Amerigroup Washington, Inc.
Apple Health | Foundational Community Supports
Amerigroup Amerivantage (Medicare Advantage)

Amerigroup

Provider News | December 2022

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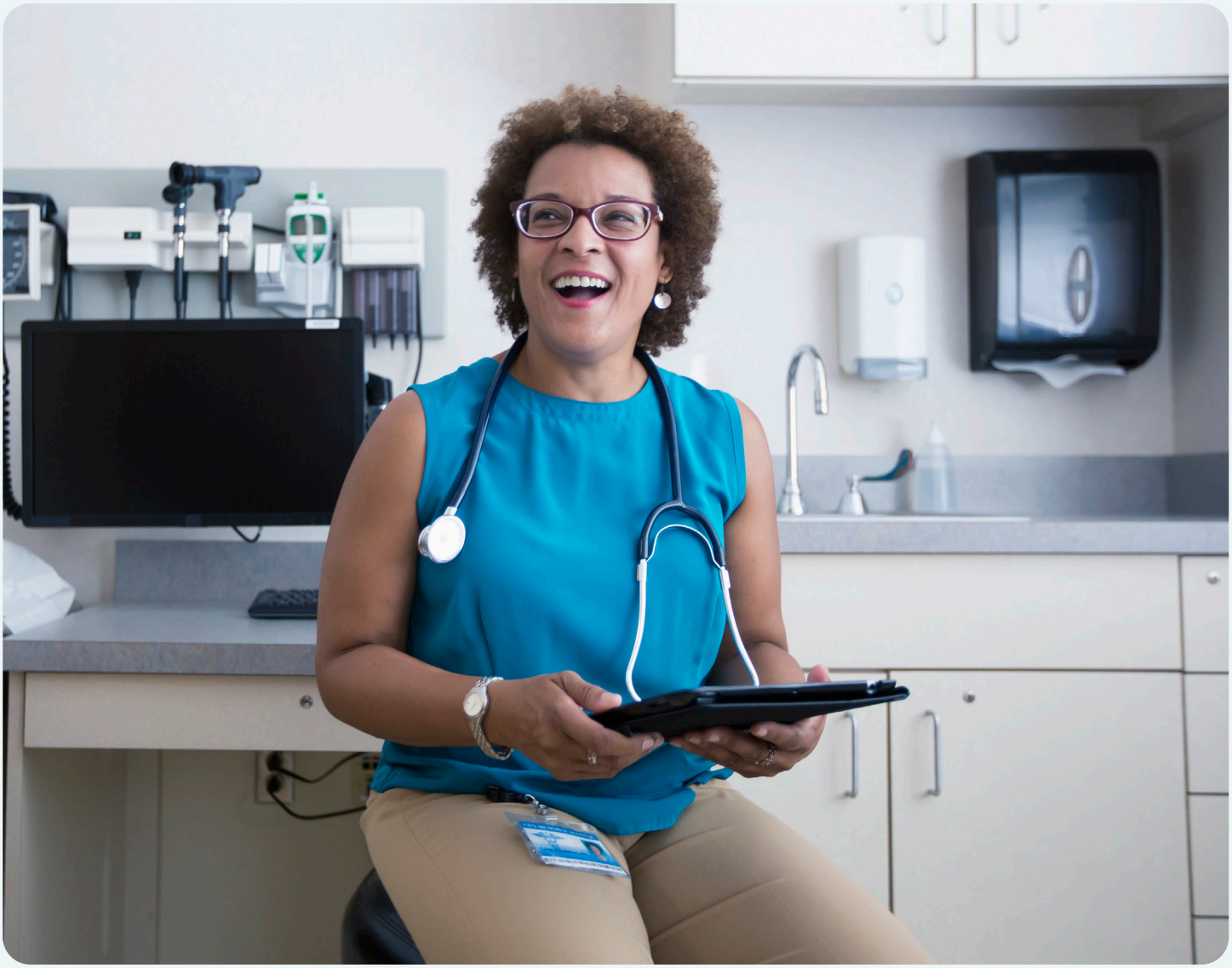
Submit your information to us using the QR code to the left or click **here**.

Coverage provided by Amerigroup Inc.
WAAGP-CDCR-012110-22



Contact Us

If you have questions or need assistance, visit the *Contact Us* section at the bottom of our provider website for up-to-date contact information and self-service tools or call Provider Services.

Provider website:

- **https://provider.amerigroup.com/WA**

Provider Services:

- Medicaid: **800-454-3730**
- Medicare Advantage: **866-805-4589**

Administrative

Medicare Advantage

2023 Medicare Advantage service area and benefit updates

An overview of notable 2023 benefit changes and service area updates are now available **online**. Please continue to check **https://provider.amerigroup.com** for the latest Medicare Advantage information.

