NewsBlast

TENNESSEE – JUNE 2014 TNPEC-0773-14

The following entries apply to all Tennessee Amerigroup Community Care Providers.

Working together to achieve better health outcomes while meeting HEDIS® measures

We know you've heard of HEDIS, which was established by the National Committee for Quality Assurance (NCQA). We send you report cards, letters and reminders about members overdue for services related to HEDIS measures — you might even be eligible for incentive payments when helping members get these important services.

Our Quality Improvement (QI) Program

When it comes to quality, we're guided by:

- Results-based studies conducted by our QI program team
- Sound advice from internal and external experts
- National standards set by the Bureau of TennCare and the NCQA
- Current research that informs the criteria we use
- First-hand experience of case managers who know our members' needs

We welcome your suggestions!

To let us know how we might improve our program, contact your Provider Relations representative.

Our comprehensive program:

- Adheres to HEDIS standards and measures our progress to meet annual goals
- Objectively monitors and evaluates the care and services our members receive
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of our program
- Reflects the demographic and epidemiological needs of each population served
- Encourages both members and providers to recommend improvements
- Identifies ways we can promote and improve patient safety

Our Benchmarks for Clinical Performance and Service Satisfaction

HEDIS — Healthcare Effectiveness Data and Information Set; a program developed by the NCQA to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 80 measures across five domains of care.

CAHPS — Consumer Assessment of Healthcare Providers and Systems; a survey evaluating member satisfaction with care and services received over the past six months by questioning a random sample of plan members on their doctors and the health plan.

Provider Satisfaction Survey — An annual survey to find out what you, our providers, think we're doing well and what we can do better in several capacities, including communication and technology, claims processing, and customer service.

HEDIS, CAHPS and the Provider Satisfaction Survey results help us identify areas of strength and areas where we need to focus our improvement efforts. We use the results to:

- Measure our performance against our goals
- Determine the effectiveness of actions we implemented to improve our results

To review the 2013 Quality improvement Program summary, call Patricia Kirkpatrick, vice president of Quality Management at 615-316-2400 – we'll be glad to send you a copy.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Quality Improvement Resources for You

We're here to support you in delivering timely, quality care to our members. Here are some tools you can take advantage of as a valued provider in our network.

Access to Case Management

Did you know, as a component of our population health programs, we offer complex case management for our high-risk members? Using claims and utilization data, we identify members at risk for or susceptible to certain diseases. Then, we:

- Use evidence-based guidelines to coordinate care with the member, his or her family, physicians and other health care providers
- Work with everyone involved in the member's care to help implement a case management plan based on the member's needs
- Provide education and support to our members and their families to help our members improve their health and quality of life
- Use a collaborative process of assessment, planning, facilitation and advocacy for options an services for our members

The goal is to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Where indicated, we coordinate and integrate case management services for those members with co-occurring behavioral health and physical health disorders.

If you have a high-risk member you would like to refer to this program, call our Provider Services team for help.

Clinical Practice and Preventive Health Guidelines

On our provider self-service site, we offer clinical care and preventive health guidelines based on current research and national standards and known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence, professional standards or expert opinion. The guidelines are based on current research and national standards, and are available on our website at providers.amerigroup.com.

- ADHD
- Adult Hypertension
- Adult Preventive Health
- Asthma
- Behavioral Health Screening, Assessment and Treatment
- Bipolar Disorder – Adolescents
- Bipolar Disorder - Adults
- Child Preventive Health
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Diabetes
- Family Planning Preventive
- High-Risk OB Guidelines
- Immunizations
- Major Depression
- Obesity – Adult
- Obesity – Child and Adolescent
- Postpartum Care
- Routine Antepartum Care
- Schizophrenia

Need a paper copy of a guideline? Call our Provider Services team.

Utilization Management Criteria

If one of our medical directors denies your service request, we'll send you and the member a notice of action letter, including the reason for denial, the criteria/guidelines used for the decision, and an explanation of your appeal process and rights. To speak with a medical director about the service request denial, call the number on your letter. To request a copy of the specific criteria/guidelines used for the decision, call our Provider Services team or write to:

Medical Management
Amerigroup Community Care
22 Century Blvd, Suite 310
Nashville, TN 37214

Our Utilization Management Team

Our team members, including the clinical professionals who coordinate our members' care, are governed by the following statements:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service, and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denial of coverage or care.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

We're available 24 hours a day, 7 days a week to accept precertification requests. Submit requests by:

- Calling our Provider Services team
- Faxing to 1-800-964-3627
- Logging in to our provider self-service website

Have questions about utilization decisions or the utilization management process in general? Ask to speak to a clinical team member when you call our Provider Services line.

