Provider Newsletter

providers.amerigroup.com

2015
Quarter 4

Medicaid

A message from President John Koehn

Every year, Amerigroup Community Care conducts a survey to measure member satisfaction with their health care, our primary and specialty care providers, and our health plan. This year the results of the survey identified a need to improve communications between our providers and members

Explaining things clearly and listening carefully are an important part of a member's ability to understand and act upon health information. This can include a member's ability to follow instructions after a provider visit. Member compliance can also be related to the quality of the interaction between provider and member. Some practices even make sure that members leave with written information or instructions from their provider. Positive transactions with members should help them to feel empowered, cared about and encouraged to take an active role in their health care.

Like many patients, Amerigroup members come from diverse cultural backgrounds. They have a wide variety of traditions, languages and ways of perceiving others and the world around them. Medicine has its own culture, with customs and mores that members must learn. Doctors interpret this set of cultural values by translating the member's health condition, illness or treatment in a way the member can understand. Even if you are unfamiliar with a member's culture, there are still ways to have a meaningful interaction based on mutual respect.

If you are serving an Amerigroup member with whom you cannot communicate, contact Member

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Services at 1-800-600-4441 (TTY 711) to access an interpreter. For immediate needs, Amerigroup has Spanish language interpreters available without delay and can provide access to interpreters of other languages in minutes. Additionally, for members with impaired hearing, providers are required to offer interpretive services to members who may need these services. Amerigroup can help you telephonically communicate with patients via a translation device. In-office sign language assistance is also available if requested in advance.

Amerigroup provides training opportunities to staff and network providers regarding cultural sensitivity and ways to effectively interact with members. To schedule training for your office, call 732-452-6092 or 732-452-6007.

John Koehn
President
Amerigroup Community Care

A message from Medical Director Dr. Geeta Sehgal

Dear Providers:
Amerigroup strives to keep providers in our network informed of the latest news and information about their relationship with Amerigroup.

To achieve this, we regularly share important and valuable information with providers participating in the Amerigroup network through a variety of print, faxed bulletins and e-newsletters. Amerigroup also publishes a quarterly provider newsletter – which you are reading now. We provide information we feel is critical to your practice and the health and well-being of our members.

We also want to know what types of information YOU want. We value your opinions and want to provide information that is both important and meaningful to you and your office staff. Please email Rachelle Graham, NJ Provider Communications, at njmarketing@amerigroup.com with any suggestions or comments that will help us improve our communications.

We look forward to hearing your suggestions.

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 providers.amerigroup.com.

The Synagis prior authorization form can also be found on our provider website at providers.amerigroup.com/NJ > 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 find additional drug information at providers.amerigroup.com/NJ.

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

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

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

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

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

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

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

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

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

Care management

Attention provider - If you have a patient that you feel would benefit from care management services, please call 1-800-452-7101, ext. 66050.

Pregnancy and postpartum (interconception) care

Amerigroup cares about the health of our pregnant members. We want to encourage all of our expectant mothers to obtain care as soon as they discover they are pregnant. Ideally, this should be in the first trimester. Compliance with prenatal care and regular obstetrical assessments are essential in reducing maternal and fetal complications. Complications such as premature births and low birth weight infants can result in long-term health and developmental problems for those infants. Timely access to high quality prenatal care is exceptionally important for pregnant members as this will significantly add to optimal birth outcomes.

We have several resources to help manage and incentivize our members' during their pregnancy. An expectant mother is enrolled in a special program called Taking Care of Baby and Me®. This program offers support for mothers who are going to have or have just had a baby.

With this program, our members can receive:

- Special gifts when they go for their prenatal checkups, including:
  - $10 Babies "R" Us gift cards for going to a prenatal checkup in their second trimester and another card for going to a third trimester visit
  - A $10 Babies "R" Us gift card when they go for their postpartum checkup between 21 and 56 days after they give birth
- Fast answers to their health questions when they call the 24-hour Nurse HelpLine at 1-800-600-4441
- A book with helpful tips and education about their developing pregnancy. (This Taking Care of Me and Baby® educational material is also available in Spanish.)

