Provider News Bulletin

Amerigroup Washington, Inc.
providers.amerigroup.com/WA
Medicaid providers: 1-800-454-3730
Medicare providers: 1-866-805-4589

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October 2016 News Bulletin

Claims tip of the month — New Policy: Reimbursement for Maximum Units Per Day effective January 1, 2017

Amerigroup Washington, Inc. allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

Refer to the Reimbursement for Maximum Units Per Day policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Highline Medical Services Organization — correction

Whoops! We errantly referred to Highline Medical Services Organization as Highline Management Services Organization in our September News Bulletin. We apologize for our error and thank our readers for pointing this out.

Amerigroup Washington, Inc. in the community

On September 9-10, 2016, Amerigroup sponsored and participated in the 2016 Fiestas Mexicanas celebrated at Lincoln Park in Wenatchee, Washington. Fiestas Mexicanas encourages the inclusion of all diverse cultural heritages. The event had over 4,000 attendees from surrounding communities. Participants learned about resources to access care, community-based organizations and colleges in the region.

If your community or practice is holding a community event to promote health and would like support, please contact your local Marketing, Community Outreach or Provider Relations representative.

Easy to do business with — authorization requirements look-up

We make it easy to learn what services require prior authorization (PA). All you have to do is go to our website, https://providers.amerigroup.com/WA, and follow the instructions below:

- Under *Provider Resources & Documents* on the left side of the page, select **Quick Tools**.
- Choose **Precertification Lookup Tool**.

- On the next page:
    - In the *Market* drop-down box, select **Washington**.
    - In the *Line of Business* drop-down box, identify Medicaid or Medicare.
    - In the *CPT/HCPCS Code or Code Description* field, enter the codes you are looking up.
- Lastly, select **Submit**. Note, hitting the enter or return key does not work.

Our system returns information as to whether prior authorization is required; however, it does not report if the code is a covered benefit. Refer to our other resources or the Health Care Authority website for this information.

Improved medical necessity appeals process

Beginning November 1, 2016, Amerigroup Washington, Inc. will manage medical necessity appeals locally from our Seattle office. We believe that utilizing our local team — who has greater familiarity with local providers — will help us manage this process more effectively. All medical necessity appeals after October 31, 2016, should be submitted to the address below:

Amerigroup Washington, Inc.
Attn: Appeals Department
705 Fifth Ave., Suite 300
Seattle, WA 98104
Fax: 1-844-759-5953

Member education during open enrollment

Amerigroup Washington, Inc. recognizes that open enrollment can be a confusing time for Washington Apple Health members, and we can help. We are happy to host a resource table in your office with information about our programs and value-added benefits. If you are interested in having a table, contact your local Marketing or Community Outreach representative or call David Escame at 206-695-7081, ext. 54464.

Contraception benefit

All female Washington Apple Health members have the right to receive the following forms of contraception:

- Birth control pills
- Birth control patch
- Birth control vaginal ring
- Injectable and implantable hormonal contraceptives
- Diaphragm/cervical cap and cervical sponge
- Male and female condoms
- Intrauterine devices (IUDs)
- Spermicides (foam, gel, suppositories and cream)
- Emergency contraception

Effective for dates of service on or after September 1, 2015, Amerigroup Washington, Inc. pays enhanced rates for physician procedure codes directly related to the insertion or implant of long-acting reversible contraceptives (LARCs). These enhanced rates are provided in the Health Care Authority's (HCA's) most current family planning fee schedule and are paid to all providers eligible to bill for these services no matter the charges listed by the provider on the claim. Applicable procedure codes are 11981, 11983 and 58300. The following Food and Drug Administration-approved LARCs are covered with the frequency listed in accordance with HCA guidelines:

- Mirena (levonorgestrel 52 mg) (J7298) — one every five years
- Liletta (levonorgestrel 52 mg) (J7297) — one every three years
- Skyla (levonorgestrel 13.5 mg) (J7301) — no limitation
- Paraguard T 380A (Copper 309 mg) (J7300) — one every 10 years
- Nexplanon (etonogestrel 68 mg) (J7307) — no limitation

Amerigroup reimburses professional services for immediate postpartum IUD and contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure codes and the facility (including hospital inpatient) delivery claim. In accordance with HCA guidelines, we do not pay separately for unbundled services billed by a hospital. When billing for an IUD or contraceptive implant device, be sure to use the appropriate HCPCS code and National Drug Code to ensure proper claim payment.

We encourage providers to write 12-month prescriptions for contraceptive supplies. All of our contracted pharmacies know they are to dispense prescriptions as written. If you have questions, please contact our Pharmacy department.

