Provider Newsletter

providers.amerigroup.com

2015
Quarter 3

Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 years of age and older. Once a woman has had a fracture, she has a four times greater risk of another fracture, reports the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

Amerigroup Community Care asks that providers encourage women 67 to 85 who have had a fracture or may be a risk for a fracture to have a bone mineral density screening or be placed on osteoporosis medication if appropriate.

Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the Journal of Rheumatology.

Quality overview: Special needs plan Model of Care

Commitment to our dual eligible-special needs plan members' health and their satisfaction with the care and services they receive is the basis for the Amerigroup quality improvement program. Annually, the plan prepares a quality program description that outlines clinical quality and service initiatives. We strive to support the patient-physician relationship through our Model of Care program, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives.

Member satisfaction

We measure member satisfaction through an annual CAHPS® survey. Analysis of the survey results helps us identify areas where we do not meet member expectations. The areas analyzed are grouped into five areas:

- Getting care quickly
- Shared decision-making
- How well doctors communicate
- Getting needed care
- Customer service

Table of contents

Medicaid

1. Osteoporosis screening, medication encouraged for women
2. Quality overview: Special needs plan Model of Care
3. Member satisfaction
4. Access to utilization management staff
5. Access to case management
6. Member rights and responsibilities
7. Availity: New eligibility and benefits functionality and features
8. Pharmacy management information
9. Hypertensive diseases: Navigating the ups and downs of documentation and coding
10. Affirmative statement about incentives
11. Clinical practice guidelines performance
12. Distribution of clinical practice and preventive health guidelines
13. Provider satisfaction
14. Quality Improvement program
15. Availability of utilization management criteria
16. ICD-10: From compliance to medical policies
17. ICD-10 documentation and diagnosis coding tips
18. ICD-10-CM: HIV status

Amerivantage

19. Disease modifying anti-rheumatic drugs help prevent long-term disability
20. Encourage Medicare Advantage members to control high blood pressure
21. Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing
22. CMS requirements: Annual medication, supplement review for special needs plan members
23. Provider requirements and Medicare notices
24. Amerigroup, Optum deliver reports to ensure members receive regular exams

Amerivantage is an HMO plan with a contract with the State Medicare program. Enrollment in Amerivantage depends on contract renewal.

For the child member satisfaction survey, results showed that key drivers for overall satisfaction were:

- Treating members with courtesy and respect
- Easy to get care believed necessary for child
- Listening carefully to members

Amerigroup supports the use of the teach-back method as a double check for providers to confirm that a member was communicated with clearly and that the information was understood. The teach-back method is a way to:

- Introduce and reinforce oral communication strategies
- Suggest ways to increase staff awareness as they interact with members
- Provide staff with examples and helpful advice on performing the Teach-back method.

For more information about the teach-back method, visit merck.qualitysolutionnavigator.com/resource_view/
CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Access to utilization management staff

We are staffed with clinical professionals who coordinate our members' care and who are available 24 hours a day, 7 days a week to accept precertification requests. You can submit precertification requests by:

- Calling us at 1-800-454-3730
- Faxing us at 1-877-842-7187
- Using the Precertification Lookup tool located at providers.amerigroup.com/GA

Have questions about utilization decisions or the utilization management process in general? Call our Clinical team at 1-800-454-3730, Monday through Friday, from 8:30 a.m. to 5:30 p.m. Eastern time.

Access to case management

In addition to our disease management programs, we also offer a complex case management program for our high-risk members. Using claims and utilization data, we can identify diseases for which members are most at-risk and to which they are most susceptible.

Our case managers use evidence-based guidelines to coordinate care with members, their families, physicians and other health care providers. They work with everyone involved in the member's care to help implement a case management plan based on members' individual needs. We provide education and support to our members and their families to help our members improve their health and quality of life. If you have a high-risk member you would like to refer to this program, please call us at 1-800-454-3730.

Member rights and responsibilities

We want to keep you informed about our members' defined rights and responsibilities. These can be found in the provider manual and on our website at providers.amerigroup.com/GA. To receive a copy in the mail, call Provider Services at 1-800-454-3730.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4441 (TTY 711).

Availity: New eligibility and benefits functionality and features

The Availity Web Portal launched new eligibility and benefits functionality and features on June 27, 2015. These changes make finding eligibility and benefits easier and faster for you. Here's a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes user's most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list displays all service types and benefits returned from the health plan.
Patient snap shot	The summary of patient information is easily found at the top of the page.
Clearer display of details	Users have a clearer and more complete view of specific benefit and financial information.
Advanced printing	By selecting which sections to print, users save paper and can customize prints to target necessary information.
Real-time feedback	Feedback buttons on each returned eligibility allows users to provide instant feedback of missing or inaccurate information.

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

Pharmacy management information

For up-to-date pharmacy information, log on to our website at providers.amerigroup.com/GA and access our formulary, prior authorization form and preferred drug list. If you have questions about the formulary or need a paper copy, call the Pharmacy department at 1-800-454-3730. Pharmacy technicians are available Monday through Friday from 8 a.m. to 8 p.m. Eastern time and Saturday from 10 a.m. to 2 p.m. Eastern time.

