Provider Newsletter

Amerigroup Kansas, Inc.
https://providers.amerigroup.com/KS
Provider Services: 1-800-454-3730

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Right to inspect records reminder

Amerigroup Kansas, Inc., the United States Department of Health and Human Services, the Office of the Inspector General, CMS, the Medicaid Fraud Unit, and the state Attorney General's Office have the right to evaluate any records pertinent to our *Provider Agreement* through inspection or other means, whether announced or unannounced. Often this includes requests for HEDIS® medical record reviews for quality, appropriateness and timeliness of services; such evaluation, when performed, shall be done with cooperation of Amerigroup and the provider. Note, providers are contractually required to cooperate with Amerigroup requests for medical records and to assist in our compliance with state and federal requirements.

For more information and special considerations, refer to your *Provider Agreement* with Amerigroup.

KS-NL-0048-17

Kansas Medical Assistance Program provider numbers

Currently, some providers are required to have a Kansas Medical Assistance Program (KMAP) provider number for Medicaid purposes. Providers affected include: rural health clinics, federally qualified health centers, hospices, nursing facilities, psychiatric residential treatment facilities, and home- and community-based services providers that use AuthentiCare.

Inactivation of KMAP enrollment affects Medicaid payments. Amerigroup Kansas, Inc. will deny preauthorizations and claim payments from providers who do not have a current and valid KMAP number for the service(s) requested/billed. Additionally, Amerigroup cannot credential, recredential or contract with providers who don't have a current and valid KMAP number for the services they wish to contract for. Revalidations can be completed on the KMAP website.

For questions or concerns about the KMAP enrollment or revalidation process, contact KMAP Provider Enrollment at 1-800-933-6593, option 3.

KS-NL-0048-17

Utilization Management affirmative statement

Amerigroup Kansas, Inc., 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.

KS-NL-0046-17

Home- and community-based services — policies, best practices and resources

- Adverse Incident Reporting Provider Update
- *The Home- and Community-Based Services (HCBS) Settings Rule: What Does it Mean for You? Guide*
- *Person-Centered Planning and HCBS Guide*
- *Kansas Medical Assistance Program General Bulletin 174014 — Provider Revalidation*
- *State Required Background Check Process Guide*
- Finalized updates to the Personal Care Services Policy and the Enhanced Services Policy: Note, CMS found a number of inconsistencies between approved waivers and the *Capable Person Policy*. By removing references to "legally responsible individual" and "capable person," these policies are designed to provide clarification on regulations and limitations in accordance with approved HCBS waiver programs for the reimbursement of personal care services for all HCBS waiver populations.
- Implementation of Residential Billing Policy Provider Update
- Functional Eligibility Assessments and Waitlist Management Policy

KS-NL-0048-17

What is a PCP?

The role of a PCP is to help members get the care they need when they need it.

- A PCP serves as a member's main doctor.
- A PCP gets to know the member and his/her medical history.
- A member can see his/her PCP for:
  - Wellness checkups.
  - Disease prevention and early detection of certain health conditions such as high blood pressure or diabetes.
  - Illness or injury.
  - Shots (also called immunizations).
  - Prescription medicines.
  - Advice about health problems.

Updates to PCP assignments may be submitted using the *PCP Change Request Form*, which is available in English and Spanish. The member/responsible party will need to identify the PCP he/she would like to be assigned to on the form and fax his/her completed form as indicated. The *PCP Change Request Form* can be found on our provider website at (https://providers.amerigroup.com/KS > Provider Resources & Documents > Forms > PCP Change Request Form).

KS-NL-0048-17

Approved waived tests

Effective January 1, 2017, the tests listed on the policy attachment have been approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Act. Modifier QW must be appended to these CPT codes to be recognized as a waived test.

