Provider Newsletter

providers.amerigroup.com

2016
Quarter 1

Prior authorization (PA) required for H.P. Acthar Gel, Prialt and Retisert

Amerigroup Community Care is adding the following drugs to the 2016 Medicaid list of injectable or infusible drugs requiring PA. As of July 1, 2016, providers must call for PA of the drugs listed below:

- H.P. Acthar Gel (Repository Corticotropin Injection) for the treatment of infantile spasms and corticosteroid-responsive conditions where there is clear documentation of why all other well-established routes for corticosteroid therapy cannot be used
  - Amerigroup Clinical Utilization Management Guideline CG-DRUG-24: (J0800=Injection, corticotropin, up to 40 units)

- Prialt (Ziconotide Intrathecal Infusion) for the management of severe chronic pain when intrathecal therapy is warranted and when intolerant or refractory to other treatment
  - Amerigroup Medical Policy Drug 00027: J2278=Injection, ziconotide, 1 microgram)

- Retisert (Fluocinolone acetonide intravitreal implant) for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye
  - Amerigroup Medical Policy DRUG.00032: (J7311=Fluocinolone acetonide, intravitreal implant)

If you have questions, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Share it with your team

The provider newsletter contains important information for you, as a provider, as well as members of your team. When you receive the latest edition, please take a

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moment to share the information with your staff. Recent editions of the provider newsletter are available online on the provider website at providers.amerigroup.com/GA under Provider Resources and Documents > Newsletters.

Intensity modulated radiation therapy (IMRT) codes require PA

Effective July 1, 2016, two intensity modulated radiation therapy (IMRT) codes that previously did not require PA will require PA. IMRT requests must be reviewed by Amerigroup for PA for dates for service on or after July 1, 2016.

Amerigroup will require PA for the following IMRT codes beginning July 1, 2016:

- 77385: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 : Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

PA request may be submitted by either of the following methods:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627

If you have questions, call Provider Services at 1-800-454-3730.

Provider manual

The provider manual contains everything you need to know about us, our programs and how we work with you. For the most up-to-date information, we encourage use of the manual available at providers.amerigroup.com/GA under Provider Resources & Documents > Manuals and Referral Directories.

ICD-10 and coding for diabetes

Below is some helpful information regarding ICD-10 and how to properly bill for diabetes.

Diabetic complications in ICD-10

A benefit of ICD-10 codes is that providers can now report more clinical details concerning diabetic complications than they could in ICD-9. The increased specificity is possible because ICD-10 contains expanded combination codes for diabetic complications. A combination code describes two or more conditions within a single code. The ICD-10 code categories E08-E13 contain the combination codes for diabetic complications. The codes include type of diabetes mellitus, body system affected and complications affecting that body system. Combination codes may require additional diagnosis codes to fully describe all associated conditions. Reporting all documented conditions to the highest level of specificity on the claim form helps to promote quality and continuity of patient care. To ensure coding specificity for diabetic complications in ICD-10, medical record documentation should include:

- Type of diabetes (i.e., Type 1, Type 2, secondary)
- Complications and body systems affected (e.g., diabetic neuropathy)

- Control status (document how well diabetes is controlled over time)
- Long-term use of insulin (report additional code Z79.4 on the claim)

Some examples of ICD-10-CM type 2 diabetes combination codes include:

Complication type	Correct code category
Kidney and renal	E11.2- Type 2 diabetes with kidney complications
Ophthalmic (eye/retinal)	E11.3- Type 2 diabetes with ophthalmic complications
Neurologic (nervous system)	E11.4- Type 2 diabetes with neurological complications
Circulatory (arteries)	E11.5- Type 2 diabetes with circulatory complications
Other specified (arthropathy, skin, ulcerations, oral, hypoglycemia and hyperglycemia)	E11.6- Type 2 diabetes with other specified complications

Note: Not an all-inclusive list. For a complete list consult the current ICD-10-CM coding manual.

