Provider Update

May 2015 News Bulletin

Claims tip of the month

Optimize your claims payment for Apple Health members! Precertification is not required for sports physicals and they are eligible for reimbursement by Amerigroup Washington, Inc. once every 12 months as a value added benefit.

To bill for the physical, use CPT code 99212 with DX V70.3. Providers may also bill Amerigroup for both a well visit and a sports physical on the same day by including modifier 25.

May new provider orientation webinar

Online via WebEx May 28, 2015

12 - 1:30 p.m. Pacific time

RSVP by Wednesday, May 27, 2015

Join us for an online network provider orientation. Talk with Amerigroup representatives and get answers to questions you may have. We'll review information such as:

- 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 emailing wa1provrelations@amerigroup.com.

Univita termination

Effective September 1, 2015, Amerigroup will begin directly managing all home health, home hospice and durable medical equipment services. We will no longer use Univita as a vendor to manage these services. If you provide these services and would like to directly contract with Amerigroup, please email your request along with your W-9 to wa1provrelations@amerigroup.com. We look forward to working with these providers directly. Stay tuned for additional information about how our authorization processes will work as we continue to provide updates throughout the summer in our news bulletins.

Amerigroup in the community

Amerigroup sponsored the Inland Northwest Baby (INWB) Community Diaper Drive and Health Fair on April 18th. Agencies including the Washington State Department of Social and Health Services, Catholic Charities, Albertsons, Walgreens, Spokane Police Department and Rockwood

Health Systems collected more than 10,000 diapers, 100 packs of diaper wipes, several jars of baby food and formula. Amerigroup will continue to work with INWB for the next year on Medicaid (Apple Health) in Spokane, Ferry, Stevens, Okanogan, Pend Oreille, Grant and Whitman counties.

Provider Update

Back pain management – new utilization management vendor

Effective July 1, 2015, back pain management treatment requests for Amerigroup members must be reviewed by OrthoNet, LLC for prior authorization (PA). Whenever one or more of the diagnoses is "back pain," the request must be sent to OrthoNet. Services included in their scope include, but are not limited to, injections, pain medicine pumps, surgeries and procedures, physical therapy and spinal cord stimulators. Prior authorization forms are available at providers.amergroup.com and your local Provider Services representative. OrthoNet is a leading musculoskeletal management company located in White Plains, NY. They are a provider-based company with ties to leading practitioners in the Amerigroup service areas.

You may request PA by submitting complete clinical information to OrthoNet by:

- Phone 1-844-887-8388
- Fax 1-844-492-8927

OrthoNet will use Amerigroup Medical Policies and Clinical Utilization Management Guidelines to determine medical necessity of the requested services. You may access these Medical Policies and Clinical Guidelines at providers.amerigroup.com/medicalpolicies. If no Amerigroup clinical utilization management guideline is applicable, Amerigroup-approved OrthoNet clinical review criteria will be applied.

Amerigroup will continue to require back pain management services be provided in a freestanding office setting unless there is a special reason for the service to be provided in a hospital setting. OrthoNet will accept Amerigroup PA request forms. The services for which Amerigroup requires prior authorization have not changed. Amerigroup will continue to adjudicate all claims.

Note: Authorization requests sent directly to Amerigroup on or after July 1, 2015, will delay medical necessity determination.

If you have questions, contact Provider Services at 1-800-454-3730 or call OrthoNet at 1-844-887-8388.

Musculoskeletal services prepayment review new vendor – OrthoNet

Effective July 1, 2015, OrthoNet will begin conducting post-service prepayment coding review of professional surgical services for all musculoskeletal provider specialties included in the Focused Claim Review program including, but not limited to, the following specialties:
Cardiology, Pediatric Sports Medicine, Dermatology, Physiatry/Physical Medicine & Rehabilitation, Enhanced Nurse Triage, Plastic Surgery, General Surgery, Podiatry, Hand Surgery, Neurosurgery, Pain Management, Neurology, Pediatric Orthopedics, Orthopedic Surgery, Pediatric Neurosurgery, Sports Medicine, Pediatric Neurology and Urology. A list of the specific surgical services they will review is available through your Provider Services representative upon request.