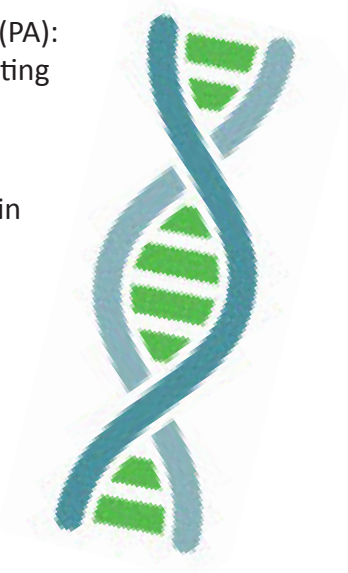
CPT code	Effective date	Description
G0477QW	February 12, 2016	Greenbrier International, Inc. Assured THC One Step Marijuana Test Cassette
G0477QW	February 12, 2016	Greenbrier International, Inc. Assured THC One Step Marijuana Test Strip
G0477QW	March 18, 2016	Safecare Biotech Urine Test Amphetamine Cassette
G0477QW	March 18, 2016	Safecare Biotech Urine Test Amphetamine Cup
G0477QW	March 18, 2016	Safecare Biotech Urine Test Amphetamine DipCard
G0477QW	March 18, 2016	Safecare Biotech Urine Test Cocaine Cassette
G0477QW	March 18, 2016	Safecare Biotech Urine Test Cocaine
G0477QW	March 18, 2016	Safecare Biotech Urine Test Cocaine DipCard
G0477QW	March 18, 2016	Safecare Biotech Urine Test Marijuana Cassette
G0477QW	March 18, 2016	Safecare Biotech Urine Test Marijuana Cup
G0477QW	March 18, 2016	Safecare Biotech Urine Test Marijuana DipCard
83986QW	May 13, 2016	Teco Diagnostics OBGYN-VpH Vaginal pH Screening Kit
G0477QW	June 9, 2016	Native Diagnostics International DrugSmart Multi-Panel Drug Screen Cup Tests
G0477QW	June 9, 2016	Native Diagnostics International DrugSmart Multi-Panel Drug Screen Cup with OPI 2000 Tests
G0477QW	June 9, 2016	Native Diagnostics International DrugSmart Dip Multi-Panel Drug Screen Dip Card Tests
G0477QW	June 9, 2016	On-Site Testing Specialists, Inc. On-Site Testing Specialists Multi-Panel Drug Screen Cup Tests
G0477QW	June 9, 2016	On-Site Testing Specialists, Inc. On-Site Testing Specialists Multi-Panel Drug Screen Cup with OPI 2000 Tests
G0477QW	June 9, 2016	On-Site Testing Specialists, Inc. On-Site Testing Specialists Multi-Panel Drug Screen Dip Card Tests
G0477QW	June 9, 2016	On-Site Testing Specialists, Inc. On-Site Testing Specialists Multi-Panel Drug Screen Dip Card with OPI 2000 Tests
G0447QW	June 9, 2016	Alfa Scientific Designs, Inc. Instant-View Multi-Drug Urine Test Cup
G0477QW	June 9, 2016	Alfa Scientific Designs, Inc. Instant-View Multi-Drug Urine Test Panel
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Marijuana Dip Card Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Marijuana Quick Cup Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Marijuana Strip Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Marijuana Turn-Key Split Cup Test

Approved waived tests continued

CPT code	Effective date	Description
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Methamphetamine Dip Card
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Methamphetamine Quick Cup Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Methamphetamine Strip Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Methamphetamine Turn-Key Split Cup
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Phencyclidine Dip Card Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Phencyclidine Quick Cup Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Phencyclidine Strip Test
G0477QW	July 18, 2016	Assure Tech. Co., Ltd. AssureTech Phencyclidine Turn-Key Split Cup Test
87631QW	July 25, 2016	Roche Molecular, cobas Liat System cobas Liat Influenza A/B and RSV Assay
G0477QW	July 28, 2016	Germaine Laboratories, Inc., AimScreen Multi-Drug Urine Test DipDevice
G0477QW	July 28, 2016	Germaine Laboratories, Inc., SafeCup II Multi-Drug Urine Test Cup
G0477QW	July 29, 2016	NexScreen LLC, NEXSCREEN Multi-Drug Urine Test Cup
G0477QW	July 29, 2016	NexScreen LLC, NEXSCREEN Multi-Drug Urine Test Dip Card
86308QW	August 4, 2016	McKesson Consult Mononucleosis Test Cassette (whole blood)
87880QW	September 4, 2016	Princeton BioMeditech StatusFirst Strep A