Improving access to developmental and behavioral services for children

As part of the Early Childhood Comprehensive Systems grant, the Washington State Department of Health is holding a conversation around improving access to developmental and behavioral screening, assessment, referrals and services for all children in the state. They will highlight multiple models being used successfully with a focus on sustainability. Families will share their experiences with systems of care to inform the discussion about how we all can adopt models that are more culturally responsive and inclusive of underserved populations. For more information or to register, visit https://washingtonstateeccs.eventbrite.com. There is no cost to attend the event, and lunch will be provided. Registration is required.

Meeting details:
Monday, October 17, 2016, from 8 a.m.-4:30 p.m.
Tukwila Community Center
12424 42nd Ave. S.
Tukwila, WA

Maternity support services/First Steps program

All pregnant women who are covered under Washington Apple Health are eligible to receive maternity support services (MSS) through the First Steps program. First Steps is a preventive health program designed to ensure healthy birth outcomes.

MSS is voluntary and offers a variety of services for low-income, pregnant women to help them have a healthy pregnancy and a healthy baby. Some services include:

- A screening and assessment to determine risk factors
- Patient-centered interventions for determined risk factors
- Brief counseling
- Basic health messages related to pregnancy and infant care
- Referral to community resources

MSS can be provided in the clinic, at the patient's home or in a community setting. Services are provided by an interdisciplinary team who coordinates and supports the medical provider's plan of care for the pregnant woman and/or infant. This team includes a:

- Community health nurse
- Behavioral health specialist
- Registered dietitian
- Community health worker (some locations)

After the infant is born and MSS has ended, the family may be eligible to receive infant case management services to help them learn about how to use needed medical, social and educational resources in their community so the baby and family can thrive.
If you would like more information about the First Steps program, visit hca.wa.gov > Free or low-cost health care > Apple Health (Medicaid) coverage > Benefits & services > Covered services > Pregnancy services > First Steps (maternity and infant care). You can direct your patients to this website, or refer them to Amerigroup Washington, Inc. at 1-855-800-600-4441. Amerigroup recommends that all pregnant women be referred to the First Steps program.

Maternal Child Services: Taking Care of Baby and Me®

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me program — a comprehensive case management (CM) and care coordination program offering:

- Individualized, one-on-one CM support for high-risk moms
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

How it works
Taking Care of Baby and Me identifies pregnant women as early in their pregnancy as possible. This is done through review of state enrollment files, claims data, lab reports, hospital census reports, provider notification of pregnancy and delivery notification forms, and self-referrals. Once identified and enrolled in the program, we act quickly to assess obstetrical risk and ensure appropriate levels of care and CM services.

Experienced case managers work with members and providers to establish a care plan. Case managers also collaborate with community agencies to ensure mothers have access to necessary services including transportation; Women, Infants and Children (WIC); home-visitor programs; breastfeeding support; and counseling.

As part of the Taking Care of Baby and Me program, members are offered the My Advocate™ program. This program provides pregnant women proactive, culturally-appropriate outreach and education through interactive voice response (IVR), text or smart phone application. The My Advocate program does not replace the high-touch CM approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, facilitate connections between them and our case managers, and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality – Mary Beth. For more information on My Advocate, visit myadovcatehelps.com.

For parents with infants admitted to the Neonatal Intensive Care Unit (NICU), we offer the You and Your Baby in the NICU program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are also provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.

Our case managers are here to help you. If you have a member in your care that would benefit from CM, please call us at 1-800-454-3730.

Incontinence, urological and ostomy supplies — change to sole source vendor
In order to provide greater consistency in our management of members with incontinence needs and reduce our related costs, effective approximately December 1, 2016, only Medline will be allowed to provide incontinence, urological and ostomy supplies to Washington Apple Health members. Prior authorization will not be provided to any other vendors after the implementation.

Amerigroup Washington, Inc. will honor any existing authorizations where the dates of the authorization extend later than November 1, 2016. Upon completion of the current authorization, we will work with the referring provider to move the member to Medline. Requests for any authorization extensions will be redirected to Medline. Affected members will receive 30 days' advance notice of this change.

Medline provides a comprehensive management program to patients with incontinence, including discrete packaging. If providers wish to contact Medline directly, their contact information is below:

- Phone: 1-866-356-4997, option 5
- Fax: 1-866-202-1563
- Email: managedcarecustomerservice@medline.com

Policy Reminder — DME Modifiers for New, Rented, and Used Equipment

Amerigroup Washington, Inc. allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For more information, refer to the DME Modifiers for New, Rented and Used Equipment policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Update — Durable Medical Equipment (Rent to Purchase)

Medicaid:

Durable Medical Equipment (DME) reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of Rental DME

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 12 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances Affecting Rental Reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days.
- If a member changes suppliers during the rental period, a new rental period will not start over.