These services may be selected for post-service prepayment coding review of professional services. Amerigroup has chosen OrthoNet to manage this portion of our coding review because of their expertise in musculoskeletal services. We appreciate the expertise they will bring to this currently self-managed process. Contact information will be provided with any affected explanations of payment for providers who may have questions about the reviews.

Exception to the rule process – prior authorizations

To ensure that Apple Health members receive the health care they need, a process is available to all members called Exception to the Rule (ETR). This process, directed by the provider and agreed to by the member, allows a request to be submitted for additional services that may be noncovered or have a benefit limitation in the Apple Health contract.

If you, as the provider are aware of a member's need for such covered services, you may submit an ETR Request Form signed by the member with supporting documentation and your preauthorization request. If services have been denied or authorized in a more limited scope than requested, you may submit an ETR Request Form signed by the member and supporting documentation post-denial to the Appeals department. The ETR process runs parallel to the appeals process and in no way interferes with the member's appeal rights.

For further questions about ETR, please call Amerigroup Health Care Management Services at 206-695-7081, ext. 36167.

The ETR Request Form may be found online at providers.amerigroup.com/WA under Forms or obtained by calling us at the number above.

Preauthorization requests may be faxed to Amerigroup at 1-855-231-8664.

Post-denial requests may be faxed to Amerigroup at 1-855-292-3770 or mailed to Amerigroup Washington, Inc. P.O. Box 62429, Virginia Beach, VA 23466-2429.

Availity: Registration information and reminders

Amerigroup recently introduced Availity web portal, a tool to help reduce costs and administrative burden for our physicians and hospitals. Whether you work with one managed care organization (MCO) or hundreds, Availity can help you quickly and easily file claims, check eligibility, process payments and more. For your convenience, Availity also offers a link back to the Amerigroup provider self-service site for all other transactions.

How to register

To initiate the registration process, your primary controlling authority (PCA) – the individual in your organization who is legally entrusted to sign documents – must first complete registration at www.Availity.com. Once your PCA completes this initial process, your primary access administrator (PAA) – the individual in your organization who is responsible for maintaining users and organization information – will receive a temporary password that will allow him or

her to add users, providers and additional enrollments for the organization. Each staff member should register with his or her own login credentials to avoid business disruptions.

Additional training
For training, visit www.Availity.com and select *Availity Learning Center* under *Resources* in the top bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

If you need assistance
For any questions or additional registration assistance, contact Availity Client Services at 1-800-282-4548, Monday through Friday, 5 a.m. – 4 p.m., Pacific time.

PCPs working together

Amerigroup annually surveys providers to understand how effectively information is shared across various care settings, including primary care and specialty offices, hospitals, emergency rooms, skilled nursing facilities and Home Health agencies. In the most recent survey, PCPs responded that they would like better communication and exchange of patient information with other PCPs.

- 71 percent of primary care providers said they get timely and useful information from specialists.
- Only 43 percent of PCPs said they get timely and useful information from other PCPs.

The Amerigroup benefit design allows members to seek treatment from any designated PCP, to ensure optimal access for member care. PCPs may not always be aware that a member is seeking services from another PCP. Be sure to ask your Amerigroup member patients about all other care they may be receiving, including medications and lab tests since their last visit with you.

Advantages of sharing information with other PCPs:

- 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.
- You can reduce redundancy of services such as laboratory and imaging services.

Amerigroup makes it easy for providers to see the care members have been receiving through other providers, Amerigroup Case Management and others by using our Patient360° tool, which is available once you log into www.Availity.com.

Sharing relevant case information in a timely, useful and confidential manner is an Amerigroup requirement. We abide by standards set by the National Committee for Quality Assurance requiring health plans to ensure coordination of care between medical providers. HIPAA allows for the sharing of information between medical providers for the purposes of coordinating care.

Provider Update

Asthma Alerts: Emergency Department Use for Asthma

Amerigroup monitors members' use of emergency rooms (ER) for asthma and the frequency of follow-up care with PCPs after the ER visit. Our most recent study shows a slight increase in post ER follow-up visits, from 23 percent in 2013 to 27 percent in 2014. There is still plenty of room for improvement so Amerigroup will begin sending fax alerts to PCPs to inform them of assigned members' recent ER visits and encourage the PCP to contact the member for a follow-up appointment within 30 days of the ER visit. (Note that you will also see this information online, along with the list of medications each member has filled when you utilize our Patient360° tool, which is available once you log into www.Availity.com.) The faxed alert will also include information on asthma management. These alerts are one way Amerigroup aims to support our PCPs in continuity of care for members who are affected by asthma. Be on the lookout for fax alerts!

