May 2024 Provider Newsletter

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Administrative | Medicaid | Apr 22, 2024

Reminder: reimbursement for early elective deliveries

Summit Community Care appreciates the recent improvements seen in early elective delivery (EED) rates across the country. These improvements resulted from the collaborative efforts of state Medicaid agencies, the March of Dimes, CMS, the Joint Commission, and the American College of Obstetricians and Gynecologists (ACOG), among others.

The implementation of hospital hard-stop policies describing the review of clinical indications and scheduling approval for EED has increased awareness of the harm that can be caused by non-medically necessary EED. It also encouraged discussion regarding EED between patients, their care providers, and hospitals. Voluntary efforts, combined with payment reform, have been found to further decrease EED rates while increasing gestational age and birth weight for the covered population.

Early elective delivery is defined as a delivery by induction of labor without medical necessity followed by vaginal or caesarean section delivery, or a delivery by caesarean section before 39 weeks gestation without medical necessity. Vaginal or caesarean delivery following non-induced labor is not considered an early elective delivery regardless of gestational weeks.

As previously communicated in a care provider update in February 2022, effective June 1, 2022, an additional field was required on the *CMS-1500* paper claim form or its electronic equivalents. Delivering physicians must complete **Field 19** when submitting claims for all deliveries. Other than the two required coding elements listed above; existing field information remains required when completing claims. Claims submitted by the delivering physician will be subject to claims editing to determine if the service was an EED.

Field 19 on the *CMS-1500* claim form, or its electronic equivalents, must contain a new *gestational age/delivery* indicator and one of four-digit alphanumeric values. If the value entered in **Field 19** contains a character that is not indicated below or is not in the format indicated, the value will be considered invalid, and the claim will be rejected with status code 626 — *Pregnancy indicator* and reject rule ID2 — *Delivery claim incomplete without report of valid gestational indicator*:

- The first and second digits represent the gestational age, based on the best obstetrical estimate. They must be numeric characters and values from 20 through 42.
- The third and fourth digits represent the method of delivery. They must be one of the following alpha characters:
  - LV — labor non-induced followed by vaginal delivery
  - LC — labor non-induced followed by caesarean delivery
  - IV — induced labor followed by vaginal delivery
  - IC — induced labor followed by caesarean delivery
  - CN — caesarean delivery without labor, nonscheduled (for example, add-ons)
  - CS — caesarean delivery, scheduled

Example: 37LV; 38LC

If the gestational age/delivery indicator contains an LV or LC value or contains a gestational age of **39 or greater**, the claim will **not** be subject to editing for EED.

If the gestational age/delivery indicator contains IV, IC, CN, or CS, and the gestational age is **less than 39**, the claim will be subject to editing for EED:

- If one of the diagnoses on the claim indicates that there is a medical indication for an early delivery, the claim will be exempt from editing and continue to process.
- Claims that have the IV, IC, CN, or CS indicator with a gestational age less than 39 weeks and do not have a qualifying diagnosis for early induction of labor and delivery will be rejected with status code 626 — *Pregnancy Indicator* and reject rule ID3 –

Service is not a covered benefit. You may resubmit the claim with the appropriate supporting diagnosis code or appeal with medical records.

Also required: All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622) with dates of service March 1, 2019, require a Z3A code indicating gestational age at the time of delivery in **Field 21.** If the code is not present on the claim, the claim will deny with the explanation code e02: *Delivery diagnoses incomplete without report of pregnancy weeks of gestation*.

Thank you for being a valued partner. We appreciate your commitment to the health of our members.

What if I need assistance?

Should you have questions about this communication, contact Provider Services at **844-462-0022**.

ARSMT-CD-052158-24

To view this article online:

Visit https://providernews.summitcommunitycare.com/articles/reminder-reimbursement-for-early-elective-deliveries-19214

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Administrative | Medicaid | May 1, 2024

Inaccurate laterality and diagnosis combination

Providers must code their claims to the highest level of specificity in accordance with industry standard coding guidelines such as ICD-10-CM coding guidelines and reporting. When an ICD-10-CM diagnosis code has a specified laterality within the code description, the modifier that is appended to a CPT® or HCPCS code must correspond to the laterality within the ICD-10 description.

For professional claims submitted on a *CMS 1500* form processed on or after August 1, 2024, Summit Community Care will apply these correct coding ICD-10-CM guidelines and deny claim lines that have a laterality diagnosis submitted with a CPT or HCPCS modifier that does not correspond to the diagnosis.