Additional member benefits include:

- Free transportation to keep up with their prenatal visits – Requires preregistration and two business days advance notice. For more information, call Logisticare at 1-866-527-9933 (TTY 711).

- Free standard breast pump – Requires a doctor's prescription and no prior authorization
- OB case management services
  - Pregnant women with high-risk pregnancies have a better outcome with the benefit of obstetrical case management. It is very important that you submit your perinatal risk assessment forms so that we may identify our members when they become pregnant. Participation in case management makes the members aware of benefits, coverage, resources and most importantly, prenatal and postpartum education, which helps ensure a healthy pregnancy for both mom and baby.
- Home skilled nursing visits – This service can be useful post-delivery to help manage such conditions as diabetes and hypertension in pregnancy. Also, they may be utilized for well-mother baby visits and wound care. To initiate home skilled nursing visits, we require a provider's prescription.
- Preterm birth prevention – Preterm birth is the leading cause of neonatal mortality and morbidity in the United States. As part of our commitment to preventing preterm birth and related complications, we cover 17 alpha-hydroxyprogesterone caproate (17P) therapy, a widely accepted preventive treatment. Please note the following:
  - Compounded 17P – No prior authorization required
  - Makena – Requires prior authorization
- Postpartum care
  - Postpartum or interconception care is essential to maintaining a woman's well-being post-delivery. Compliance with prenatal care is the best predictor that a woman will keep her postpartum visit. We encourage members to return for their postpartum visit between 21 and 56 days after their delivery. (A wound check at two weeks would not qualify as a post-partum visit).
  - Amerigroup provides an incentive to our providers for completion of a postpartum visit. We will give you an additional $20 for performing the visit if you complete the following steps:
    - Complete a postpartum visit between 21 and 56 days after your patient's delivery. This visit must be within this time-frame to be able to redeem the incentive payment.
    - Bill a postpartum claim to Amerigroup with the CPT Category II code 0503F, including the postpartum visit date

Resources for our members with diabetes

Amerigroup cares about the health of our members. We have several resources to help our members with diabetes better manage their condition:

- Glucose meter and test strips - NIPRO diagnostics TRUEresult, TRU2go meters and TRUEtest test strips are the preferred glucose testing products for Amerigroup members. The meters are also marketed as national pharmacy store brand meters (i.e., CVS, Rite Aid, etc.) A prescription is required for both. All other brands of meters will be considered non-formulary and will require prior authorization. Providers may request demonstration meters for their offices by calling 1-855-253-2408.
- Blood pressure monitors – Require a prescription.
- Annual diabetic retinal eye exam from an eye care professional – Members with diabetes are eligible to receive an annual comprehensive diabetic eye examination.

Please follow these steps to make sure you are documenting the care you provide our members:

- Ensure members come in for their follow-up visits

- Conduct kidney disease monitoring for nephropathy – Prescribe an angiotensin-converting enzyme or angiotensin II receptor blocker as appropriate or microalbumin test
- Address hypertension
- Follow-up on referrals for care from specialists (i.e., ophthalmology, cardiology, endocrinology, nephrology, etc.)

Amerigroup appreciates the time and care you offer our members. Together, we can help them to experience the benefits of comprehensive diabetes management.

Adherence to access and availability standards improves access to care

Amerigroup has established access and availability standards to ensure timely health services are accessible to all members. These standards comply with regulatory requirements and are periodically measured through member satisfaction surveys, member complaint analysis, provider office-site visits and special surveys.

Availability standards

The following standards apply:

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 (non-urgent, 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)	In accordance with the Bright Futures/American Academy of Pediatrics 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 early and periodic screening, diagnosis and treatment (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

Type of care	Standard
Prenatal care • Initial visit • High-risk visit • Visit in first and second trimester • Visit in third trimester	 Within three weeks of positive pregnancy test Within three days of identification of high risk Within seven days of request Within three 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
Behavioral health/substance abuse	Immediately for emergency services Within 24 hours for urgent care Within 10 days of request for routine care

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 members out of the emergency room during his or her shift.

