

Provider Newsletter

<https://providers.amerigroup.com/GA>



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Interactive Care Reviewer tool: Register and start using today!

Now your practice can initiate online preauthorization requests for Georgia Families members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Web Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Web Portal.* There are no changes to the preauthorization capabilities on the provider website (<https://providers.amerigroup.com/GA>).

How do I gain access to the ICR?

You can access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select **Register** in the upper right-hand corner of the page. If your organization already has access to Availity, your Availity administrator can grant you access to “authorization and referral request” for submission capability and “authorization and referral inquiry” for inquiry capability. You can then find our tool under Patient Registration > Authorizations & Referrals. From this area, you can select the authorizations or authorization/referral inquiry option as appropriate.



Whom can I contact with questions?

For questions regarding our ICR tool, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

What benefits/efficiencies does the ICR provide?

- **You are automatically routed to our ICR.** Once the ICR is available, when you go to *Authorizations* in the Availity Web Portal, you are automatically routed to the ICR in order to begin your prior authorization request.
- **You can determine if prior authorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **You will have inquiry capability.** Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax, ICR or another online tool (e.g., AIM Specialty Health®, OrthoNet LLC, eReview).
- **The ICR is easy to use.** You can submit outpatient and inpatient requests for services online using the same, easy-to-use functionality.
- **The ICR reduces the need to fax.** The ICR allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR is a no-cost solution that’s easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **You receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submit online, including the status of your requests and specific views that provide case updates and a copy of associated letters.





* For preauthorization requests for Medicaid members where the request type = inpatient and the case type = maternity, the ICR tool will display the following message on the patient confirmation page: Precertification must be submitted through the GHP website at <https://www.mmis.georgia.gov/portal>.

GA-NL-0036-17

CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Amerigroup Community Care seeing Georgia Families members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following best practice standards:

	<p>1. Emergency plan</p>	<p>Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.</p>
	<p>2. Policies and procedures</p>	<p>Develop and implement policies and procedures based on the plan and risk assessment.</p>
	<p>3. Communication plan</p>	<p>Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.</p>
	<p>4. Training and testing program</p>	<p>Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.</p>

Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (<https://www.cms.gov> > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

GA-NL-0038-17

Utilization Management affirmative statement

Amerigroup Community Care, as a corporation and as individuals involved in Utilization Management (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 reward practitioners or other individuals for issuing denials 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.

GA-NL-0048-17



Behavioral health provider survey

Amerigroup Community Care is committed to finding the best ways possible to support our members and providers, and you can help! We are looking to identify areas of expertise or services for which you are licensed and have at least two years of clinical experience. To make the collection of this information easy, we have created a short online survey; all you need to do is follow the link/instructions below. The information collected will be used to help us locate services for members more efficiently.



The *Behavioral Health Areas of Expertise Profile* is designed to capture informational data only. While not all services listed are covered benefits in your state, having complete information on what our providers offer will be valuable should changes occur.

You can access the online survey below:

- [Behavioral health facilities](#)
- [Behavioral health individual practitioners and medical groups](#)

You may also access the survey via the provider website (<https://providers.amerigroup.com/GA> > Provider Resources & Documents > Behavioral Health > Behavioral Health Facility Survey or Behavioral Health Practitioner Survey).

For your convenience, you can include up to five locations per survey. For behavioral health facility practitioners, if you have more than five locations, please complete an additional survey for the remaining locations. For behavioral health individual practitioners, please complete one survey for every practitioner in your organization.

Your response is critical in helping us match your services to our members' needs. If you have questions about completing the survey or would like a paper copy of the survey, please contact Provider Relations.

GA-NL-0037-17

New pregnancy notification process using the Availity Web Portal Benefit Look-up Tool



As you know, Amerigroup Community Care offers pregnant women several services and benefits through the Taking Care of Baby and Me[®] program. It is our goal to ensure all pregnant members are identified early in their pregnancy so they can take full advantage of the education, support, resources and incentives Amerigroup provides throughout the prenatal and postpartum period.

We've partnered with Availity, the vendor supporting the Benefit Look-up Tool you may currently use in your OB office, to send us information about newly identified pregnant women.* This new process, including HEDIS[®] maternity attestation, will help providers connect patients with additional benefits as soon as possible. The reporting process includes a few simple steps.

How it works:

When a Georgia Families member of childbearing age visits an OB office, the office associate will be prompted to answer the question "Is the member pregnant?" during the eligibility and benefits inquiry process. If the response is "yes," Amerigroup will inquire about the due date, and a *Maternity Attestation Form* will be generated for the OB office to complete. On this electronic form, the provider will enter other important information including the date of the first prenatal care visit, delivery date and postpartum visit date.

This new, user-friendly workflow will generate timely information that will help members, providers and Amerigroup improve birth outcomes with early intervention and ensure compliance with HEDIS benchmarks.

We will be working hard to ensure providers receive necessary training for this new workflow and that all questions are answered. If you have any specific questions regarding the new Availity maternity attestation, please feel free to reach out to Provider Services at 1 800 454 3730.

** This process does not replace the need to submit state required notification of pregnancy forms or health risk assessments.*

GA-NL-0042-17

Provider FAQ — Availity Web Portal pregnancy notification and HEDIS® attestation

As you know, Amerigroup Community Care offers pregnant women several services and benefits through the Taking Care of Baby and Me® program. It is our goal to ensure all pregnant members are identified early in their pregnancy so they can take full advantage of the education, support, resources and incentives Amerigroup provides throughout the prenatal and postpartum period.

