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Behavioral health town hall

Introduction

Topics of discussion

- **Documentation**
- **Crisis Intervention**
- **Community Transition Planning Code**
- **Discharge Planning**
- **Psychological Testing**
- **PHP Boarding with Review**
- **Billing, Coding, and Telehealth Guidelines**
- **Formulary Management**
- **HEDIS**
- **Behavior Health and Physical Health Integration**
- **Grievances and Appeals**
- **Social Determinants of Health**

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Documentation

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Documentation

Typical findings in medical records that are reviewed:

- Missing comprehensive assessments
- Missing rating scales, such as child and adolescent functional assessment scale (CAFAS), level of care utilization system (LOCUS) or child and adolescent needs and strengths (CANS)
- Missing member or guardian signatures on individual recovery plan (IRPs)/treatment plans
- Incorrect procedure code was used:
  - Service must meet the service definition requirements.
  - Service documentation should include the procedure code and all necessary modifiers.
  - Identified service is correct but specific procedure code is not supported by documentation.
- G9001 documentation was missing

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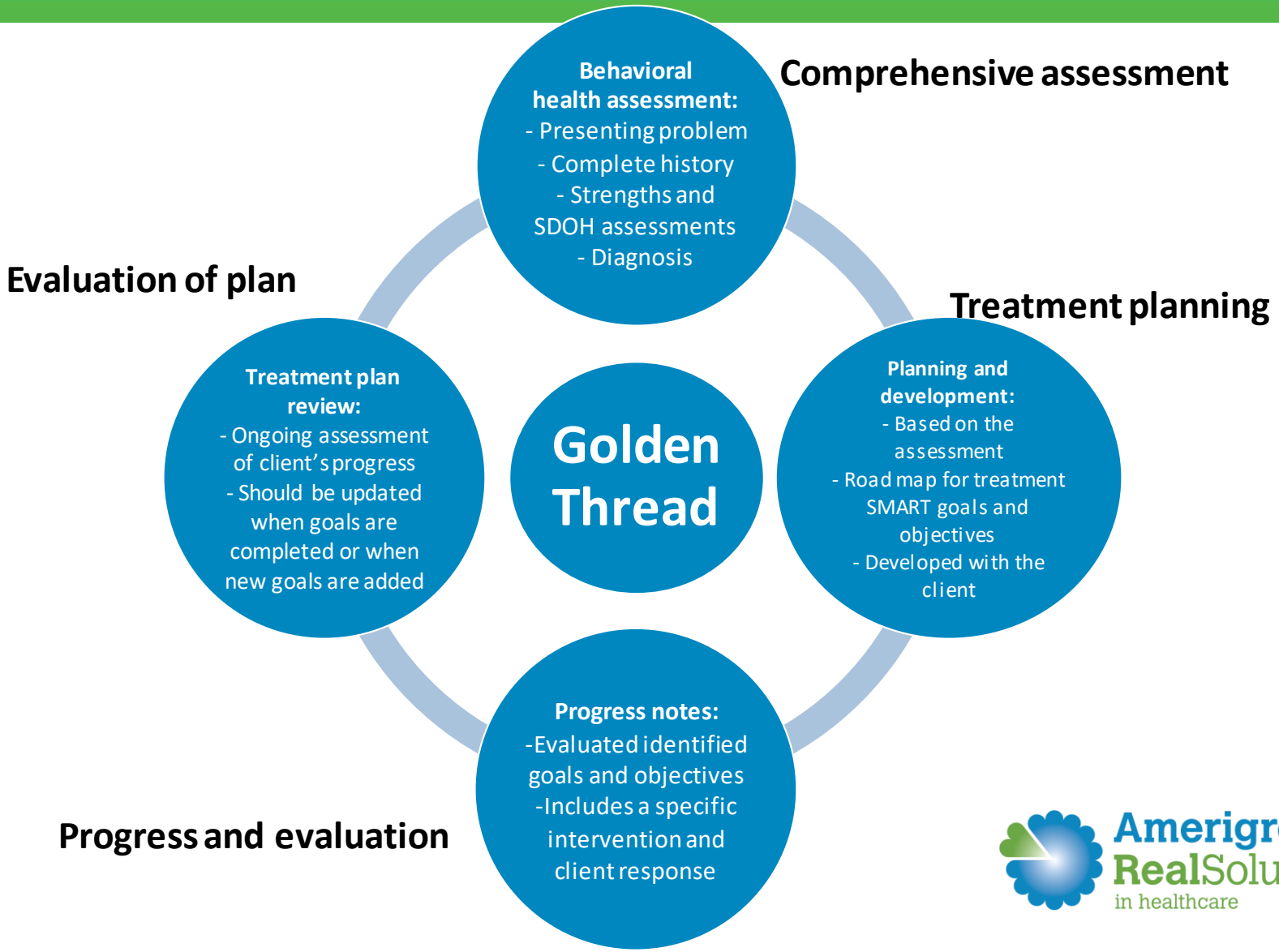
Documentation — the golden thread



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Prior authorization (PA)

- Medical necessity is defined as healthcare services that a medical practitioner provides to a covered individual for the purposes of preventing, evaluating, diagnosing and treating an illness, injury or disease, or symptoms of an illness, injury or disease.