Access to utilization management staff

We are staffed with clinical professionals who coordinate member care and are available 24 hours a day, 7 days a week to accept precertification requests. You can submit precertification requests by:

- Calling us at 1-800-454-3730
- Faxing requests to 1-800-964-3627
- Logging in to providers.amerigroup.com/WA and using the Precertification Lookup Tool

Do you have questions about utilization decisions or the utilization management process in general? Call our clinical team Monday through Friday from 8 a.m. to 5 p.m. Pacific time at 1-800-454-3730.

To request a copy of the specific criteria/guidelines used for the decision, please call Provider Services or write to:

Medical Management
Amerigroup Washington, Inc.
705 Union Station, Suite 110
705 Fifth Ave. South
Seattle, WA 98104

Pharmacy management information

Need up-to-date pharmacy information? Log in to our website, providers.amerigroup.com/WA, to access our formulary, prior authorization form, processes and the Preferred Drug List. Have questions about the formulary or need a paper copy? Call our Pharmacy department at 1-800-454-3730. Pharmacy technicians are available Monday through Friday from 5 a.m. to 5 p.m. Pacific time and Saturdays from 7 a.m. to 11 a.m. Pacific time.

Provider Update

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.

ICD-10 made easy

We know that ICD-10 can look daunting. But there is no need to memorize all of the new ICD-10 diagnosis and inpatient procedure codes. If you are not an inpatient facility, you only need to be concerned with the most common ICD-10 PCS diagnosis codes your practice uses today. For example:

- If you are a cardiologist and only treat cardiac patients, focus only on those diagnoses related to your specialty during the course of your ICD-10 remediation work.
- If you practice general or pediatric medicine, so you treat patients with a wide range of medical conditions, use the 80/20 rule to determine which ICD-10 codes are most pertinent.
- 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. You only need to have enough clinical detail in your clinical documentation to determine the code in your ICD-10 coding tool, whether it is a book or online.

For more information, visit our ICD-10 web page at providers.amerigroup.com/Pages/ICD10.

Recovery look-back period to align with CMS

To align with Centers for Medicare & Medicaid Services guidelines, Amerigroup will begin recovering Medicare Advantage claim overpayments within four years of the claim payment date. Currently, Amerigroup recovers overpayments within three years of the claim payment date.

What this means to you

Effective May 1, 2015, providers will be notified in writing of any Medicare Advantage claim overpayments identified with good cause within four years of the claim payment date consistent with the CMS guidance below unless a different time frame is specifically noted for Medicare Advantage plans in the provider's contract.

CMS Guidance

42 CFR § 405.980 gives guidance to payors that overpayment recoveries can occur
(1) Within one year from the date of the initial determination or redetermination for any reason.

(2) Within four years from the date of the initial determination or redetermination for good cause as defined in § 405.986.
(3) At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.
(4) At any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.
(5) At any time to effectuate a decision issued under the coverage appeals process.

In addition, CMS' Medicare Integrity Program employs recovery audit contractors to identify and correct improper Medicare payments. The Recovery Audit Contractor program allows for a look-back period of up to five years. Some overpayment examples include:

- Billing errors, such as deviation from National Correct Coding Initiative guidelines and improper use of billing modifiers.
- Payment errors, such as an incorrect fee schedule applied to the claim or identification of a member's other health insurance that would be primary.

The appeals process remains unchanged. If you have any questions please call the Provider Services Unit at 1-866-805-4589 or contact your Provider Relations representative. We appreciate your care for our Medicare Advantage members.

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

Documentation and diagnosis coding tips

Documenting specificity for accurate diagnosis coding

The purpose of this document is to help providers understand the importance of diagnosis coding and reporting member conditions. This ICD-9 coding tips sheet is the groundwork for our next document which is an ICD-10 coding tips sheet. The approach is to build on current practice and lead into the coming transition. The ICD-10 coding tips sheet will be distributed closer to the October 1, 2015, implementation date. The goal is to reach as many PCP providers as possible for each market with free documentation and coding resources. Ultimately we want to ensure that providers have ongoing assistance/support with ICD-10 diagnosis coding and reporting.

