Provider Newsletter

https://providers.amerigroup.com/GA

Amerigroup RealSolutions® in healthcare

2016
Quarter 3

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Reimbursement Policies

Vascular embolization or occlusion services to require prior authorization

Effective November 1, 2016, vascular embolization or occlusion services will require prior authorization (PA).

Vascular embolization or occlusion services requests must be reviewed by Amerigroup Community Care for PA for dates of service on and after November 1, 2016. To request PA, use one of the following methods:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627

For a list of Amerigroup reimbursement policies and more information on PA requirements, please visit our website at https://providers.amerigroup.com/GA.

- For reimbursement policies, select Reimbursement Policies.
- For authorization requirements, select Precertification Lookup Tool.

If you have questions about this communication or need assistance with any other item, call Provider Services at 1-800-454-3730.

PCP Change Request form now available on provider website

Amerigroup Community Care has implemented a new way to perform PCP changes for members. You can now download the PCP Change Request form from the provider website and fax it to the number provided.

- Download the form from the provider website: https://providers.amerigroup.com/GA > Provider Resources & Documents > Forms > PCP Change Request Form.
- Ensure the form is completed in its entirety by the member. Forms will not be processed unless all fields are completed.
- Fax form to 1-866-840-4993.
- Allow 24 to 72 hours for processing.

Please note: PCP changes are effective the date the fax is received. Retroactive requests will not be processed.

If you have any questions about the new PCP Change Request form, contact your Provider Relations representative or advise the member to call Member Services toll free at 1-800-600-4441.

Pharmacy management information

Up-to-date pharmacy information is available on our provider website. You can access our formulary, Prior Authorization (PA) form and Preferred Drug List.

If you have questions about the formulary or would like a paper copy, call the Pharmacy department at 1-800-454-3730. Pharmacy technicians are available Monday through Friday from 7 a.m.-9 p.m. ET and Saturday from 10 a.m.-2 p.m. ET.

Provider satisfaction

Every year, Amerigroup Community Care conducts a provider satisfaction survey. Analysis of the survey responses helps us to identify aspects of performance that do not meet provider expectations and to initiate an action plan to improve performance. A positive working relationship with our contracted providers is important to the delivery of health care to our members. The objective of the survey is to measure overall provider satisfaction with, and loyalty to, Amerigroup, as well as identify areas of strength and opportunities for improvement. The survey also assesses provider satisfaction in the following categories:

- Customer service at the call center
- Local health plan provider services
- Communication and technology
- Claims processing and provider reimbursement
- Network
- Utilization management
- Quality management
- Pharmacy and drug benefits
- Disease Management Centralized Care Unit
- Continuity and coordination of care

We distributed our latest survey from July to September 2015. The overall Amerigroup satisfaction ranking was 85 percent, which was a slight decrease from 86 percent in 2014. For key drivers, we have made improvements in provider training, HEDIS®* data, provider communications, timeliness of the Amerigroup medical director's response to your concerns and disease management.

Thank you for participating in our network, for providing quality health care to our members and for cooperating in our annual review process.

*HEDIS is a registered trademark of the NCQA.

Distribution of clinical practice and preventive health guidelines

Evidence-based guidelines are clinical practice guidelines (CPG) known to be effective in improving health outcomes. Guideline effectiveness is determined through scientific evidence, professional standards or expert opinion. Amerigroup Community Care provides clinical care and preventive health guidelines to our network physicians. These guidelines are based on current research and national standards. CPGs are available on our website (https://providers.amerigroup.com/GA > Provider Resources & Documents > Clinical Practice Guidelines > Clinical Practice Guidelines Matrix).

Providers should become familiar with these guidelines. We are grateful to the providers who participated in the medical record review project, which monitors providers' CPG compliance in more than 450 ADHD, asthma and diabetes medical records.

We also suggest you refer to the American Academy of Pediatrics (AAP) (aap.org) recommendations for preventive pediatric health care guidelines for children up to age 21. Additionally, immunization schedules can be found on their website (aap.org > Advocacy & Policy > AAP Health Initiatives > Clinical Resources > Immunization > Immunization Schedule).

For the Bright Futures Periodicity schedule, visit brightfutures.aap.org.

If you would like a paper copy of any of the guidelines noted, call Provider Services at 1-800-454-3730.