Services rendered by medical practitioners are:

- Performed in accordance with generally accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent and duration.
- Considered effective for the member's conditions.
- Not primarily for the convenience of the member, physician or other healthcare providers.
- Not more costly than alternative services that produce similar or equivalent results for the member's diagnosis or treatment.

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PA (cont.)

Generally accepted standards of medical practice:

- Accepted standards are based on credible scientific evidence published in peer-reviewed medical literature that are generally recognized by the relevant medical community.
- These include recommendations by the National Physician Specialty Society and the views of medical practitioners practicing in relevant clinical areas.

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PA (cont.)

- Services are justified through comprehensive, person-centered, service-related assessments and treatment plans or based on medical necessity
- Reflect interventions (consistent with the level of service) designed to achieve objectives listed in the treatment plan
- The clinical information provided should describe symptoms, behaviors or skill deficits
- The clinical information should properly quantify behavior, progress and demonstrate interventions consistent with the level of service being requested

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Crisis intervention

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Crisis intervention

- Develop crisis or safety planning at enrollment/admission and then implement and update as necessary throughout treatment.
- The member should be a full participant in the safety planning and all crisis stabilization steps should be clearly identified.
- Providers are required to be available for crisis services 24/7 with a crisis response time of two hours.
- The IRP may indicate that the crisis intervention service is provided as needed.
- If crisis intervention is a part of the services outlined in the IRP, it is expected that a crisis plan be developed and in place to direct the crisis service.

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Community transition planning code

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Community transition planning code

Members are at their highest risk when transitioning between levels of care.

- Smooth transition from a hospital setting to a community-based setting is critical. As such, Amerigroup Community Care will now allow outpatient behavioral health providers to bill T2038 in an effort to aid in this transition.
- Effective since January 1, 2021, all outpatient behavioral health providers will be able to bill T2038 (community transition planning) while assisting members in transitioning from an inpatient level of care.

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Community transition planning code (cont.)

- Inpatient levels of care include acute psychiatric facilities, crisis stabilization units (CSUs) and psychiatric residential treatment facilities (PRTFs).
- The code is a 15-minute unit.
- There will be a maximum of eight units billable in a day.
- At least one billable session must occur face-to-face with the member. This can include services being rendered via telehealth capacities (Zoom, etc.).
- The goal is to help the facility link members to the outpatient provider's services and to orient the member to that provider before discharge. If a member is not already connected to an outpatient provider, this code will allow the referred provider to engage the member before discharge.
- As this is not a required code for care management organizations, Amerigroup will be closely tracking utilization and outcomes.

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Discharge planning

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Discharge planning

- Planning for the member's discharge from treatment should be discussed as part of the initial treatment plan.
- At the time of discharge, a discharge summary should be shared with the member/guardian to indicate services and treatment provided as well as necessary plans for referral.
- Progress notes should outline how interventions help the member progress toward reaching the goal or outcomes targeted for discharge.

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Psychological testing

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Psychological testing

- Licensed clinical providers must request a PA and receive approval before a psychologist renders psychological testing services.
- Determination of medical necessity and PA for psychological testing is made using InterQual® criteria, effective on January, 2, 2020.
- A peer-to-peer review is available to the provider as part of the PA process.

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Psychological testing (cont.)

- When billing for psychological testing, providers should bill the appropriate code that pertains to the testing component administered for the corresponding time on the date of service.
- **For example:**
  - Test evaluation services by a psychologist — 96130, 96131
  - Test administration and scoring by a psychologist — 96136, 96137
  - Test administration and scoring by a technician — 96138, 96139
  - Test administration and scoring via electronic platform — 96146
- Providers should bill the codes and units specific to each date of service over the span of testing, not billing all codes and units on the last date of testing.

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Psychological testing (cont.)

Psychological testing is not considered medically necessary when it is being used:

- For educational or vocational services.
- As part of annual or regular checkups.
- To determine placement or admission to non-medical programs.
- As part of a non-medical, court-ordered test.

Psychological testing is not considered medically necessary when:

- Diagnosis, symptoms or behaviors do not suggest the need for testing.
- Testing is being used to evaluate suspected attention deficit and/or hyperactivity disorder.
- Similar testing has been performed in the last 12 months, subject to individual case consideration.

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Psychological testing (cont.)

Examples of applicable uses of psychological testing:

- When a member has been treated for a condition, but has not made improvements and there is a need for additional diagnostic clarification.
- Differentiating between organic and psychogenic conditions.
- Clarifying a diagnosis after the provider has completed a thorough clinical assessment, obtained data from other sources (for example, family, collateral contacts and medical records), and administered questionnaires or rating scales.

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Psychological testing (cont.)