MULTI-AGP-CR-010756-22-CPN10053/WAAGP-CR-012226-22-CPN10053

Medicare Advantage

Personal home helper benefit ending

Navigating the complexities and nuances associated with the COVID-19 pandemic requires frequent review of benefits and their impacts to our member's social drivers of health. In recent evaluations, significant challenges have been identified by many agencies supporting our personal home helper benefit.

These nationwide impacts have led to many members unable to use the benefit to its fullest capacity. Therefore, effective January 1, 2023, the personal home helper benefit will no longer be offered within any Medicare individual plans offered by Amerigroup Washington, Inc. Members have been notified via their *Annual Notice of Change*. Improving the life of our members is our focus and, while this change is difficult, Amerigroup will make best efforts to identify other resources for members or benefits to enhance their quality of life.

Please direct any member concerns or questions to the member services number on the back of their card.

MULTI-AGP-CR-011947-22-CPN11945

Medicaid

Update to the *Pregnancy Notification Form*

Amerigroup Washington, Inc. is excited to share that we have recently made an update to our *Pregnancy Notification Form*, which will allow us to gather additional information. This information will provide Amerigroup with important details about a member's conditions that are not easily garnered from claims alone. The information you provide on the *Pregnancy Notification Form*, as well as the health information that we are able to leverage via claims and authorizations, will allow Amerigroup to better identify pregnant members with high risk factors so that we can provide timely and comprehensive care management.

The *Pregnancy Notification Form* is available on the Amerigroup Washington, Inc. **provider website** > Resources > Forms under the Maternal Child Services section for easy access and will replace any existing pregnancy notification form you are currently using.

You may also download the form **online**.

If you have questions, please contact Provider Services at **800-454-3730** or your OB Practice Consultant.

WAAGP-CD-008832-22

Medicaid

Network providers must be in active status in ProviderOne

The Health Care Authority (HCA) has announced that they will begin rejecting encounters for providers who are not in active status in ProviderOne. Effective January 1, 2022, Amerigroup Washington, Inc. will begin rejecting claims for providers who are not in active status with the HCA. If you are not in active status, contact the HCA at provider enrollment@hca.wa.gov or **800-562-3022, extension 16137**.

As a reminder, providers cannot bill the client unless the client was informed prior to receiving services that the provider is not an active Apple Health provider. The client must agree to receive and pay for the services, and this agreement must be documented in the client's record.

Visit **https://bit.ly/3CZU5BT** to read the FAQ for Medicaid requirements for ordering, prescribing, and referring providers to assist your network. If you have further questions, email the HCA at mailbox hcamcprograms@hca.wa.gov with Provider not in Active Status in the subject line.

WAAGP-CD-004377-22/WAAGP-CD-009298-22

Medicaid

Roster submission to provider demographics/data team

When submitting a roster to the provider demographics/data team, we kindly request that only additions, changes, and terminations are submitted. This will prevent the potential opportunity for any possible additional provider records being created when not necessary. Additions, changes, and terminations can be emailed directly to the provider demographics/data team at waopsrequest@amerigroup.com.

WAAGP-CD-009989-22

Signature requirements for laboratory orders or requisitions

Amerigroup Washington, Inc. strives to ensure our providers understand documentation compliance, and we are committed to educating our providers in hopes of eliminating errors in documentation practices. It is a best practice and industry standard that physicians sign and date laboratory orders or requisitions.

Although the provider signature is not required on laboratory requisitions, if signed and dated, the requisition will serve as acceptable documentation of a physician order for the testing and so it is strongly encouraged. In the absence of a signed requisition, documentation of your intent to order each laboratory test must be included in the patient's medical record and available to Amerigroup upon request. Documentation must accurately describe the individual tests ordered; it is not sufficient to state "labs ordered."

Amerigroup will consider laboratory order or requisition requirements met with one of the following:

- A signed order or requisition listing the specific test(s)
- An unsigned order or requisition listing the specific test(s), and an authenticated medical record supporting the physician's intent to order the test(s)
- An authenticated medical record (for example, office notes or progress notes) supporting the physician's intent to order the specific test(s)

Attestation statements are not acceptable for unsigned physician order or requisitions. Signature stamps are not acceptable.

References:

- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf**
- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf**
- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html#BloodCount**
- **Title 42 CFR §410.32**
- *Documentation Standards for Episodes of Care – Professional Administrative*

WAAGP-CDCR-005970-22-CPN5368

Policy Updates

Medicaid | Medicare Advantage

Medical drug benefit *Clinical Criteria* updates

June 2022 update

On May 20, 2022, and June 23, 2022, the Pharmacy and Therapeutic (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised, or reviewed to support clinical coding edits.

