Provider Newsblast

https://providers.amerigroup.com/TN

Amerigroup RealSolutions in healthcare

November 2016

Table of Contents

The key to great health care communication

Last year, Amerigroup Community Care conducted a survey to get a better understanding about how members view the health care delivery system of Amerigroup. The scores below are a direct reflection of how they view Amerigroup providers.

2016 CAHPS* scores:

- How well doctors communicate: 85.95%
- Coordination of Care: 23.52%

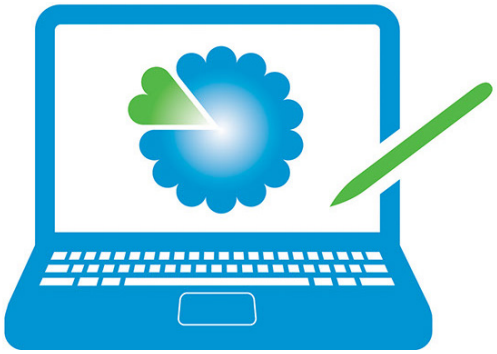
Tips for providers about how to better communicate with members (from the member perspective):

- Acknowledge patient concerns and ask questions.
- Actively listen to the patient without multitasking or rushing through appointment.
- Provide written documentation when possible.
- Speak in layman's terms so patients understand what is being communicated.
- Explain how to take medications and the reasons for taking the medication.
- Be respectful and courteous.
- Try to include the patient in decisions regarding their health.
- Coordinate care with other providers for patients in a timely manner.
- Compliment what the patient is doing right instead of only pointing out faults.
- Show concern.
- Smile; it goes a long way.

There is always a chance a member may leave the provider office thinking he or she did not receive the services that were expected. But there should never be a time when the member wasn't listened to and a clear course of treatment wasn't communicated.

Thanks for being an Amerigroup provider and listening to the concerns of our members and your patients.

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



Provider Website Survey

Amerigroup Community Care relies on your feedback to improve and strengthen our processes and operations. Our *Provider Website Survey* is a new tool to evaluate the effectiveness of our Medicaid provider websites. Input about your experience with our website is essential to our goal of efficient and effective provider resources. We will use your survey responses to better understand your experiences and continue to improve our site. Providing exceptional service to our providers is one of our strongest commitments.

Thank you in advance for taking the time to complete this brief survey. To access the survey, go to https://www.surveymonkey.com/r/7PHY5BL.

Elective one and two vessel coronary artery bypass graft to require prior authorization

Effective January 1, 2017, elective one and two vessel coronary artery bypass graft (CABG) will require prior authorization (PA).

What is the impact of this change?

Amerigroup Community Care will require PA for the elective one and two vessel CABG beginning January 1, 2017. Please refer to the provider self-service website for detailed PA requirements (https://providers.amerigroup.com/TN > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes:

- 33510 — coronary artery bypass, vein only; single coronary venous graft
- 33511 — coronary artery bypass, vein only; two coronary venous grafts
- 33517 — coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for primary procedure)
- 33518 — coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for primary procedure)
- 33530 — reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (list separately in addition to code for primary procedure)
- 33533 — coronary artery bypass, using arterial graft(s); single arterial graft
- 33534 — coronary artery bypass, using arterial graft(s); two coronary arterial grafts

To request PA, contact us via phone (1-800-454-3730), fax (1-800-964-3627) or the provider website.

The Utilization Review team will utilize the InterQual Procedures criteria for CABG requests.

Inpatient behavioral health precertification reminder

If a mobile crisis provider refers a member to an inpatient facility, it is the responsibility of the inpatient facility to obtain authorization. Inpatient hospital admissions, including urgent and emergent admissions, should be submitted for authorization prior to admission or within 24 hours of admission. Amerigroup Community Care utilization review clinicians determine the member's clinical status through communication with the hospital's Utilization Review department.

What this means to you:

If you are the admitting facility, please request authorization within 24 hours of admission or prior to admission.

Prior authorization requirements for new injectable/infusible drugs: Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb)

Effective February 1, 2017, Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb) will require prior authorization (PA) under the medical benefit.

What is the impact of this change?

For dates of service on or after February 1, 2017, PA will be required for five injectable/infusible drugs covered by Amerigroup Community Care for TennCare members. These drugs are Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb). **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the codes below:

- Istodax (romidepsin) — J9315
- Ixempra (ixabepilone) — J9207
- Doxil (doxorubicin) — Q2049 and Q2050
- Torisel (temsirolimus) — J9330
- Inflectra (infliximab-dyyb) — Q5102

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

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/TN > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-800-454-3730 for PA requirements if they are not able to access the website.