Additional access standards include:

- Member in-office wait times for an appointment must be within 45 minutes
- Provider response time for telephone call-back wait time, including:
  - After regular business hours, within 30 to 45 minutes for nonemergent, symptomatic issues
  - Same-day call-back for nonsymptomatic concerns
  - Call-back within 15 minutes for crisis situations

Provider offices must have telephone protocols in place to ensure the following situations are handled appropriately:

- Answering telephone inquiries in a timely manner
- Prioritizing appointments
- Scheduling a series of appointments and follow-ups as needed
- Identifying and rescheduling missed appointments
- Identifying special member needs while scheduling appointments (for example, wheelchair-bound members and members with interpretive linguistic needs)
- Triage noncompliant individuals with behavioral health issues for medical and dental conditions and special behavioral needs

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, a Provider Relations representative will visit the office to review the standards and to discuss corrective actions.

OrthoNet to conduct professional service coding reviews for musculoskeletal providers

Effective November 1, 2015, OrthoNet will conduct a post-service, prepayment coding review of professional services for all musculoskeletal provider specialties included in the focused claim review program, including but not limited to the specialties below:

- Cardiology
- Dermatology
- ENT
- General surgery
- Hand surgery
- Pain management
- Pediatric orthopedics
- Pediatric neurosurgery
- Pediatric neurology
- Pediatric sports medicine
- Physiatry/physical medicine and rehabilitation
- Plastic surgery
- Podiatry
- Neurosurgery
- Neurology
- Orthopedic surgery
- Sports medicine
- Urology

If you have questions, contact your local Provider Relations representative or call Provider Services toll free at 1-800-454-3730.

Member rights and responsibilities reminder

Amerigroup sends members a copy of their rights and responsibilities each year, but it's important that you and your office staff are familiar with these, too.

As an Amerigroup member, members have the right to:

- Receive a current directory of providers within the Amerigroup network that includes addresses, telephone numbers and a list of providers that accept members who speak languages other than English.
- Choose any of our Amerigroup network specialists. Members need to get a referral from their PCPs first. The referral is based on whether the specialist can take new patients. Some services do not need a referral.
- Be referred by their PCP to get care from a specialist who has treated chronic disabilities
- Get in touch with their PCP or a backup PCP 24 hours a day, 365 days a year for urgent care. This information is on the member ID card.
- Call 911 without getting an okay from Amerigroup if they have an emergency medical condition. This information is on the member ID card.

- Talk with their doctors about all medical treatments, even if they are not covered. Members can also get information on treatment they can have or other care options. This includes anything listed in the clinical guidelines. A copy is available by calling Member Services at 1-800-600-4441 (TTY 711).
- File a complaint or appeal with Amerigroup or the state and not be penalized. Please refer to the Complaints, Grievances and Medical Appeals section of the handbook for more information.
- Be treated with respect and dignity.
- Have information about Amerigroup, our services, policies and procedures, network providers, member rights and responsibilities, and any changes made to this information.
- Refuse treatment to the extent of the law and be aware of the results. This includes the right to refuse to be a part of research.
- Have an advance directive in effect.
- Expect that their records and communications will be kept confidential. They will not be given to anyone unless the member allows it.
- Choose their own PCPs in the Amerigroup network, choose a new network PCP and have privacy when seeing providers.
- Have a choice of specialists and get information on how to get a referral to a specialist or other provider, like an eye doctor.
- Have their medical information given to a person they choose or have it given to a person who is legally authorized when concern for their health makes it inadvisable to give such information to the member.
- Get help from someone who speaks their language or through a TTY line.
- Be free from billing by providers for covered services that are medically necessary and were authorized by Amerigroup, unless there is a copayment.
- Offer suggestions for changes in the way Amerigroup does business.
- Be free of hazardous procedures.
- Be fully informed by their PCPs, care managers or other Amerigroup network providers and help make decisions about their health care.
- Take part in developing and implementing a plan of care that promotes the best results and encourages independence.
- Have services that promote quality of life and independence. Amerigroup wants to help keep and encourage members' natural support systems.
- Have a doctor be the one to decide if their coverage is to be denied or limited.
- Voice complaints about Amerigroup or the care provided and recommend changes to policies and services to Amerigroup staff, providers and outside representatives of their choice, free of limits, interference, force, discrimination or attack by Amerigroup or our providers.
- Refuse care from specific providers.
- Have access to their medical records in accordance with federal and state laws.
- Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse, or neglect.
- Make recommendations regarding the member rights and responsibilities policy.
- Receive a second opinion.

