Provider Newsletter

Amerigroup
District of Columbia

https://providers.amerigroup.com/DC

December 2019

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Availity technical support

In the event that you encounter technical issues within the Availity system, please reach out directly to Availity using one of the methods below:

- Visit https://www.availity.com and select Help & Training > Find Help.
- Call 1-800-AVAILITY (1-800-282-4548) toll free.
- E-mail support@availity.com.

Your Provider Relations representative does not have the ability to troubleshoot issues that are a direct result of Availity, a multi-payer vendor. If the issues experienced are directly related to Amerigroup District of Columbia, Inc., please contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

DC-NL-0255-19

24-hour Nurse HelpLine

Did you know your patients have options when they need care right away? Care after-hours or when your patients can't reach you, the 24-hour Nurse HelpLine can help your patients get the care they need. 24 hours a day, 7 days a week, including holidays, registered nurses are available to help:

- Find a doctor after-hours or on weekends.
- Find an open urgent care center or a walk-in clinic.
- Schedule a visit with a doctor.
- Speak directly with a doctor/staff about their health needs.

To receive 24-hour phone advice from a registered nurse, call the 24-hour Nurse HelpLine at:

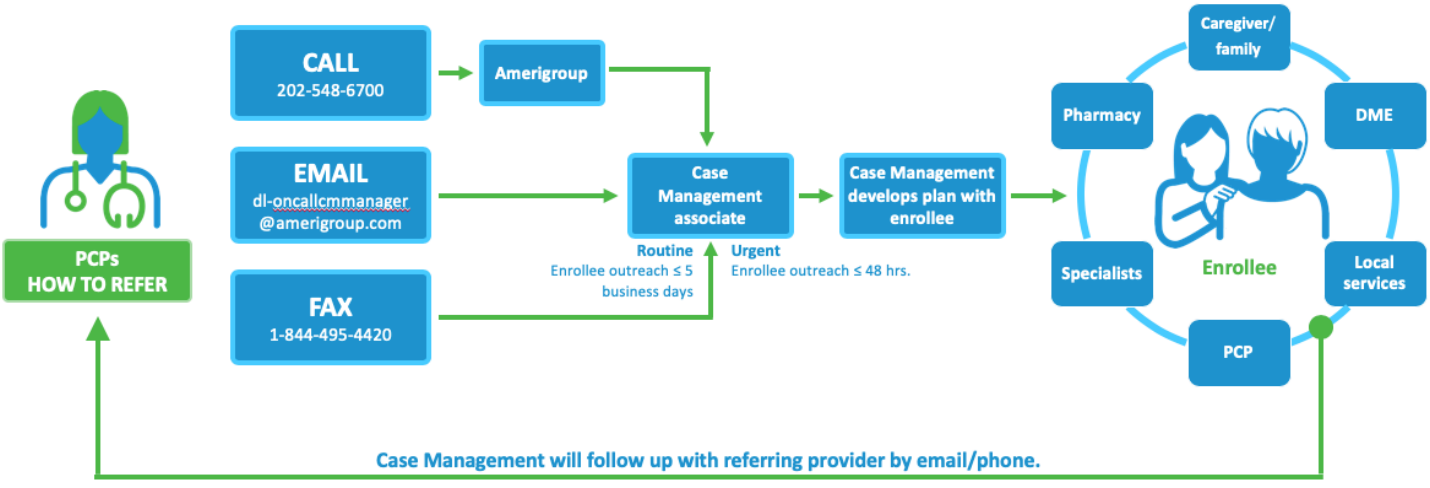
- English: 866-864-2544
- Spanish: 866-684-2545
- TTY: 711

DC-NL-0258-19

Amerigroup District of Columbia, Inc. case management referrals

How can we work together?

1. Refer enrollees who may benefit from case management to us.
2. Our case managers may call you for information, clarification or to coordinate care for an enrollee.
3. Help us prevent readmissions! Enrollees are more likely to avoid readmission if seen by a PCP within seven days of discharge. We ask for your support in accommodating these urgent requests.