See examples below:

- **Reported diagnosis**: E11.3593 (Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, **bilateral**):
  - **Billed CPT code:** 67228-**RT** Treatment of extensive or progressive retinopathy (for example, diabetic retinopathy), photocoagulation.
  - **Determination**: It is not appropriate to report the RT modifier when the laterality of **bilateral** is identified in the ICD-10 diagnosis. Therefore, the claim line will be denied.
- **Reported diagnosis:** S91.011A (Laceration without foreign body, **right** ankle, initial encounter):
  - **Billed CPT code:** 27786-LT (Closed treatment of distal fibular fracture: lateral malleolus; without manipulation)
  - **Determination:** It is not appropriate to report a LT modifier when the laterality of right is identified in the ICD-10 diagnosis. Therefore, the claim lime will be denied.

Additionally, the ICD-10-CM diagnosis code should correspond to the medical record, CPT, HCPCS code(s), and/or modifiers billed.

Summit Community Care will continue to enhance its editing system to automate edits and simplify remittance messaging supported by correct coding guidelines. The enhanced editing automation will promote faster claim processing and reduce follow-up audits and/or record requests for claims not consistent with correct coding guidelines.

EOB message

Diagnosis codes with a specified laterality description should be submitted with the appropriate modifier of specificity and procedure code. Ex codes: v19 and 00V19

If you have questions about this communication or need assistance, contact your provider relationship account manager. We are committed to a future of shared success.

ARSMT-CD-053392-24-CPN52942

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Digital Solutions | Medicaid | Jul 17, 2023

Ready, set, renew

Background

It's time for some of your patients to renew their Medicaid benefits. As states begin to recommence Medicaid renewals, we want to ensure you have the information needed to help your Medicaid patients renew their healthcare coverage. Some patients have never had to renew their coverage at all, while other patients may have forgotten the process entirely.

We're here to help.

What steps do my patients need to take?

- Ready: Patient gets their documents ready.
- Set: Patient ensures their form is all set.
- Renew: Patient sends renewal form via:
  - Web: **Ar.gov/renew**
  - Phone: **844-872-2660**
  - Mail: Send to your local Department of Human Services (DHS) county office.

What if I need assistance?

Availity* Chat with Payer is available during normal business hours. Get answers to your questions about eligibility, benefits, authorizations, claims status, and more. To access Availity Essentials, go to **availity.com** and select the appropriate payer space tile from the drop-down. Then, select **Chat with Payer** and complete the pre-chat form to start your chat.

For additional support, visit the *Contact Us* section at the bottom of our provider website for the appropriate contact.

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

ARSMT-CD-027637-23, ARSMT-CD-047510-23-CPN047298, ARSMT-CD-056714-24-CPN56608

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Digital Solutions | Medicaid | Apr 19, 2024

Coming soon — Submit behavioral health authorizations through the Authorization application on Availity

Soon, you will be able to submit all your authorizations in one application on **Availity.com**.

You may already be submitting your physical health authorizations through the Availity Essentials multi-payer Authorization application — taking advantage of the time savings and speed to care through digital authorization submissions. You will soon be able to submit both your physical health and behavioral health authorizations through one Authorization application on **Availity.com**.

Using the Availity Authorization application to submit your behavioral health authorizations will not be much different from the process you follow today. You may enjoy more intuitive screens or learn sooner if an authorization is required, but the digital submission process is still the best way to submit your authorization requests and the fastest way to care for our members.

You will continue to use Interactive Care Reviewer (ICR) to submit an appeal or authorization for medical specialty prescriptions.

Accessing the Availity Authorization application is easy. Ask your organization's Availity administrator to ensure you have the Authorization role assignment. Without the role assignment, you will not be able to access the Authorization application. Then, log on to **Availity.com** to access the app through the *Patient Registration* tab by selecting **Authorizations and Referrals**.

Training is available

Training is available for the Availity Authorization application. Once registered with the authorization role assignment, visit the training site to enroll for an upcoming live webcast or to access an on-demand recording at the **Availity Authorization Training Site**.

We are focused on reducing administrative burdens, so you can do what you do best — care for our members.

ARSMT-CD-049425-23-CPN48753

To view this article online:

Visit https://providernews.summitcommunitycare.com/articles/coming-soon-submit-behavioral-health-authorizations-through-19235

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Digital Solutions | Medicaid | Apr 25, 2024

Introducing new functionality for non-medical providers

Save time and get faster results by using Availity Essentials to submit disputes for atypical care providers.

