

# Provider Newsletter



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2016  
Quarter 2

## Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

### Additional coverage information

As previously communicated, routine screening pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, 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<sup>1</sup>, the American College of Obstetricians and Gynecologists<sup>2</sup>, the American Cancer Society<sup>3</sup>, the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical pap alone every three years
Women aged 30-65 years	Human papillomavirus (HPV) and cervical pap co-testing every five years or cervical pap alone every three years

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Population	Recommended screening
Women older than 65 years	No screening is necessary after adequate negative prior screening results
Women 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. United States 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; 127:el-20.
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; 62:147-72.

### New Claims Status Listing Tool

On June 18, 2016, a new Claims Status Listing Tool will be offered on the Amerigroup Payer Spaces on Availity. This application enables you to generate a list and view the status of multiple claims submitted to Amerigroup.

Besides your current claims status inquiry functionality on Availity, we will provide an added benefit with the Claims Status Listing Tool. With this tool, you can obtain a list of your claims submitted to Amerigroup for a specified period of time (span of up to 30 days) and up to two years back. You will have the opportunity to see the status of multiple claims in one report, if you choose, instead of looking them up one at a time.

#### Here's how to access the Claims Status Listing Tool:

- Log into the Availity Web Portal
- From the Availity Web Portal home page, select Payer Spaces
- Select the Payer from the list of payer options
- Select Applications, then select Open located below Claims Status Listing Tool

#### My organization does not use Availity. What do I need to do?

To initiate the registration process, have your primary controlling authority (PCA), a person who is authorized to sign on behalf of your organization, register. Click Get Started under the Register Now button and complete the online registration wizard.

After your PCA completes registration for the organization, your designated primary access administrator (PAA) will receive an email from Availity with a temporary password and next steps. Once logged in, the PAA can add users, providers and additional enrollments, if applicable. Please make sure each user has his or her own login and password. Logins and passwords should not be shared.



## New Reimbursement Policies

### Medical Recalls

(Policy 06-111, effective 10/01/2016)

Amerigroup does not allow reimbursement for repair or replacement of items due to a medical recall. The following are applicable items:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/vaccines

Amerigroup will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Amerigroup will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

For additional information, refer to the Medical Recalls reimbursement policy at <https://providers.amerigroup.com>.

### Multiple Procedure Payment Reduction

(Policy 15-002, effective 10/01/2016)

We allow reimbursement for multiple procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

When services are performed on the same date of service during the same patient encounter and by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- Cardiovascular procedures
- Ophthalmology procedures

“Always therapy” services are not subject to MPPR.

For additional information regarding reimbursement for these services and procedures, refer to the Multiple Procedure Payment Reduction policy at <https://providers.amerigroup.com>.

## Reimbursement Policy Reminder

### Facility Take Home DME and Medical Supplies

(Policy 06-081, originally effective 12/22/2009)

Amerigroup does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for nonparticipating vendors

Amerigroup allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

For additional information, refer to the Facility Take Home DME and Medical Supplies reimbursement policy at <https://providers.amerigroup.com>.

### Effective November 1, 2016 ClaimsCheck® upgrade to ClaimsXten™

Amerigroup appreciates your participation in our network. Amerigroup uses ClaimCheck 10.2, a comprehensive nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. The purpose of this update is to notify you that we are upgrading ClaimCheck 10.2 to ClaimsXten, McKesson's next generation code auditing system. As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, AMA/CPT, Specialty Society guidelines and Amerigroup policy. The upgrade will become effective November 1, 2016.

#### What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that in combination with claims processing systems:

- Reinforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed

#### Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes



## How will the upgrade to ClaimsXten affect you?

Providers will continue to see similar edits as under ClaimCheck 10.2. ClaimsXten has enhanced audit logic and the ability to analyze claims submission history. Outpatient services will be analyzed for such issues as:

- Rebundled or unbundled services
- Multi-channel services
- Mutually exclusive services
- Incidental procedures
- Incorrect use of CPT codes
- 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 being billed with inappropriate modifiers

## What types of edits appear on my explanation of payment (EOP) when an edit is applied by ClaimsXten to a service I submitted?

The following list, which is not all inclusive, contains edits that may appear on your EOP when rule is triggered in ClaimsXten:

Rule	Provider type	Description
Inappropriate age	Professional/ facility	Procedure code is either inappropriate for the member's age or an age-specific CPT code does not match the member's age.
Deleted code	Professional/ facility	Procedure code has been deleted from CPT.
Invalid diagnosis code	Professional/ facility	Procedure submitted with an invalid diagnosis code.
Inappropriate gender	Professional/ facility	Procedure code is either inappropriate for the member's gender or a gender-specific CPT code does not match the member's gender.
Invalid modifier-procedure	Professional/ facility	Modifier used is invalid with the submitted procedure code.
Multiple radiology reduction	Facility	Reduction applied to multiple contiguous radiology procedures using the same modality on the same date of service (DOS).
Assistant surgeon	Professional	Assistant surgeon not eligible for procedure.
Base code quantity	Professional	Base code with units >1, where add-on code would be appropriate.
Bundled services	Professional	Services incidental to the primary procedure.
Multiple surgery reduction	Professional	Reduction applies to multiple procedures on the same DOS. Procedure with highest reimbursement paid as primary.
Global surgical edits	Professional	Pre-op visit, post-op visit, procedure or other service considered part of the global surgical period.
Maximum units	Professional	Medically unlikely number of units on the same DOS.

Rule	Provider type	Description
Global component	Professional/ facility	Audits across multiple providers to ensure that professional and technical components are not reimbursed more than once for the same member, procedure and date of service.
Anesthesia not eligible	Professional	Audits claim lines containing nonanesthesia services submitted by an anesthesiologist as described by the American Society of Anesthesiologists.
Outpatient consultations	Professional	Audits for claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same provider with at least one matching diagnosis within a six-month period.
Inpatient consultations	Professional	Audits for claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a five-day period.
New patient code for established patient	Professional	Audits for claim lines containing a new patient E&M code when another claim line containing any E&M code was billed within a three-year period.
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount.

If you have questions regarding ClaimsXten edits that you receive on your explanation of payment, please call the Provider Services at 1-800-454-3730 and select the appropriate prompt.