Accurately reporting uncontrolled diabetes

Previously, diabetes mellitus codes were classified as controlled or uncontrolled. In ICD-10-CM diabetes described as not being controlled is classified as hyperglycemia which is considered a complication. When documentation contains terms such as *inadequately controlled, out of control and poorly controlled, the index leads to* diabetes with hyperglycemia (see example below). Assign as many codes that are needed to accurately describe the patient's diabetic condition(s).

Documentation	Correct code
Male patient is seen and evaluated for diabetes mellitus type 2 poorly controlled.	E11.65 Type 2 diabetes mellitus with hyperglycemia
Female patient is seen and evaluated for shooting pain and numbness in toes and feet. The provider diagnosis type 1 diabetic neuropathy in adequately controlled.	E10.40 Type 1 diabetes mellitus with diabetic neuropathy E10.65 Type 1 diabetes mellitus with hyperglycemia

Documenting to support accurate coding

Since diagnosis coding is based on provider documentation, it is critical that providers include all known details about coexisting and chronic conditions (e.g., diabetes) in the medical record for each patient encounter.

Details such as the provider's assessment/evaluation of the condition, medications prescribed, recommendations, referrals and even patient noncompliance help support accurate coding. Documenting support for all current medical conditions improves quality of care and ensures coding guidelines are followed.

ICD-10 Coding Guidelines, Section IV Diagnostic coding and Reporting Guidelines for Outpatient Services

- .I *Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions.*
- .J *Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management*.

When diabetic complications are present, it is important that medical record documentation support the cause and effect relationship between diabetes and the other conditions with linking verbiage. Examples of linking verbiage include:

- Diabetic
- Due to diabetes
- Secondary to diabetes
- Caused by diabetes

Documenting cause and effect for diabetic complications If documentation does not properly link the condition(s), a diabetes combination code should not be assigned. Each condition must be coded separately when documentation does not establish a causal link (see example below).

Documentation	**Correct code**
Female patient evaluated for type 1 diabetes and stage 1 chronic kidney disease. (Cause and effect not documented)	E10.9 Type 1 diabetes mellitus without complications N18.1 Chronic kidney disease, stage 1
A male patient is seen and evaluated for diabetic chronic kidney disease-stage 3, he takes insulin on a daily basis.	E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease N18.3 Chronic kidney disease, stage 3 (moderate) Z79.4 Long-term (current) use of insulin

For complete instructions and guidelines, please refer to the current ICD-10-CM coding manual.

24/7 tools available online

In partnership with Availity, we make it easy for you to take care of business on your schedule. With a single sign-on using your Availity credentials, we offer the following tools for providers:

At providers.amerigroup.com/GA, you can:

- Request precertification and look up requirements
- Download your panel listings
- File and check claims appeals
- View important updates, download a copy of our Provider Manual and access forms and documents for both you and your patients

At Availity.com, you can:

- Submit and check the status of claims
- Verify real-time member eligibility and benefits
- Easily navigate back to the Amerigroup provider self-service website to use the additional tools available there

For training, visit Availity.com and select Availity Learning Center under Resources in the top bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

For any questions or additional registration assistance, contact Availity Client Services at 1-800-282-4548, Monday through Friday, 8 a.m. to 7 p.m. Eastern time.

New collection agency partnership

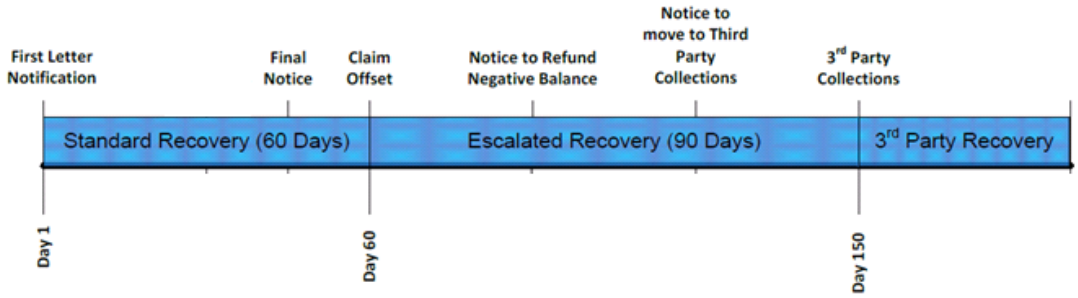
The Amerigroup Community Care Cost Containment Unit (CCU) has partnered with third party collection agency, Lamont, Hanley & Associates, Inc. (LHA) to assist in the recovery of overpayment refunds.