Medicaid

Read more online.

WAAGP-CD-006363-22

Medicare Advantage

Read more online.

MULTI-AGP-CR-006365-22-CPN5937

Visit the ***Clinical Criteria* website** to search for specific policies. If you have questions or would like additional information, reach out via **email**.

Medicaid

Prior authorization updates for medications billed under the medical benefit

Effective for dates of service on and after January 1, 2023, the following medication codes billed on medical claims from current or new *Clinical Criteria* documents will require prior authorization.

Please note, inclusion of a national drug code on your medical claim is necessary for claim processing.

Visit the ***Clinical Criteria* website** to search for the specific *Clinical Criteria* listed below.

Note: Prior authorization requests for certain medications may require additional documentation to determine medical necessity.

Clinical Criteria	HCPCS or CPT® code(s)	Drug name
ING-CC-0205	J9331	Fyarro (sirolimus albumin bound)
ING-CC-0206	J3490, J3590	BESREMi (ropeginterferon alfa-2b-njft)
ING-CC-0207	J9332	Vyvgart (efgartigimod alfa-fcab)

WAAGP-CAID-002123-22

Clinical Criteria	HCPCS or CPT® code(s)	Drug name
ING-CC-0072	C9097	Vabysmo (faricimab-svoa)

WAAGP-CD-008133-22-CPN7504

Medicaid

Prior authorization requirement changes

Effective February 1, 2023, prior authorization (PA) requirements will change for several code(s). The medical code(s) listed will require PA by Amerigroup Washington, Inc. for Amerigroup members.

Read more online.

WAAGP-CD-005339-22-CPN4725 | UM AROW 3350

Medicaid | Medicare Advantage

Medical Policies and *Clinical Utilization Management Guidelines* update

The *Medical Policies, Clinical Utilization Management (UM) Guidelines, and Third-Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed.

To view a guideline, visit **https://provider.amerigroup.com/washington-provider/medical-policies-and-clinical-guidelines**.

Notes/updates

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive:

- DME.00046 — Intermittent Abdominal Pressure Ventilation Devices:
  - Intermittent abdominal pressure ventilation devices are considered investigational & not medically necessary for all indications
- DME.00047 — Rehabilitative Devices with Remote Monitoring:
  - The use of rehabilitative devices with remote monitoring or adjustment capabilities (for example, ROMTech PortableConnect® and ROMTech AccuAngle®) is considered investigational & not medically necessary for all indications
- DME.00048 — Virtual Reality-Assisted Therapy Systems:
  - Use of virtual reality systems (for example, EaseVRx, SootheVR, and RelieVR) for screening, diagnosis, or treatment of a health condition is considered investigational & not medically necessary for all indications
- GENE.00059 — Hybrid Personalized Molecular Residual Disease Testing for Cancer:
  - Oncologic hybrid personalized molecular residual disease (MRD) tests are considered investigational & not medically necessary for all indications
- LAB.00048 — Pain Management Biomarker Analysis:
  - The functional pain biomarker urine test panel is considered investigational & not medically necessary for chronic pain management and for all other indications
- MED.00139 — Electrical Impedance Scanning for Cancer Detection:
  - Electrical impedance scanning for cancer detection is considered investigational & not medically necessary for all indications
- TRANS.00039 — Portable Normothermic Organ Perfusion Systems:
  - Outlines the medically necessary and investigational & not medically necessary criteria for Portable Normothermic Organ Perfusion Systems
- CG-MED-90 — Chelation Therapy:
  - Moved content of MED.00127 Chelation Therapy to new clinical UM guideline document with the same title
- CG-SURG-61 — Cryosurgical, Radiofrequency or Laser Ablation to Treat Solid Tumors Outside the Liver:
  - Removed the reference to glomerular filtration rate from the radiofrequency and cryosurgical ablation treatment of renal cancer
  - Added the term metastatic to the radiofrequency ablation treatment of metastatic lung cancer to clarify extra-pulmonary disease
  - Added not medically necessary statement for laser ablation therapy
  - Removed examples from the cryosurgical and radiofrequency ablation not medically necessary statements
- GENE.00023 — Gene Expression Profiling of Melanomas and Cutaneous Squamous Cell Carcinoma:
  - Expanded Scope and Position Statement to include cutaneous squamous cell carcinoma

Medical Policies and *Clinical Utilization Management Guidelines* update (cont.)

Medicaid:

Medical Policies

On May 12, 2022, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup Washington, Inc. These guidelines take effect December 20, 2022.

Clinical UM Guidelines

On May 12, 2022, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines adopted by the Medical Operations Committee for Medicaid members on June 23, 2022. These guidelines take effect December 20, 2022.

Read more online.