Amerigroup members have the right to get information each year on:

- Member rights and responsibilities
- Amerigroup benefits and services and how to get these benefits and services
- Provisions for after-hours and emergency coverage
- Charges to members, if charges apply, including:
  - How to pay charges.
  - Copayments and fees.
  - What to do if they get a bill for services.
  - Termination of or changes in benefits, services, health care facilities or providers.
  - How to appeal decisions that affect their coverage, benefits or relationship with Amerigroup.
  - How to change PCPs.
  - How to disenroll from Amerigroup for good cause.
  - How to file a complaint or grievance and how to recommend changes they think Amerigroup should make.
- The percentage of Amerigroup network providers who are board-certified.
- A description of:
  - How to get services, including authorization requirements.
  - Any special benefit rules that may apply to services they receive outside of the Amerigroup network.
  - How to get services covered by fee-for-service Medicaid.
  - How to get out-of-area coverage.
  - Policies on referrals for specialty and ancillary care.

Amerigroup members have the responsibility to:

- Let their family doctors know as soon as possible after an emergency treatment.
- Treat their doctors, their staffs and Amerigroup employees with respect and dignity.
- Get information and consider treatments before they are done.
- Discuss any problems about following their doctors' directions.
- Know what refusing treatment recommended by a doctor can mean.
- Help their family doctor get medical records from the provider they had before. Members should help their provider fill out a new record, as well.
- Get permission from their family provider or the provider's associates before seeing a consultant or specialist. They should also get permission from their doctor before going to the emergency room unless they have an emergency.
- Call Amerigroup and change their doctor before seeing a new doctor.
- Continue following Amerigroup policies and procedures until they are disenrolled.
- Make and keep appointments and be on time. Always call if it's necessary to cancel an appointment or if they will be late.
- State complaints, concerns and opinions in an appropriate and courteous way.
- Learn and follow the policies and procedures outlined in the handbook.
- Tell their doctor who they want to be told about their health.

- Become involved in their health care. The member should work with his or her doctor about recommended treatment. The member must then follow the plans and instructions for care that he or she has agreed upon with his or her provider.
- Carry their Medicaid and Amerigroup ID card at all times. The member should report any lost or stolen cards to Amerigroup as soon as possible. Also, the member should contact Amerigroup if information on his or her card is wrong or if he or she has changes in name or address.
- Provide, to the extent possible, information needed by Amerigroup, their doctors and professional staff in caring for them, including the names of any doctors they are currently seeing.
- Understand their health problems and take part in developing mutually agreed-upon treatment goals, to the degree possible.

Send claim medical attachments through Availity

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

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

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

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

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

To access additional training on this new Availity feature:

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

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

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

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

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

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

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

Reimbursement policies: updates and reminders

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

Policy updates

Emergency Services: Nonparticipating Providers and Facilities

(Policy 06-092, originally effective 09/20/2006)

Amerigroup allows reimbursement for emergency services provided by nonparticipating providers and facilities.

Please note, Amerigroup, in accordance with New Jersey State Regulations, will reimburse nonparticipating in-state hospitals at 90 percent of the Medicaid fee-for-service.

Preadmission Services for Inpatient Stays

(Policy 07-017, originally effective 09/28/2007)

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

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

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

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

Prosthetic and Orthotic Devices

(Policy 06-084, originally effective 09/06/2006)

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

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

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

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

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

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

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

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

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

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

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

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

Amerivantage

Emergency room level 5 professional claim review

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

Imaging site scores for outpatient diagnostic imaging could impact reimbursement

Amerigroup is dedicated to meeting the evolving needs of our members and ensuring that they receive the most appropriate care possible. We are pleased to introduce a new program for imaging services administered by AIM Specialty Health® (AIM).