DC-NL-0256-19

HEDIS Coding Tips sheet

Amerigroup District of Columbia, Inc. would like to share some helpful HEDIS® coding tips that can reduce the number of medical records we request during HEDIS medical record review, which takes place from January-May each year. Adding these codes to a claim will help us identify additional information about the visit and improve the accuracy of reporting quality measures. Review the *HEDIS Coding Tips* sheet online.

If you need any additional support, please contact Nikura Staves, HEDIS Coordinator, via email at Nikura.Staves@anthem.com or phone at 202-815-1857.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

DC-NL-0179-19

Coding spotlight — provider's guide to coding respiratory diseases

ICD-10-CM coding

Respiratory diseases are classified in categories J00 through J99 in Chapter 10, "Diseases of the Respiratory System" of the *ICD-10-CM Official Guidelines for Coding and Reporting*.

Pneumonia

Pneumonia is coded in several ways in ICD-10-CM. Combination codes that account for both pneumonia and the responsible organism are included in Chapter 1, "Certain Infectious and Parasitic Diseases" and Chapter 10, "Diseases of the Respiratory System." Examples of appropriate codes for pneumonia include:

- J15.0 — pneumonia due to Klebsiella
- J15.211 — pneumonia due to Staphylococcus aureus
- J11.08 + J12.9 — viral pneumonia with influenza.

Read more online.

DC-NL-0261-19

Coding spotlight — provider's guide to coding behavioral and emotional disorders

ICD-10-CM coding

Codes within categories F90-F98 represent behavioral and emotional disorders with onset usually occurring in childhood and adolescence and may be used regardless of the age of the patient.

Attention deficit hyperactivity disorder (ADHD) is among these common childhood disorders. While ADHD is not a learning disability, it can impact the ability to learn. This disorder is characterized by classic symptoms of inattention, hyperactivity and impulsivity. The following subtypes of ADHD have been identified:

- Hyperactive/impulsive type — The patient does not show significant inattention.
- Inattentive type – The patient does not show significant hyperactive-impulsive behavior.
- Combined type – Patient displays both inattentive and hyperactive-impulsive symptoms.
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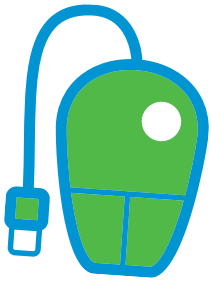
- Inattentive type – The patient does not show significant hyperactive-impulsive behavior.
- Combined type – Patient displays both inattentive and hyperactive-impulsive symptoms.

Read more online.

DC-NL-0186-19

Electronic submission is preferred method for requesting pharmacy prior authorization



Our electronic prior authorization (ePA) process is the preferred method for submitting pharmacy prior authorization requests. The online process is faster and easier to complete, and the response is automatic, which helps patients get their medications sooner. You can complete this process through your current electronic health record/electronic medical record (EHR/EMR) system or via the following ePA sites:

- **Surescripts®:** https://providerportal.surescripts.net/providerportal
- **CoverMyMeds®:** https://www.covermymeds.com/main

Creating an account is free and takes just a few minutes. If you are experiencing any issues or have a question about how the systems operate:

- For questions or issues with accessing the Surescripts portal, call 1-866-797-3239.
- For questions or issues with accessing the CoverMyMeds portal, call 1-866-452-5017.

For questions regarding pharmacy benefits, contact your IngenioRx call center at 1-800-454-3730.

DC-NL-0185-19

Medical drug *Clinical Criteria* updates

July 2019 update

On June 20, 2019, the Pharmacy and Therapeutic (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup District of Columbia, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the *Clinical Criteria* web posting.

DC-NL-0184-19

August 2019 update

On August 16, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Amerigroup District of Columbia, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Effective dates are reflected in the *Clinical Criteria* web posting.

DC-NL-0253-19

The *Clinical Criteria* is publicly available on our provider website under *News & Announcements*. Visit the *linical Criteria* website to search for specific policies.

Please submit your questions to email.

CPT Category II code reimbursements

Effective January 2, 2020, you can earn additional reimbursement on health and wellness services provided to District of Columbia Healthy Families Program enrollees. Amerigroup District of Columbia, Inc. is offering reimbursement for the use of CPT® Category II codes starting in 2019 to encourage continued improvements in member care. The use of CPT Category II codes benefits the health care system by providing more specific information about health care encounters, such as how data can be used to help providers work more efficiently and effectively in the best interest of each enrollee.