WAAGP-CD-006085-22-CPN5614

Medicare Advantage:

Medical Policies

On May 12, 2022, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup Washington, Inc. These guidelines take effect November 20, 2022.

Clinical UM Guidelines

On May 12, 2022, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines adopted by the Medical Operations Committee for Medicare members on June 23, 2022. These guidelines take effect November 20, 2022.

Read more online.

MULTI-AGP-CR-006086-22-CPN5614

Medicaid | Medicare Advantage

AIM Specialty Health Cardiology *Clinical Appropriateness Guidelines* CPT Code List update

Effective for dates of service on and after February 1, 2023, the following code updates will apply to the AIM Specialty Health®* diagnostic coronary angiography and the percutaneous coronary intervention *Clinical Appropriateness Guidelines*.

Read more online.

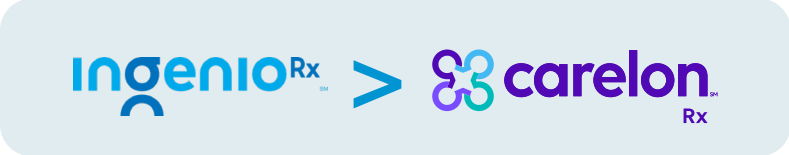
**AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc.*

WAAGP-CDCR-008156-22-CPN7092

Medicaid | Medicare Advantage

IngenioRx will become CarelonRx, Inc. on January 1, 2023

Our pharmacy benefit management partner, IngenioRx,* will join the Carelon family of companies and change its name to CarelonRx, Inc. on January 1, 2023.



This change will not affect the ways in which CarelonRx, Inc. will do business with care providers and there will be no impact or changes to the prior authorization process, how claims are processed, or level of support.

If your patients are having their medications filled through IngenioRx's home delivery and specialty pharmacies, please take note of the following information:

- IngenioRx Home Delivery Pharmacy will become CarelonRx Mail.
- IngenioRx Specialty Pharmacy will become CarelonRx Specialty Pharmacy.

These are name changes only and will not impact patients' benefits, coverage, or how their medications are filled. Your patients will not need new prescriptions for medicine they currently take.

When e-prescribing orders to our mail and specialty pharmacies:

- Prescribers will need to choose **CarelonRx Mail or CarelonRx Specialty Pharmacy, not IngenioRx,** if searching by name.
- If searching by NPI (National Provider Identifier), the **NPI will not change.**

In addition to our mail and specialty pharmacies, your patients can continue to have their prescriptions filled at any in-network retail pharmacy.

Keeping you well informed is essential and remains our top priority. We will continue to provide updates prior to January and throughout 2023.

** IngenioRx, Inc./CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Amerigroup Washington, Inc.*

WAAGP-CDCR-005486-22/WAAGP-CDCR-013085-22

Medicaid

HEDIS spotlight — preventive services and screenings for women

As providers and managed care organizations (MCOs), we are in a crucial position to encourage women to complete recommended preventive services and screenings to help maintain a healthy lifestyle and minimize any health risks. These screenings give ample opportunity for providers to appropriately evaluate and counsel women based on age and risk factors.

Cervical Cancer Screening (CCS)

HEDIS® definition

The percentage of women 24 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 24 to 64 years of age who had cervical cytology performed within the last three years. If no cervical cytology in this time frame, then one of the two options below is tested:
  - Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
  - Women 30 to 64 years of age who had cervical cytology/hrHPV co-testing within the last five years.

Documentation tips

Measurement period	**Hybrid measure:** ■ Both administrative data and medical record reviews are used for scoring. ■ The denominator is obtained from members in the 24 to 64 age group as of December 31 of the measurement year with a look back to age 21.
Record your efforts	**Make sure the medical records reflect:** ■ The date when the cervical cytology was performed. ■ The results or findings. ■ Documentation in patient's chart if the patient has a history of hysterectomy by completing details if it was a complete, total or radical abdominal or vaginal hysterectomy with no residual cervix; also, document history of cervical agenesis or acquired absence of cervix. Include, at a minimum, the year the surgical procedure was performed. ■ Mandatory exception = palliative care or members using hospice services anytime during the measurement year. ■ Hysterectomy exceptions that apply anytime during the member's history through December 31 of the measurement year: ■ Evidence of hysterectomy with no residual cervix ■ Complete, total, or radical hysterectomy (abdominal or vaginal or unspecified) ■ Hysterectomy plus vaginal Pap smear ■ Vaginal hysterectomy ■ Documentation of hysterectomy and Pap smear is no longer required

Helpful tips:

- Discuss the importance of well-woman exams, mammograms, Pap tests, and HPV testing with all female members between ages 21 to 64 years.
- Be a champion in promoting women's health by reminding them of the importance of annual wellness visits.
- Refer member to another appropriate provider if your office does not perform Pap tests and request copies of Pap test/HPV co-testing results be sent to your office.
- Talk to your Amerigroup Washington, Inc. Provider Experience associate to determine if a health screening clinic day has been scheduled in your community. Amerigroup may be able to help plan, implement and evaluate events for a particular preventive screening, like a cervical cancer screening or a complete comprehensive women's health screening event (only if this is offered in your practice area).
- Train your staff on the use of educational materials to promote cervical cancer screening.
- Use a tracking mechanism (for example, EMR flags and/or manual tracking tool) to identify members due for cervical cancer screening.
- Display posters and educational messages in treatment rooms and waiting areas to help motivate members to initiate discussions with you about screening.
- Train your staff on preventive screenings or find out if we provide training.
- If using an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Amerigroup Provider Experience associate for additional details and questions.

How can Amerigroup help?

We help you get Amerigroup members this critical service by:

- Offering you access to our *Clinical Practice Guidelines* on our provider self-service website.
- Coordinating with you to plan and focus on improving health awareness for our members by providing health screenings, activities, materials, and resources if available or as needed.
- Educating members on the importance of cervical cancer screening through various sources, such as phone calls, post cards, newsletters, and health education fliers if available.
- Members are eligible for transportation assistance at no cost, contact Member Services for arrangement.

Coding

Description	CPT®/HCPCS/LOINC/ICD-10
Cervical cytology lab test	**CPT:** 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-GO145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
hrHPV lab test	**CPT:** 87624, 87625 **HCPCS:** G0476 **LOINC:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3
Absence of cervix diagnosis	**ICD-10-CM:** Q51.5, Z90.710, Z90.712
Hysterectomy with no residual cervix	CPT: 51925, 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956 **ICD-10-PCS:** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

Breast Cancer Screening (BCS)

HEDIS® definition

The percentage of women 52 to 74 years of age who had a mammogram or a digital breast tomosynthesis to screen for breast cancer:

- The denominator includes women who were 52 to 74 years of age as of December 31 of the measurement year.
- The measure is looking for one or more mammograms or digital breast tomosynthesis screenings any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Documentation tips to meet HEDIS requirements

- This is an administrative measure not requiring medical record review.
- Biopsies, MRIs, and ultrasounds do not count for this measure as they are diagnostic and not screening procedures.
- If using an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Provider Experience associate for additional details and questions.
- Reach out to members to schedule screenings prior to their annual exam visits.
- Include a schedule for breast screening on a preventive medicine chart in the medical record.
- If breast screening is done by another provider, request a copy of the test.
- Discuss the need for testing with patients.
- Ask about patient's previous experiences to determine likelihood of complying with testing.
- Consider implementing standing orders for breast cancer screening.

Record your efforts	Include documentation of all types and methods of mammograms including: ■ Screening. ■ Diagnostic. ■ Film. ■ Digital. ■ Digital breast tomosynthesis. In establishing health history with new members, please make sure you ask about when the member's last mammogram was performed, document year performed in the member's health history.
Exclusions	■ Member using hospice services anytime during the measurement year. ■ Members receiving palliative care. ■ Women who had a bilateral mastectomy or unilateral mastectomy with a bilateral modifier (must be from the same procedure).

Coding

Description	CPT/LOINC
Mammography and digital breast tomosynthesis	■ **CPT:** 77061-76063, 77065-77067 ■ **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0

HEDIS spotlight (cont.)

Coding	
Description	**CPT/LOINC**
Online assessments	■ **CPT:** 98970, 98971, 98972, 99421, 99422, 99423, 99457 ■ **HCPCS:** G0071, G2010, G2012
Telephone visits	■ **CPT:** 98966, 98967, 98968, 99441, 99442, 99443

Note: The Logical Observation Identifier Names and Codes (LOINC) are for reporting clinical observations and laboratory testing.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY 2022 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

WAAGP-CD-004261-22

HEDIS spotlight — diabetes measures

This month there is going to be a focus on diabetes measures. Diabetes can affect almost every part of the body. With the help of the healthcare team, we want to promote and help our members live a healthy life with diabetes. Adhering to medications, attending the necessary appointments, and providing education can help prevent or delay serious diabetes complications such as heart disease, kidney disease, and vision loss.

Eye Exam for Patient With Diabetes (EED)

HEDIS® definition	
This HEDIS measure evaluated the percentage of members 18 to 75 years of age with diabetes (types 1 and 2) who received a retinal eye exam.	
Documentation tips	
Measurement period	■ A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. ■ A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. ■ Bilateral eye enucleation at any time during the member's history through December 31 of the measurement year.
Exclusions	■ Members who do not have a diagnosis of diabetes. ■ Members in hospice or using hospice services anytime during the measurement year. ■ Members receiving palliative care.

