Provider Newsletter

Summit COMMUNITY CARE

https://www.summitcommunitycare.com/provider

March 2019

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All services referenced in this material are funded and provided under an agreement with the Arkansas Department of Human Services.

AR-NL-0011-18 March 2019

Precertification and prior authorization

Effective March 1, 2019, prior authorization (PA) requirements will change for several services to be covered by Summit Community Care. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services 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.

PA requirements will be added to the following:

- **Behavioral/mental health** — All inpatient, residential, partial hospitalization, intensive outpatient program, supported housing, psychological testing, and some outpatient psychiatric and substance abuse services
- **Dental/oral surgery** — osteoplasty, osteotomy, LeFort I/II/III, implant, osseous, osteoperiosteal or cartilage graft and synthetic graft procedures
- **Drugs** — drugs administered other than by oral method (infusible/injectable), radiopharmaceuticals, during dialysis, chemotherapy, biological and parenteral and enteral nutrition (PEN)
- **Durable medical equipment (DME)** — ambulatory aid, apnea monitor, bathroom equipment, commodes, hospital bed, NC-Mattress, pressure mattress pad, nebulizer, oxygen, respiratory assistive device, suction machine, patient lifts, traction/trapeze apparatus, diabetic equipment, insulin pump, infusion pump, blood glucose monitor, wheelchair/wheelchair accessories and maintenance/repair for DME
- **Home health care services** — skilled nursing, unskilled home health aide (i.e., companion, day care, domestic service, foster care, personal care attendant and respite), assisted living, occupational/physical/respiratory/speech therapy, hospice, home management, medicine administration, and personal emergency response system
- **Laboratory** — for select genetic testing
- **Medical supply** — enteral formula, parenteral nutrition solution, PEN supply, surgical supplies and wound care
- **Surgery** — procedures on auditory, cardiovascular, digestive, eye/ocular adnexa, integumentary, genital, musculoskeletal, nervous, respiratory, reproductive implantable defibrillator and urinary systems, angioplasty, pacemakers, implants, diagnostic, ablation, endoscopy, arthroscopy, excision/destruction, in utero (fetal) procedure, transplant, sterilization, atherectomy (open or percutaneous), cataract/lens removal, endovenous ablation therapy, stereotactic RS, fetal shunt placement, and pain management
- **Medicine** — procedures relating to pulmonary, sleep study, cardiology, diagnostics, neurology, occupational/physical therapy, nonspeech-generating device, special otorhinolaryngology services and serum globulins
- **Orthotic** — custom, helmet, lower/upper extremity, shoe, shoe accessory, orthotic procedures and devices

Precertification and PA (cont.)

- **Prosthetic** — cochlear implant and lower/upper extremity
- **Radiology** — magnetic resonance angiography, magnetic resonance imaging, radiation therapy, bone density, computed tomography, diagnostic radiology/imaging, nuclear medicine, radiation oncology treatment, ultrasound and single-photon emission computerized tomography scan
- **Transportation** — air ambulance
- **Vision** — iris supported intraocular lens and posterior chamber intraocular lens procedures

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

- **Web:** https://www.availity.com
- **Fax:**
  - Behavioral/mental health: 1-877-434-7578
  - Nonbehavioral/mental health: 1-501-224-1355
- **Phone:** 1-844-462-0022

Not all PA requirements are listed here. PA requirements are available to contracted and noncontracted providers on our provider website. Providers may also call us at 1-844-462-0022 for PA requirements.

AR-NL-0006-18

Introducing a new clinical criteria web page for injectable, infused or implanted drugs covered under the medical benefit

Beginning March 1, 2019, providers will be able to view the Clinical Criteria website to review clinical criteria for all injectable, infused or implanted prescription drugs.

This new website will provide the clinical criteria documents for all injectable, infused, or implanted prescription drugs and therapies covered under the medical benefit. These clinical criteria documents are not yet being used for clinical reviews, but are available to providers for familiarization of the new location and formatting.

Once finalized, providers will be notified prior to implementation of clinical criteria documents. Injectable oncology drug clinical criteria will not be posted on this website until mid-2019. Until implementation, providers should continue to access the clinical criteria for medications covered under the medical benefit through the standard process.

If you have questions or feedback, please email.

AR-NL-0013-18

Availity overview for electronic data interchange services

Summit Community Care has designated Availity to operate and service your electronic data interchange (EDI) entry point (otherwise known as the EDI gateway) as a no-cost option to our direct trading partners. With this change, Summit Community Care aims for consistency between the provider website and the EDI gateway.

What is Availity?