Effective November 1, 2015, Amerigroup Medicare Advantage plans will begin collecting information about the imaging capabilities of all Amerigroup Medicare Advantage contracted providers who provide the technical component of the following outpatient diagnostic imaging services for our individual Medicare Advantage members:

- Computed tomography (CT)
- Magnetic resonance (MR)
- Positron emission tomography (PET)
- Nuclear medicine (NUC)
- Ultrasound
- X-Ray
- Echocardiograph

Emergency room outpatient diagnostic imaging services are excluded.

AIM's online registration tool, OptiNet®, will continue to collect modality-specific data from providers who render imaging services in areas such as facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

That data will continue to be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. Each modality or piece of equipment will receive its own score. Providers with an imaging site score of 76 or higher for the applicable modality will see no change in reimbursement.

Effective March 1, 2016, for providers who have not completed the online registration, claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will

receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

Effective March 1, 2016, for providers with an imaging site score below 76 for the applicable modality for any of the outpatient diagnostic imaging services listed above, claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

Members cannot be balance billed if a line-item denial occurs.

Please note that any decision to deny reimbursement and/or approval of an imaging service is separate and apart from the determination of the medical necessity of the same service.

Please note that the line-item denial for a site score below 76 for the applicable modality applies only to individual Medicare Advantage claims at this time.

AIM will send the site score to the provider within one business day of the provider's completion of the online registration. Providers may use the online registration at any time to update their score.

Providers who score below 76 will receive individualized information they can use to improve their score. **Amerigroup strongly encourages any provider who scores below 76 to improve their site score for the applicable modality before the line item denial of claims begins on claims submitted for dates of service on or after March 1, 2016.** Providers who have not registered and therefore have no score will also be subject to line-item denials for claims submitted for dates of service on or after March 1, 2016.

AIM will conduct random audits to ensure that the provider's survey information is supported by documentation. Recovery of technical component payments will occur for those providers found to have had a score less than 76 at the time of the outpatient diagnostic imaging service.

Contracted providers will be asked to update their online information periodically.

The provider registration is available online at aimspecialtyhealth.com/goweb. Simply select Amerigroup from the drop down menu. Only those providers who have completed the provider registration will be able to view their information online. Site information will be available for review online starting November 1, 2015. If you have questions or need help completing the registration, please call AIM Customer Service at 1-800-252-2021.

Please note that if you have already completed the registration in connection with another health plan, you do not need to re-enter your information. Please review what has been prepopulated, make any updates and submit your information to register for Amerigroup. To copy your registration, select Copy from the

Actions column on the site list after you log in and follow the steps when prompted.

The online registration tool was designed with convenience in mind. You can save your data as you go, which means you will not need to complete it in one sitting. These resources are accessible on AIM's ProviderPortalSM website (accessible via aimspecialtyhealth.com/goweb). Once you complete the registration, the tool will remain available so you can update your information at any time. We recognize your office is busy and we appreciate the time spent completing the registration.

Below is some additional information on the Medicare Advantage Utilization Management Policy:

- This policy has been established to ensure site imaging of low tech and high tech modalities, to include the following: computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET), nuclear medicine (NUC), ultrasound, x-ray or echocardiography
- In accordance with MMCM Ch. 1, Sec. 20, Amerigroup contracts with a network of CMS approved providers to deliver the benefit package approved by CMS. The Coordinated Care Plan (CCP) network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality requirements.
- Amerigroup providers will be required to complete the OptiNet survey tool to calculate site scores for the applicable modality for providers who render imaging services to individual Medicare Advantage members. The imaging site score is derived using measures and a methodology as outlined by the American College of Radiology. (i.e., an industry based standard). If providers do not complete the survey or have an imaging site score of less than 76, further action will be taken as outlined in this policy.
- For providers and imaging services governed by this policy, AIM's Portal and MACESS application will only display providers on the service provider list that have completed a survey and met the minimum site threshold of 76 for the applicable modality.
- When a member goes for any of the following – CT, MR, PET, NUC, ultrasound, x-ray or echocardiography – at a provider that does not meet the minimum site score of 76 for the applicable modality, the request for payment associated with the above listed procedures will be denied. Any associated professional services that are otherwise deemed medically necessary and are covered by the applicable benefit plan will be approved and paid.
- The health plan's claims system (Facets) will be configured to deny the technical component of any imaging services set forth above that are provided during the period in which the provider had an imaging site score less than 76 for the applicable modality.
  Any denied technical component of a claim for imaging services for providers with an imaging site score of less than 76 for the applicable modality will not subsequently be paid if the site score is raised to or above the minimum score of 76 for the applicable modality after the date of service. The full claim will not be denied; only the technical component of the service not meeting the minimum standard will be denied. The provider may not charge or hold the member liable for the denied technical component. The member is only responsible for paying the Medicare plan–allowed cost-sharing amount.
- Should the provider disagree with the site survey score for the applicable modality, the provider shall follow the health plan's provider payment dispute resolution process.