KSPEC-1488-17

Genetic testing services to require prior authorization



Effective June 1, 2017, the following genetic testing services require prior authorization (PA): epidermal growth factor receptor (EGFR) testing, prothrombin coagulation (factor II) testing and methylenetetrahydrofolate reductase mutation (MTHFR) testing.

What is the impact of this change?

For dates of service on or after June 1, 2017, PA is required for EGFR testing, prothrombin coagulation (factor II) testing and MTHFR testing covered by Amerigroup Kansas, Inc. for KanCare members. Federal and state law as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following codes: 81235, 81240 and 81291.

To request PA, contact us by phone at 1-800-454-3730, by fax at 1-800-964-3627 or via the Availity Web Portal (https://www.availity.com).

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/KS > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

KS-NL-0044-17

National Correct Coding Initiative Medically Unlikely Edits for 76519 and 92136

For dates of service on and after April 1, 2017, the following changes to the Practitioner (PRA) Medically Unlikely Edits (MUE) file take effect:

- 76519: ophthalmic biometry by ultrasound echography (A-scan) with intraocular lens power calculation — service limit = two
- 2136: ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation — service limit = two

For both codes, the previously posted April PRA MUE file listed the service limit as one and an effective date of January 1, 2017. Prior to January 1, 2017, the MUE was two. The revised April PRA MUE file lists the MUE for both codes as two with an effective date of October 1, 2010, for 76519 and January 1, 2012, for 92136.

KSPEC-1572-17

Clinical Laboratory Improvement Amendments requirements for procedure code G0499

Effective for dates of service on and after January 1, 2017, new procedure code G0499 (hepatitis B screening in nonpregnant, high-risk individuals including hepatitis B surface antigen HBsAg followed by a neutralizing confirmatory test for initially reactive results, antibodies to HBsAg and hepatitis B core antigen) is subject to Clinical Laboratory Improvement Amendments (CLIA) editing.

CLIA regulations require facilities to be appropriately certified for each test performed. To ensure that Medicaid only pays for laboratory tests performed in certified facilities, each claim with an HCPCS code that is considered a CLIA laboratory test is edited at the CLIA certificate level.

KSPEC-1571-17

Prior authorization notice

Effective April 1, 2017, Amerigroup Kansas, Inc. requires prior authorization (PA) for the specific medications noted below.

Medication	Therapeutic class
Amrix© (cyclobenzaprine ER)	Muscle relaxant
Avandaryl© (rosiglitazone/glimepiride)	Sulfonylurea/thiazolidinedione combination
Exondys 51® (eteplirsen)	Duchenne muscular dystrophy agent
GoNitro® (nitroglycerin sublingual powder)	Nitroglycerin agent (for angina)
Yosprala® (aspirin/omeprazole)	Aspirin/proton pump inhibitor combination
Zegerid® (omeprazole/sodium bicarbonate)	Omeprazole (proton pump inhibitor)/sodium bicarbonate combination
Zinplava® (bezlotoxumab)	Human monoclonal antibody
Zolpimist® (zolpidem tartrate spray)	Sleep agent

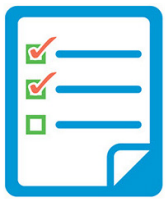
Note, these PA criteria changes were reviewed and approved by the Kansas Drug Utilization Review Board.

KS-NL-0048-17

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 Kansas, Inc. seeing KanCare 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:

	**1. Emergency plan**	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
	**2. Policies and procedures**	Develop and implement policies and procedures based on the plan and risk assessment.
	**3. Communication plan**	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.
	**4. Training and testing program**	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.

