NEW JERSEY
ProviderNews
2013 • Quarter 3

Behavioral Health — Our Whole-person Approach

Health care professionals have long known this paradox: Most patients seek behavioral health treatment from Primary Care Providers (PCPs), while the mentally ill often lack adequate primary care. Our PC-INSITE and Behavioral Health Homes (BHHs) programs synthesize behavioral and primary health care to address these gaps. This whole-person approach gives patients the care they need in single locations while reducing morbidity rates and costs for government-funded programs.

Our PC-INSITE Program

"Most people with behavioral health issues go to PCPs for treatment — they don't go to mental health professionals," said program sponsor and founding member Dr. Julia Ekong. "If you refer patients to mental health care, a significant number won't follow through. People don't want to be labeled due to the stigma, so we must find ways to treat behavioral health in primary care clinics."

PC-INSITE brings the expertise of behavioral health coaches and supporting psychiatrists into PCP offices to improve the detection, diagnosis and treatment of behavioral health conditions. It relieves PCPs of their roles as de facto mental health providers by targeting patients with complaints like headaches, nausea and unexplained pains often unrecognized as symptoms of underlying behavioral health conditions.

Our pilot programs in Maryland, Tennessee and Texas will add 17 new Amerigroup Behavioral Health coaches to our staff and assign supporting psychiatrists to participating practices through a phased approach over the next few years.

Our behavioral health coaches:

- Conduct member screenings and assessments
- Educate our members about their conditions and how to manage them
- Monitor treatments and conduct follow-up

Our supporting psychiatrists for participating practices:

- Prescribe medications and treatments
- Conduct overall case reviews
- Assess complex conditions

Behavioral Health Homes

The converse of PC-INSITE, BHHs coordinate care between psychiatric professionals and PCPs for our members with severe mental illnesses. BHHs combat the deadly consequences of this group's elevated risk for treatable conditions caused by smoking, obesity, substance abuse and infectious diseases. These factors, compounded by lack of adequate primary care, cause these patients to die at an average of 25 years earlier than others.

Did you know?

Antidepressants are prescribed at 9.3 percent of primary care visits.

Nonpsychiatrists write more than 75 percent of antidepressant prescriptions.

Up to 70 percent of pediatric primary care visits are for issues related to psychosocial concerns.

Our BHH model builds upon patient-centered medical home concepts to provide total care with:

- Centralized primary and behavioral health services
- Dental, vision, podiatry and other specialty care
- Health screenings and specialist referrals
- Transportation, housing and resources for families and caregivers

This year, we launched our first BHH pilot in New York and are developing expansion pilots in Texas and in our parent company's Anthem Virginia health plan. Work groups in Kansas and Washington are also preparing for the Centers for Medicare & Medicaid Services (CMS) requests for applications for pilot programs due this fall.

Amerigroup RealSolutions® in healthcare

What to Expect
From Your Provider Relations Representative

Your local Provider Relations representative is your go-to source for questions about your contract, community events, patient outreach support opportunities, quality or incentive programs, and training opportunities. Quick resolution of your questions or concerns is the goal or our Provider Services team.

When you need help, you have several options. Your first stop should be our provider self-service website — it puts most of the information you need for day-to-day care of our members right at your fingertips. Or you can call our national Provider Services team at:

- **1-800-454-3730** for Medicaid providers
- **1-866-805-4589** for the Medicare provider Designated Service Unit

Online, you can:

- File claims electronically, check claims status and receive electronic funds for reimbursements
- Get precertification information and approvals
- Check member eligibility and download your Amerigroup-assigned patient panel
- Update your practice demographic and contact information
- Get training
- Find resources like provider manuals and quick reference guides

By phone, you can:

- Get help with questions about claims, precertifications, member benefits and more
- Receive swift resolution of complex claims issues

Your Provider Relations representative wants to make it easy for you and your staff to do business with us. You can expect him or her to contact you throughout the year to schedule in-person meetings convenient to your schedule.

HELPING YOU...

Make Sense of **Health Reform**

Public policy and health reform are intrinsic to the Amerigroup mission — helping those who need a little help and making the health care system work better while keeping it more affordable for taxpayers.

With almost two decades of experience managing health care for the nation's most vulnerable, we are:

- Well-positioned to meet the challenges and opportunities of health reform
- Already poised to address the influx of enrollment we'll see from Medicaid expansion
- Ready to leverage efficiencies by managing even more people who are dually eligible for Medicaid and Medicare

Our dedicated team of health reform policy analysts manages our health care reform website — a one-stop resource for keeping up with reform news and decisions made in your state.