1. What is the purpose of this new process?

As you know, Amerigroup Community Care offers pregnant women several services and benefits through the Taking Care of Baby and Me® program. It is our goal to ensure all pregnant women are identified early in their pregnancy so they can take full advantage of the education, support, resources and incentives Amerigroup provides throughout the prenatal and postpartum period.

This new, user-friendly workflow will generate timely information that will help you, your patients and Amerigroup improve birth outcomes with early intervention and will ensure compliance with HEDIS benchmarks.

2. When will the new pregnancy-related questions display?

When an OB/GYN office conducts an eligibility and benefits inquiry for a Georgia Families member 15-44 years of age in the Availity Web Portal, the system will display pregnancy-related questions. If the office confirms the patient is pregnant, a *Maternity HEDIS Attestation Form* will be generated. If the patient is not pregnant, the desired eligibility and benefits information will display, and no further action is required.

3. Does the *Maternity HEDIS Attestation Form* replace the need for an OB global authorization?

Responses provided in the Availity pregnancy notification system do not replace the need to submit a request for OB global authorization. A request for OB global authorization can be submitted by phone or fax as well as online through the secure provider self-service website that can be accessed through the Availity Web Portal.

4. Does the *Maternity HEDIS Attestation Form* replace the need for any state-required notification of pregnancy?

This process does not replace the need to submit state-required notification of pregnancy forms or health risk assessments.

5. How should our office reply when a patient presents as a transfer from another OB provider?

You should answer the pertinent pregnancy questions and complete the *Maternity HEDIS Attestation Form* as usual. Even though the first prenatal visit question typically relates to prenatal care in the first trimester or within 42 days of plan enrollment, you can simply enter the date you first provided prenatal care for the patient.

6. If a patient transfers out of our practice during her prenatal course, how should our office complete the *Maternity HEDIS Attestation Form*?

It is alright to leave the HEDIS attestation in a pending status as it provides Amerigroup with pertinent prenatal care information up to the point that the patient transfers out of the practice. The form will remain in place until it is automatically retired 19 months later.

7. If we have confirmed the patient is pregnant but she suffers an early miscarriage or chooses to end the pregnancy, how should our office communicate this important information?

In this situation, you should select the option on the *Maternity HEDIS Attestation Form* that states “this pregnancy ended or the baby delivered prior to 20 weeks.” This action will allow the office to close out and submit the *Maternity HEDIS Attestation Form* for this pregnancy.

8. Do I have to answer all the questions on the *Maternity HEDIS Attestation Form* all at once?

No, the workflow is designed so you may enter and save information as it becomes available during the pregnancy. After the delivery and postpartum visit dates are entered, you will be given the option to complete and submit the attestation. Until then, you may save the information you enter and continue on with other tasks.

9. Is there an easy way for me to obtain a list of all patients for whom I need to enter prenatal or postpartum visit dates?

Your organization will receive two notifications to complete the *Maternity HEDIS Attestation Form*.

- In order to prompt you to complete the form and enter the first prenatal visit date, the first notification is posted at the time the form is created.
- In order to alert you to schedule the postpartum visit (if not already done) and to enter the postpartum visit date, the second notification is posted 14 days prior to the estimated due date.

You may access the work queue at any time by going to *Payer Spaces*. Next, select the payer title from the list. Then select **Amerigroup HEDIS Attestation for Maternity**.

10. How can I get additional help, support or training?

- Availity offers integrated help and on-demand training demonstrations (select **Help** and search using the keyword “maternity”).
- You can launch training demonstrations from associated help topics as well as the HEDIS attestation for maternity work queue.
- If you have technical difficulties related to the HEDIS attestation for maternity workflow, contact Availity at 1-800-282-4548.
- If you have specific member concerns, please contact Provider Services at 1-800-454-3730.

GA-NL-0043-17

Reimbursement Policies

Policy Update

Modifier 63: Procedure Performed on Infants Less Than 4 kg

(Policy 06-015, effective 09/15/2017)

Currently, Amerigroup Community Care allows additional reimbursement of 120 percent for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, Amerigroup will allow reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100 percent of the applicable fee schedule or contracted/negotiated rate. Please note, the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

Key Definition

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding Modifier 63 to the procedure.

In applicable circumstances, Amerigroup does not allow reimbursement for Modifier 63.

To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants Less Than 4 kg Reimbursement Policy at <https://providers.amerigroup.com> > Quick Tools > Reimbursement Policies > [Medicaid/Medicare](#).

GA-NL-0026-16

Policy Update

Maternity Services

(Policy 14-001, effective 11/01/17)

Amerigroup Community Care allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). If a provider

or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.



What's New?

We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

For additional information, refer to the Maternity Services Reimbursement Policy at <https://providers.amerigroup.com> > Quick Tools > Reimbursement Policies > [Medicaid/Medicare](#).

GA-NL-0032-17

Policy Update

Modifier 22: Increased Procedural Service

(Policy 07-020, effective 11/01/17)

Amerigroup Community Care allows reimbursement for procedure codes appended with Modifier 22. Beginning November 1, 2017, reimbursement will be based on 100 percent of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure.



Refer to Modifier 22: Increased Procedural Service Reimbursement Policy for more information at <https://providers.amerigroup.com> > Quick Tools > Reimbursement Policies > [Medicaid/Medicare](#).

GA-NL-0031-17