Example: In a child with a primary diagnosis of ADHD and disturbances in mood and behavior:

- Learning disorders have been ruled out by testing at school
- Behavior rating scales conducted by provider have mixed or unclear findings
- Child has been treated with various medications and behavioral treatment without improvement
- PCP requests testing to aid in clarifying diagnosis and to shape treatment planning

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PHP with boarding program overview

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What is PHP?

- PHP is an acronym for **P**artial **H**ospitalization **P**rogram. PHP is designed to provide members dealing with mental, emotional or substance use disorders with coordinated, intensive and comprehensive treatment.
- PHP provides group/individual/family therapy sessions in a very structured, organized and intimate manner.
- Members meet with an MD for medication adjustment at least once weekly
- PHP is five to seven days a week and is usually from 9 a.m. to 3 p.m.

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PHP with boarding program overview

- PHP with boarding is designed to meet the needs of adolescents who are clinically appropriate for a PHP program, but lack secure transportation and/or housing necessary close to a PHP.
- PHP with boarding is five to seven days per week;
  - However, members can go home on weekend passes as appropriate and/or necessary.
- Boarding ensures that members and their families are able to focus on treatment as opposed to further socioeconomic stressors.

PHP with boarding program overview (cont.)

Level of care rationale/criteria:

- The member has relapsed or failed to make significant clinical gains in a less intensive level of care; **or**
- Less intensive levels of care are judged insufficient to provide the treatment necessary; **or**
- The member is ready for discharge from an inpatient setting, but is judged to be in continued need of ongoing intensive therapeutic interventions, daily monitoring and support that cannot be provided in a less intensive level of care

PHP with boarding — Pilot Program

- Amerigroup has entered a joint collaboration with Ridgeview and DFCS to offer a PHP with boarding Pilot Program, which started on June 22, 2020.
- Amerigroup has weekly treatment team meetings with Ridgeview and DFCS to discuss progress of each member.
- Members can admit directly to PHP or be admitted as a step down from inpatient or PRTF at any facility.
- Boarding is available at Ridgeview for adolescents between the ages of 12 to 17 who require the clinical advantage of PHP but are unable to be in their home environment or live too far from a PHP in their area.
- Programming includes therapy, medication management, daily group therapy, weekly individual therapy and weekly family therapy with guardians. The therapeutic residences include three meals, a home like environment, healthy activity alternatives and close supervision. Teachers are also onsite to coordinate with schools and guidance counselors.

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Goals of PHP with boarding

- Having PHP with boarding ensures that our members are placed in the most appropriate level of care regardless of socioeconomic and state access barriers
- Minimize the number of youth placed in an inappropriate setting due to placement concerns
- PHP with boarding provides a directed, individualized, intensive level of treatment without long stays away from the community
- Pilot provides the framework necessary to offer this as an opportunity to partner with other hospitals to increase asses to PHP with boarding throughout the state

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Billing, coding and telehealth guidelines

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Billing code reminders

Individual practitioners:

- Providers should only bill for services they have directly rendered and may not bill for any services rendered by another provider or by an unlicensed individual under their supervision
- Coding and billing of each service rendered should be done in conjunction with the appropriate modifier specific to provider licensure:
  - **M.D.: no modifier**
  - **NP and APRN: SA**
  - **Ph.D. and Psy.D.: HP**
  - **LCSW, LMFT and LPC: HO**

Billing code reminders (cont.)

Community providers (CORE, IFI, CSB):

- Providers must use the appropriate POS code applicable to the location of the service rendered:
  - POS 99 is only to be used in instances where there is no other appropriate code that applies to the rendering location.
  - Coding and billing of each service rendered should be done in conjunction with the appropriate practitioner level modifier specific to the provider's level of licensure
  - Evaluation and Management (E&M) services should only be billed by providers who hold a medical licensure (for example, M.D., N.P., P.A., APRN) and can only be billed for sessions that are medically focused; non-medical sessions provided by a lower level provider should not be billed as an E&M service
  - POS 53 should not be used by community providers as this is a facility place of service code specific to Community Mental Health Centers

E&M — Selecting Level of Service (LOS)

Components for accurately selecting the level of service using revised criteria:

- Effective January 1, 2021, history and exam will no longer make up two of the three components needed in selecting the level of service.
- Instead, E&M levels will be determined by:
  - Medical decision making (MDM) or
  - Time only, regardless of whether more than half of the visit was comprised of counseling.

2021 Center for Medicare & Medicaid Services (CMS) E&M code changes

The American Medical Association (AMA) implemented major changes to the 2021 Current Procedural (CPT®) code set in an effort to simplify coding and documentation of office visits and other outpatient Evaluation and Management (E&M) services in these areas:

- Extensive E&M guideline additions, revisions, and restructuring
- Deletion of CPT code 99201 (due to low utilization)
- Revision of CPT codes 99202-99215
- Components for code selection: MDM and Time
- Revisions to Appendix C

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2021 E&M CPT code updates — Community Behavioral Health Rehab Services (CBHRS) providers

- In accordance with 2021 changes proposed by the AMA and globally adopted by the CMS, Department of Behavioral Health and Developmental Disabilities (DBHDD) and Department of Community Health (DCH) revised codes and reimbursement for CBHRS providers.
- Information on the CPT and rate updates can be found in Appendix C of the CBHRS manual on GAMMIS site: https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Community%20Behavioral%20Health%20Rehabilitation%20Services_%20202012301 40433.pdf
- Additional information on changes to services for E&M codes can be viewed in the DBHDD Provider Manual for Community Behavioral Health Providers located at: https://dbhdd.georgia.gov/be-connected/community-provider-manuals.