- Document the reason for each visit along with all conditions that coexist at the time of the encounter. Coexisting conditions include chronic conditions that require or affect patient care, such as hypertension, asthma or diabetes. Chronic conditions that coexist need to be documented and reported, at minimum, once per year.
  - **Example 1:** A patient presents for a regularly scheduled physical examination. A code from category V70 (general medical examination*)* should be assigned, along with a diagnosis code for any coexisting condition(s) documented and supported in the medical record.

- **Example 2:** A patient presents to an ENT specialist for treatment of chronic sinusitis. The patient also has type II DM with secondary CKD. A code from category 473 (chronic sinusitis*)* should be assigned, followed by codes 250.4x and 585.x for type II DM with secondary CKD.

- All diagnosed conditions must be expressly stated. Probable, suspected, questionable, rule out or working diagnoses cannot be reported in an outpatient setting per ICD-9 outpatient coding guidelines IV.I.
- Document the status of diagnoses, test results, prescription management, recommendations, and conclusions in the final assessment and plan.
- Documentation should clearly reflect how the reported condition was treated and/or managed. Each diagnosis must contain supporting documentation per ICD-9 outpatient coding guideline IV.J and IV.K
  - **IV.J:** Chronic disease treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition.
  - **IV.K:** Code all documented conditions that coexist at the time of the encounter and require or affect patient care treatment or management.
- Use explanatory words to better describe the medical condition. For example:
  - **Acute** bronchitis
  - **Major** depression
  - **Stable** CKD
  - **Uncontrolled** DM
- Document the cause and effect relationship when one condition is caused by another condition, such as:
  - Neuropathy **due to** diabetes
  - Alcoholic dementia
  - Acute myocarditis **caused by** influenza
  - Cirrhosis **secondary to** alcoholism
- When instructed by ICD-9 guidelines, use additional diagnosis codes to fully describe the conditions.
  - Insomnia due to mental disorder (327.02)
    - Code first mental disorder
  - Other late effects of CVA (438.89)
    - Use additional code to identify the late effect

Locating official coding advice

- The *American Hospital Association (AHA) Coding Clinic*™ is the CMS approved resource for clarification of ICD-9-CM. Volumes are published quarterly and contain new or updated information on the use of ICD-9-CM, as well as clarification of previously published coding advice.

Patient history vs history (of)

- Providers may document a condition as history (of) to show that the patient has had the diagnosis for a long period of time. The term history (of) from a coding perspective indicates

that the patient had the condition in the past and that condition no longer exists.

- History of CHF: Incorrect
  - Instead document status as **compensated** CHF
- History of COPD: Incorrect
  - Instead document status as **stable** COPD

- Use V-codes to report historical status if pertinent to the current visit. For example, with a history of CVA:
  - **V12.54:** Use when no residual effects from the stroke remain.
  - **438.x:** Use when documentation supports remaining deficits, hemiplegia, dysphagia, etc.

Signature and legibility

- Make sure all progress notes and medical records are signed by the provider using first name, last name, and credentials for each date of service.
  - John Smith, MD
  - Rick Santos, PA
- Write legibly so others can read it.
  - Other providers need to have a clear understanding of what the documentation means.
  - Good documentation is good patient care.

Status codes

- Status codes indicate that a patient is a carrier of a disease, has the residual of past diseases or conditions, or has another factor influencing health. Check the review of systems, physical exam, and/or history section of the medical record. As with chronic conditions, status conditions need to be documented and reported, at minimum, once per year.
  - Transplant (V42.x)
  - Dialysis (V45.xx or V56.x)
  - Ventilator (V46.xx)
  - Current ostomy (V44.x or V55.x)
  - Amputation (V49.6x and V49.7x)
  - Asymptomatic HIV infection (V08)
  - Old myocardial infarction (412)
  - Long-term (current) insulin use (V58.67)
  - Adult/child body mass index, when clinically relevant (V85.xx)

Locating the correct diagnosis code in the ICD-9 code book

- Use a current ICD-9 code book. Become familiar with the coding conventions and follow all instructions related to specific codes. Be aware of include and exclude instructions, inclusion

terms, and use additional code and other code-related instructions in the Official ICD-9-CM Guidelines for Coding and Reporting.