Reimbursement for the administrative task of completing and reporting CPT Category II codes can only be claimed once per service, per enrollee, per year; it is earned by completing the criteria for billing the CPT Category II codes listed in *Table 1*.

CPT Category II codes must be billed with one of these outpatient visit codes: 99201-99215.

The additional reimbursement applies to physicians and qualified health care allied practitioners including all primary care providers (PCPs), cardiologists, endocrinologists, pulmonologists, internal medicine, nephrologists, rheumatologists, nurse practitioners, physician assistants and federally qualified health centers.

What is a CPT Category II code?

- A CPT Category II code provides more detailed information about the clinical service(s) performed.
- CPT Category II codes are billed similar to the way your office bills for regular CPT codes and are placed in the same location on the claim form.

Benefits of using CPT Category II codes include:

- A reduction in the need for Amerigroup to review your medical records by providing more detailed information through your claims submissions.
- Better tracking and management of enrollee care needs from the use of detailed information provided with the billing of CPT Category II codes.

Next steps you need to take:

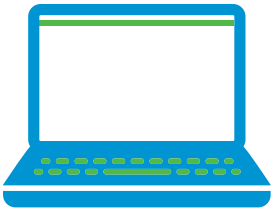
- Review the CPT Category II code billing opportunities in Table 1 and set up your billing system to bill us for the codes when applicable.
- Be sure that you meet the criteria for billing the CPT Category II codes in Table 1 by matching the diagnosis codes and age ranges, and set up your billing system to bill appropriately.

Note: All CPT Category II codes are eligible for payment only once per enrollee, per calendar year. Continuation of payment and payment rates for billing the CPT Category II codes in Table 1 (see next page) will be evaluated annually.

Take advantage of this great revenue opportunity by enhancing your billing processes. Thank you for delivering health and wellness care to our enrollees.

DCPEC-1016-19

Precertification Lookup Tool — easy access to prior authorization guidelines on the Availity Portal



Amerigroup District of Columbia, Inc. has an online tool that displays prior authorization guidelines to help you quickly determine whether certain services for Amerigroup enrollees require a prior authorization.

You can access the Precertification Lookup Tool through the Availity Portal. The Precertification Lookup Tool will let you know if clinical edits apply, information such as the medical necessity criteria used in making the authorization decision and if a vendor is used — without the need to make a phone call.

Where is the Precertification Lookup Tool located on Availity?

Navigate to the Precertification Lookup Tool on the Availity Portal by selecting either 1) **Payer Spaces** or 2) **Patient Registration** from Availity's homepage. You can also reach Availity via phone at 1-800-AVAILITY (1-800-282-4548). Access to the information does not require an Availity role assignment, tax ID or NPI.

Through Availity Payer Spaces:

- Select Amerigroup from the *Payer Spaces* menu.
- Select the **Applications** tab.
- Select the **Precertification Lookup Tool**.

From the Patient Registration menu:

- Select **Authorizations and Referrals**.
- Select the **Precertification Lookup Tool** link located under *Additional Authorizations & Referrals*.

Once you have accessed the Precertification Lookup Tool, choose a line of business from the menu selection offered, then type the CPT®/HCPCS code or a code description to determine if a prior authorization is required.