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).

KS-NL-0040-17

Notification process reminder

Effective April 24, 2017, failure to obtain precertification for KanCare members and failure to notify Amerigroup Kansas, Inc. of a member's admission or transfer within established time frames (as outlined below) will result in your claims being administratively denied, and you will not receive payment for the service(s). For participating providers, this is a contractual obligation and has been in effect since the execution of your contract. As a reminder, providers cannot balance bill members for services that are administratively denied. Members who are retroactively enrolled into the plan by the state are deemed out of scope.

If your claim is administratively denied, you may file an appeal in accordance with rules and regulations. As part of the appeal, you must demonstrate that you notified or attempted to notify Amerigroup within the contractually established time frame and that the service(s) are medically necessary.

Notification requirements:

Amerigroup must be notified of all member admissions or transfers within one business day of admission or transfer. Ideally, notification should occur the day of admission or transfer; however, you have one business day to notify Amerigroup without penalty. A business day is considered Monday-Friday and does not include weekends or weekdays that fall on federal holidays.

Notification for all post-stabilization admissions including transfers should occur within one business day of admission. The following clinical scenarios are excluded:

- Admission to a Neonatal Intensive Care Unit (NICU) level III
- Admission to an Intensive Care Unit (ICU)
- Direct admission to an operating room (OR)/recovery room
- Direct admission to a telemetry floor
- Involuntary behavioral health admission

Notification process reminder continued

Note, admission to a general ward is considered in scope for our notification requirements. Failure to notify us within one business day of admission to the general ward or NICU level I or II is considered failure to notify, and administrative denial applies. Once the member has been downgraded to a general ward from the NICU level III, ICU, OR/recovery or telemetry, the requirement for notification within one business day applies.

Notification of OB antepartum/postpartum admissions that do not result in a delivery should occur within one business day.

Precertification requirements:

Precertification is required for the following:

- Nonemergent inpatient transfers between acute facilities
- Elective inpatient admissions
- Rehabilitation facility admissions
- Long-term acute care admissions
- Skilled nursing facility admissions
- Behavioral health levels of care (as outlined in the provider handbook and precertification documents)
- Out-of-area/out-of-network services
- Outpatient services (as outlined within the Precertification Lookup Tool on the website)
- Outpatient durable medical equipment purchases and rentals (as outlined within the Precertification Look-up Tool on the website)

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

To obtain precertification or to verify member eligibility, benefits or account information, follow instructions outlined on the provider website or in the quick reference guide, provider manual, interactive voice response system or Availity® Web Portal where applicable.

For additional information and/or detailed precertification requirements, refer to the provider website (https://providers.amerigroup.com/KS > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

KSPEC-1457-16

Centers for Disease Control and Prevention — live attenuated influenza vaccine alert

Live attenuated influenza vaccine (LAIV) effectiveness data presented to the advisory committee indicated that the LAIV did not offer significant protection against the predominant flu virus (influenza AH1N1pdm09) among study participants 2-17 years of age during the 2015-2016 flu season. Therefore, claims for the LAIV will be denied.

The LAIV accounts for about 8 percent of the total flu vaccine supply in the United States. The Centers for Disease Control and Prevention (CDC) believes that there will be enough inactivated influenza vaccine to meet demand this flu season, but it will require the entire medical community working together and remaining flexible in their preference of vaccine presentation. The CDC is developing a policy on vaccine distribution that focuses on ensuring vaccines are available for everyone.

Additionally, FluMist, a LAIV that is administered intranasally, is rendered noncovered. Per a recommendation to the CDC by their advisory board and supported by the American Academy of Family Physicians and the American Academy of Pediatrics, FluMist should not be used during the 2016-2017 flu season. This noncoverage would be for administration to any age, but this is generally considered for usage with the pediatric population.