Availity is a well-known web portal and claims clearinghouse that also functions as an EDI gateway for multiple payers. Availity will be the single EDI connection. In Availity, your organization can submit or receive the following:

- Institutional claims (837)
- Professional claims (837)
- Dental claims (837)
- Electronic remittance advices (ERAs) (835)
- Claims statuses (276/277)
- Eligibility requests (270/271)
- Prior authorizations (278)

Get started with Availity

If you wish to continue using your clearinghouse, please work with them to ensure connectivity (otherwise, no action necessary on your part). If you wish to submit directly, Availity setup is easy. Visit https://apps.availity.com/web/welcome to begin the process of connecting to Availity.

View the quick start guide, which will assist you with any EDI connection questions you may have.

Please use the Availity payer ID: PASSE.

Electronic funds transfer (EFT) registration

To register or manage account changes for EFT only, use EnrollHub™, a CAQH Solutions™ enrollment tool.

This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

ERA registration

Use Availity to register and manage account changes for ERA. Manage your paper remittance voucher suppression.

If you have any questions, please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548) Monday-Friday, 8 a.m.-7:30 p.m. Central time.

AR-NL-0009-18/ARPEC-0327-19

New pregnancy notification process using the Availity Portal Benefit Look-Up Tool

As you know, Summit Community Care offers pregnant women several services and benefits through the Taking Care of Baby and Me® program. It is our goal to ensure all pregnant members are identified early in their pregnancy so they can take full advantage of the education, support, resources and incentives Summit Community Care provides throughout the prenatal and postpartum period.

We've partnered with Availity, the vendor supporting the Benefit Look-Up Tool you may currently use in your OB office, to send us information about newly identified pregnant women. This new process, including the *HEDIS® Maternity Attestation* form, helps connect patients with additional benefits as soon as possible. The reporting process includes a few simple steps.

How it works

When a Summit Community Care member of childbearing age visits the OB office, the office associate is prompted to answer the question "Is the member pregnant?" during the eligibility and benefits inquiry process. If the response is yes, the system asks about the due date, and a *HEDIS Maternity Attestation* form is generated for the OB office to complete. On this electronic form, providers are asked to provide other important information including the date of the first prenatal care visit, delivery date and postpartum visit date.

This new, user-friendly workflow generates timely information that aids members, providers and Summit Community Care in improving birth outcomes with early intervention and ensures compliance with HEDIS benchmarks.

For more information, check out the *Provider FAQ — Availity Portal Pregnancy Notification and HEDIS Maternity Attestation*.

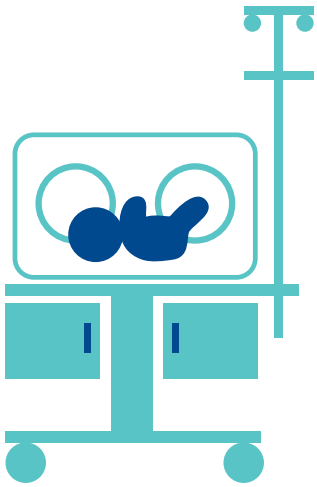
We are working hard to support providers throughout Arkansas in receiving necessary training for this new workflow. If you have specific questions regarding the new Availity maternity attestation process, please feel free to reach out to Provider Services at 1-844-462-0022.

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

AR-NL-0004-18/AR-NL-0005-18

Summit COMMUNITY CARE

The Prior Preterm Pregnancy program



To support your efforts in preventing preterm delivery in high-risk pregnant women, Summit Community Care is launching a program to ensure providers are aware of members who may benefit from administration of 17 alpha-hydroxyprogesterone caproate (17P). You will receive an alert listing members on your panel identified through our high-risk screening survey as potential candidates for 17P.

If you wish to prescribe 17P for your patient, we offer the following guidance on how you may obtain 17P for delivery and administration:

- **For office administration of 17P, prior authorization is required:**
  - Refer to *Clinical Utilization Management Guideline CG-Drug-19* for prior authorization criteria.
  - Complete the *Prior Authorization* form and fax it to 1-844-429-7762 or call 1-844-462-0022.
  - Once prior authorization is obtained, fax the prescription and a copy of the member's ID card to Accredo Specialty Pharmacy at 1-800-824-2642 or call in the prescription to 1-800-870-6419.
- **For home health administration, a separate prior authorization is required:**
  - Refer to *Clinical Utilization Management Guideline CG-MED-23* for prior authorization.
  - Prior to requesting home health administration of 17P, verify that 17P has been approved.