Telehealth

Originating site:

- An **originating site** is the **location of the eligible Medicaid member** at the time the service is delivered via a ***HIPAA-compliant*** telecommunications system.
  - Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS® code Q3014.

Distant site:

- A **distant site** is the site where **the physician or practitioner providing the professional service is located** at the time the service is delivered via a telecommunications system.
  - Telemedicine services provided by the **distant site** provider must be billed with the appropriate CPT and/or HCPCS codes, GT modifier, and with the point of service (POS) code 02 to indicate telehealth services.

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Telehealth

- Providers must use an interactive audio and video telecommunications system that permits real time communication between the provider, at the distant site, and the member, at the originating site.
- All interactive video telecommunications must comply with *HIPAA* patient privacy regulations at the site where the member is located, the site where the consulting provider is located and in the transmission process.
- Use of the GT modifier indicates real-time telehealth services are provided by audio and video systems, not by telephone unless the code description or regulatory guidelines support the service can be provided by phone.

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Common billing practices

- Family therapy is billable once per member per day:
  - 90846 and 90847 are not separately reimbursable for the same member on the same date of service.
  - Family therapy is not separately reimbursable for each member of the same family on the same date of service
- Interactive complexity should be used appropriately according to standard guidelines:
  - Billed only in conjunction with appropriate psychiatric services.
  - Used only with respect to difficulties experienced rendering services — not time.
  - Documented in the medical record specifying the difficulties that led to the utilization of the code.
  - Interactive complexity is not to be used in conjunction with all psychiatric services.

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Common billing practices

- Psychotherapy add-on with E&M:
  - The psychotherapy add-on codes with E&M are:
    - 90833 — 30 minutes.
    - 90836 — 45 minutes.
  - These add-on codes are to be used to bill for distinct psychotherapy services provided by a medical provider (MD) in conjunction with an E&M visit.
  - Providers must document a distinct start and stop time for the psychotherapy service.
  - The time billed for the psychotherapy service does not include the time spent providing the E&M service.

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Formulary management

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Formulary management

Preferred Drug List (PDL):

- The *PDL* consists of preferred drugs within the most commonly prescribed therapeutic categories.
  - Based on mandatory generic use whenever available unless otherwise specified.
- The *PDL* is updated every quarter and communicated to our providers by:
  - Blast fax.
  - Posting on the provider website at https://provider.amerigroup.com/georgia-provider/communications/news-and-announcements.
  - Provider Relations representative at on-site visits.
- The *PDL* with information on additional requirements and limitations, such as prior authorization, quantity limits, age limits, or step therapy can be found on the website at https://provider.amerigroup.com/agp/pages/quicktools/formularycaid.html.
- Providers can use real-time prescription benefit functionality, which is a tool supported by Surescripts®* integrated within the e-prescribing process to check formulary status, available alternatives, and PA or step edit requirements.

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Formulary management (cont.)

Pharmacy PA:

- When a member cannot use a preferred product because of failure, contraindication or intolerance, providers are required to submit a PA before sending the prescription to the retail or specialty pharmacy.
- PAs are required for the use of any antipsychotic agent in children age 17 and under to encourage appropriate use in accordance with the FDA-approved or medically accepted indications.
- PA requests may be submitted in three ways:
  1. Electronically (for example, ePA) through www.covermymeds.com*
  2. Faxing the completed form to **1-844-490-4736** (for drugs under pharmacy benefit) or to **1-844-490-4870** (for drugs under medical benefit)
  3. Calling the PA Center at **1-833-293-0659** (Monday to Friday 7 a.m. to 11 p.m., Saturday to Sunday 8 a.m. to 6 p.m.) or Provider Services at **1-800-454-3730** (Monday to Friday 8 a.m. to 8 p.m., Saturday 10 a.m. to 2 p.m.)
- Pharmacy PA requests are processed within 24 hours of receipt or up to 72 hours if additional information is needed.

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Formulary management (cont.)

Pharmacy PA (cont.):

- PA decisions are based on medical necessity for the following circumstances:
  - Drugs not listed on the *PDL*
  - Brand-name products for which there are therapeutically equivalent generic products available
  - Drugs that require specific *Clinical Criteria*
  - Drugs that exceed certain quantity limits
- In an emergency situation, Amerigroup allows coverage for a three-day (72-hour) supply of certain eligible outpatient prescription drugs before a PA decision is rendered.
- When a patient with an approved PA for a drug is admitted to an inpatient facility:
  - If discharged on the same medication, a new PA **is not** required.
  - If discharged on a different dosage strength or frequency (within established criteria or quantity limits), a new PA **is not** required.
  - If discharged on a different dosage form (for example, tablet to IM or tablet to suspension), a new PA **is** required.
  - If a PA is needed, providers should submitted it **prior to** discharging patients from an inpatient facility.