KS-NL-0024-16

Interpreter services

No-cost interpreter services are available to members when calling our Member Services team with questions about our programs, when calling Amerigroup On Call, during appointments with health care providers, and during grievance or appeals processes.

For interpretation services during scheduled appointments, call our Member Services team at 1-800-600-4441 and be ready to provide the following information:

- Appointment type (e.g., PCP, specialist, behavioral health, etc.)
- Appointment date and time
- Member name
- Member number
- Provider name
- Provider address

The information provided will be forwarded to our in-house interpreter manager who will determine the best method of service delivery — either phone or onsite. The manager will coordinate with the member and provider to ensure interpreter services are available at the time of the appointment. Requests by phone should be accommodated the same day while on-site interpretation requires five days' advanced notice.

KS-NL-0024-16

Adverse incident reporting

Adverse occurrence (e.g., major critical events) reports must be made by each participating provider to all appropriate agencies, as required by licensure as well as state and federal laws, within the specified time frames immediately following the event.

Kansas requirement

A report must be filed with the Kansas Department for Aging and Disability Services through their Adverse Incident Reporting system within 24 hours. Examples of adverse occurrences include but are not limited to:

- Treatment complications (including medication errors and adverse medication reactions)
- Accidents or injuries to a member
- Morbidity
- Suicide attempts
- Death of a consumer
- Allegations of physical abuse, sexual abuse, neglect and mistreatment, and/or verbal abuse
- Use of isolation, mechanical restraint or physical holding restraint
- Any clear and serious breach of accepted professional standards of care that could endanger the safety or health of a member or members

For more information on adverse incident reporting with the state, visit https://www.kdads.ks.gov > Providers > Behavioral Health Services Provider Information > Adverse Incident Reporting.

Amerigroup Kansas, Inc. requirement

Providers must report critical incidents to Amerigroup in accordance with applicable requirements. The maximum time frame for reporting an incident to Amerigroup is 24 hours. The initial report of an incident may be submitted verbally within 24 hours, and the person, agency or entity making the initial report must submit a written, follow-up report within 48 hours.

For more information on reporting adverse incidents to Amerigroup, reference the Critical Incident Reporting and Management section of the *Provider Manual* (https://providers.amerigroup.com/KS > Provider Resources & Documents > Manuals & Referral Directories > Kansas Provider Manual).

KS-NL-0024-16

Member rights and responsibilities

We want to keep you informed about our members' defined rights and responsibilities. These can be found in your *Provider Manual* and on our website, https://providers.amerigroup.com/KS. If you would like a paper copy mailed to you, 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 711).

KS-NL-0024-16

Member health and wellness tools

On our member website (myamerigroup.com/KS > Health & Wellness), members have access to health and wellness topics provided through HealthWise. The site provides quick, easy access to information, interactive tools and tips to help members reach their health goals. Be sure to share this great resource with your patients.

KS-NL-0024-16

Quality Improvement Program

The Amerigroup Kansas, Inc. Quality Improvement Program (QIP) is one way we are committed to excellence in the quality of service and care our members receive as well as the satisfaction of our network providers. Our comprehensive QIP:

- Adheres to the Kansas program standards.
- Objectively monitors and evaluates the care and services provided to members.
- Helps us plan studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of the program.
- Reflects the demographic and epidemiological needs of the population served.
- Encourages both members and providers to weigh in with recommendations for improvement.
- Identifies areas where we can promote and improve patient safety.
- Measures our progress to meet annual goals.

Throughout the year, we evaluate data trends related to how our members receive health care and preventive care services and compare our findings to national practice guidelines. You are key in helping us collect this information and improve our quality performance.

Clinical performance and service satisfaction are based upon results from:

- **Medicaid HEDIS®**: HEDIS is a program developed by the National Committee for Quality Assurance (NCQA) to measure performance on important dimensions of care and service. HEDIS measures address 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 Healthcare Providers and Systems (CAHPS®)**: CAHPS surveys evaluate member satisfaction with care and services received over the past six months; a random sample of plan members answer questions about their doctors and the health plan.