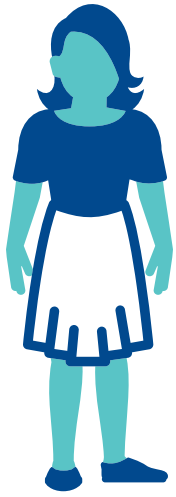
Preterm birth (delivery before 37 weeks and zero/seven days of gestation) is a leading cause of infant morbidity and mortality in the United States. For women who have had a spontaneous preterm delivery, the risk for preterm delivery in subsequent pregnancies is 1.5-2 times higher. For pregnant women with a singleton pregnancy and a history of spontaneous preterm delivery, 17P can reduce the risk of preterm birth by approximately 30 percent. The U.S. Food and Drug Administration approved hydroxyprogesterone caproate injections to reduce the risk of preterm delivery in pregnant women with a history of prior preterm birth. As with any drug, there are risks that may outweigh these benefits.

ARPEC-0035-18

Routine cervical cancer screening

This communication outlines new coverage information regarding the frequency of cervical cancer screening for women at average risk and women younger than 21 years of age. Immunocompromised women and women with a history of prior abnormal results, precancerous cervical lesions or cervical cancer are not included in this update.

Additional coverage information



Routine screening Pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective March 1, 2019, routine screening frequency for women ages 21-65 will be reimbursed no more than once every three years. Reimbursement for routine Pap testing for women 66 and older with prior negative screening results will be denied.

Screening method and intervals

The U.S. Preventive Services Task Force[1], the American College of Obstetricians and Gynecologists[2], the American Cancer Society[3], the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology all agree the optimal screening interval is no more than every three years.

Population of women	Recommended screening
Younger than 21 years of age	No screening
21-29 years of age	Cervical Pap test alone every three years
30-65 years of age	Human papillomavirus and cervical Pap cotesting every five years or cervical Pap test alone every three years
66 years of age and older	No screening is necessary after adequate negative prior screening results
Those who underwent total hysterectomy (with no residual cervix)	No screening is necessary

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow-up.

1 U.S. Preventive Services Task Force. *Cervical Cancer*. March 2012.

2 American College of Obstetricians and Gynecologists. *Practice Bulletin Number 157: Screening for Cervical Cancer*. Obstet Gynecol. 2016 Jan; 127(1):e1-e20.

3 Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62(3): 147-72.

ARPEC-0121-18

Reimbursement for early elective deliveries

We appreciate the recent improvements in early elective delivery (EED) rates across the country. The collaborative efforts of state Medicaid agencies, the March of Dimes, CMS, The Joint Commission, the American Congress of Obstetricians and Gynecologists and many others contributed to these improvements. Hospital hard stop policies describing the review of clinical indication and scheduling approval for EEDs also increased awareness of the harm that can be caused by nonmedically necessary EEDs and encouraged discussion between patients, care providers and hospitals. Additionally, voluntary efforts in conjunction with payment reform have been found to further decrease EED rates while increasing gestational age and birth weight for the covered population.

To improve birth outcomes for our members and further reduce EEDs, effective March 1, 2019, we will require a Z3A diagnosis code indicating the gestational age on all professional delivery claims with supporting medical necessity diagnosis codes for EEDs. We will apply MCG Care Guidelines, which define medically necessary criteria for EEDs.

All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620 and 59622) with dates of service March 1, 2019, or after will require a Z3A code indicating the gestational age at the time of delivery. If the code isn't on the claim, the claim will be denied with the explanation code *Delivery diagnoses incomplete without report of pregnancy weeks of gestation*. You may resubmit the claim with the appropriate Z3A code.

Professional delivery claims with dates of service March 1, 2019, or after with gestational ages of 37 and 38 weeks require a supporting medically necessary diagnosis code for the early delivery. If a professional delivery claim is submitted without evidence of medical necessity, the claim will be denied with the explanation code k34. You may resubmit the claim with the appropriate supporting diagnosis code or submit an appeal with the relevant medical records. For more information on the appeal process, refer to your provider manual.

* Dahlen, H. M., et al. (2017). *Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age and Birthweight*. Health Affairs, 36 (3), 460-467.

ARPEC-0122-18

Reimbursement Policies

Effective March 1, 2019, reimbursement policies will become effective and available on the Summit Community Care provider website. For policy-specific information, go to https://www.summitcommunitycare.com/provider.

We want to assist our physicians, facilities and other providers in accurate claims submissions and to provide an outline for the basis of reimbursement if the service is covered by a member's benefit plan. Keep in mind, services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are also required, along with the use of industry-standard compliant codes on all claim submissions.

Code and clinical editing

Summit Community Care applies code and clinical editing guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. Summit Community Care uses sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices.

Summit Community Care does not apply CCEG to state-defined local procedure codes. Editing sources include the *CMS National Correct Coding Initiative*, *Clinical Utilization Management Guidelines* and *Medical Policies*. Summit Community Care is committed to working with you to ensure timely processing and payment of claims.

AR-NL-0010-18