As part of our ongoing efforts to optimize and enhance the Claims Status application in Availity Essentials, we recently launched the ability for non-medical/atypical care providers — such as providers of non-emergency transportation, case management, or environmental modifications — to use the *Dispute* functionality in the enhanced Claims Status app. This new functionality allows atypical care providers to be more efficient and accurate in their dispute submission process.

Below are a few simple and important steps and reminders to follow for the best experience and results.

First step

Register with Availity Essentials

Non-medical/atypical care providers can submit a dispute using Availity Essentials. Care providers need to first **register** an organization with Availity Essentials, ensuring an administrator is chosen and their provider information — including tax ID — is added to *Manage My Organization*.

Once the organization is set up as *Non-Medical/Atypical* on Availity Essentials, it can use various functions, such as submitting disputes. Atypical care providers do not use an NPI to bill claims; therefore, it's important that the setup is completed.

Second step

Go to the Claims Status app:

- Navigate from the home page to Claims & Payments > Claim Status > select your organization and payer > Claim Status Inquiry page will open.
- When *Manage My Organization* has been completed, you can select the care provider from the drop-down menu and the tax ID field will display.
- Complete an inquiry by entering the required fields and selecting **Submit** for requested claims to display.

Third step

Select *Dispute*

To complete a dispute:

- Locate the claim and, if there is an option to appeal, select **Dispute** to initiate.
- Select **Go to details** to be navigated to the *Appeals Application.*
- Locate your initiated dispute and select the action menu to complete the dispute request.
- Choose the request reason, upload supporting documents, and submit the request.

Once completed, your progress will appear in the *Notifications Center* on the Availity Essentials home page when **Web** is selected in the contact field.

Explore training and resources

We are here to support you along the way through on-demand training and resources.

Availity Essentials offers keyword search assistance with the option to attend live or recorded demos:

- On the Availity Essentials home page, select **Help & Training**, then select **Get Trained** to register for upcoming live and recorded training demos for all Availity Essentials capabilities.

- Use the search bar to locate specific appeals training.
- The Availity Learning Center **user guide** will assist with how to locate training.

For questions, contact Availity Client Service:

- Online: Help & Training > Availity Support > Contact Support > **Create a case** or **Chat with Support**
- By phone: Call **800-AVAILITY (282-4548)** Monday through Friday from 8 a.m. to 8 p.m. Eastern time

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ARSMT-CD-054898-24-CPN54404

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Digital Solutions | Medicaid | May 1, 2024

Roster automation update

Roster Automation is our technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel template.

On March 29, we introduced a new Roster Automation functionality on the Upload Roster File page of Availity PDM. With this enhancement, you can view:

- Date received and status of rosters submitted in the last 12 months.
- Errors in submitted rosters that result in the need of manual intervention to process. The types of issues included in the error report will be incorrectly formatted data and required data elements that are missing from the roster.

Understanding the errors made when completing a roster allows you to ensure subsequent submissions do not contain those issues. Error-free rosters reduce the need for manual intervention, which improves data accuracy and processing time.

As you learn how to use the information available in the new error reports, we will continue to correct issues on your behalf.

In the future, you will need to correct any errors submitted in a roster (for example, missing data, incorrectly formatted data). Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems. More information about when you will need to correct errors, and how to do so, will be sent in future communications and covered in future virtual webinars.

Utilize the Roster Submission Guide

Find it online: On **Availity.com** > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

MULTI-ALL-CD-057942-24-CPN57211

To view this article online:

Visit https://providernews.summitcommunitycare.com/articles/roster-automation-update-19416

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Digital Solutions | Medicaid | May 1, 2024

Digital Request for Additional Information is now available for all lines of business

Digital Request for Additional Information (RFAI) is the easiest way to submit attachments requested by your payer using Availity Essentials. There is no need to fax or mail paperwork to complete your claim submissions anymore; just use the digital channels provided for your organization.

Availity Essentials notification center

The notification center is located on the top of the Availity Essentials homepage. If your payer has requested documentation, there will be a message stating there are requests in your work queue. Simply select the hyperlink to be navigated to the **Attachment Dashboard** to view the request.