- Locate the term in the alphabetic index and then verify the code in the tabular list. Reliance on EHR systems and cheat sheets alone can lead to coding errors.

Medicare Claim Rejections

We apologize for a now-corrected system error that caused Medicare claims to deny as "Subscriber and subscriber ID not found" when the member was in fact, eligible. This affected some claims submitted between January 1 and March 23. Providers may contact our Amerivantage Call Center at 1-866-805-4589 if their claims have not already been corrected.

Members Changing Primary Care Providers

The fastest way to make primary care provider (PCP) assignment changes for members is by calling the Amerigroup National Call Center (NCC) at 1-800-600-4441:

- Call made by member – all the member needs to know is the full name or NPI of the provider they want to change to.
- Call made by provider – the change can be done in the provider's office, but the member needs to be present during the call. The NCC will ask to speak to the member to verify the change.

Calling the NCC will ensure the member is moved to the correct provider/location. We will make the change effective within 24-72 hours of the call. All family members will be moved as may be requested and the member/provider will receive confirmation the change has been completed. Please remember that PCPs do not need to be the member's assigned PCP in order to be paid for services rendered.
**ADD: Also remember you can still see a member even if you are not the PCP listed on the member's card.

Preferred Laboratories – Updated

All laboratory tests must be submitted to LabCorp, PACLAB, PAML, Quest Diagnostics or TriCities Laboratory, the preferred lab vendors for our members.
Precertification is required for all laboratory services furnished by non-network providers, except hospital laboratory services occurring in events of emergency medical conditions.
For more information or to receive a specimen drop box, testing solutions and services, or to set up an account, contact any of the following labs:

- LabCorp: 1-800-345-4363
- PACLAB/PAML/TriCities Lab: 1-800-541-7891 or
- Quest Diagnostics: 1-866-MY-QUEST (1-866-697-8378)

Provider Update

The Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Visit our website to view the Amerigroup HEDIS Guide, a full reference document featuring many of the HEDIS measures and the charting elements required for each one. Choose the Quality Management link under Provider Resources & Documents.

Primary care and behavioral health providers: Working together to treat the whole person

Why PCPs and BH providers should 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 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 BH providers.

When PCPs and BH providers should exchange health information

- When a member first accesses a physical or behavioral health service
- When a change in the member's health or treatment plan requires a change to the other provider's treatment plan (e.g., when a member who has been taking lithium becomes pregnant)
- When a member discontinues care
- When a member is admitted to or discharged from the hospital
- When a member is admitted and a consultation is warranted
- Once a quarter if not otherwise required
- When a member has a physical exam and/or laboratory or radiological tests

In the 2014 survey of Amerigroup participating providers, 49 percent of primary care providers said they get timely and useful information from behavioral health specialists. Only 29 percent of behavioral health specialists said they get timely and useful information from PCPs and 19 percent from other specialists.

Provider Update

Tips and tools for screening and follow-up care

When screening for substance abuse and depression, please use standard screening tools or these brief screening questions. If your patient's answer to any of these questions is yes, refer the patient for a complete behavioral health evaluation. Contact us if you need help making this referral. Screenings should be completed annually.
In the last year, did you ever drink or use drugs more than you meant to?

☐Yes ☐No

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

☐Yes ☐No

Over the past two weeks, have you felt down, depressed or hopeless?

☐Yes ☐No

Over the past two weeks, have you felt little interest or pleasure in doing things?

☐Yes ☐No

Access consultation through Partnership Access Line

The Washington Health Care Authority provides access to consultation with a child psychiatrist through the Partnership Access Line (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 is not required to provide payment to prescribers for voluntarily accessing the PAL.

To learn more about PAL, visit http://palforkids.org.

Credentialing and Recredentialing:

If you are a first-time applicant or adding a new provider to your practice, please send all credentialing materials to us via email at wa1provrelations@amerigroup.com or fax them to us at 1-855-270-9583. We are currently taking 90-120 days to process new clean applications. We have implemented new processes and resources to speed up the process and look forward to reporting reduced 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 business and we are not currently doing this, please email the request to us at wa1provrelations@amerigroup.com. Feel free to copy your Provider Relations representative on the email message. In the email, be sure to include the following: provider group name, tax identification number, contact information (name, phone number, fax number, email address, mailing address) and a list of providers with their NPI numbers.

Provider Update

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.

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.

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