Helpful tips	■ Make sure to document the required documentation for compliance: Date, correct provider type, and retinopathy result.
	■ If your practice uses electronic medical records (EMRs), have flags or reminders set in the system to alert your staff when a patient's screening is due.
	■ Follow up on lab test results, eye exam results, or any specialist referral and document on your chart.
	■ Refer members to the network of eye providers for their annual diabetic eye exam.
	■ Remember to include the applicable Category II reporting code on the claim form to help reduce the burden of HEDIS medical record review.
	■ If using an EMR system, consider electronic data sharing with your health plan to capture all coded elements. Contact your Provider Experience associate for additional details and questions.
	■ Educate your members and their families, caregivers, and guardians on diabetes care, including:
	  ■ Taking all prescribed medications as directed.
	  ■ Adding regular exercise to daily activities.
	  ■ Having a diabetic eye exam each year with an eye care provider.
	  ■ Regularly monitoring blood sugar and blood pressure at home.
	  ■ Maintaining a healthy weight and ideal body mass index.
	  ■ Eating heart-healthy, low-calorie, and low-fat foods.
	  ■ Stopping smoking and avoiding second-hand smoke.
	  ■ Keeping all medical appointments; getting help with scheduling necessary appointments, screenings, and tests to improve compliance.

Documentation tips (cont.)	
How we can help	■ Supplying copies of educational resources on diabetes that may be available for your office. ■ Members are eligible for transportation assistance at no cost. Contact Member Services at **800-600-4441** for arrangement.
Coding	
Description	**CPT/HCPCS**
Unilateral eye enucleation left	■ **ICD-10-PCS:** 08T1XZZ
Unilateral eye enucleation right	■ **ICD-10-PCS:** 08T0XZZ
Diabetic retinal screenings	■ **CPT:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 ■ **HCPCS**: S0620, S0621, S3000
Diabetic retinal screening negative in the prior year	■ **CPT-CAT II:** 3072F
An eye exam with evidence of retinopathy	■ **CPT-CAT II:** 2022F, 2024F, 2026F
An eye exam without evidence of retinopathy	■ **CPT-CAT II:** 2023F, 2025F, 2033F

Hemoglobin A1c Control for Patients With Diabetes (HBD)

HEDIS® definition
This measure evaluated the percentage of members 18 to 75 years of age with diabetes (type 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: ■ HbA1c control (< 8%) ■ HbA1c poor control (> 9%)

Documentation tips	
Record your efforts	■ Document the date with which the HbA1c test was performed and the result.
Exclusions	■ Members who do not have a diagnosis of diabetes. ■ Members in hospice or using hospice services anytime during the measurement year. ■ Members receiving palliative care.
Helpful tips	■ Follow up on lab test results and document them on your chart. ■ Draw labs in your office if accessible or refer members to a local lab for screenings.
Coding	
Services	**CPT/HCPCS/LOINC**
HbA1c level greater than 9	■ **CPT-CAT II:** 3046F

Coding	
Services	**CPT/HCPCS/LOINC**
HbA1c level less than 7	■ **CPT-CAT II:** 3044F
HbA1c level greater than or equal to 7 or less than 8	■ **CPT-CAT II:** 3051F
HbA1c level greater than or equal to 8 or less than 9	■ **CPT-CAT II:** 3052F
HbA1c tests results or findings	■ **CPT-CAT II:** 3044F, 3046F, 3051F, 3052F
HbA1c lab test	■ **CPT:** 83036, 83037 ■ **LOINC:** 17856-6, 4548-4, 4549-2
Online assessments	■ **CPT:** 98970, 98971, 98972, 99421, 99422, 99423, 99457 ■ **HCPCS:** G0071, G2010, G2012
Telephone visits	■ **CPT:** 98966, 98967, 98968, 99441, 99442, 99443

Kidney Health Evaluation for Patients With Diabetes (KED)

HEDIS® definition

Members 40 to 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.

Two rates are reported:

- Received statin therapy: members who were dispensed at least one statin medication of any intensity during the measurement year.
- Statin Adherence 80%: members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Documentation tips		
Record your efforts	■ Document review of continued use of prescribed medications during member visits. ■ Document evidence of exclusion criteria.	
Exclusions	■ CABG ■ MI ■ PCI ■ Other revascularization procedures ■ Ischemic vascular disease (IVD) ■ Pregnancy ■ Polycystic ovarian syndrome ■ In vitro fertilization ■ Prescription for clomiphene ■ ESRD	■ Cirrhosis ■ Myalgia, myositis, myopathy or rhabdomyolysis ■ Members age 66 and older who meet both frailty and advanced illness criteria ■ Members receiving palliative care ■ Members in hospice or using hospice services anytime during the measurement year.