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

To review the current QIP summary, call Provider Services at 1-800-454-3730, and we'll send you a copy. You may also find a copy of this information on our website at https://providers.amerigroup.com/KS.

KS-NL-0024-16

Provider surveys

Each year, we reach out to our providers to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers. Thank you in advance for cooperating in our annual review process.

KS-NL-0024-16

Access to case management

Did you know that, in addition to our disease management programs, we offer a complex case management program for our high-risk members?

Using claims and utilization data, we can identify the 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 the member, their family, physicians and other health care providers. They work with everyone involved in the member's care to help implement a case management plan based on the member's 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.

KS-NL-0024-16

Distribution of *Clinical Practice Guidelines* and *Preventive Health Guidelines*

Evidence-based guidelines are *Clinical Practice Guidelines (CPGs)* known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence, professional standards or expert opinion. Amerigroup Kansas, Inc. provides *Clinical Practice Guidelines* and *Preventive Health Guidelines* to our network physicians. The guidelines are based on current research and national standards. *CPGs* are available on our website at (https://providers.amerigroup.com/KS > Provider Resources & Documents > *Clinical Practice Guidelines*). If you would like a paper copy of a guideline, call Provider Services at 1-800-454-3730.

KS-NL-0024-16

Pharmacy management information

Up-to-date pharmacy information is available on our provider website (https://providers.amerigroup.com/KS). You can access our formulary, *Prior Authorization* form and *Preferred Drug List*.

If you have questions about the formulary or would like a paper copy, call the Pharmacy department at 1-800-323-4696. Pharmacy technicians are available Monday-Friday from 8 a.m.-8 p.m. and Saturday from 10 a.m.-2 p.m. CT.

KS-NL-0024-16

Utilization management

Availability of utilization management (UM) criteria

Amerigroup Kansas, Inc. 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 the 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 913-749-5955. 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 Kansas, Inc.
9225 Indian Creek Parkway, Building 32
Overland Park, KS 66210

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:

- **Phone**: 1-800-454-3730
- **Fax**: 1-800-964-3627
- **Online**: https://providers.amerigroup.com/KS > 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 a.m.-5 p.m. CT.

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.

KS-NL-0024-16

Recredentialing

Recredentialing is required every three years by NCQA. Amerigroup Kansas, Inc. will perform recredentialing at least every 36 months if not sooner. Network practitioners and providers will receive requests for recredentialing applications and supporting documentation in advance of the 36-month anniversary of their original credentialing or last credentialing cycle. Information from quality improvement activities and member complaints will be assessed, along with assessments and verifications listed above.

KS-PM-0016-16

Updated Kansas Organizational Provider Credentialing/ Recredentialing Application

In an effort to streamline the current KanCare credentialing process, an updated *Kansas Organizational Provider Credentialing/ Recredentialing Application* will be available for use by all providers applying to a KanCare managed care organization (MCO) beginning May 1, 2017. This new application will replace any previous versions and will be required for all applications received by the MCOs on and after June 1, 2017.

On May 1, 2017, the updated *Kansas Organizational Credentialing/Recredentialing Application* will be available as a fillable PDF form.

It is required to be completed in its entirety only one time. For providers wanting to enroll with multiple MCOs, they can open the completed application, change their MCO attestation, print, and sign the application. An original, wet signature is required for each individual MCO. The updated application is also required for those providers needing to be recredentialed.

Read the full *KMAP General Bulletin 17085*.

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Access and Availability

Primary Care Provider Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an:
  - On-call physician
  - Nurse practitioner with physician backup
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow our referral/precertification guidelines. This is a requirement for covering physicians.

We encourage you to offer after-hours office care in the evenings and on Saturdays. It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.

