Provider Update

May 2016 news bulletin

Claims status reports through Availity - enhancement

On June 1, a new Claims Status Listing Tool will be offered on the Amerigroup Washington, Inc. Payer Spaces on Availity. This application enables you to generate a list and view the status of multiple claims submitted to Amerigroup.

Besides your current claims status inquiry functionality on Availity, we will provide an added benefit with the Claims Status Listing Tool. With this tool, you can obtain a list of your claims submitted to Amerigroup for a specified period of time (span of up to 30 days) and up to two years back. You will have the option to see the status of multiple claims in one report instead of looking them up one at a time.

Here's how to access the Claims Status Listing Tool:

- Log into the Availity Web Portal
- From the Availity Web Portal home page, select *Payer Spaces*
- Select the *Payer* from the list of payer options
- Select *Applications* and then select *Open* located below **Claims Status Listing Tool**.

For questions or additional registration assistance, call Availity Client Services at 1-800-282-4548, Monday through Friday from 5 a.m. to 4 p.m. Pacific time.

Amerigroup in the community

In April, Amerigroup provided a grant through its foundation to Evergreen Community Aquatic Center (ECAC) in Seattle. This grant will be used to help ECAC provide life-saving instruction and swimming lessons for underserved youth across King County. Swimming lessons empower youth to be well prepared for emergency situations around water. According to the Centers for Disease Control and Prevention, about one in five people who die from drowning are children ages 14 and younger. For every child who dies from drowning, another five receive emergency department care for nonfatal submersion injuries. We're pleased to support the ECAC's prevention work through education.

Easy to do business with

We recognize that providers want the administrative side of health care to be as easy as possible and limited to what is really necessary to provide high quality care to their patients. At Amerigroup, we agree! We continuously strive to improve our tools and processes so we can meet this shared goal. This month, we are converting all of our provider online forms to editable PDFs. By the end of May, you will be able to see the updates at https://providers.amerigroup.com/pages/wa.aspx.

If you have suggestions for how Amerigroup can be easier to do business with, please contact your local Provider Services representative.

Medela breast pump availability

Medela or Ameda electric breast pumps are available to all Amerigroup members after delivery of their newborns. Providers, Women, Infants and Children (WIC) program or Maternity Support Services may submit the request form from one month prior to birth until up to 6 months after birth, as long as the mother and baby are enrolled with Amerigroup. This is limited to one electric pump (code E0603) per mother's lifetime. Manual pumps are available for each pregnancy. Pumps are available through Medline. Use the **Electric Breast Pump Request Form** at https://providers.amerigroup.com/pages/wa.aspx, under **Maternal Child Program**.

Hip and knee procedures have new authorization requirements

Effective June 1, 2016, knee arthroscopy will require prior authorization through Amerigroup. Note that we originally notified providers this would be effective May 1, 2016, but we have moved the date. Additionally, effective June 1, 2016, knee and hip arthroplasty will also require prior authorization. Please refer to the provider self-service tool at https://providers.amerigroup.com/WA for specific detailed authorization requirements. To request prior authorization, please call us at 1-800-454-3730 or fax your request to 1-800-964-3627.

After-hours availability requirement

The Health Care Authority (HCA) requires that all providers contracted with Medicaid Managed Care Organizations (MCOs) offer patient telephonic access 24 hours a day, 7 days a week. Every summer, Amerigroup calls our contracted providers to monitor this access. To meet this requirement, the phone may be answered by a designee, such as:

- An on call physician.
- A nurse practitioner with physician backup.
- An answering service or a pager system. However, this must be a confidential line for member information and/or questions. If an answering service or pager system is used, the call must be returned within 30 minutes by a health care professional.
- A recorded message with the option to:
    - Connect to an answering service meeting the above listed requirements.
    - Connect to the provider, a physician or nurse practitioner with physician backup.
    - Leave a message for the provider or his/her designee, who will be back within 30 minutes.

Please be sure your office is set up to meet this requirement and that you test periodically to ensure it is working. If you have questions about this, contact your local Provider Services representative.

Cervical cancer screening coverage for women under 21 years of age

Cervical cancer screening is considered **medically necessary** for women under 21 years of age who are chronically immunosuppressed (for example, organ transplant recipients or seropositive for the human immunodeficiency virus [HIV]). Cervical cancer screening for women under 21 years of age is considered **not medically necessary** for all other indications not listed above.

