Provider Newsletter

https://providers.amerigroup.com/GA

Amerigroup RealSolutions® in healthcare

2017
Quarter 1

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Reimbursement Policies:

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Community Care previously announced plans to upgrade from ClaimCheck® to the ClaimsXten™ auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten™ applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten™ edits you receive on your *EOP*, please call Provider Services at 1-800-454-3730.

ClaimCheck and ClaimsXten are registered trademarks of McKesson Technologies Inc. and McKesson Health Solutions LLC, respectively.

GA-NL-0034-17

Intracardiac electrophysiological studies and catheter ablation to require prior authorization

Effective May 1, 2017, intracardiac electrophysiological studies and catheter ablation will require prior authorization (PA). All requests with dates of service beginning on or after May 1, 2017, must be submitted for PA.

Please refer to the provider self-service tool for detailed authorization requirements. To locate the provider self-service tool:

- Go to https://providers.amerigroup.com and select your state
- Under Provider Resources & Documents, select Quick Tools and then select Precertification Lookup Tool.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

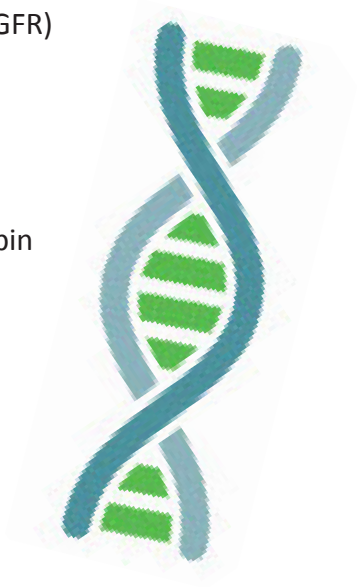
Please use one of the following methods to request PA:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: https://providers.amerigroup.com

Federal and state law, state contract language, CMS guidelines and definitions, as well as specific contract provisions and exclusions take precedence over these PA rules and must be considered first when determining coverage.

GA-NL-0029-16

Genetic testing services to require prior authorization



Effective June 1, 2017, genetic testing services for epidermal growth factor receptor (EGFR) testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing require prior authorization (PA).

What is the impact of this change?

For dates of service on or after June 1, 2017, PA is required for EGFR testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing covered by Amerigroup Community Care for Georgia Families members. Federal and state law as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following codes:

- 81235
- 81291
- 81420
- 81507
- 0009M

To request PA, contact us by phone (1-800-454-3730) or fax (1-800-964-3627) or use the GAMIS portal.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/GA > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

GA-NL-0030-16

Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) updates

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the *DSM-5*.

When transitioning from the *DSM-IV-TR* to the *DSM-5*, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in *DSM-5*.

Although formatted differently, the same information is found within the *DSM-5* diagnostic system. *DSM-5* combines *DSM-IV-TR* axes I-III diagnoses into one list, as shown in Table 1.

Table 1: D*SM-5* diagnosis:

***DSM-IV* multiaxial system**	***DSM-5* nonaxial system**
Axis I: clinical disorder (d/o) and other conditions that are focus of treatment **Axis II:** personality d/o and mental retardation **Axis III:** general medical conditions	Combined attention to clinical disorders, including personality disorders and intellectual disability, other conditions that are the focus of treatment, and medical conditions.
Axis IV: psychosocial and environmental stressors	Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.
Axis V: Global Assessment of Functioning (GAF)	Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of *DSM-5* entitled Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis V GAF was removed from *DSM-5*. Alternatively, WHODAS 2.0 is included in section III of *DSM-5*.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the *DSM-5* for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

***Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®)* updates continued**

Revisions to the *DSM-5* may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at http://psychiatryonline.org. Select **View the DSM-5® Update (September 2016)**.

Table 2:

Disorder	Codes effective October 1, 2016
Avoidant/Restrictive Food Intake Disorder	F50.89
Binge-Eating Disorder	F50.81
Disruptive Mood Dysregulation Disorder	F34.81
Excoriation (Skin-Picking) Disorder	F42.4
Gender Dysphoria in Adolescents and Adults	F64.0
Hoarding Disorder	F42.3
Obsessive-Compulsive Disorder	F42.2
Other Specified Depressive Disorder	F32.89
Other Specified Feeding or Eating Disorder	F50.89
Other Specified Obsessive-Compulsive and Related Disorder	F42.8
Pica, in adults	F50.89
Premenstrual Dysphoric Disorder	F32.81
Social (Pragmatic) Communication Disorder	F80.82
Unspecified Obsessive-Compulsive and Related Disorder	F42.9

Some resources that may best help you include:

- *American Medical Association, Professional Edition CPT* (current procedural terminology), 2016.
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA, American Psychiatric Association, 2013.
- *ICD-10-CM and ICD-10-PCS Coding Handbook*, 2016.

GAPEC-1688-16

New Policy

Modifier 26 and TC: Professional and Technical Component

(Policy 15-004, effective 07/01/17)

Amerigroup Community Care allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC when appropriate.

Professional Component (Modifier 26)

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

Technical Component (Modifier TC)

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable X-ray suppliers should bill only for the technical component by appending Modifier TC.

Global Procedure

In the absence of Modifier TC and Modifier 26, the physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Amerigroup does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only, or global test only of a selected diagnostic test

Amerigroup reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

For additional information and to view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

GA-NL-0019-16

Policy Update

Reimbursement for Reduced and Discontinued Services

(Policy 10-003, effective 04/27/2015)

Amerigroup Community Care allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Modifiers 52, 53, 73 and 74 can be appended for reduced and discontinued services, if applicable.

Modifier 52 indicates procedures for which services performed are significantly less than usually required. Reimbursement is reduced to [50 percent] of the applicable fee schedule or contracted/negotiated rate. Do not report Modifier 52 on Evaluation & Management (E&M) and consultation codes.

Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes.

Modifier 73 indicates the physician canceled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

Modifier 74 indicates a procedure was stopped after the administration of anesthesia or after the procedure was started. Reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

GA-NL-0012-16

Policy Update
Modifier Usage
(Policy 06-006, effective 08/01/16)

Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

GA-NL-0015-16

Policy Update
Modifier 91: Repeat Clinical Diagnostic Laboratory Test
(Policy 06-020, effective 07/01/17)

Amerigroup Community Care allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100 percent of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

GA-NL-0016-16

Policy Reminder

Claims Timely Filing

(Policy 06-050, originally effective 07/01/2013)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 180 days from the first calendar day following the month in which services were rendered for participating and nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

GA-NL-0014-16

Policy Reminder

Split-Care Surgical Modifiers

(Policy 11-005, effective 08/01/16)

Reimbursement of **surgical codes** appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 70 percent
- Modifier 55 (postoperative management only): 20 percent
- Modifier 56 (preoperative management only): 10 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

GA-NL-0020-16