Provider Update

March 2015 News Bulletin

Tip of the Month: Corrected Claims

To ensure that corrected claims go through the adjustment process more smoothly and do not hit timely filing edits, be sure to reference the original denied claim number.

Credentialing and Recredentialing

If you are a first time applicant or adding a new provider to your practice, please email all credentialing materials to wa1provrelations@amerigroup.com or fax to 1-855-270-9583. We are currently processing new, clean applications within 90 to 120 days of receipt. We have implemented new processes and resources to streamline the process and look forward to reporting faster turnaround times soon.

If you have received a recredentialing request from our vendor, Medversant, please be sure to respond promptly to ensure your credentialing does not expire. Respond to them directly using the contact information provided in their communications. If you have any difficulties with the recredentialing, please let your Provider Relations representative know.

If you want Amerigroup and Medversant to contact one person at your practice for all credentialing matters, please email the request to us at agpcred@amerigroup.com. Feel free to copy your Provider Relations representative on the email message. Be sure to include the following: provider group name, tax identification number, contact information (name, phone number, fax number, email address and mailing address) and a list of providers with their NPI numbers.

Amerigroup in the Community

Amerigroup Washington, Inc. joined the Grays Harbor community in Aberdeen for a Services and Health fair hosted by Project Homeless Connect and Point In Time Homeless Count. Attendees were provided with various items, including employment and education information, legal aid, benefits and assistance with social security, advocacy and support, veteran services, housing, food and clothing. The community was also offered haircuts, vaccinations and hot meals.

Provider Update

Provider Satisfaction Survey Results

Last year, we surveyed providers to learn more about areas that need improvement and areas where we excel. We appreciate your responses. We perform this survey annually and look forward to additional responses in 2015. We are already hard at work identifying how to improve our operations in response to the 2014 survey. Here's what you said.

Strengths: Our claims turnaround and payment accuracy rates were the highest rated plan functionality by providers, with 77 percent of those surveyed stating they are somewhat or very satisfied. Amerigroup continues to pay most claims in less than five days from receipt and exceed 95 percent accuracy rates on payment accuracy. You also appreciated our new provider orientation. If you have not attended orientation, we encourage you to do so.

Improvement Opportunities: These are the four primary functionalities where providers were not satisfied with our performance:

- Responsiveness by Amerigroup in the medical necessity appeal process
- Member understanding of benefits and preventive care/wellness programs
- Disease management centralized care unit overall, though 42 percent of respondents also said our unit is better than those of other Medicaid plans
- Provider communications

The directors and managers responsible for each of these areas are engaged to identify and implement ways to respond to providers' concerns. In fact, work on several areas was already being done prior to learning the survey results. We are overhauling our appeals process during the first quarter of 2015. During and after the survey, we sent reminders to members to obtain their (HEDIS®) services and included incentives to encourage participation. We changed our provider communications from multiple individual notices to primarily one faxed update monthly. We will continue to make improvements and share those with you in a future newsletter. If you have any specific suggestions you would like to offer, please give those to your Provider Services representative.

ICD-10 Coded Prior Authorizations

The transition from ICD-9 to ICD 10 goes into effect on October 1, 2015. Amerigroup Washington, Inc. will begin accepting ICD-10 coded authorizations beginning June 1, 2015. These will only be for those authorization requests where the dates of service are October 1, 2015 or later. Authorization requests for dates of service prior to October 1, 2015 will continue to be coded using ICD-9.

Provider Update

Getting Ready to Transition to ICD-10

To help ensure you are ready, here are some additional things to remember:

- Make sure your practice management system and/or billing system is ICD-10 ready. Talk with your vendor about the support and services you might need to be compliant for ICD-10.
- There is no need to memorize all of the new ICD-10 diagnosis. If you are not an inpatient facility, you only need to be concerned with the most common medical conditions your practice sees today and understand how ICD-10 impacts them.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record.
- If your practice treats a wide range of medical conditions use the 80/20 rule to determine which ICD-10 diagnosis codes are most pertinent. This would include family practice, pediatric medicine, or internal medicine.

The Centers for Medicaid and Medicare Services (CMS) offers the "Road to ICD-10" – a comprehensive tool where you can explore common codes, primers for clinical documentation, clinical scenarios, and additional resources associated by specialty. Visit www.roadto10.org to find information for:

- Family Practice
- Pediatrics
- OB/GYN
- Cardiology
- Orthopedics
- Internal Medicine
- Other Specialties

Did you know you also have the opportunity to earn continuing medical education (CME) credits while preparing for ICD-10? CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition. The video lectures are specifically for physicians, while the article covers more general topics for all health care providers. CME credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion. The modules are free and can be found at http://www.cms.gov/Medicare/Coding/ICD10.

Provider Update

Improving your experience: Availity eligibility and benefits (E&B) updates

Availity is launching new eligibility and benefits features for their Web Portal during the second quarter of 2015. These enhancements will make finding eligibility and benefits easier and faster for you. View the chart below for more information on what's coming:

New Request page	The new Request page design makes it faster for you to submit member inquiries. Now, you can submit multiple inquiries without having to wait for individual results to show before starting another request.
Patient history list	The results list summarizes your most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only the information relevant to that member is displayed.
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list includes key coverage elements and only shows information returned from the payer.
Organization-wide view of E&B transactions	You can now see transactions by other users within your organization (shared history) – resulting in less duplication of work already completed by your peers.
Organization dropdown menu	Users responsible for more than one organization can switch organizations while staying on the same page, providing a convenient, streamlined workflow.
Payer section	In this section, value-added services were consolidated so you can access these services (e.g., a patient care summary) from the same page.