HEDIS spotlight (cont.)

Coding	
Services	**CPT/HCPCS/ICD-10**
Online assessments	■ **CPT:** 98970, 98971, 98972, 99421, 99422, 99423, 99457 ■ **HCPCS:** G0071, G2010, G2012
Telephone visits	■ **CPT:** 98966, 98967, 98968, 99441, 99422
Diabetes	■ **ICD-10:** E10.10-11, E10.21-22, E10.29, E10.311, E10.319, E10.321, E10.3211-E10.3213, E10.3219, E10.329, E10.3291, E10.3292, E10.3293, E10.3299, E10.331, E10.3311-E10.3313, E10.3319, E10.339, E10.3391-E10.3393, E10.3399, E10.341, E10.3411-3413, E10.3419, E10.349, E10.3491-E10.3493, E10.3499, E10.351, E10.3511-E10.3513, E10.3519, E10.3521-E10.3523, E10.3529, E10.3531-E10.3533, E10.3539, E10.3541-E10.3543, E10.3549, E10.3551-E10.3553, E10.3559, E10.359, E10.3591-E10.3593, E10.3599, E10.36, E10.37X1-E10.37X3, E10.37X9, E10.39-E10.44, E10.49, E10.51-E10.52, E10.59, E10.610, E10.618, E10.620-E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00-E11.01, E11.10-E11.11, E11.21-E11.22, E11.29, E11.311, E11.319, E11.321, E11.3211-E11.3213, E11.3219, E11.329, E11.3291-E11.3293, E11.3299, E11.331, E11.3311-E11.3313, E11.3319, E11.339, E11.3391-E11.3393, E11.3399, E11.341, E11.3411-E11.3413, E11.3419, E11.349, E11.3491-E11.3493, E11.3499, E11.351, E11.3511-E11.3513, E11.3519, E11.3521-E11.3523, E11.3529, E11.3531-E11.3533, E11.3539, E11.3541-E11.3543, E11.3549, E11.3551-E.11.3553, E11.3559, E11.359-E11.3593, E11.3599, E11.36, E11.37X1-E11.37X3, E11.37X9, E11.39-44, E11.49, E11.51-52, E11.59, E11.610, E11.618, E11.620-22, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21-22, E13.29, E13.311, E13.319, E13.321, E13.3211-E13.3213, E13.3219, E13.329, E13.3291-E13.3293, E13.3299, E13.331, E13.3311-E13.3313, E13.3319, E13.339, E13.3391-E13.3393, E13.3399, E13.341, E13.3411-E13.3413, E13.3419, E13.349, E13.3491-E13.3493, E13.3499, E13.351, E13.3511-E13.3513, E13.3519, E13.3521-E13.3523, E13.3529, E13.3531-E13.3533, E13.3539, E13.3541-E13.3543, E13.3549, E13.3551-E13.3553, E13.3559, E13.359, E13.3591-E13.3593, E13.3599, E13.36, E13.37X1-E13.37X3, E13.37X9, E13.39, E13.40, E13.41-44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620-22, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011-024.013, O24.019, O24.02, O24.03, O24.111-113, O24.119, O24.12, O24.13, O24.311-313, O24.319, O24.32, O24.33, O24.811-813, O24.819, O24.82, O24.83

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The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS MY 2022 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.

WAAGP-CD-006528-22

Medicaid

Dental spotlight

Topical fluoride application

HEDIS® definition	
Members 0 to 18 years of age are eligible for covered dental-related preventive services, including but not limited to prophylaxis treatment with the use of topical fluoride treatment.	
Treatment	

Topical fluoride treatment	This treatment is covered per client, per provider, or clinic:
	■ Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, three times within a 12-month period with a minimum of 110 days between applications for clients:
	  ■ Age six and younger
	  ■ During orthodontic treatment
	■ Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, two times within a 12-month period with a minimum of 170 days between applications for clients:
	  ■ From age seven through 18; or
	  ■ Of any age residing in alternate living facilities or nursing facilities.
	■ Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients ages 19 and older, once within a 12-month period.
	■ Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
	■ Topical fluoride treatment for clients of the developmental disabilities administration of DSHS according to WAC 182-535-1099.