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Formulary management (cont.)

Pharmacy Peer-to-Peer (P2P) consults:

- When a PA has been denied, providers may request a pharmacy P2P consult to review the decision with a pharmacist and provide additional clinical information to support overturning the denial.
- Providers should contact the PA Center directly at **1-833-293-0659**, option 2 to leave a voicemail to request a P2P:
  - Standard P2P requests will be responded to within 24 to 72 business hours.
  - Urgent P2P requests will be responded to within 24 business hours.
- Pharmacy P2P requests cannot be submitted by email.
- The P2P process cannot be initiated once a PA denial has been appealed (for example, filed or completed).

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HEDIS measures

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HEDIS

- What is HEDIS?
  - Created and administered by the National Committee for Quality Assurance (NCQA) to measure performance on care and service.
  - A comprehensive set of performance measures designed to provide purchasers and consumers with the information they need to compare health plan performance.
  - Relates to many significant public health issues, such as behavioral health, heart disease, asthma and diabetes.
  - Data can be utilized to identify opportunities for improvement and monitor the success of quality improvement initiatives.

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HEDIS measures

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- Antidepressant Medication Management (AMM)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

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Metabolic monitoring for children and adolescents on antipsychotics (APM)

- Description: Children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions dispensed and had metabolic testing (blood glucose and cholesterol)
- Measurement year: January 1 to December 31
- Performed by: any provider type

- *Note: The American Academy of Child and Adolescent Psychiatry guidelines recommend metabolic monitoring, including monitoring of glucose and cholesterol levels, for children and adolescents on antipsychotic medications.*

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Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- Members 18 to 64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Measurement year: January 1 to December 31
- Performed by: any provider type

Note: People being treated with antipsychotics are at increased risk of developing diabetes. Periodic screening allows for early identification and treatment of diabetes.

Note: If the screening indicates the member is diabetic, the member should be monitored and/or referred for diabetes care.

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Antidepressant Medication Management (AMM)

- Members 18 years of age and older with a diagnosis of major depression who were treated with an antidepressant medication and remained on an antidepressant medication for the following treatment periods:
  - Effective acute phase treatment: at least 84 days (12 weeks)
  - Effective continuation phase treatment: at least 180 days (six months)
- Performed by: any provider type
- *Note: The treatment period is the number of calendar days that the member is covered with prescriptions. Consider writing a 60-day supply of antidepressant medications.*

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Follow-Up After Hospitalization for Mental Illness (FUH)

- The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
- Two rates are reported:
  - The percentage of discharges for which the member received follow-up care **within seven days of discharge**
  - The percentage of discharges for which the member received follow-up care within 30 days of discharge
- Performed by: a mental health provider
- *Note: Visits that occur on the date of discharge do **not** count as a follow-up visit for this measure.*

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Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse/Dependence (FUA)

- The percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:
  - The percentage of ED visits for which the member received follow-up within **seven days of the ED visit** (8 total days).
  - The percentage of ED visits for which the member received follow-up within **30 days of the ED visit** (31 total days).
- Performed by: any provider type
- *Note: Visits that occur on the date of the ED visit* **do** *count as a follow-up visit for this measure. Follow-up visits must be billed with a principal diagnosis of AOD abuse or dependence to count for compliance*

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Follow-Up After Emergency Department Visit for Mental Health (FUM)

- This HEDIS measure looks at emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:
  - The percentage of ED visits for which the member received follow-up within **seven days of the ED visit** (8 total days).
  - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- Performed by: any provider type
- *Note: Visits that occur on the date of the ED visit **do** count as a follow-up visit for this measure. Follow-up visits must be billed with a principal diagnosis of a mental health disorder or with an intentional self-harm and mental health disorder to count for compliance*

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HEDIS provider office and health plan roles

- Health plan role:
  - Provide education on quality performance measures, applicable billing codes, and health plan initiatives
  - Provide individualized reports of patients who are due or overdue for services
  - Provide convenient ways to submit medical records and/or data
  - Share quality performance and results, best practices and helpful tips
  - Work with providers to evaluate their performance and customize a plan specific to the office

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HEDIS provider office and health plan roles (cont.)

- Provider office role:
  - Understand quality performance measures and process
  - Review data and resources provided
  - Use results and feedback to improve performance
  - Ensure accuracy in proper coding and report services timely
  - Ensure medical record documentation is complete
  - Comply with returning medical records requests timely

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What are we doing?

- Ongoing interdepartmental workgroups to review data and discuss initiatives as well as opportunities for improvement, if applicable
- Case rounds to discuss member care, resources, etc.
- Solicit feedback from members, providers, and/or community partners:
  - Medical Advisory Committee (provider forum)
  - Health Education Advisory Committee (member forum that includes providers and/or community partners)
  - 1:1 Provider meetings
  - CAHPS® Surveys
- Offer case management/disease management programs to members
- Offer member/provider incentive programs

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What are we doing?