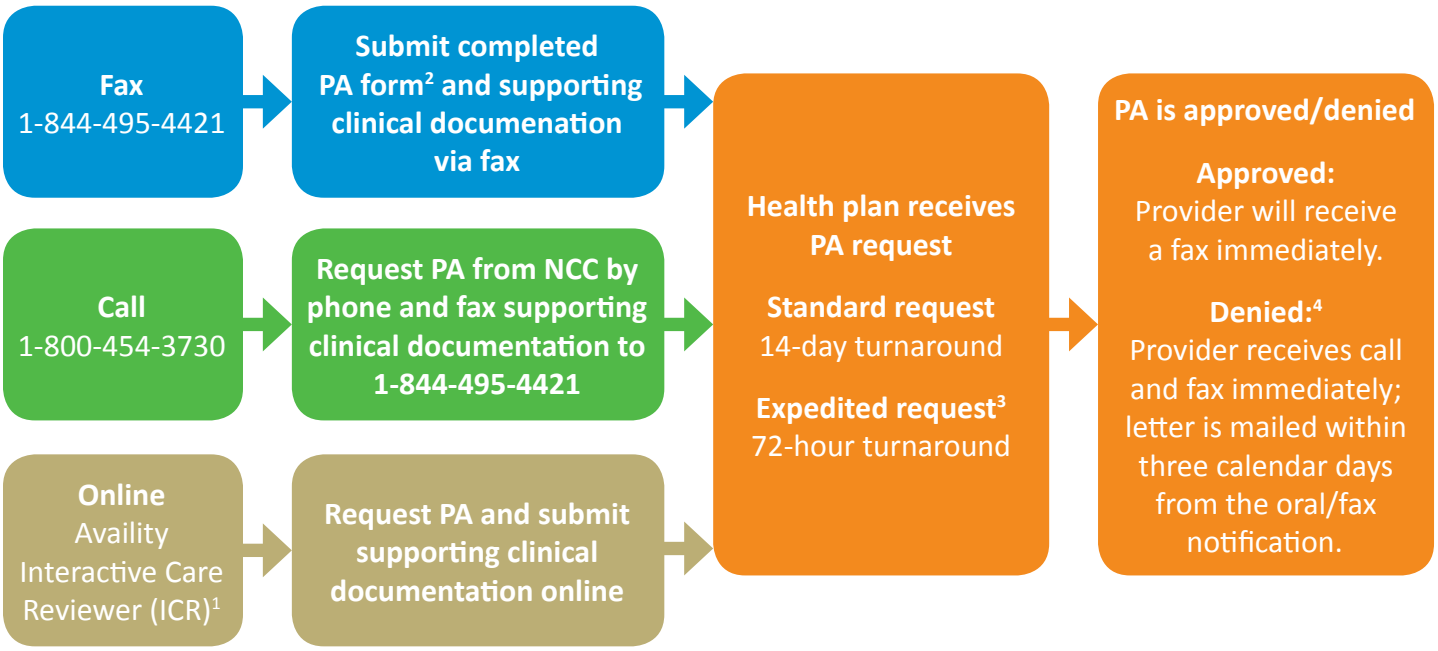
Other ways to access:

If you are currently accessing the Precertification Lookup Tool either through your health plan's public or secure provider portal, those options are still available for you.

DC-NL-0191-19

Outpatient prior authorization process

How to request an outpatient prior authorization (PA):



1. Link to Availity is posted on the provider homepage
2. *Prior Authorization Form* (Provider Home Page > Forms > NCC Prior Authorization Form)
3. Urgent/expedited criteria
   Please note the criteria to qualify for urgent/expedited (NCQA Standards)
   A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:
   - Could seriously jeopardize the life, health or safety of the enrollee or others, due to the enrollee's psychological state
   - In the opinion of a practitioner with knowledge of the enrollee's medical or behavioral condition, would subject the enrollee to adverse health consequences without the care or treatment that is the subject of the request
4. If your request is denied for the following reasons:
   - Medical necessity: Request a peer-to-peer by calling 1-844-421-5656 within 2 business days from the date of the denial
   - Administrative: Call 1-800-454-3730 and mail appeal within 60 days of denial to Payment Dispute Unit, P.O. Box 61599, Virginia Beach, VA 23466-1599

DC-NL-0257-19

Prior authorization (PA) requirements

Global 3M19 Medical Policy and Technology Assessment Committee PA requirement updates

Effective February 1, 2020, PA requirements will change for several services to be covered by Amerigroup District of Columbia, Inc. for our enrollees.

Read more online.

DC-NL-0238-19

Federal and District law, as well as District contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

To request PA, you may use one of the following methods:

- **Web:** https://www.availity.com
- **Phone:** 1-800-454-3730
- **Fax:**
  - **Pharmacy:** 1-800-964-3627
  - **Retail:** 1-844-487-9292]
  - **Medical injectables:** 1-844-487-9294

Not all PA requirements are listed here. Detailed PA requirements are available to providers on our provider website > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool and at https://www.availity.com. Providers may also call Provider Services at 1-800-454-3730 for PA requirements.