Quality Improvement Program (QIP)

The Amerigroup Community Care QIP is committed to excellence in the quality of service and care our members receive, as well as the satisfaction of our network providers. We are always looking for ways to refine our comprehensive QIP, which includes:

- Adhering to federal, state and Georgia Families Program standards
- Objectively monitoring and evaluating the care and services provided to members
- Planning studies across the continuum of care to ensure ongoing, proactive evaluation and refinement of the program
- Reflecting the demographic and epidemiological needs of the population served
- Encouraging both members and providers to weigh in with recommendations for improvement
- Identifying areas where we can promote and improve patient safety
- Measuring our progress to meet annual goals

We would like to share with you our annual QIP summary of our goals, processes and outcomes related to clinical performance and service satisfaction. Throughout the year, we evaluate data trends related to how our members receive health care and preventive care services, and then we compare our findings to national practice guidelines. You – our network physicians and office staff – are the key to helping us collect this information and improve quality performance.

Clinical performance and service satisfaction are based upon results from performance measures.

Performance measures

Healthcare Effectiveness Data and Information Set (HEDIS) is a program developed by the National Committee for Quality Assurance (NCQA) to measure important dimensions of care and service performance. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided and strengthen health outcomes of children in Medicaid and CHIP, as well as include a core measure set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs. These measures evaluate a broad range of important health issues, including immunizations, preventive care and screening, comprehensive diabetes care, asthma medication use, controlling hypertension, and access to care.

Consumer Assessment of Health Providers and Systems (CAHPS®*) surveys evaluate member satisfaction related to care and services received over the past six months. Plan members are randomly sampled and answer questions about their doctors and the health plan.

HEDIS and CAHPS results help us identify areas of strength and areas where we need to focus our improvement efforts. We use the results to measure our performance against our goals and to determine the effectiveness of plans we implemented to improve our results.

*CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

2015 QIP accomplishments:

- Achieved a 93 percent overall compliance score on external quality review compliance audit
- Maintained NCQA accreditation at the commendable level
- Ensured continuous activities were in place to increase HEDIS and other performance rates from the previous year, resulting in improved rates for measurement year 2014 (reported in 2015) for several measures, including developmental screening, weight assessment and counseling for nutrition and physical activity for children/adolescents and body mass index percentile, nutrition and physical activity, preventive dental services, medical assistance with smoking and tobacco cessation, timeliness of prenatal care, cesarean section rate, comprehensive diabetes care (HbA1c testing), eye exam, medical attention to neuropathy, initiation and engagement of alcohol and other drug dependence treatment (initiation and engagement), and reduction in emergency room visits/1000
- Achieved a 75th percentile for "Rating of Health Plan and Customer Service" on 2015 child CAHPS survey
- Achieved rating in the 75th percentile on the adult CAHPS survey for "Rating of Health Care, How Well Doctors Communicate" and "Health Promotion and Education"
- Achieved 85 percent overall satisfaction with the health plan on the 2015 provider satisfaction survey
- Expanded practices in Pay 4 Performance Programs by 26 sites and 156 providers
- Grew number of NCQA-certified, patient-centered medical homes by five
- Expanded number of health plan staff with Lean Six Sigma Certification
- Improved compliance with evidence-based practices based on clinical practice guideline monitoring
- Maintained greater than 90 percent overall performance on health check provider audits
- Created new local high-risk disease management team
- Provided expanded oversight of delegated vendor activities through formation of a plan oversight committee
- Submitted the required performance improvement projects to Georgia Department of Community Health (DCH)

The quality improvement direction for 2016:

- Continue collaboration with DCH and CMS on quality improvement initiatives
- Execute on rapid cycle improvement projects to identify effective interventions to spread to our network providers and improve overall performance measure results
- Ensure continuous survey readiness for NCQA reaccreditation in 2016
- Complete a successful external quality review audit
- Continue PCP medical record reviews for clinical practice guideline adherence and monitoring health check compliance for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program screening rates to meet required targets
- Continue focus on health promotion and education
- Increase collaboration with physicians on quality improvements and continue to improve provider satisfaction
- Take actions to reduce racial and ethnic disparities in health care
- Collaborate with the network to improve member satisfaction
- Increase provider and member involvement on our health advisory committees

To review or receive a copy of the current QIP documents, or if you would like more information about our QIP, data results and progress toward meeting our goals, please call our office at 678-587-4840 and ask for Charmaine Bartholomew.