To learn more about these time-saving features, go to www.availity.com and take a quick tour, view the recorded webinar or join Availity for a live webinar.

Provider Update

Medicare Advantage national coverage determinations

National coverage determinations (NCDs) are developed by CMS to identify member benefits and for provider guidance. Effective January 1, 2015, claim edits will be enhanced to consistently apply NCD criteria during the adjudication process for Amerigroup Amerivantage (Medicare Advantage).

Clearinghouse helps ensure timely and accurate claims payment for vaccines covered by Medicare Part D

Providers who have administered a shingles or tetanus vaccine to our individual and group sponsored Medicare Advantage plan members with pharmacy benefits may encounter a denial as these claims are covered under Medicare Part D only.

To streamline claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRX. This clearinghouse for claims submission may be used by physicians, facilities, health clinics and pharmacies.

To use TransactRX, please visit www.transactrx.com or call the Customer Service department at 1-866-522-3386. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

For more information on Part D vaccines visit www.cms.gov and follow the steps below:

1. Select Outreach & Education from the top menu bar
2. Under Look up topics, select Medicare
3. Select Medicare Learning Network® (MLN) general information
4. Select the first option from the list, MLN Education Products
5. Under MLN products on the left-hand side, select MLN Publications and type June 2013 in the search box
6. Select the third option, Vaccine Payments Under Medicare Part D

Amerivantage is an HMO plan with a Medicare contract and a contract with the Washington Medicaid program. Enrollment in Amerivantage depends on contract renewal.

Provider Update

ClaimCheck Version 55 Upgrade Effective July 2015

In 2015, Amerigroup will complete two upgrades to newer versions of ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in Version 55 of the upgrade are effective July 2015. The changes included in Version 56 of the upgrade are effective August 2015.

What this means to you

No action is required by you. 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
- 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 billed with inappropriate modifiers

Provider Update

Core Provider Agreement Required

The Washington State Health Care Authority (HCA) now requires that all providers who serve Medicaid enrollees through a managed care organization also hold a Washington State Medicaid Core Provider Agreement (CPA) with the HCA. If you do not currently have an agreement, you must apply with HCA online at: http://www.hca.wa.gov/medicaid/providerenroll/Pages/index.aspx.

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 Core Provider Agreement (CPA) submits a nonbilling application, the CPA is replaced by the agreement given in the nonbilling application. http://www.hca.wa.gov/medicaid/providerenroll/Pages/nonbilling.aspx If you have questions, please call HCA at 1-800-562-3022, ext. 16137. You may also contact Provider Services at 1-800-454-3730.

Join the Medical Advisory or Credentialing Committees

Amerigroup Washington, Inc. invites you to participate on its Medical Advisory and/or Credentialing committees. Participants provide valuable feedback and input to our Medicaid Managed Care partnership. Participants make a difference regarding how Amerigroup provides services to its Medicaid enrollees.

Participants should be licensed in the field of pediatrics or OB-GYN (M.D., D.O., P.A. and ARNP) and have a willingness to share ideas with us. The commitment includes a one-hour monthly meeting, which is held by telephone. Amerigroup offers a $200 stipend for participants.

We hope you will join one or both of these valuable committees and collaborate with us about continuing to provide quality care to Medicaid recipients in Washington. For additional information, contact Lani Spencer, Vice President of Health Care Management Services at 206-674-4470 or toll free at 1-855-323-4688.

March New Provider Orientation Webinar

Join us for our March new provider orientation online via WebEx Thursday, March 26, 2015, from 12 p.m. to 1:30 p.m. Pacific time. Join us for an online network provider orientation. Talk with Amerigroup representatives and get answers to questions you may have. We'll review information like:

- Online tools
- Claims, coding and billing procedures

- Medical management
- Reference materials and support services

Your support staff is invited, too. Attendance is required for all providers joining our network. RSVP to the Provider Relations department by calling 206-674-4479.

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.

New Corrected Claim Requirement for CMS 1500

Summary of update
Effective June 15, 2015, professional corrected claims billed on CMS 1500 forms must be submitted to Amerigroup Washington, Inc. **in their entirety**.

What this means to you
As of June 15, 2015, when submitting a correction for a previously billed claim on a CMS 1500 form, you must include all services on the new submission. If any previously submitted charges or services are not billed on the corrected claim form, they will be removed in the adjustment. In order to ensure that all claims accurately reflect the services performed, providers will no longer be permitted to submit individual lines for correction on a CMS 1500 form. Adjustments to the previously processed claim will reflect exactly what is shown on the new corrected claim submission. The updated process for CMS 1500 corrected claims will mirror the current process for institutional replacement claims submitted on CMS 1450 (UB-04) claim forms.

By making this change, we will be able to remove possible discrepancies between the intention of the correction and the way the claim is actually adjusted in our systems. The process for submitting facility replacement claims billed on a CMS 1450 form is not affected by this change.

Standard timely filing guidelines apply to all corrected and replacement claims.

How will this change affect me?
If you submit a claim correction and fail to include services that were correctly paid on your original submission, they will be removed on the adjusted claim. Any reduction in payment amount would result in a negative account balance and/or a refund request.

What if I need help?

If you have questions about this communication or need help with anything else, contact your local Provider Relations representative or call us at 1-800-454-3730.

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