Provider Newsletter

providers.amerigroup.com

2016
Quarter 2

New Claims Status Listing Tool

On June 18, 2016, a new Claims Status Listing Tool will be offered on the Amerigroup Community Care 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.

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

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

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.

New Reimbursement Policies

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

Amerigroup Community Care 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)

Amerigroup Community Care allows 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 are performed 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):

- "Always therapy" services
- Cardiovascular procedures
- Ophthalmology procedures

For market-specific information regarding reimbursement for these services and procedures, refer to the MPPR policy at https://providers.amerigroup.com.

Reimbursement Policy Reminders

Facility Take Home DME and Medical Supplies
(Policy 06-081, effective 12/10/2015)

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 non-participating 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 Community Care 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
- Determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Processes those services according to industry standards

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.

Rule	Provider type	Description
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.
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.