The ability for Amerigroup Kansas, Inc. to provide quality access to care depends upon your accessibility.* You are required to adhere to the following access standards:

Primary Care Provider Access and Availability

Type of Care	Standard
Emergency	Immediately
Urgent care	Withing 48 hours
Routine or preventive care	Within three weeks

Specialty Care Providers' Access and Availability

Type of Care	Standard
Emergency	Immediately
Urgent care	Withing 48 hours of referral
Nonurgent sick care	Within 10 calendar days

Type of Care	Standard
Routine lab, X-ray (Radiology) and optometry	Within three weeks
Mental health	■ **Poststabilization:** Within one hour from referral for poststabilization services (both inpatient and outpatient) in an emergency room. ■ **Emergent:** Within three hours for an outpatient MH services; within one hour from referral for an emergent concurrent utilization review screen ■ **Urgent:** 48 hours from referral for outpatient MH services; within 24 hours from referral for an urgent concurrent utilization review screen. ■ **Planned Inpatient Psychiatric:** Referral within 48 hours; assessment and/or treatment within five working days from referral. ■ **Routine Outpatient:** Referral within five days; assessment and/or treatment within nine working days from referral and/or 10 working days from previous treatment.
Substance Use Disorder (SUD) services	■ **Emergent:** Treatment is considered an on demand service and does not require precertification. Members are asked to go directly to an emergency room for services if individual is either unsafe or their condition is deteriorating. ■ **Urgent:** Means a service need that is not emergent and can be met by providing an assessment within 24 hours of the initial contact, and services delivered within 48 hours from initial contact without resultant deterioration in the individual's functioning or worsening of his or her condition. If the Member is pregnant they are to be placed in the urgent category. ■ **Routine:** Means a service need that is not urgent and can be met by a receiving an assessment within 14 calendar days of the initial contact, and treatment within 14 calendar days of the assessment, without resultant deterioration in the individual's functioning or worsening of his or her condition. ■ **IV Drug Users:** If a Member has used IV drugs within the last six months, and they do not fall into the Emergent or Urgent categories because of clinical need, they will need to be placed in this category. Members who have utilized IV drugs within the last six months need to be seen for treatment within 14 calendar days of initial contact. There is not a time standard requirement for the assessment, nor is there an IV Drug User category in the KCPC. ■ These members are categorized as routine but are to receive treatment within 14 days of their initial contact, not within 14 days of their assessment.
All other specialty care	Within 30 calendar days

** In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.*

For more information please refer to our provider manual online https://providers.amerigroup.com/ProviderDocuments/KSKS_Prov_Manual.pdf. Or reach out to your Network Relations Consultant.

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

Amerigroup Kansas, Inc. 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.

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Policy Update
Modifier 22: Increased Procedural Service
(Policy 07-020, effective 11/01/17)

Amerigroup Kansas, Inc. allow reimbursement for procedure codes appended with Modifier 22. Reimbursement is 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.

Amerigroup allows reimbursement of Modifier 22 on Radiology, Laboratory/Pathology, and Medicine codes; and Surgery and Anesthesia codes which have a global period of 000, 010, 090, or YYY identified on the Medicare Physician Fee Schedule Relative Value File. Modifier 22 should not be used on E&M services. E&M codes with a modifier 22 will be denied.

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

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Policy Reminder

Modifier 78: Unplanned Return to the Operating/Procedure Room By the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

(Policy 06-016, originally effective 07/24/11)

Amerigroup Kansas, Inc. allows reimbursement for claims billed with Modifier 78 when the following criteria are met:

- The return to the operating or procedure room is unplanned.
- The procedure appended with Modifier 78 is:
- The appropriate surgical code for the procedure performed.
- Performed by the same physician who provided the initial procedure.
- Related to the initial procedure.
- Performed during the postoperative period of the initial procedure.

Amerigroup Kansas, Inc. reimburses services appended with Modifier 78 the appropriate percentage as indicated in the MPFSDB (Medicare Physician Fee Schedule Data Base). For those procedure codes that have surgical indicator YYY and are assigned a global period of 010 or 090 days, reimbursement of Modifier 78 is 80 percent.

For market-specific information, refer to Modifier 78 Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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