Lamont, Hanley & Associates, Inc. is a New Hampshire-based, nationwide debt collection agency with a long history of providing excellent collection services for Anthem, parent company of Amerigroup. LHA was chosen due to its philosophy of "customer service approach to collections," a value we identify with and one that is critical in ensuring a successful partnership, understanding the sensitivity of releasing a collection agency in our provider networks.

A brief excerpt from LHA…
Our methodology incorporates sales techniques with financial guidance to provide your customers with a program that results in clearing their balance in a non-confrontational, business-like manner. This process results in a higher liquidation and maintains a professional image for our company and our clients. We combine this with our collectors' abilities to resolve disputes and expedite files, making us unique in the collection industry.

The CCU claim collection life cycle will include three phases:

- A standard recovery process requesting refunds from providers
- An escalated recovery process which attempts to obtain check refunds from the providers for any offsets not satisfied by the 60th day following a negative balance adjustment
- Lastly, a third party recovery process initiated by LHA if claims are not successfully fulfilled during the escalated recovery process.



Your market is already live and this notification is to inform you of the role LHA plays in the collection process

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

Reimbursement Policy updates

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

Locum Tenens
(Policy 06-063, originally effective 08/23/2006)

Amerigroup allows reimbursement of locum tenens physicians in accordance with the CMSguidelines. Amerigroup will reimburse the member's regular physician or medical group for all covered services provided by a locum tenens physician during the absence of the regular physician in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis.

Please note that, Amerigroup requires the regular physician or medical group to identify the locum tenens physician by entering their Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

For market-specific information, refer to the Locum Tenens reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Professional Providers
(Policy 06-029, originally effective 06/16/2006)

Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original CMS-1500 Health Insurance Claim Form to us for payment of health care services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include specific information outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Professional Providers reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Facilities
(Policy 06-030, originally effective 06/16/2006)

Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original CMS UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to us for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and Amerigroup can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Facilities reimbursement policy at providers.amerigroup.com.

Documentation Standards for Episodes of Care
(Policy 11-004, originally effective 12/07/2011)

Amerigroup requires that documentation for all episodes of care must meet the following criteria:

- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated and timed.
- Documentation must reflect all aspects of care.

- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

For a complete list of minimum documentation requirements, refer to the Documentation Standards of Episodes of Care reimbursement policy at providers.amerigroup.com.

Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative. Medicaid providers can call Provider Services at 1-800-454-3730.

Enhanced Availity eligibility and benefits inquiry

Beginning in Q2 2016, users will have the added benefit to query for multiple members at one time through the Availity eligibility and benefits inquiry.

You can check up to 50 members' eligibility and benefits during one system transaction. You no longer have to request eligibility information one member at a time, and you can download the results of all your eligibility and benefits inquiries across multiple payers.

My organization is not using 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. Go to availity.com, select **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 every user has their own login and password. Logins and passwords should not be shared.

How can I get additional training on Availity?
Once you complete registration, you can view the current training resources by selecting **Help**, then **Get Trained**, at the top of any page in the Availity Web Portal to view Availity workshops and webinars that are available.

For questions or additional registration assistance, contact Availity Client Services at 1-800-282-4548, Monday through Friday from 5 a.m. to 4 p.m. Pacific time.

If you have questions about the tools and resources available on the Amerigroup Community Care or Availity websites, please visit providers.amerigroup.com. If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.