Effective with service dates on or after June 7, 2016, cervical cancer screening procedures and testing will not be reimbursed as a covered benefit for average risk women younger than age 21. Please access CG-Med-53 on the Amerigroup provider website at medicalpolicies.amerigroup.com to review the guideline.

The American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology all recommend against the use of cervical cancer screening in women younger than age 21. The American College of Obstetricians and Gynecologists recommends that cervical cancer screening should begin at age 21, and women younger than 21 should not be screened regardless of the age of sexual initiation or the presence of other behavior-related risk factors. The United States Preventive Services Task Force (USPSTF) currently recommends against cervical cancer screening for women younger than age 21, giving it a D rating. This means that there is moderate or high certainty that the service has no net benefit or the harms outweigh the benefits.

Core Provider Agreement (CPA) 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 (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 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.

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. These state and federal requirements are also part of the providers' agreements with managed care plans.

Instructions on how to become a nonbilling provider are given in 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. 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.

Accountable Communities of Health (ACH)

Do you know what's going on with the ACH serving your region? Each ACH has been evaluating the needs and opportunities of the population within its region. Many have already started to develop goals and strategies for meeting these needs and opportunities. Providers are stakeholders who play an important role in driving the work of each ACH. Find out below what your ACH's priorities are and how you can learn more.

Accountable Community of Health	Counties	Lead contact information	Priorities/focuses
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Stevens, Spokane	Alison Carl White Website	• Access to oral health care • Community-based care coordination • Linkages in housing, food security and income stability systems • Obesity reduction and prevention • Whole-person care; integration of physical, behavioral and oral health care
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum	Winfried Danke Website	• Access to care and provider capacity • Adverse childhood experiences (ACEs) prevention and mitigation • Chronic disease prevention and management • Economic and educational opportunities • Health integration and care coordination
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	Carol Moser Website	• Behavioral health • Care coordination • Healthy youth and equitable communities • Obesity/diabetes • Oral health - primary caries prevention
King County	King	Marguerite Ro and Gena Morgan Website	• Physical/behavioral health integration • Care coordination for complex needs • Health equity • Housing Health intersections • Prevention - chronic disease and social determinants of health

Accountable Community of Health	Counties	Lead contact information	Priorities/focuses
North Central	Chelan, Douglas, Grant, Okanogan	Barry Kling Deb Miller	• Diabetes prevention and management • Primary care transformation
North Sound	Island, San Juan, Skagit, Snohomish, Whatcom	Lee Che Leong Website	• Behavioral health integration and access • Care coordination • Dental and primary care access • Health disparities • Housing • Prevention
Olympic Community of Health	Clallam, Jefferson, Kitsap	Elya Moore Website	• Access to care (coverage and capacity) • Population health improvements • Access to "whole person" support (clinical coordination and integration) • Data management and infrastructure
Pierce County	Pierce	Laura Johnson Website	• Access to care • Behavioral health • Chronic disease • Health equity and social determinants of health • Housing
Southwest Washington Regional Health Alliance	Clark, Skamania		• Access to care • Behavioral health integration • Care coordination

Member self-referrals

Members may self-refer for family planning services, sexually transmitted disease screening and treatment services provided at participating and nonparticipating providers including, but not limited to, family planning agencies. Note that Amerigroup is contracted with all Planned Parenthood agencies in the state of Washington.

Additionally, members have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through the state of Washington.

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.

Potentially preventable readmissions

In alignment with the HCA's refined hospital readmission payment policies, Amerigroup is advising hospitals of the following requirements.
Hospitals are prohibited from the following practices:

- Not disclosing or billing for its own readmissions
- Bundling its own separate hospital encounters/admissions into fewer encounter/admission claims than actually occurred
- Withdrawing one or more of its own hospital encounter/admission claims and then resubmitting them bundled into fewer encounter/admissions than actually occurred
- Inducing or collaborating with another hospital provider not to disclose, not to bill for or to withdraw the other hospital's encounters/admissions/claims because they could be a potentially preventable readmission for the hospital
- Engaging in any activity, coding changes or practices that are intended to, or have the effect of, masking or hiding from Amerigroup or HCA the existence of a potentially preventable readmission

If you have questions about these requirements, please contact Provider Services at 1-800-454-3730.