Availity Essentials Attachment Dashboard

The Attachment Dashboard is where all attachment requests are displayed. You can use the hyperlink in the notification center or navigate to **Claims & Payments** > **Attachments New**.

To locate a specific RFAI request, the request number will begin with *RFAI*. If you notice multiple requests in your dashboard, take advantage of the filters. You have the option to search, filter, and sort for multiple values, such as Tax ID, NPI, and Request Type.

Select **Upload Attachment** to view the type of document requested. Your uploaded requests will be visible in the History tab once accepted. Select the **Record History** icon on the right side of the request to view the **Availity Transaction ID** for specific Availity Essentials questions or **Health Plan Transaction ID** if you need to contact your payer for questions.

Get trained

Availity Essentials has training on-demand. This includes a pre-check for administrators and a *Learn How to Submit Digital Requests for Additional Information* training. Log in to Availity Essentials > **Help & Training** > **Get Trained** > enter *RFAI* in the keyword search.

If you have questions, call Availity Client Services at **800-Availity** (**800-282-4548**). Availity Client Services is available Monday to Friday, 8 a.m. to 8 p.m. ET.

With your help, we can continually build toward a future of shared success.

ARSMT-CD-052581-24-CPN52155

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Pharmacy | Medicaid | Apr 16, 2024

Notice of Material Amendment to Healthcare Contract

Prior authorization updates for medications billed under the medical benefit

Effective August 1, 2024, the following medication codes will require prior authorization.

Please note, inclusion of a National Drug Code (NDC) on your medical claim is necessary for claims processing.

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

Clinical Criteria	HCPCS or CPT® code(s)	Drug name
CC-0244	J9286	Columvi (glofitamab-gxbm)
CC-0245	C9162	Izervay (avacincaptad pegol)
CC-0246	J9333	Rystiggo (rozanolixizumab-noli)
CC-0207	J9334	Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-gvfc)
CC-0072	C9161	Eylea HD (aflibercept high dose)

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local provider relations representative or call Provider Services at **844-462-0022.**

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

ARSMT-CD-050799-24-CPN50561

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Quality Management | Medicaid | Apr 23, 2024

Take action to improve adolescent immunizations rates

Estimates suggest that around 35 million American adolescents fail to receive at least one recommended vaccine.* The CDC and the American Academy of Pediatrics advise pre-teens between 10 and 12 years old receive three vaccines: (1) one dose for meningococcal; (2) one dose for tetanus, diphtheria, and pertussis (Tdap); and (3) two doses of human papillomavirus (HPV) given five months apart.

Encourage pre-teen immunizations

Take action to provide clear and specific guidance to your patients' parents to get the recommended vaccines on time. Convey the importance by administering vaccines as part of routine visits and by offering vaccine clinics during non-traditional times when your patients and their parents might be more available. It is helpful to remind patients of their upcoming appointments, follow up to reschedule any missed appointments, and address any concerns or barriers. Although you should check your patients' benefits, immunizations are generally a covered benefit.

Reporting and documenting for HEDIS

Take action to make sure that all vaccine doses given, including those administered in a pharmacy and an urgent care, are clearly documented in your electronic medical system, your patient's medical record, and state Immunization Registry. Doses should be clearly reported on claim forms with the assistance of CPT® codes to maximize data collection and to reduce the burden of HEDIS® medical record review, especially since NCQA strongly encourages the electronic collection of Immunizations for Adolescents (IMA) HEDIS data. Contact your provider relationship management representative for additional information and assistance with establishing electronic data exchange.

Opportunities to learn more:

- An on-demand webinar about the importance of the HPV vaccine and starting the conversation early with parents of 9-year-olds can be found on the **Clinical Quality Webinars Hub**. One continuing education unit is provided upon completion.
- **Mydiversepatients.com** includes free resources and courses that might help you with your diverse patient population.
- **Letsvaccinate.org** provides ready-to-use resources and strategies to help your care team increase vaccination rates.

Through our shared health vision, we can affect real change.

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* Das, Jai K., et al. *Systematic Review and Meta-Analysis of Interventions to Improve Access and Coverage of Adolescent Immunizations*. Journal of Adolescent Health. 2016 Oct; 59 (4 Suppl): S40-S48. **ncbi.nlm.nih.gov/pmc/articles/PMC5026683**.

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ARSMT-CD-051181-24-CPN50907

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Visit https://providernews.summitcommunitycare.com/articles/take-action-to-improve-adolescent-immunizations-rates-19229

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