Physicians: Update to MU requirements for PIPP

Physicians, Nurse Midwives, Nurse Practitioners, Physician Assistants

The records of the TennCare Medicaid EHR Provider Incentive Payment Program (PIPP) indicate that a number of providers have begun the attestation process, but have not gone beyond one or two EHR incentive payments. Does that describe you? We know some providers may have stopped attesting because they did not meet the 30% patient volume (PV) requirement. Have you checked your mix of patients lately? You may not realize that your patient load has changed and you again meet the PV requirement.

Some providers stopped attesting because they felt meeting Meaningful Use (MU) was too complex or difficult. Did you know CMS heard you? MU requirements have changed – some have been eliminated; the targets for some measures have been lowered or otherwise changed. Whatever the reason which caused you to stop attesting, we would like to hear from and try to help you get back on track. Send an email to TennCare. EHRIncentive@tn.gov, let us know what's going on and we'll do our best to help you complete the EHR Incentive Program.

Physicians: enrollment deadline for PIPP — updated

Physicians, Nurse Midwives, Nurse Practitioners, Physician Assistants

Program Year 2016 Provider Incentive Payment Program (PIPP) attestations are due March 31, 2017, at 11:59 PM CT. This means that if you have never registered before to participate, you must register at CMS, and then get that first attestation to TennCare by March 31, 2017.

Need more information about PIPP, please go to the TennCare EHR Incentive web site: http://www.tn.gov/tenncare/section/electronic-health-record. You can email TennCare at TennCare.EHRIncentive@tn.gov for assistance. Got a question about Meaningful Use? Send an email to EHRMeaningfuluse.TennCare@tn.gov.

Note: Physician Assistants: In order to participate, you must be working in a PA-led FQHC or an RHC so led by a PA to receive the EHR Provider Incentive Payment. See our web site for more information.

Hospitals: Update to MU requirements for PIPP

Acute Care Hospitals, Critical Access Hospitals, & Children's Hospitals

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Some providers stopped attesting because they felt meeting Meaningful Use (MU) was too complex or difficult. Did you know CMS heard you? MU requirements have changed – some have been eliminated; the targets for some measures have been lowered or otherwise changed. Whatever the reason which caused you to stop attesting, we would like to hear from and try to help you get back on track. Send an email to TennCare.EHRIncentive@tn.gov, let us know what's going on and we'll do our best to help you complete the EHR Incentive Program.

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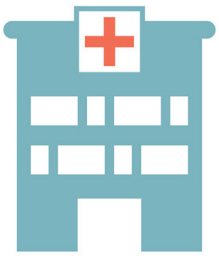

Program Year 2016 Provider Incentive Payment Program (PIPP) attestations are due March 31, 2017, at 11:59 PM CT. This means that if you have never registered before to participate, or haven't submitted your first EHR attestation, you must register at CMS, and then get that first attestation to TennCare by March 31, 2017.

Need more information about PIPP, please go to the TennCare EHR Incentive web site: http://www.tn.gov/tenncare/section/electronic-health-record. You can email TennCare at TennCare.EHRIncentive@tn.gov for assistance. Got a question about Meaningful Use? Send an email to EHRMeaningfuluse.TennCare@tn.gov.

Clarification — requesting authorization for certain arterial duplex imaging procedures

Amerigroup Amerivantage Medicare Advantage* is collaborating with AIM Specialty Health (AIM) to conduct medical necessity reviews for vascular ultrasound management for Amerigroup Amerivantage (Medicare Advantage) members.

What is the impact of this change?

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request a clinical appropriateness review no later than 10 business days after you perform these procedures and before you submit a claim.

Please note, failure to contact AIM for review within the 10-day postservice window will result in a denial of payment.

Impacted codes are as follows:

CPT code	Brief description
93925	Dup-scan lxtr art/artl bpgs compl bi study
93926	Dup-scan lxtr art/artl bpgs uni/lmtd study
93930	Dup-scan uxtr art/artl bpgs compl bi study
93931	Dup-scan uxtr art/artl bpgs uni/lmtd study

To submit a review request, visit the AIM website (aimspecialtyhealth.com).

What if I need assistance?

For additional assistance, contact AIM at 1-800-714-0040, Monday-Friday from 7 a.m.-7 p.m. CT.

**In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.*