Provider Update

April 2016 News Bulletin

Claims tip of the month

Claims payment disputes where the provider believes the claim was incorrectly adjudicated need to be filed within 24 months of the adjudication date on your explanation of payment. The Provider Payment Dispute and Correspondence – Submission Form for provider appeals is available on our website at https://providers.amerigroup.com/WA in the *Forms* section. Mail to:

Payment Dispute Unit
Amerigroup Washington, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

If you just have a claims question, please call our National Call Center at 1-800-454-3730.

How to submit provider changes

If you need to provide demographic changes, changes to member accepting status or any other changes affecting how Amerigroup Washington, Inc. reflects providers in its databases, submit that information to us by fax at 1-855-270-9583 or email to wa1provrelations@amerigroup.com. If submitting by fax, submit information on the provider's letterhead.

Provide the following information with the request:

- Provider's full name and national provider identifier (NPI)
- Effective date of change
- Affected location(s)
- Full name and title of person submitting change
- If changing the name or taxpayer identification number (TIN) of the practice, submit a new completed W-9 Form

Core Provider Agreement required

42 C.F.R. 455.410(b), states "*The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers*."

Any provider who renders a service to a Medicaid client, or orders (including prescribing) or refers a client for a service for which Medicaid is the payer must be a participating provider with the Medicaid agency (Health Care Authority HCA). There are no exceptions, and all providers are subject to this requirement.

Effective July 1, 2016, managed care organizations (MCOs) will be financially penalized if the paid claims encounters they submit to the HCA do not reflect NPI numbers associated with providers holding Washington State Medicaid Core Provider Agreements (CPAs). Thus, we will be diligently comparing our providers' information to HCA's list of contracted providers and contacting any providers who do not hold CPAs. If you do not currently have a CPA, you must apply with HCA online at www.hca.wa.gov/medicaid/providerenroll/Pages/index.aspx.

Amerigroup RealSolutions® in healthcare

Providers are not required to accept Medicaid fee-for-service members but must have an active CPA. This allows the HCA to ensure specific communications reach all Medicaid providers and that all providers specifically adhere to state and federal requirements which are also part of providers' agreements with managed care plans.

Instructions on how to become a nonbilling provider are given at the link below at HCA's website. As explained on the website, if a provider who already has a CPA submits a nonbilling application, the CPA is replaced by the agreement given in the nonbilling application.

Please visit hca.wa.gov/medicaid/forms/Documents/13_002.pdf. Or, for nonbilling organizations such as clinics or pharmacies, visit hca.wa.gov/medicaid/forms/Pages/index.aspx.

If you have questions, please call Provider Services at 1-800-454-3730.

Behavioral Health Organizations (BHOs)

As of April 1, 2016, BHOs replaced the Regional Support Networks (RSNs) across Washington State, with the exception of Clark and Skamania counties. State law created BHOs to purchase and administer public mental health and substance use disorder treatment under managed care on a regional basis for people with Medicaid coverage. BHOs contract with the Department of Social and Health Services, Division of Behavioral Health and Recovery.

Prior to April 1, 2016, the RSNs managed mental health services, and County Substance Use Coordinators managed outpatient substance use disorder services.

Washington Medicaid enrollees have access to two separate mental health benefits. The first benefit is for those who need short-term mental health treatment in a clinic. This service is managed by Apple Health through the Washington State HCA. To access mental health services through Apple Health plans such as Amerigroup:

- If your client is already enrolled in an Apple Health managed care plan, they may contact their plan directly.
- If your client is not enrolled in an Apple Health managed care plan, or they don't know how to reach their plan, they can call the HCA at 1-800-562-3022 for help with finding a mental health provider that accepts Medicaid insurance.

The second benefit is for those who need additional mental health services not covered by the Apple Health plan, and for those who need substance use disorder treatment services. This benefit is managed by the BHOs. A complete list of these services available from BHOs is provided below. To access these additional mental health services or substance use disorder services from BHOs, clients may:

- Contact the BHO for their region directly.
- Contact the BHO-contracted community mental health agency or substance use treatment outpatient provider directly.
- Contact the 24-hour, free and confidential Washington Recovery Help Line at 1-866-789-1511 (TTY 1-206-461-3219), or go to www.warecoveryhelpline.org. They will be referred to a BHO that will connect them with a provider.

For more information about this change and references to assist providers in managing behavioral health care, please visit our website at http://providers.amerigroup.com/WA and select the *Behavioral Health* link.

HCA webinar on earlier enrollment

The HCA Earlier Enrollment training webinar for providers presented on March 17, 2016, is now available online.

HCA encourages those who work with or assist individuals with applying for and renewing Apple Health coverage in Washington Healthplanfinder, in addition to any provider or provider office staff who is responsible for identifying the payer for services rendered, to view this presentation to learn about changes to the Apple Health managed care enrollment policy on April 1, 2016. This includes community services office staff, navigators, brokers, volunteer assisters, providers who deliver direct services to clients, vendors, health care clinic and office billing staff, hospital financial advisers, and hospital billing staff.

This webinar, as well as past recordings (including Health Care Integration – Early Adopter, which is also coming April 1, 2016), are posted to the HCA Training and Education Web page under *Webinars, Video and Presentations* at www.hca.wa.gov/hcr/me/Pages/Webinars,-Video,-and-Presentations.aspx.

Please find below the direct link to the recorded presentation and slide deck.