- Please note that any decision to deny reimbursement and/or approval of an imaging service subject to this policy is separate and apart from the determination of the medical necessity of the same service.
- Providers who score below the threshold of 76 for the applicable modality will be able to improve their score at any time by correcting any issues that are impacting their score and completing the survey. Once the score meets 76 for the applicable modality or better, the provider will be eligible for review and payment of claims that otherwise meet coverage and medical necessity criteria. The survey tool includes questions about the provider's policies, procedures, accreditation and equipment associated with the provider's imaging site of care.
- Site survey questions cover site specific details such as:
  - Site hours
  - Site accessibility
  - Site measures
  - Site accreditation
  - Site certification of added qualifications (CAQ)
  - Site number of modalities (The number of service modalities offered at the location.)
  - Site MD location (Onsite or offsite physician)
  - Site survey questions vary by modality (e.g., CT, MR and PET)
- Common areas assessed include:
  - Equipment age
  - Equipment quality
  - Accreditation
  - Policies and procedures
  - Technologists
  - MD certification
  - Pediatric availability
- Additional survey questions are in place for echocardiography:
  - Schedule lead times
- Random audits will be performed by AIM to ensure that provider's information entered into the site survey is supported by documentation. If it is determined that a provider's documentation does not support information entered into the OptiNet survey tool by the provider, recovery efforts may occur against that provider subject to the terms of the provider agreement.
- Acronyms/definitions:
  - AIM – vendor that authorizes imaging services on behalf of the Medicare Advantage plans
  - CT - computed tomography
  - MR - magnetic resonance
  - NUC – nuclear medicine
  - OptiNet - one of AIM Network Optimization tools. It's an online tool completed by the provider which is also referred to as survey, registration, or application. The OptiNet survey tool gathers information about providers' training and capability related to technical imaging services, imaging equipment, capacity and access.
  - PET - positron emission tomography

  - UM - utilization management
  - Facets – the health plan's claims system for processing the claims for Medicare Advantage benefits
- Revision history:
  - This UM policy aligns directly with the internal UM policy and procedure, Policy Title: Optinet, but was reformatted as an appropriate provider facing notification document. Approvals and ownership of this UM policy is from the Medicare Advantage UM leadership team.

If you have any questions, please contact your local Provider Services representative or call Provider Services at 1-866-805-4589.

Reimbursement Policy updates

(This article contains information specific to Medicare.)

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

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

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

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

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

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

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

Reimbursement is allowed for prosthetic and orthotic devices when provided as part of a physician's services or ordered by a physician and used in accepted medical practice. Reimbursement is based on the applicable fee schedule or contracted/ negotiated rate for the prosthetic or orthotic device dispensed. The design, materials, measurements, fabrications, testing, fitting and training in the use of the device are included in the reimbursement of the device and are not separately reimbursable expenses. In instances of theft, a police report is required for consideration of replacements.

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

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

Amerigroup allows reimbursement for transport to and from covered services or other services mandated by contract. Please note, Amerigroup does not allow reimbursement for mileage when the transport service has been denied or is not covered. Amerigroup also does not allow separate reimbursement for additional medical personnel, unusual waiting time and disposable/first aid supplies.

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

For additional information, refer to the Reimbursement Policies at providers.amerigroup.comand click on Quick Tools.

Your continued feedback is critical to our success. If you have questions, contact your local Provider Relations representative or call 1-866-805-4589.