Coding	
Services	**CPT®/CDT**
Topical fluoride	■ **CPT:** 99188 ■ **CDT:** D1206, D1208, D1354

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WAAGP-CD-006732-22

HEDIS spotlight — Respiratory Conditions Appropriate Testing for Pharyngitis and Pharmacotherapy Management of COPD Exacerbation

Appropriate Testing for Pharyngitis (CWP)

HEDIS® definition

The percentage of episodes for members 3 years and older, where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode

- Intake period: a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year
- Episode date: The date of service for any outpatient, telephone, observation, or emergency department (ED) visit, e-visit, or virtual check-in during the intake period with a diagnosis of pharyngitis

Documentation tips

Requirements	■ **Negative medication history** — a period of 30 days prior to the episode date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug, or no prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date ■ **Negative comorbid condition history** — a period of 12 months prior to and including the episode date when the member had no claims/encounters with any diagnosis for a comorbid condition ■ **Negative competing diagnosis** — the episode date and three days following the episode date when the member had no claims/encounters with a competing diagnosis
Exclusion	■ Do not include visits that result in an inpatient stay. ■ Members in hospice or using hospice services anytime during the measurement year.

Record your efforts	■ Document results of all strep tests or refusal for testing in medical record.
	■ If antibiotics are prescribed for another condition, ensure accurate coding and documentation will associate the antibiotic with the appropriate diagnosis.
	■ If a patient tests negative for group A strep, but insists on an antibiotic:
	  ■ Refer to the illness as a sore throat due to a cold; members tend to associate the label with a less-frequent need for antibiotics.
	  ■ Write a prescription for symptom relief, such as over-the counter medications.
	■ Educate members on the difference between bacterial and viral infections. This is the key point in the success of this measure. Use CDC handouts or education tools as needed.
	■ Discuss with members ways to treat symptoms:
	  ■ Get extra rest.
	  ■ Drink plenty of fluids.
	  ■ Use over-the-counter medications.
	  ■ Use the cool-mist vaporizer and nasal spray for congestion.
	  ■ Eat ice chips or use throat spray/lozenges for sore throats.
	■ Educate members and their parents or caregivers that they can prevent infection by:
	  ■ Washing hands frequently.
	  ■ Disinfecting toys.
	  ■ Keeping the child out of school or day care for at least 24 hours until antibiotics have been taken and symptoms have improved.
	■ If utilizing an electronic medical records (EMR) system, consider electronic data sharing with Amerigroup Washington, Inc. to capture all coded elements. Contact your Provider Experience representative for additional details and questions.

Coding:	
Description	**CPT®/HCPCS/ICD-10/ LOINC**
Pharyngitis	■ **ICD-10:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
Group A streptococcal tests	■ **CPT:** 87070, 87071, 87081, 87430, 87650-87652, 87880 ■ **LOINC:** 11268-0, 17656-0, 17898-8, 18481-2, 31971-5, 49610-9, 5036-9, 60489-2, 626-2, 6557-3, 6558-1, 6559-9, 68954-7, 78012-2
Online assessments	■ **CPT:** 98970, 98971, 98972, 99421, 99422, 99423, 99457 ■ HCPCS: G0071, G2010, G2012
Telephone visits	■ **CPT:** 98966, 98967, 98968, 99441, 99442, 99443

Pharmacotherapy Management of COPD Exacerbation (PCE)

HEDIS® definition

The percentage of chronic obstructive pulmonary disease (COPD) exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year, and who were dispensed appropriate medications — Two rates are reported:

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Systemic corticosteroid medications		
Glucocorticoids	■ Cortisone ■ Hydrocortisone ■ Prednisolone	■ Dexamethasone ■ Methylprednisolone ■ Prednisone
Bronchodilator medications		
Anticholinergic agents	■ Aclidinium bromide ■ Ipratropium	■ Tiotropium ■ Umeclidinium
Beta 2-agonists	■ Albuterol ■ Arformoterol ■ Formoterol ■ Indacaterol	■ Levalbuterol ■ Metaproterenol ■ Olodaterol ■ Salmeterol
Bronchodilator combinations	■ Albuterol-ipratropium ■ Budesonide-formoterol ■ Fluticasone-salmeterol ■ Fluticasone-vilanterol ■ Fluticasone furoate-umeclidinium-vilanterol	■ Formoterol-aclidinium ■ Formoterol-glycopyrrolate ■ Formoterol-mometasone ■ Glycopyrrolate-indacaterol ■ Olodaterol-tiotropium ■ Umeclidinium-vilanterol

HEDIS spotlight (cont.)

Measure tips	
Best practices	■ Provide members with a prescription for a bronchodilator and systemic corticosteroid following an emergency department visit or inpatient discharge for COPD. ■ Follow up with members to make sure any new prescriptions are filled post-discharge. ■ Educate members on the importance of getting their prescriptions filled and remaining compliant. ■ Members with active prescriptions for these medications are administratively compliant with the measure. ■ An active prescription is one that's noted as having available medication left in the "days' supply" through the episode date or further. ■ The "episode date" for an acute inpatient stay is the admission date. ■ The "episode date" for the emergency department visit is the date of service.

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