Visit hcr.amerigroup.com to find:

Timelines summarizing major provisions affecting the U.S. health system and health care industry, and select publicly funded health care programs

Activity maps outlining decisions made in each state

Issue briefs — statutory information of the Patient Protection and Affordable Care Act broken into easy-to-understand, issue-oriented briefings

A resource and health reform education library, including the Policy Options for States series, white papers and reading lists

A health reform glossary and acronym guide

You can even sign up for e-news alerts from our team.

With Preparation for **ICD-10 Compliance**

Are you on track for the switch to ICD-10 coding in October 2014? Are the practice management software vendors you work with ready? If you haven't started preparing for these changes, CMS says now is the time to confirm system and software changes and updates with your vendors. Make sure these are completed, received and internally tested.

You can also begin external testing of transactions and claims with your business partners. This includes clearinghouses and any other entity with which you exchange impacted transactions like eligibility, authorization requests and, of course, claims.

If you're not yet that far along, don't panic. CMS has helpful implementation guides, timelines and other information available at www.cms.gov.

Need help with electronic transactions with Amerigroup? Call our EDI hotline at 1-800-590-5745.

Serve a **Diverse Community**

We can help you develop skills to effectively work with patients from diverse backgrounds so you can deliver the best care possible. By understanding the influence culture and tradition plays on patients' perceptions and attitudes toward health care, you can incorporate those variables in assessment, interaction and treatment plans.

When patients understand symptoms and comply with treatment plans, you may see:

- Better efficiency in practice operations and appointment availability
- Fewer repeat calls from the same patients for the same issues
- Financial rewards from our quality incentive programs
- Increased job satisfaction from seeing better health for your patients

Take the cultural competency training on our provider self-service website. Select Cultural Competency under Provider Resources & Documents > Training Programs.

2013 Provider Satisfaction Surveys

Our 2013 provider satisfaction surveys were completed in July and August of this year. We rely on your feedback to strengthen our processes and operations — our survey helps us engage you in evaluations that help us improve. Your input about your experience with us is essential to maintaining dialogue in support of our mutual goal to provide efficient, effective health care solutions.

By continuously monitoring our business practices and the service we provide you, we can forge a closer partnership.

We already made these improvements as a direct result of last year's survey:

- Provider self-service site redesign, giving you easier access to more information
- Enhanced online precertification and claims tools
- Self-serve access to your Amerigroup-assigned member panels
- Redesigned online provider directory for referrals
- Specialized training for our Provider Services Unit associates in our national call center to respond more quickly and fully to your calls and claims issues
- Additional personal contact from our local Provider Relations representatives
- New and improved provider orientation and training programs

We look forward to sharing, through future communications, a summary of 2013 survey results and actions we'll take in response to your input. Thank you for taking time to respond and for your ongoing support in caring for our members.

2012 Survey Results

We worked with Morpace, a survey research and consultation firm, to conduct a satisfaction survey of a sampling of our providers. Of those responding to the survey,

84 percent are satisfied with us overall **and**
87 percent would recommend us **to other providers.**

We also measured the following areas:

- Customer service at our national call center
- Local health plan provider services
- Communication and technology
- Claims processing and provider reimbursement
- Our network
- Utilization management
- Quality management
- Pharmacy benefits
- Our Disease Management Centralized Care Unit (DMCCU)
- Continuity and coordination of care

Of provider offices surveyed, 8.2 percent responded. Areas of improvement over the 2011 survey are:

Area surveyed	Percentage of improvement over 2011
Overall provider satisfaction	9%
Providers who would recommend us to other providers	8%
Courtesy of provider representatives	11%
Timeliness of provider representatives in answering questions/resolving problems	13%
Frequency of provider representatives in-person visits/phone contact	21%
Effectiveness of provider representatives in-person visits/phone contacts	13%
Customer service	12%
Provider services	15%
Network	5%

Compared to other areas assessed, providers are more satisfied with the areas of technology, claims processing/ reimbursement, utilization management and our network.

Our local health plan provider services and customer service are rated most favorably among other Medicaid and Medicare plans.

