Provider Newsletter

https://providers.amerigroup.com/FL

Amerigroup RealSolutions® in healthcare

2017
Quarter 2

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Reimbursement Policies:

Interactive Care Reviewer tool: Register and start using today!

Beginning mid-April, your practice can initiate online preauthorization requests for Statewide Medicaid Managed Care Managed Medical Assistance members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Web Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Web Portal. There are no changes to the preauthorization capabilities on the provider website (https://providers.amerigroup.com/FL).

How do I gain access to the ICR?

You can access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select **Register** in the upper right-hand corner of the page. If your organization already has access to Availity, your Availity administrator can grant you access to "authorization and referral request" for submission capability and "authorization and referral inquiry" for inquiry capability. You can then find our tool under Patient Registration > Authorizations & Referrals. From this area, you can select the authorizations or authorization/referral inquiry option as appropriate.

Whom can I contact with questions?

For questions regarding our ICR tool, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY. Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

What benefits/efficiencies does the ICR provide?

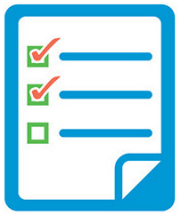
- **You are automatically routed to our ICR.** Once the ICR is available, when you go to *Authorizations* in the Availity Web Portal, you are automatically routed to the ICR in order to begin your prior authorization request.
- **You can determine if prior authorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **You will have inquiry capability.** Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax, ICR or another online tool (e.g., AIM Specialty Health®, OrthoNet LLC, eReview).
- **The ICR is easy to use.** You can submit outpatient and inpatient requests for services online using the same, easy-to-use functionality.
- **The ICR reduces the need to fax.** The ICR allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR is a no-cost solution that's easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **You receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submitted online, including the status of your requests and specific views that provide case updates and a copy of associated letters.

FL-NL-0032-16

CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Amerigroup seeing Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA) members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following best practice standards:

	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
	**2. Policies and procedures**	Develop and implement policies and procedures based on the plan and risk assessment.
	**3. Communication plan**	Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
	**4. Training and testing program**	Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

FL-NL-0040-17

Utilization Management affirmative statement

Amerigroup, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not reward practitioners or other individuals for issuing denials of coverage or care.
- Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

FL-NL-0046-17

Policy Update
Modifier 63: Procedure Performed on Infants Less Than 4 kg
(Policy 06-015, effective 09/15/2017)

Currently, Amerigroup allows additional reimbursement of 120 percent for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, Amerigroup will allow reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100 percent of the applicable fee schedule or contracted/negotiated rate. Please note, the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

Key Definition
Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding Modifier 63 to the procedure.

In applicable circumstances, Amerigroup does **not** allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants Less Than 4 kg Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

FL-NL-0027-16

Policy Update
Maternity Services
(Policy 14-001, effective 11/01/17)

Amerigroup does not allow reimbursement for global obstetrical codes. Antepartum care, deliveries and postpartum care must be billed as individual services. Amerigroup will not reimburse for duplicate services during the course of the pregnancy.

What's New?
We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

For market-specific information, refer to the Maternity Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

FL-NL-0034-17

Policy Update

Modifier 22: Increased Procedural Service

(Policy 07-020, effective 11/01/17)

Amerigroup allows reimbursement for procedure codes appended with Modifier 22. Beginning November 1, 2017, reimbursement will be based on 100 percent of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure.

Refer to Modifier 22: Increased Procedural Service Reimbursement Policy for more information at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

FL-NL-0033-17

Policy Reminder

Modifier 78: Unplanned Return to the Operating/Procedure Room By the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

(Policy 06-016, originally effective 07/24/11)

Amerigroup allows reimbursement for claims billed with Modifier 78 when the following criteria are met:

- The return to the operating or procedure room is unplanned.
- The procedure appended with Modifier 78 is:
  - The appropriate surgical code for the procedure performed.
  - Performed by the same physician who provided the initial procedure.
  - Related to the initial procedure.
  - Performed during the postoperative period of the initial procedure.

Reimbursement is based on 100 percent of the fee schedule or contracted/negotiated rate of the surgical procedure code when the modifier is valid for the service performed. Reimbursement is based on the surgical procedure **only**, not including preoperative or postoperative care. Procedures rendered during the postoperative period and not billed with Modifier 78 are normally denied as included in the global surgical package.

For market-specific information, refer to Modifier 78 Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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