Amerigroup RealSolutions in healthcare

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July 2016 news bulletin

Claims tip of the month: screening, brief interventions and referral to treatment (SBIRT) services

We have identified a trend that prevents providers from being paid for interventions as follow-up to an SBIRT screening. The most frequent cause of claims denials is providers not showing as SBIRT-approved providers through the Washington State Department of Social and Health Services (DSHS). Providers must complete a four-hour training course and submit proof of their certification through ProviderOne in order to be considered an SBIRT provider and bill for related services. If you have questions about where to obtain training and billing requirements, please see the Washington State Physician-Related Services/Healthcare Professional Services Provider Guide at http://www.hca.wa.gov/medicaid/billing/pages/bi.aspx.

Amerigroup Washington, Inc. in the community

On Wednesday, June 9, Amerigroup was proud to sponsor the Children's Alliance Voices for Children luncheon.

The Children's Alliance advocates for kids. They ensure laws, policies and programs work for kids. The Children's Alliance is focused on a number of programs that include dental access, ending hunger, early learning and health care coverage for all children and youth.

Easy to do business with

We provide a national call center for providers who need assistance or just have questions. The Provider Relations call center offers precertification, automated member eligibility, case and disease management, claims assistance (including simple adjustments), health education materials, outreach services, and more. Call 1-800-454-3730, Monday through Friday from 8 a.m. to 5 p.m. Pacific time. We encourage providers to use our call center as their primary source for assistance as they have abilities the local Provider Relations team does not, such as performing simple claims adjustments while providers are on the phone and sending out health education materials on a large variety of topics meaningful to Amerigroup Washington, Inc. members.

If you have an idea for how we can be easier to do business with, please let your local Provider Relations representative know.

New provider orientation

Did you miss out on new provider orientation? If you have not participated in a new provider orientation and would like to schedule an in-person training for your office, please let your local Provider Relations representative know. If you don't know who that is, please call our Provider Services at 1-800-454-3730 so we may connect you.

New psychiatry and addictions case conference series by the University of Washington (UW) starts in July

Amerigroup Washington, Inc. is pleased to share information about a valuable training program provided through UW. The UW Psychiatry and Addictions Case Consultation series (UW PACC) is a new

continuing medical education (CME)-accredited program designed to expand the mental health and addictions care capacity of health care professionals in Washington state.

Modeled after the University of New Mexico's Project ECHO (Extension for Community Healthcare Outcomes), UW PACC will offer telehealth resource support to build the confidence and skills of providers who care for patients with mental and behavioral health conditions. The new series is appropriate for primary care providers and psychiatrists willing to engage in a proven model of distance learning.

Using interactive video, UW PACC will offer weekly online sessions, providing real-time clinical consultation between community providers and UW psychiatrists. Mental health and addictions experts will provide a short didactic session followed by in-depth case consultations. The goal of UW PACC is to develop a regional peer learning and support network for treating mental health and addictions that will ultimately result in better patient care. Details include:

WHAT: UW PACC series
WHEN: Thursdays, noon – 1:30 p.m. beginning July 2016
WHO: Any primary care provider or psychiatrist in Washington wanting to improve mental health and addictions care for their patients
COST: No cost – Nominal fee for those desiring CME credits

Please contact Provider Relations at 1-800-454-3730 if your clinic has concerns about or lacks video conferencing capabilities; we may be able to assist.

PCPs and behavioral health providers: working together to treat the whole person

Why is it important for PCPs and behavioral health providers to work together?

- **Physical and behavioral health go hand-in-hand** – Comorbid conditions can complicate treatment of and recovery from both physical and behavioral health issues. A member is more likely to stick to a medical treatment plan if his or her behavioral health needs are properly met, and vice versa.
- **Collaboration leads to well-informed treatment decisions** – Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes and avoiding adverse interaction.
- **Sharing relevant case information in a timely, useful and confidential manner is an Amerigroup Washington, Inc. requirement** – We abide by standards set by the National Committee for Quality Assurance (NCQA) requiring health plans to ensure coordination of care between PCPs and behavioral health providers.

When screening for substance abuse and depression, please use standard screening tools like the Patient Health Questionnaire (PHQ-9) or the Drug Abuse Screening Test (DAST). If your patient needs a referral for a complete behavioral health evaluation and you don't know where to turn, contact us for a referral. Screenings should be completed annually.