Several attributes posted significant increases this year:

- **Customer service** — demonstrated professional skills and understanding of the reason for a call
- **Local health plan provider services** — frequency of provider rep visits/phone contacts
- **Technology** — Clinical practice guidelines

We learned 46 percent of our Primary Care Physicians (PCPs) coordinate care with members' behavioral health specialists upon learning the member receives behavioral health care. When receiving one of our members as a new patient, 27 percent of behavioral health specialists coordinate care with the members' PCPs. Our members see better overall health outcomes when care is coordinated across providers, so it is important that you reach out to members' other providers to coordinate services.

You can help to encourage coordination of care by:

- Educating members on the importance of sharing medical and psychosocial histories with their PCPs by signing release of information forms
- Asking members to share the names of their PCPs with their behavioral health specialists, and if they are receiving behavioral care, to share the names of their behavioral health providers with their PCPs
- Demystifying HIPAA by explaining all communication between a member and their practitioners is confidential and will not result in adverse action

We look forward to sharing, through future communications, a summary of 2013 survey results and actions we'll take in response to your input. Thank you for taking time to respond and for your ongoing support in caring for our members.

Is Your Office Up to Standard?

Access to Care

The following availability standards must be followed for Amerigroup members in New Jersey:

Type of Care	Standard
Emergency care	Immediately; otherwise, refer to an emergency room
Urgent care	Within 24 hours
Routine care/preventive care (well visits)	Within 28 days of request
Symptomatic acute care (nonurgent, symptomatic conditions or chronic problems)	Within 72 hours of request
Specialty care	Within four weeks of referral, based on severity of condition
Urgent specialty care	Within 24 hours of referral
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Health Track screens	In accordance with the Heath Track periodicity schedule for well-child examinations and the Centers for Disease Control and Prevention (CDC) immunization schedule
Initial health visit — adult	Within 180 days of enrollment with Amerigroup
Initial health visit — child and adult Division of Developmental Disabilities clients	Within 90 days of enrollment with Amerigroup or in accordance with EPSDT periodicity schedule
After-hours care	Answering service or telephone message with directions on how to obtain urgent care must be available 24 hours a day, 7 days a week
Prenatal care	
■ **Initial visit**	Within three weeks of positive pregnancy test
■ **High-risk visit**	Within three days of identification of high risk
■ **Visit in first and second trimester**	Within seven days of request
■ **Visit in third trimester**	Within seven days of request
Laboratory/radiology services	Within three weeks for routine appointments Within 48 hours for urgent services
Dental services	Within 48 hours of emergency Within three days of referral for urgent care services Within 30 days of referral for routine care
Behavioral health/substance abuse	Immediately for emergency services Within 24 hours for urgent care Within 10 days of request for routine care

We've established access and availability standards to ensure timely health services are available to all members. The standards comply with regulatory requirements and are periodically measured through member satisfaction surveys, member complaint analysis, provider site visits and special surveys.

Access Standards

Participating providers are responsible for offering members access to covered services 24 hours a day, 7 days a week. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. The covering provider may not sign out of the emergency room during his or her shift.

Noncompliance

In the event a provider's office is found noncompliant with our standards, the provider's office is notified and resurveyed approximately six months later. If, upon resurvey, the provider's office remains noncompliant, an Amerigroup Provider Relations representative will visit the office to review the standards and discuss corrective action plans. For a complete list of our access and availability standards, review our provider manual on our provider self-service website.

Avoid Common Claims Errors — Get Paid Faster

Watch for these common mistakes to avoid rejected claims:

1. **The claim is not specific enough:** Accurately code condition(s) to the highest degree of certainty for each encounter/visit, including symptoms, signs, abnormal test results or other reason for the visit.

2. **Data is missing:** Record all encounter data completely and provide supporting documentation when necessary. This includes:
   - Member name (first and last name)
   - Member ID
   - Member date of birth
   - Provider name according to contract
   - Amerigroup provider ID
   - Coordination of benefit information
   - Date of encounter
   - Diagnosis code
   - Types of services provided (using current procedure codes and modifiers if applicable)
   - Provider tax ID number
   - NPI/API number — Claims submitted without your NPI will be rejected and returned to you

3. **Untimely filing:** We deny claims submitted after filing deadlines. Timely filing periods begin from the date of discharge for inpatient services and from the date of service for outpatient/physician services. Timely filing requirements are defined in your provider agreement and outlined in our provider manual.

HEDIS

Medical Records

Requests

Our Quality Management (QM) department performs annual medical record data collections for Healthcare Effectiveness Data and Information Set (HEDIS). As a participating provider, you may be contacted to supply medical records for HEDIS reporting. If contacted, please take the time to provide the requested records to the QM department for review.

