FLORIDA
Provider News
2015 • Quarter 1

ICD-10 coded prior authorizations

The transition from ICD-9 to ICD-10 goes into effect on October 1, 2015.

Amerigroup will begin accepting ICD-10 coded authorizations beginning June 1, 2015. These will only be for those authorization requests where the dates of service are October 1, 2015, or later. Authorization requests for dates of service prior to October 1, 2015, will continue to be coded using ICD-9.

Getting ready to transition to ICD-10

To help ensure you are ready, here are some additional things to remember:

- Make sure your practice management system and/or billing system is ICD-10 ready. Talk with your vendor about the support and services you might need to be compliant for ICD-10.
- There is no need to memorize all of the new ICD-10 diagnosis codes. If you are not an inpatient facility, you only need to be concerned with the most common medical conditions your practice sees today and understand how ICD-10 impacts them.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record.
- If your practice treats a wide range of medical conditions, use the 80/20 rule to determine which ICD-10 diagnosis codes are most pertinent. This would include family practice, pediatric medicine or internal medicine.

The Centers for Medicare & Medicaid Services (CMS) offers the "Road to ICD-10" – a comprehensive tool where you can explore common codes, primers for clinical documentation, clinical scenarios and additional resources associated by specialty.

Visit www.roadto10.org to find information for:

- Family Practice
- Pediatrics
- OB-GYN
- Cardiology
- Orthopedics
- Internal Medicine
- Other Specialties

Did you know you also have the opportunity to earn continuing medical education (CME) credits while preparing for ICD-10?

CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition. The video lectures are specifically for physicians, while the article covers more general topics for all health care providers. CME credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion.

The modules are free and can be found at www.cms.gov/Medicare/Coding/ICD10.

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Amerigroup RealSolutions® in healthcare

Improving your experience:

Availity eligibility and benefits (E&B) updates

Availity is launching new eligibility and benefits features for their Web Portal during the second quarter of 2015. These enhancements will make finding eligibility and benefits easier and faster for you.

View the chart below for more information on what's coming:

New Request page	The new Request page design makes it faster for you to submit member inquiries. Now you can submit multiple inquiries without having to wait for individual results to show before starting another request.
Patient history list	The results list summarizes your most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only the information relevant to that member is displayed.
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list includes key coverage elements and only shows information returned from the payer.
Organization-wide view of E&B transactions	You can now see transactions by other users within your organization (shared history) – resulting in less duplication of work already completed by your peers.
Organization dropdown menu	Users responsible for more than one organization can switch organizations while staying on the same page, providing a convenient, streamlined workflow.
Payer section	In this section, value-added services were consolidated so you can access these services (e.g., a patient care summary) from the same page.

To learn more about these time-saving features, go to **www.availity.com** and take a quick tour, view the recorded webinar or join Availity for a live webinar.

Questions?

If you have questions about this newsletter or need assistance with any other item, call Provider Services at 1-800-454-3730 or contact your local Provider Relations representative.

ClaimCheck® Version 55 upgrade effective July 2015

In 2015, Amerigroup will complete two upgrades to newer versions of ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in Version 55 of the upgrade are effective July 2015. The changes included in Version 56 of the upgrade are effective August 2015.

What this means to you

No actions required; for your information only.

Background information

Amerigroup uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesia codes and processes those services according to industry standards.

Why is this change necessary?

ClaimCheck is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes.

Amerigroup uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Procedures billed with inappropriate modifiers

Clearinghouse helps ensure timely and accurate claims payment for vaccines covered by Medicare Part D

Providers who have administered a shingles or tetanus vaccine to our Medicare Advantage plan members with pharmacy benefits may encounter a denial as these claims are covered under Medicare Part D only.

To streamline claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRx. This clearinghouse for claims submission may be used by physicians, facilities, health clinics and pharmacies.

To use TransactRx, please visit www.transactrx.com or call the Customer Service department at 1-866-522-3386. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

For more information on Part D vaccines, visit www.cms.gov and follow the steps below:

1. Select Outreach & Education from the top menu bar.
2. Under Look up topics, select Medicare.
3. Select Medicare Learning Network® (MLN) general information.
4. Select the first option from the list, MLN Education Products.
5. Under MLN products on the left-hand side, select MLN Publications and type June 2013 in the search box.
6. Select the third option, Vaccine Payments Under Medicare Part D.

Medicare Advantage national coverage determinations

National coverage determinations (NCDs) are developed by CMS to identify member benefits and for provider guidance. Effective January 1, 2015, claim edits will be enhanced to consistently apply NCD criteria during the adjudication process for Amerigroup Amerivantage (Medicare Advantage).

Amerigroup RealSolutions in healthcare

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ProviderNews

New corrected claim requirement for CMS 1500

Effective June 15, 2015, professional corrected claims billed on CMS 1500 forms must be submitted to Amerigroup in their entirety.

What this means to you

As of June 15, 2015, when submitting a correction for a previously billed claim on a CMS 1500 form, you must include all services on the new submission. If any previously submitted charges or services are not billed on the corrected claim form, they will be removed in the adjustment.

In order to ensure that all claims accurately reflect the services performed, providers will no longer be permitted to submit individual lines for correction on a CMS 1500 form. Adjustments to the previously processed claim will reflect exactly what is shown on the new corrected claim submission. The updated process for CMS 1500 corrected claims will mirror the current process for institutional replacement claims submitted on CMS 1450 (UB-04) claim forms.

By making this change, we will be able to remove possible discrepancies between the intention of the correction and the way the claim is actually adjusted in our systems. The process for submitting facility replacement claims billed on a CMS 1450 form is not affected by this change.

Standard timely filing guidelines apply to all corrected and replacement claims.

How will this change affect me?

If you submit a claim correction and fail to include services that were correctly paid on your original submission, they will be removed on the adjusted claim. Any reduction in payment amount would result in a negative account balance and/or a refund request.