- Provide educational materials/resources to members (Ameritips, gap in care letters, etc.)
- Ongoing provider notifications and/or education:
  - Provider town halls
  - Newsletters
  - Blast Faxes
  - Provider portal:
    - Quality Reporting and Performance Measures booklet (HEDIS booklet)
    - Clinical practice guidelines
- Provider Reporting:
  - Gap in care reports, letters, etc.
  - Provider performance reports/scorecards

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Behavioral health and physical health integration

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Provider responsibilities

- Identification of high-risk or high-need members for referral
- Communication of inappropriate ER usage
- Communication of hospital discharge upon notification
- Documentation and sharing of care coordination documents
- Communication of barriers and roadblocks between providers to ensure efficient and effective care coordination

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Co-management

- Establishing treatment responsibilities for each provider
- Medication management collaboration and communication:
  - Consults
  - EMR sharing
- Referrals to each other and to outside providers
- Sharing of crisis and safety plans
- Identification and addressing of care gaps:
  - Diabetes management
  - High blood pressure
  - Dental
  - Pediatric and adolescent wellness

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Provider communication

- Items that will be communicated between the providers:
  - Intake and assessment integrated summary
  - Life transition
  - Crisis
  - Medication
- Methods of communication:
  - Care coordination forms
  - EMR interface
  - Dedication referral coordinators
- Frequency of communication
- Response time

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Member communication

- Clarification of the roles each provider will play in their care
- Appointment scheduling assistance
- Relevant test results
- Self-management skills
- Member consent

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Grievances and appeals

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Grievances

- A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination (denial of an authorization).
- This could include, but is not limited to, the following examples of dissatisfaction from members:
  - Rudeness of a provider or an employee
  - Difficulty filling a medication
  - Quality of care
  - Difficulty finding a provider
  - Received incorrect information from an employee

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How are grievances filed?

- Grievances may be filed verbally or in writing
- Grievances are filed verbally by contacting the member services team at **1-800-600-4441**
- Grievances are filed in writing by mailing to the address below:
  - Amerigroup Community Care

    Appeals and Grievances

    740 West Peachtree Street NW

    Atlanta, GA 30308-1199

    Fax: **1-877-842-7183**
- Members may submit a grievance at any time after the issue occurs

Grievance process

Once a grievance is received, the G&A representative completes the following tasks:

- Contact the member to clarify the nature of their concern
- Send an acknowledgment letter to the member within 10 business days of receipt
- Act as a liaison on behalf of the member to resolve the grievance. May include contacting the pharmacy department, provider relations, vendors, etc.
- Resolve the grievance within 90 calendar days of receipt and document all interactions with the member
- Send member a resolution letter that includes the outcome of the grievance

Appeals

- An appeal is defined as a request for a review of an adverse benefit determination (denied authorization)

The types of appeal requests may include but are not limited to:

- Pharmacy.
- Behavioral health.
- Radiology services.
- Outpatient services.
- Dental.

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Appeals process

- Members may file appeals verbally or in writing
- Providers may also file appeals via the website https://provider.amerigroup.com/ga
- Appeals filed verbally by contacting the member services team at **1-800-600-4441**.
- Appeals filed in writing by submitting to the address below:
  - Amerigroup Community Care

    Appeals

    P.O. Box 62429

    Virginia Beach, VA 23466-2429
- Members may submit an appeal within 60 days of the date on the Adverse Benefit Determination notice (denial letter)

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Appeals Process

Once an appeal is received, the appeals team completes the following tasks:

- Send an acknowledgment letter to the member within 10 business days of receipt
- Request additional clinical information from the member/provider
- Complete a medical necessity review and make a recommendation to the Medical Director
- The Medical Director makes the final determination within 30 calendar days for standard appeals and 72 hours for expedited appeals
- The appeals nurse ensures that the Medical Director assigned to review the appeal was not involved in the initial determination and has a similar specialty as the requesting provider
- Send member a resolution letter that includes the rationale for the appeal decision

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Social Determinants of Health (SDOH)