HEDIS measures the performance of our health plan and participating practitioners on important aspects of preventive, acute and chronic health care established by the National Committee for Quality Assurance (NCQA). HEDIS data are used by insurance purchasers and consumers, as well as regulatory and accreditation agencies. New Jersey requires Amerigroup and our network physicians to comply with HEDIS initiatives and report the results to the state. The U.S. Department of Health and Human Services confirms supplying the requested records to us for HEDIS reporting does not violate the HIPAA Privacy Rule. See 45 CFR 164.506(c) (4).

Your cooperation in completing requested medical record reviews will help us communicate to the medical and consumer community our commitment to meeting the highest standards of care.

State Medicaid agencies and Medicaid managed care organizations **will pay eligible providers increased rates for eligible services rendered** between January 1, 2013, and December 31, 2014. Check our provider self-service site for news on the progress of this initiative in your state.

Each state determines its own procedures for attestation of eligibility and payments of the rate increase (pending approval of state plan amendments filed with CMS). Our site gives you updated information as we hear it and links to previous communications, required forms, and state announcements or websites for further info about this ongoing initiative.

Medicare News

High-Risk Medications for the Elderly

Certain behavioral health medications may have adverse effects on patients over age 65.

For example, amatriptyline can cause sedation, weakness, constipation and decline in cognitive function. Safer alternative therapies for depression include serotonin norepinephrine reuptake inhibitors and selective serotonin reuptake inhibitors. Nortriptyline, gabapentin or pregabalin (Lyrica) can safely be prescribed for neuropathic pain.

We'll notify you by fax or mail if a medication you prescribed poses a potential risk to your Medicare patient. If you have questions about a notification or need recommendations for medication therapies, call our Pharmacy team at 1-866-805-4589.

Medication Therapy Management

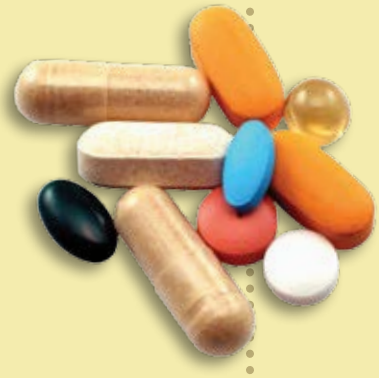
Our no-cost service helps members who use our case management services to meet their therapeutic goals.

Our Medication Therapy Management (MTM) pharmacists conduct comprehensive medication reviews to:

- Evaluate medications, including over-the-counter medications and supplements, against present medical conditions
- Determine drug therapy problems like adverse drug reactions or interactions, ineffective doses, and nonadherence
- Identify medications that may be contraindicative with members' behavioral health, other prescriptions and medical conditions
- Create individual medication care plans with you and the member

Our case managers are reaching out to eligible members to schedule appointments for over-the-phone medication reviews. You'll also receive a notice if your patient is eligible for this service. Patients are more likely to participate if they know you support the program, so please contact them and recommend this service.

For more information about MTM, call us at 1-855-535-7142 Monday through Friday from 8:00 a.m. to 7:00 p.m. Central time. To recommend a member for MTM, call our Pharmacy team.



Medicare News

Discharge Planning Checklist

Follow these steps to make sure your patient has a smooth transition to outpatient services:

Start discharge planning as soon as your patient enters the hospital.

Revisit your plan throughout your patient's stay.

Confirm all follow-up appointments are scheduled with in-network providers.

Refer your patient back to his or her current outpatient providers for continuity of care.

Fax the Important Message from Medicare notice signed by the patient to our Behavioral Health Inpatient team at 1-877-434-7578 at least two days before discharge.

Steps to Complete the Important Message From Medicare Notice

1. **Print the notice** from www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

   Ensure the Department of Health & Human Services, Centers for Medicare & Medicaid Services and OMB number 0938-0692 are listed in the upper right hand corner of page 1.

2. **Fill in the patient's full name, ID number and physician's name.** The ID number cannot be the patient's Social Security number. Information can be typed in 12-point font, handwritten or provided on a patient label.

3. **Insert the name of the hospital's** Quality Improvement Organization (QIO) and telephone number (including TTY) under the caption *Report any concerns you have about the quality of care you receive to the Quality Improvement Organization listed here.*

4. **Fill in the hospital telephone** number and contact name for the patient or representative to call with questions about the notice under the caption *To speak with someone at the hospital about this notice, call.*

5. **Ensure the patient or representative** signs the notice and completes the date and time to indicate he or she received and understands its content.