HCA Medicaid Update Webinars

2016

- Earlier Enrollment - Provider Training | Presentation slides

Questions about this enrollment policy change may be directed to hcamcprograms@hca.wa.gov.

Prenatal ultrasound policy change reminder

Amerigroup covers CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816 and 76817 for outpatient prenatal ultrasounds for our pregnant Medicaid members. This policy communication is limited to these specific CPT codes and does not apply to ultrasounds performed by maternal fetal medicine specialists, in hospital settings or by radiology providers. Please refer to clinical guideline entitled “Maternal Ultrasound in the Outpatient Setting,” (CG-Med-42), on the Amerigroup provider website, for detailed medical necessity criteria for maternal ultrasound.

In alignment with the Washington State HCA Provider Guide dated January 1, 2016, effective April 1, 2016, Amerigroup will cover two routine prenatal ultrasounds for dating and fetal anatomic survey per pregnancy (76801, 76805). Additional ultrasounds for CPT codes 76811, 76812, 76815, 76816 and 76817 for suspected maternal/fetal abnormality or follow-up require an appropriate diagnosis indicating medical necessity. Without appropriate diagnosis codes supportive of medical necessity, ultrasounds for procedural codes 76811, 76812, 76815, 76816 and 76817 will not be reimbursed. Prior authorization is not required for prenatal ultrasounds.

Our policies are based on medical necessity, consideration of nationally accepted medical practice standards, review of medical literature and government approvals. We referred to the American College of Obstetricians and Gynecologists (ACOG) practice bulletin, Ultrasonography in Pregnancy (number 101, February 2009) to create this policy. According to this bulletin, ultrasonography in pregnancy should be performed only when there is a valid medical indication. Specifically, the ACOG practice bulletin states, “The use of either two-dimensional or three-dimensional ultrasonography only to view the fetus, obtain a picture of the fetus, or determine the fetal sex without a medical indication is inappropriate and contrary to responsible medical practice.”

For a list of the prenatal ultrasound procedure codes with their corresponding medically necessary diagnosis codes, please call our national Provider Relations team at 1-800-454-3730 or contact your local Provider Services representative.

Medical policies update

On February 4, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Amerigroup. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The medical policies were made publicly available on the Amerigroup provider website on the effective date listed below. Visit medicalpolicies.amerigroup.com/search to search for specific policies. Existing precertification requirements have not changed.

Medical policy effective date	Medical policy number	Medical policy	Medical policy (new/revised)
April 5, 2016	RAD.00065	Radiostereometric Analysis (RSA)	New
April 5, 2016	SURG.00142	Genicular Nerve Blocks and Ablation for Chronic Knee Pain	New
February 11, 2016	DME.00035	Electric Tumor Treatment Field (TTF)	Revised
February 11, 2016	DRUG.00052	Pertuzumab (Perjeta®)	Revised
February 11, 2016	DRUG.00077	DRUG.00077 Secukinumab (Cosentyx®)	Revised
April 5, 2016	RAD.00029	CT Colonography (Virtual Colonoscopy) for Colorectal Cancer	Revised

Clinical Utilization Management Guidelines update

On February 4, 2016, the MPTAC approved the following Clinical Utilization Management (UM) Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations Committee for the Government Business Division on February 29, 2016.

On February 4, 2016, the clinical guidelines were made publicly available on the Amerigroup Medical Policies and Clinical UM Guidelines subsidiary website. Visit medicalpolicies.amerigroup.com/search to search for specific policies. Existing precertification requirements have not changed.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	Revised or new (new/revised)
April 5, 2016	CG-BEH-14	Intensive In-Home Behavioral Health Services	New
April 5, 2016	CG-DME-38	Continuous Interstitial Glucose Monitoring	New
May 2, 2016	CG-SURG-53	Elective Total Hip Arthroplasty	New
May 2, 2016	CG-SURG-54	Elective Total Knee Arthroplasty	New
April 5, 2016	CG-DRUG-04	Use of Low Molecular Weight Heparin Therapy, Fondaparinux (Arixtra®), and Direct Thrombin Inhibitors in the Outpatient Setting	Revised
April 5, 2016	CG-DRUG-20	Enfuvirtide (FUZEON®)	Revised
April 5, 2016	CG-LAB-09	Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain	Revised

February 11, 2016	CG-MED-35	Retinal Telescreening Systems	Revised
February 11, 2016	CG-MED-54	Strapping	Revised
February 11, 2016	CG-SURG-27	Gender Reassignment Surgery	Revised
April 5, 2016	CG-SURG-36	Adenoidectomy	Revised
To be determined	CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting	Revised
February 11, 2016	CG-SURG-47	Surgical Interventions for Scoliosis and Spinal Deformity	Revised

Archived Clinical Utilization Management Guidelines

The following two Clinical UM Guidelines have been archived on the effective date listed below. These guidelines will no longer appear on the site and the criteria should no longer be used.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title
April 5, 2016	CG-BEH-08	Employee Assistance Program Outpatient Treatment
April 5, 2016	CG-DRUG-07	Hepatitis C Pegylated Interferon Antiviral Therapy

Milliman Care Guidelines

For health plans utilizing Milliman Care Guidelines (MCG), the MCG 20th edition care guidelines were discussed at the February 4, 2016, MPTAC meeting. The MCG 20th edition care guidelines will be available for use upon release through MCG.

Affirmative statement about incentives

As a corporation and as individuals involved in utilization management (UM) decisions, we are governed by the following statements:

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. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.