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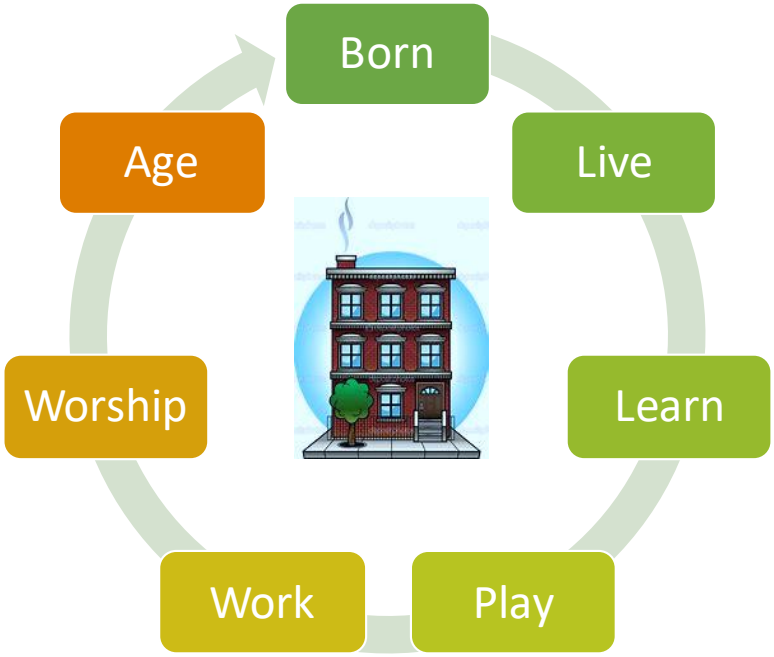
Introduction to SDOH

SDOH are:

- Conditions in which people are born, live, learn, play, work, worship and age.
- Circumstances shaped by distribution of money, power and resources at global, national and local levels.
- Responsible for health inequities, which are avoidable differences in health status seen within and between groups.



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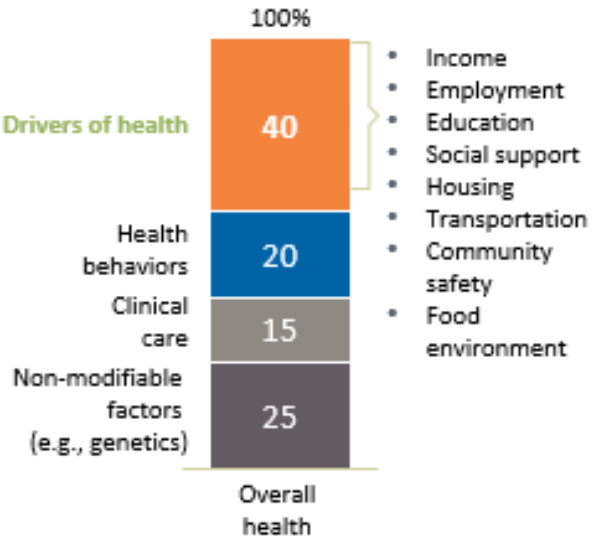
Impact of SDOH

Social determinants, or "drivers of health" are **the conditions in which people are born, grow, work, live, and age**[1]

Academic research indicates that these drivers of health contribute to health status



These social drivers can have negative or positive effects on health

1 World Health Organization

SOURCE: RWJF County Health Rankings, Humana Bold Goals, MassHealth, Lyft Blog

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SDOH five key areas

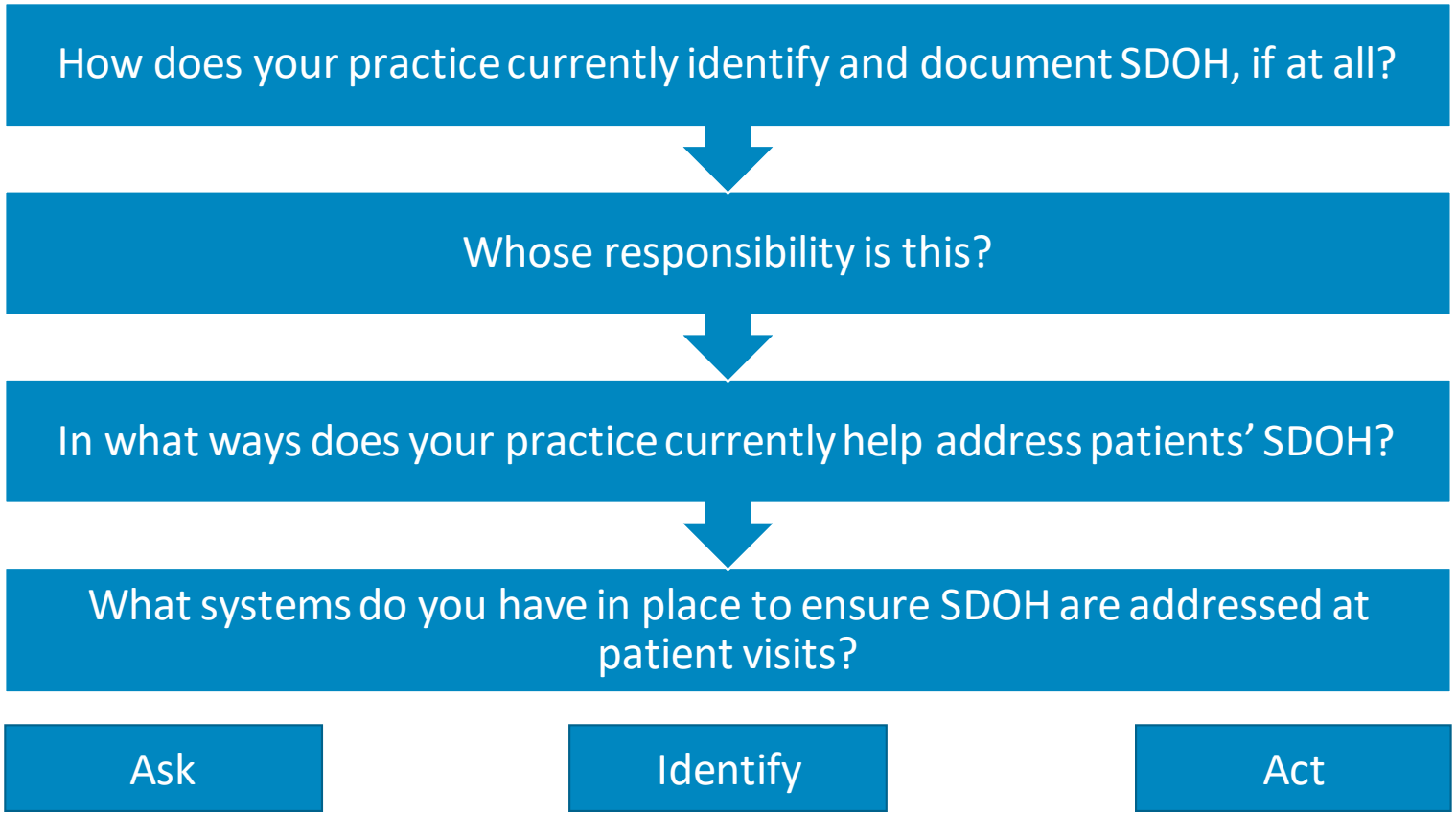
- Factors that influence health and outcomes include:

Economic stability	Education	Social and community context	Health and healthcare	Neighborhood and built environment
Employment	Early childhood education and development	Civic participation	Access to healthcare	Access to healthy food
Food security	High school education/graduation	Discrimination	Access to primary care	Crime and violence
Housing stability	Enrollment in higher education	Incarceration	Health literacy	Environmental conditions
Poverty	Language and literacy	Social integration		Quality of housing

https://www.cdc.gov/nchs/data/hpdata2020/HP2020MCR-C39-SDOH.pdf

Addressing SDOH in behavioral health

What is your practice's approach to SDOH?



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Screening tools

Accountable Health Communities Screening Tool	• CMS developed • 10-item screening tool to identify patient needs in five domains (food security, housing, transportation, utility and safety) • Designed to be short, accessible, consistent and inclusive
The PRAPARE Tool	• Set of national core measures • Aligns with national initiatives prioritizing SDOH (Health People 2020) • Emphasizes measures that are actionable • Templates exist for eClinicalWorks, Epic, GE Centricity and NextGen
Health Leads	• 10-item screening tool • Updated language to foster meaningful/effective dialogue between providers/patients around essential needs • Fully translated questionnaire template to remove barriers for Spanish-speaking patient populations

https://healthleadsusa.org/resources/the-health-leads-screening-toolkit

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Documentation and coding for SDOH (cont.)

ICD-10-CM code examples:

Economic stability

- Z59.4 — Lack of adequate food and safe drinking water
- Z59.5 — Extreme poverty
- Z59.6 — Low income

Education

- Z55.0 — Illiteracy and low level literacy
- Z55.1 — Schooling unavailable and unattainable
- Z55.2 — Failed school examinations

Social and community context

- Z60.2 — Problems related to living alone
- Z62.21 — Child in welfare custody
- Z63.4 — Disappearance and death of family member

Health and healthcare

- Z75.3 — Unavailability and inaccessibility of health care facilities
- Z75.4 — Unavailability and inaccessibility of other helping agencies

Neighborhood and built environment

- Z59.0 — Homelessness
- Z59.1 — Inadequate housing
- Z65.1 — Imprisonment and other incarceration

- These codes are found in *Chapter 21* of the ICD-10-CM code set.
- They are acceptable to be billed just like any other diagnosis code.
- The medical record documentation should support all codes reported on the claim.

How you can help — next steps

- Implement/maintain a team-based approach to addressing SDOH.
- Assess opportunities where your staff/resources/workflows could better address SDOH.

- Leverage SDOH screening tools.
  - Accountable Health Communities Screening Tool

- Familiarize team with local health department and statewide resources that address SDOH.

- Establish/maintain workflows for referring patients to SDOH resources in the community/case management.

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How you can help — next steps (cont.)

- Refer eligible members to case management or care coordination.
- Guide members to the Aunt Bertha* website.
- Tell members to contact the customer care line to learn about value-added benefits including:
  - Transportation
  - Taking Care of Baby and Me® program
  - Personalized wellness programs

https://provider.amerigroup.com/docs/gpp/GA_CAID_ProviderManual.pdf?v=202012182324

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*CoverMyMeds® is an independent company providing prior authorization services on behalf of Amerigroup Community Care. Surescripts® is an independent company providing e-prescribing services on behalf of Amerigroup Community Care. Aunt Bertha is an independent company providing referral platform services on behalf of Amerigroup Community Care.