Anger management tips

In light of the recent mass shooting in Orlando, we recognize many people are experiencing feelings of anger. Amerigroup Washington, Inc. is offering a few tips providers can share with their patients about

anger management in patient-friendly language. If you would like free flyers with this information for your patients, please call Provider Relations at 1-800-454-3730.

What is anger?
Everyone gets angry from time to time. It's a normal feeling that can range from annoyance to rage. Anger causes changes in your body. For example, your heart rate and blood pressure may go up. Anger can be helpful or harmful. It depends on how you handle and express it.

What causes anger?
Some of the most common causes of anger are:

- Feeling that you have been picked on or unfairly treated
- Not getting your way
- Feeling that your plans are not working out
- Experiencing things you can't control, like traffic jams

Sometimes you're right to be angry. But too much anger can cause problems with your family and friends. It can also lead to problems at work, with money, with the law — even with your health.

How should I deal with anger?
Often, you can't control things that make you mad. But you can control how you express your anger. Angry outbursts or violence is dangerous. They will make the situation worse.

Here are some things to try when you start to feel angry:

- Stop what you are doing. Try to calm down.
- Count to 10 while taking deep breaths. If you are still angry, count to 10 again.
- If you can't calm down, walk away from what is making you angry.
- When you are calm, think about how best to deal with what made you angry.

Some everyday habits can help, too:

- Keep my sense of humor.
- Get plenty of rest and exercise.
- See other people's side of things.
- Relax by doing things I enjoy.

Behavioral health resources: access consultation through Partnership Access Line (PAL)

The Washington Health Care Authority provides access to consultation with a child psychiatrist through the PAL. Minimize the need for required medication reviews and get assistance in meeting the needs of children with mental health diagnoses by consulting with child psychiatrists and social workers. For assistance, call the PAL toll-free number at 1-866-599-7257. Please note Amerigroup Washington, Inc. is not required to provide payment to prescribers for voluntarily accessing the PAL. To learn more about PAL, visit palforkids.org.

Electronic Medical Records (EMR) checklist

Maximize your EMR to make sure you are meeting quality standards for all your Medicaid patients. Below is a checklist of what your EMR review should include:

- **Link4Health.** Talk with your vendor about submitting data to OneHealthPort. No later than February 1, 2017, provider organizations with certified EHRs that see Washington Apple Health Managed Care enrollees must begin submitting clinical summaries from the provider's EHR to the Link4Health Clinical Data Repository (CDR) after each visit. OneHealthPort is hosting monthly webcasts to share information about how provider organizations and their EHR vendors can get started with and prepare for consolidated clinical document architecture (C-CDA) data submissions to the CDR. Provider webcasts are held monthly on Tuesday mornings from 9 a.m. - 10 a.m. Pacific time beginning on June 14. Please register for one or more of the webcasts by going to https://onehealthport.formstack.com/forms/cdr_clinical_webcast_registration.
- **Screening, brief interventions and referral to treatment (SBIRT) coding.** If you are billing for SBIRT services, be sure your providers are SBIRT-certified with the Health Care Authority (HCA). Also, be sure to check HCA's billing guidelines for allowed CPT and ICD-10 code combinations.
- **Coding for quality.** Capture all revenue due to you with proper billing. Do you have questions about the proper coding of claims for Health Effectiveness Data and Information Set (HEDIS®*) compliance? We have a guide available for you with correct coding for all measures. Contact your local Provider Relations representative or our national call center at 1-800-454-3730. (*HEDIS is a registered trademark of the National Committee for Quality Assurance NCQA.)
- **Quality reports to Amerigroup Washington, Inc.** You can reduce the work of copying medical records by setting up regular reporting directly to us from your EMR. We will work with you to set up the reports and when it comes to the "HEDIS Season," we should not have to ask you for copies of records. Please contact us at HealthPromotionTeam@amerigroup.com with questions.

Text messaging preventive care reminders

We would like to share an exciting new way that Amerigroup Washington, Inc. is communicating with members. We have recently launched a text campaign for our members in need of well-child visits/immunizations, an adolescent well-child visit, adult preventive care visit or cervical cancer screen.

