetings to receive updates and new information
- Continue to encourage members on the use of the pre-visit brochure provide a blank copy when they leave their appointments so they'll have it ready for next time
- Make use of patient education materials provided by Amerigroup and federal/state entities. Visit healthfinder.gov for more information
- Assist members in scheduling appointments with a specialist

Keys to effective member communication

Communication between a member and his or her provider is the single most effective predictor of patient compliance to prescribed treatment plans. However, there are major barriers to effective communication between providers and members, including health literacy, language differences and how patients feel about health care and treatment within their own cultural context. We know it is worth the effort to overcome these barriers.

According to the Institute for Health Care Communication (formerly the Bayer Institute), successful communication with patients involves four elements[1]:

1. **Engagement** is a connection between you and your patient that continues throughout the visit and establishes a partnership. Engage a member by showing interest in him or her as a person, finding out upfront what the member hopes to get out of the visit and using the patient's language instead of medical terminology or jargon.
2. **Empathy** is the ability to imagine oneself in another's place and understand the other's feelings, desires, fears and actions. You can show empathy by making proper introductions while members are fully clothed. This can be accomplished while the member's vitals are being taken. Once inside the exam room, make eye contact, approach members at eye level, acknowledge what members are saying and speak in a friendly manner.

[1] Mock, Kathleen. "Effective clinician-patient communication." *Physician's News Digest* (2001): 1-6.

3. **Education** involves providing the member increased knowledge and understanding while decreasing his or her uncertainty and anxiety. You can start this process by asking, "What do you think is going on?" You might be surprised by the valuable information this question elicits. Always be clear in describing or defining terms to avoid confusion.
4. **Enlistment** is your invitation to the member to collaborate in the decision-making process. If members feel involved in the process, they are more likely to comply with agreed-upon treatment plans. Try offering members possible explanations and ask if your findings are in line with what they thought. Be sure to discuss any differences in the diagnosis. Lay out all the variables for members in a simple format, including dosage requirements and the benefits of treatment. Solicit feedback from the member to confirm true collaboration. At the end of the visit, summarize the mutually agreed-upon treatment plan and discuss next steps.

Members spend about two percent of their time with you and 98 percent of their time living with and managing their illnesses. With effective communication, you can help them become educated participants in their treatment and help them take ownership of their health.

Want more information about how to effectively engage with members and communicate in a culturally competent way? Our website offers no-cost cultural competency training for you and your staff.

Provider Self-Service tools make it easy to do business with our organization

The Provider Self-Service (PSS) web portal offers 24/7 access to update basic provider demographic information like practice address information, practice roster, or termination of a provider in the practice by simply attaching supporting documentation.

Other available tools on the secure PSS site include, but are not limited to:

- Access to PCP member panels
- Patient 360 tool to quickly retrieve detailed records about your patients
- Member eligibility and benefits
- The ability to submit and check status of:
  - Authorizations
  - Claims

You must be a registered user to access the secure PSS tool at providers.amerigroup.com with your Availity username and password. If you do not have a login, go to www.availity.com, select the *Register Now* option and follow the Availity registration process instructions. Once you have your Availity username and password and have logged in, you may take an online tutorial under *Provider Education* to guide you through the process to make provider updates.

If you experience any difficulty, contact your local Provider Relations representative or call our Provider Services team at 1-800-454-3730, from 8 a.m. to 5 p.m., Monday through Friday for assistance.

Reimbursement Policy: updates and reminders

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

Policy update
Preadmission Services for Inpatient Stays
(Policy 07-017, originally effective 09/28/2007)

Amerigroup allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window). For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three days prior to and including the day of the member's admission, and therefore are not separately reimbursable expenses. For other hospitals and units, applicable preadmission services are included in the inpatient reimbursement within one day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses. For critical access hospitals, outpatient diagnostic services are not subject to either the three-day- or one-day-payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

Please note, the three-day- or one-day-payment window does not apply to outpatient diagnostic services included in the rural health clinic or federally qualified health center all-inclusive rate.

Applicable preadmission services consist of all diagnostic outpatient services (including nonpatient laboratory tests) and clinically related nondiagnostic (e.g., therapeutic) services that are related to the inpatient stay and are included in the inpatient reimbursement. A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately.

For additional information and/or nonreimbursable services, refer to the Preadmission Services for Inpatient Stays Reimbursement Policy at providers.amerigroup.com.

Prosthetic and Orthotic Devices
(Policy 06-084, originally effective 09/06/2006)

Reimbursement is allowed for prosthetic and orthotic devices when provided as part of a physician's services or ordered by a physician and used in accepted medical practice. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the prosthetic or orthotic device dispensed. The

design, materials, measurements, fabrications, testing, fitting and training in the use of the device are included in the reimbursement of the device and are not separately reimbursable expenses. In instances of theft, a police report is required for consideration of replacements.

For additional information and/or nonreimbursable services, refer to the Prosthetic and Orthotic Devices Reimbursement Policy at providers.amerigroup.com.

Transportation Services: Ambulance and Nonemergent Transport
(Policy 07-036, originally effective 02/26/2008)

Amerigroup allows reimbursement for transport to and from covered services or other services mandated by contract. Due to the complex nature of transportation services, Amerigroup recommends that providers also review individual state guidelines for coverage requirements.

Please note, Amerigroup does not allow reimbursement for mileage when the transport service has been denied or is not covered.

For additional information and/or nonreimbursable services, refer to the Transportation Reimbursement Policy at providers.amerigroup.com.

Policy reminder
Reimbursement of Sanctioned and Opt-Out Providers
(Policy 10-002, originally effective 10/11/2010)

Reimbursement is not allowed for providers who are excluded, debarred or who opt out from participation in state and federal health care programs. Reimbursement is also not allowed for providers who have rendered services to members enrolled in any Medicare program if such provider has opted out from participation in Medicare. Services that are rendered by a provider who is sanctioned or who has opted out of participation in Medicare may only be reimbursed in urgent or emergent situations. Claims received for services other than emergency services submitted by sanctioned or opt-out providers as provided herein will be denied. Amerigroup screens providers through all applicable state and federal exclusion lists.

For additional information, refer to the Reimbursement of Sanctioned and Opt-Out Providers Reimbursement Policy at providers.amerigroup.com.

State-specific requirements apply to these policies. For additional information, refer to the Reimbursement Policies at providers.amerigroup.com and click on Quick Tools.

Your continued feedback is critical to our success. If you have questions, contact your local Provider Relations representative or call 1-800-454-3730.

Amerivantage

Emergency room level 5 professional claim review

We are initiating a review of emergency room (ER) professional claims billed with a level 5 ER E/M code (99285 or G0384) to ensure the documentation meets or exceeds the components necessary to support its billing. The review for the necessary components will be based on the coding guidelines outlined in the AMA CPT coding reference. Documentation will be requested and the review will be performed on a pre-pay basis. The review for selected ER professional claims with level 5 E/M codes is scheduled to begin April 1, 2016.

Reimbursement Policy: updates

(This article contains information specific to Medicare.)

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Amerivantage (Medicare Advantage) benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Reimbursement Policies, visit our website at providers.amerigroup.com and select Quick Tools.

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For additional information and/or nonreimbursable services, refer to the Transportation Reimbursement Policy at providers.amerigroup.com.

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