Amerigroup Washington, Inc. allows reimbursement for oxygen equipment for a maximum of 36 months; however, we will continue to reimburse for oxygen contents.

For additional information, refer to the Durable Medical Equipment (Rent to Purchase) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Medicare:

Durable Medical Equipment (DME) reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of Rental DME

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 13 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances Affecting Rental Reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days.
- If a member changes suppliers during the rental period, a new rental period will not start over.

Amerigroup allows reimbursement for oxygen equipment for a maximum of 36 months; however, we will continue to reimburse for oxygen contents.

For additional information, refer to the Durable Medical Equipment (Rent to Purchase) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program.

Pharmacy management information

Need up-to-date pharmacy information?

Log in to our website, https://providers.amerigroup.com/WA, to access our Medicaid and Medicare formularies, *Prior Authorization Form*, procedures for generic substitution and step therapy. Changes to the formularies may be made monthly and posted on the website on or before the effective date of the change.

Have questions about the formulary?
Call our Pharmacy department; technicians are available Monday-Friday from 5 a.m.-5 p.m. PT and Saturday from 7 a.m.-11 a.m. PT.

- Medicaid: 1-800-454-3730
- Medicare — Part B: 1-866-797-9884, option 5
- Medicare — Part D: Express Scripts Provider Services 1-800-338-6180*

*Available 24 hours a day, 7 days a week

To request an exception to the formulary, providers can submit a prior authorization request online or use the *Prior Authorization Form*. For nonpreferred medication and medications prescribed outside of FDA labeling, providers must document why other medications are not acceptable by listing other medications tried by the member, adverse effects, inadequate responses, medical necessity and any other explanations. Upon review, the provider may be asked to provide a copy of the member's medical record and/or office notes as substantiation.

Providers can send a request for a prescription coverage determination or an appeal for a Medicare plan by email to medicarepartdparequests@express-scripts.com rather than fax or phone.

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.

What is an advance directive?

Advance directive refers to the verbal and written instructions about an individual's future medical care in the event the individual is unable to express their medical wishes. There are two types of advance directives: a health care directive (or living will) and a durable power of attorney for health care.

A health care directive is a legal document that specifies an individual's wishes regarding the care they receive at the end of life should they be unable to communicate. In Washington, this directive is used if the individual has a terminal condition where life-sustaining treatment would only artificially prolong life or if the individual is in an irreversible coma with no reasonable hope of recovery.

A durable power of attorney for health care is a legal document allowing a person to be named by an individual as a health care agent — someone who is authorized to consent to, stop or refuse most

medical treatment for the individual if a physician determines that the individual cannot make the decision for themselves. When this is put in place, the health care agent speaks on behalf of the individual anytime that person is not able to make their own medical decisions — not only at the end of life. This type of advance directive is also referred to as a health care proxy, appointment of health care agent or a medical power of attorney.

Amerigroup Washington, Inc. and its providers are not required to implement an advance directive as a matter of conscience as long as there is a clear and precise statement of limitation and the state allows such objection. At minimum, the statement must:

- Clarify any differences between Amerigroup conscientious objections and those raised by individual providers
- Identify the state legal authority permitting such objection
- Describe the range of medical conditions or procedures affected by the conscientious objection

Additionally, Amerigroup is not required to provide care that is in conflict with an advance directive. For more information, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Health Care Authority Link4Health

The Health Care Authority (HCA) has become aware of some misinformation that has been circulated regarding certified electronic health records (EHRs), clinical data repository (CDR) requirements and fees. To clear up any confusion, please review the information below:

- If you **do not have** a certified EHR, you are not required to purchase one.
- If you **do have** a certified EHR, you are required to submit to the CDR by February 2017 and are required to pay the annual OneHealthPort subscription fee.

If you do have a certified EHR and are concerned about your ability to pay the annual fee or have other questions about Link4Health, please contact the HCA at healthit@hca.wa.gov for guidance.

Hospital observation service limits

An Amerigroup Amerivantage* Medicare Advantage member's time in observation (and hospital billing) begins with the member's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. The billed units of service should equal the number of hours the patient receives observation services.

Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.

Beginning January 2017, the number of units reported with HCPCS code G0378 (hospital observation service, per hour) must equal or exceed eight hours, but are limited to 72 hours. Observation services

billed outside of these parameters will be denied. This pertains to both contracted and noncontracted providers.

Additional information and discussion regarding hospital observation services can be found in the *Medicare Claims Processing Manual*, Chapter 4 – Part B Hospital, 290.2.2.

*In Washington, Amerigroup Washington, Inc.

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