The text campaign began with a welcome message asking the member to let us know if they do not wish to receive the texts. Following messages will share the importance of the needed service and let the member know they can receive an incentive for completing the needed service. They are asked to text back, at which time Amerigroup will send an incentive brochure to the member. At the member's appointment, the doctor signs the brochure. The member sends it back to Amerigroup and we'll mail the member the associated incentive.

If you have any questions, please contact the Amerigroup Quality Department at HealthPromotionTeam@amerigroup.com.

Update: Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information about the frequency of cervical cancer screening for women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

As previously communicated, routine screening Pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine Pap testing for women 66 and older, with prior negative screening results, will be denied.

Screening method and intervals

The U.S. Preventive Services Task Force[1], the American College of Obstetricians and Gynecologists[2], the American Cancer Society[3], the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical Pap alone every three years
Women aged 30-65 years	Human papillomavirus (HPV) and cervical Pap co-testing every five years or cervical Pap alone every three years
Women older than 65 years	No screening is necessary after adequate negative prior screening results
Women who underwent total hysterectomy (with no residual cervix)	No screening is necessary

1. United States Preventive Services Task Force. Cervical Cancer. March 2012.
2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:el-20.
3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.

Effective October 1, 2016
ClaimsCheck® upgrade to ClaimsXten™

Amerigroup Washington, Inc. uses ClaimCheck 10.2, which is a comprehensive, nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. We are upgrading ClaimCheck 10.2 to ClaimsXten, McKesson's next generation code auditing system. As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, American Medical Association/CPT, Specialty Society guidelines and Amerigroup policy. The upgrade will become effective October 1, 2016.

What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that, in combination with claims processing systems:

- Reinforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed
- Determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Processes those services according to industry standards

Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes

How will the upgrade to ClaimsXten affect you?
Providers will continue to see similar edits as under ClaimCheck 10.2. ClaimsXten has enhanced audit logic and the ability to analyze claims submission history. Outpatient services will be analyzed for such issues as:

- Rebundled or unbundled services
- Multi-channel services
- Mutually exclusive services
- Incidental procedures
- Incorrect use of CPT codes
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

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

What types of edits appear on my explanation of payment (EOP) when an edit is applied by ClaimsXten to a service I submitted?

The following list, which is not all-inclusive, contains edits that may appear on your EOP when rule is triggered in ClaimsXten:

Rule	Provider type	Description
Inappropriate age	Professional/ facility	Procedure code is either inappropriate for the member's age or an age-specific CPT code does not match the member's age.
Deleted code	Professional/ facility	Procedure code has been deleted from CPT.
Invalid diagnosis code	Professional/ facility	Procedure submitted with an invalid diagnosis code.
Inappropriate gender	Professional/ facility	Procedure code is either inappropriate for the member's gender or a gender-specific CPT code does not match the member's gender.
Invalid modifier-procedure	Professional/ facility	Modifier used is invalid with the submitted procedure code.
Multiple radiology reduction	Facility	Reduction applied to multiple contiguous radiology procedures using the same modality on the same date of service (DOS).
Assistant surgeon	Professional	Assistant surgeon not eligible for procedure.
Base code quantity	Professional	Base code with units >1, where add-on code would be appropriate.
Bundled services	Professional	Services incidental to the primary procedure.
Multiple surgery reduction	Professional	Reduction applies to multiple procedures on the same DOS. Procedure with highest reimbursement paid as primary.
Global surgical edits	Professional	Pre-op visit, post-op visit, procedure or other service considered part of the global surgical period.
Maximum units	Professional	Medically unlikely number of units on the same DOS.
Global component	Professional/ facility	Audits across multiple providers to ensure that professional and technical components are not reimbursed more than once for the same member, procedure and date of service.

Anesthesia not eligible	Professional	Audits claim lines containing nonanesthesia services submitted by an anesthesiologist as described by the American Society of Anesthesiologists.
Outpatient consultations	Professional	Audits for claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same provider with at least one matching diagnosis within a six-month period.
Inpatient consultations	Professional	Audits for claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a five-day period.
New patient code for established patient	Professional	Audits for claim lines containing a new patient evaluation and management (E&M) coding when another claim line containing any E&M code was billed within a three-year period.
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount.

If you have questions regarding ClaimsXten edits that you receive on your explanation of payment, please call Provider Relations at 1-800-454-3730 and select the appropriate prompt.

Thank you for your support.