6. **Insert the contact name** and telephone number (including TTY) of the QIO that performs reviews for the hospital in bold print under the caption *Here is the contact information for the QIO.*

7. **Fill in the name of the hospital** and its Medicare provider ID number under the caption *The name of this hospital is.*

8. **Complete the Additional Information** section for additional documentation like the patient's initials, date and time to document delivery of a follow-up copy of the notice or to document a patient's refusal.

Screen for Behavioral Health Conditions at Every Visit

Primary care providers are often the first doctors patients go to for help with Behavioral Health (BH) conditions. Multiple office visits for symptoms like unexplained headaches, nausea and pain may be a sign of an underlying mental health condition. Screening, Brief Intervention, and Referral to Treatment (SBIRT) or the Patient Health Questionnaire (PHQ-9) can help you identify depression, alcoholism and other mental health conditions during your primary care visits.

For help referring your patients to BH specialists, call 1-888-830-4300.

Call 1-888-830-4300 to learn how our Disease Management Centralized Care Unit behavioral health programs can help your Amerigroup patients.

Members can visit www.myamerigroup.com for program details.

Medicare-covered **Behavioral Health** Services

See the Summary of Benefits in your Amerivantage provider manual to find out if your patients are covered for:

- Biofeedback therapy
- Central nervous system assessments and tests (diagnostic psychological and neuropsychological tests)
- Electroconvulsive therapy
- Family psychotherapy (patient present)
- Group psychotherapy
- Hypnotherapy
- Individual psychotherapy
- Inpatient psychiatric hospital services
- Interactive psychotherapy
- Narcosynthesis
- Psychiatric diagnostic interviews
- Psychoanalysis
- Pharmacologic management

When are inpatient psychiatric hospital **services covered?**

Medicare patients treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness with a 60-day lifetime reserve. They are covered for 190 days of care in freestanding psychiatric hospitals.

Medicare also covers other inpatient psychiatric hospital services when the following requirements are met:

- The patient is furnished active psychiatric treatment that can reasonably be expected to improve his or her condition.
- Services are provided while the patient is receiving either active psychiatric treatment or related services necessary for diagnostic treatment.
- A physician provides certification at the time of admission (or as soon thereafter as reasonably possible and practical to the patient's needs) stating active inpatient treatment will be furnished directly by or with the supervision of Inpatient Psychiatric Facility (IPF) personnel on a daily basis.
- A physician provides the first recertification as of the 12th day of hospitalization and subsequent recertifications at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses, but no less than every 30 days) stating the patient continues to need active inpatient treatment furnished directly by or with the supervision of IPF personnel on a daily basis.

Fax your behavioral health precertification requests and notifications to:

1-800-505-1193
for **outpatient** services

1-877-434-7578
for **inpatient** services

Log in to providers.amerigroup.com and check the status of your request with our Precertification Lookup tool.

Amerigroup RealSolutions in healthcare

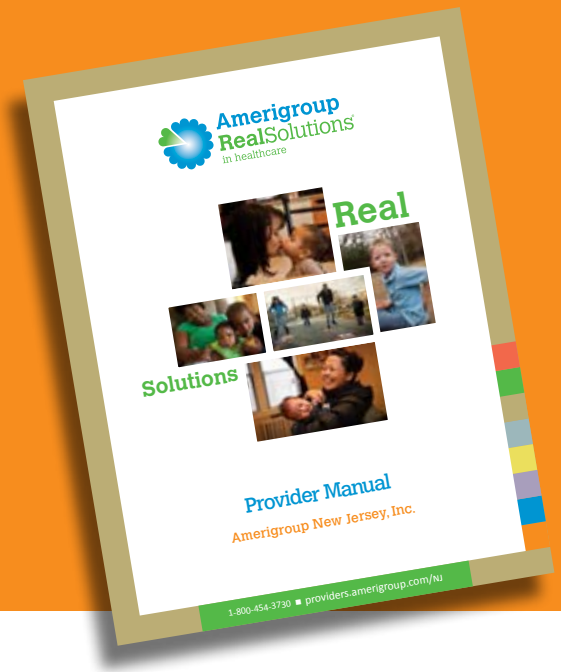
P.O. Box 62509
Virginia Beach, VA 23466-2509

ProviderNews

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

Keep up-to-date on policies, procedures and resources available to you.

Visit our provider self-service website to download the latest version of your state's provider manual and quick reference card under our Resources & Documents library on the home page.



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