Pharmacy Tools

Need up-to-date pharmacy information? Log in to our provider self-service site to access TennCare's Preferred Drug List, our medical injectables, prior authorization forms and clinical criteria for prior authorizations.

Have questions about the formulary or need a paper copy? Ask to speak to a Pharmacy team member when you call our Provider Services line**.** Pharmacists and pharmacy technicians are available Monday through Friday from 8:00 a.m. to 8:00 p.m., and Saturday from 10:00 a.m. to 2:00 p.m. Central time.

Our Members' Rights and Responsibilities

Our members' defined rights and responsibilities are in your provider manual on our provider self-service site. If you'd like us to mail you a copy, call our Provider Services team.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4441 (TTY 1-800-855-2880).

TNPEC-0767-14

We Reward Members for Completing Their Preventive Screenings

Summary: Want to encourage patients to get their preventive screenings? We do, too. We offer several incentives that reward our members for completing these screenings.

✦ **What this means to you:** Please pass this information along to your office staff. This is for your information only.

Members can receive incentives for the following six screenings:

- **Comprehensive diabetes care –** Members with a diabetes diagnosis may receive a $25 gift card when they complete an LDL screening, HbA1c blood test, blood pressure check, microalbumin urine test, retinal eye exam and foot exam annually.
- **Blood Pressure Check –** Members with a hypertension diagnosis may receive a $10 gift card after completing an annual blood pressure check.
- **Breast Cancer Screening** – Women between the ages of 50 and 74 may receive a $10 gift card after completing an annual mammogram.
- **Well-child Visit** – Members between the ages of 3 and 6 years will be entered into a monthly drawing for a $25 iTunes gift card after completing an annual TENNderCare wellness checkup.
- **Adolescent Well-child Visit** – Members between the ages of 12 and 20 will be entered into a quarterly drawing for an iPod shuffle or a movie gift card after completing an annual TENNderCare wellness checkup.
- **Mobile Mammography Unit** – Women between the ages of 50 and 74 will be entered into a monthly $100 gift card drawing after completing an annual mammogram at a mobile mammography unit.

How can I help my patients get these incentives?

- **Brochures** – Members must fill out the appropriate incentive brochure and have their Primary Care Provider (PCP) sign it, stating the service was performed. Members can mail the brochure back on the prepaid postage form. Once we receive the completed brochure and verify a claim for the requested service, we will send the member a gift card.
- **Mobile mammography unit** – Schedule your patients at one of our mobile mammography units or host a Clinic Day, and we will bring the unit to you.

What if I need assistance?

If you would like incentive brochures or are interested in hosting a Clinic Day or the mobile mammography unit, please call our Quality Management department at 615-316-2400.

TNPEC-0763-14

Medicaid Provider Manual Update Now Available Online

Summary: The latest update to your Amerigroup Community Care provider manual is now available online at our provider website at providers.amerigroup.com/TN.

✦ **What this means to you:** You can find the most current version of our provider manual on our Tennessee home page at providers.amerigroup.com/TN. Please take an opportunity to review the updated manual.

Why is this update necessary?

Hosting our provider manual online is an environmentally friendly way for us to offer you easy access to the most current information about our programs.

How can I get a hard copy of the manual?

Contact Provider Services if you would like a hard copy of the updated manual for your practice.

TNPEC-0507-13

ClaimCheck Version 54 Upgrade Effective August 1, 2014

Summary: We are upgrading to version 54 of ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in the upgrade will become effective August 1, 2014.

✦ **What this means to you:** Please pass this information along to your office staff. This is for your information only.

Background information

Amerigroup uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to industry standards.

Why is this change necessary?

ClaimCheck is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes.

Amerigroup uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- Diagnosis to procedure mismatch
- Upcoded services
- Fragmented billing of pre- and postoperative care

Other procedures and categories reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Procedures billed with inappropriate modifiers

PEC-ALL-1239-14

The following reminder applies to Primary Care Providers.

My PCP Connection

Remember to only provide services to members on your assigned PCP member listing or the listing of another participating PCP in your group. Our My PCP Connection program helps to centralize a member's treatment information, minimizing the chances of missing or incomplete records.

Excerpt from TNPEC-0620-13