Availability of utilization management (UM) criteria

Amerigroup Community Care uses nationally recognized criteria to assist our medical management staff in making decisions concerning the medical necessity of:

- In-hospital level-of-care and length of stay
- Admissions
- Outpatient services
- Behavioral health services
- Pharmacy services

If an Amerigroup medical director denies a service request, both provider and member will receive a notice of action letter that will include the reason for the denial and the criteria/guidelines used for the decision, as well as explain the appeal process and provider and member rights. To speak with a medical director about the service request denial, call Provider Services at 1-800-454-3730 or the local health plan at 678-587-4840. To request a copy of the specific criteria/guidelines used for the decision, please call 1-800-600-4441 or send a written request to the address below:

Medical Management
Amerigroup Community Care
303 Perimeter Center N, Suite 400
Atlanta, GA 30346

Access to UM staff

We are staffed with clinical professionals who coordinate our members' care and who are available 24 hours a day, 7 days a week to accept precertification requests. You can submit precertification requests by:

- Calling us at 1-800-454-3730.
- Going to mmis.georgia.gov/portal, Availity.com or our provider website at https://providers.amerigroup.com/GA > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool.

If you have questions about utilization decisions or the UM process in general, call our Clinical team at 1-800-454-3730, Monday-Friday from 8:30 a.m.-5:30 p.m. ET.

Affirmative statement about incentives

Amerigroup, as a corporation and as individuals involved in UM decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Member rights and responsibilities

Amerigroup Community Care wants to keep you informed about our members' defined rights and responsibilities; therefore, they can be found in the provider manual and on our website. To receive a copy in the mail, call Provider Services at 1-800-454-3730.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4441 (TTY 1-800-855-2880).

Member satisfaction

We measure member satisfaction through an annual CAHPS survey. Analysis of the survey results helps us identify areas where we do not meet member expectations. The areas analyzed are grouped into five areas:

- Getting care quickly
- Shared decision making
- How well doctors communicate
- Getting needed care
- Customer service

We distributed our latest survey in March 2015. This report is compiled from the responses of the 780 Amerigroup members who responded to the survey. The overall satisfaction ranking for the child survey question "rating of the health plan" was 86.8 percent. Amerigroup is partnering with a study provider to test interventions to spread to providers and improve overall member satisfaction.

Access to case management

In addition to disease management programs, Amerigroup Community Care offers a complex case management program for our high-risk members. Using claims and utilization data, we can identify diseases for which members are most at risk and to which they are most susceptible.

Our case managers use evidence-based guidelines to coordinate care with members and their families with physicians and other health care providers. They work with everyone involved in members' care to help implement a case management plan based on members' individual needs. We provide education and support to our members and their families to help our members improve their health and quality of life. If you have a high-risk member you would like to refer to this program, please call us at 1-800-454-3730.

Synagis (palivizumab)

Respiratory syncytial virus (RSV) season begins as early as September and runs through April. 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 https://providers.amerigroup.com/GA .

The Synagis prior authorization form can be found on provider website at https://providers.amerigroup.com/GA > 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.

In most cases, Express Scripts, Inc, is the preferred provider for Synagis requests. However, some markets prefer other vendors. Please check with your local Provider Services representative or our Provider Services team at 1 800 454 3730 for specific details on how to obtain Synagis. You can also find additional drug information at https://providers.amerigroup.com/GA.

Reimbursement Policies

New Policy

Reimbursement for Maximum Units Per Day

(Policy 15-003, effective 01/01/2017)

Amerigroup Community Care allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

For additional information, refer to the Reimbursement for Maximum Units Per Day policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Update

Durable Medical Equipment (Rent to Purchase)

(Policy 06-052, effective 01/01/2017)

Amerigroup Community Care allows reimbursement for Durable Medical Equipment (DME). Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of Rental DME

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied

Circumstances Affecting Rental Reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage more than 60 days
- If a member changes suppliers during the rental period, a new rental period will not start over

Note, Amerigroup in Georgia considers respiratory related equipment to be an indefinite rental.

For additional information, refer to Durable Medical Equipment (Rent to Purchase) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Reminder

DME Modifiers for New, Rented, and Used Equipment

(Policy 06-053, effective 3/14/16)

Amerigroup Community Care allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For more information, refer to the DME Modifiers for New, Rented and Used Equipment policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.