Hypertensive diseases: Navigating the ups and downs of documentation and coding

Blood pressure is the force of blood against the walls of the arteries. Abnormally high pressure or hypertension damages blood vessels, causing them to become scarred, hardened and brittle. The damaged vessels are no longer able to adequately supply blood to the organs and tissues of the body. Hypertenstion can lead to strokes, organ failure or heart attacks when not properly controlled.

Treating hypertension

Hypertension is a chronic condition that requires lifelong treatment for most people. Treatment is aimed at controlling blood pressure and treating underlying or secondary conditions. The American Heart Association recommends blood pressure levels below 120/80 and screenings starting at 20 years of age. Hypertension is typically treated with medications, exercise/diet, stress management and not smoking.

Documentation and coding
The medical record documentation for patients with hypertension should include each of the following:
- Type of hypertension – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- Complications – body system such as heart or kidney that are affected by hypertension.
- Specific conditions – details on the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)
- Assessment/treatment – all measures aimed at controlling the hypertension or treating symptoms of complication(s)

Diagnosis code assignment is based on provider documentation and the medical record must support the codes submitted on the claim.

Essential (primary) hypertension 401
Code assignment is based on the type of hypertension documented (benign, malignant or unspecified). Statements such as high blood pressure, hypertension and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign **code 796.2** elevated blood pressure reading without diagnosis of hypertension.

Hypertensive heart disease 402
Assign category 402 hypertensive heart disease when a cardiac condition is stated (due to hypertension) or implied (hypertensive). The physician must document cause and effect between the two conditions. Category 402 is futher specified based on the presence of heart failure. Use additional codes from (428.0 - 428.43) to specifiy type of heart failure if known.

Hypertensive chronic kidney disease 403
ICD-9 coding guidelines assume a cause and effect relationship when both hypertension and chronic kidney disease (CKD) are documented. Assign codes from category 403 hypertensive chronic kidney disease along with additional codes for the stage of CKD from category 585 chronic kidney disease.

Hypertensive heart and chronic kidney disease 404
When documentation supports heart and kidney complications with hypertension, the rules of cause and effect are as follows:
- Assumed cause and effect for hypertension and chronic kidney disease
- Requires documented cause and effect for hypertension and heart disease

Intructional notes state to use additional codes from 428.0 – 428.43 to specifiy the type of heart failure (if known) and the stage of CKD from category 585 chronic kidney disease.

Secondary hypertension 405
Hypertension caused by underlying conditions such as adrenal gland disorders, kidney disease and drugs are called secondary hypertension. Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

AHA Coding Clinic advice
When the provider establishes a link or relationship between two conditions, they should be coded as such. The entire record for the date of service should be reviewed to determine whether a relationship between the two

conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean that they are related. A different cause may be documented by the provider. If it is unclear whether or not two conditions are related, coders should query the provider (AHA Coding Clinic Q3, 2012.)

Hypertensive diseases in ICD-10

An important change for hypertension is that ICD-10 does not require documentation of the type of hypertension for correct code assignment. Providers will need to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

ICD-10	Description
I10	Essential (primary) hypertension
I11	Hypertensive heart disease (with or without heart failure) Use an additional code from I50 to specify type of heart failure (if present)
I12	Hypertensive chronic kidney disease Use an additional code from N18 to identify stage of chronic kidney disease
I13	Hypertensive heart and chronic kidney disease Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease
I15	Secondary hypertension Requires two codes, one for underlying cause and on from category I15 to identify secondary hypertension Sequencing is based on circumstances of visit and documentation

Affirmative statement about incentives

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 specifically reward practitioners or other individuals for issuing denial 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.

Clinical practice guidelines performance

Amerigroup provides clinical care and preventive health guidelines to our network physicians. These clinical practice guidelines (CPG) are available on our website at providers.amerigroup.com/GA under Provider Resources and Documents > Clinical Practice Guidelines.

We are grateful to the providers who participated in the medical record review project which monitors provider's CPG compliance in over 450 ADHD, asthma and diabetes medical records.

ADHD

Rating scale is one piece in the guideline. As providers document the rating scale, we request the use of an ADHD rating scale when seeing a new member on ADHD medications, even if the member was referred by another provider. Here are two ADHD rating scales to use:

- Vanderbilt Assessment Scale at myadhd.com/vanderbiltparent6175.html
- The Conner's Test at mhs.com

We understand coordination between parents and schools is time consuming and we appreciate the effort put forward in completing these screenings.

Diabetes

Receiving lab results, documenting history and physical and educating patients about the risks and next steps to controlling his or her diabetes are some components to the diabetes guideline.
For more information and tools to better educate patients, please visit the American Diabetes Association website at diabetes.org.

Asthma

Patient education about risk factor assessment, asthma action plan and appropriate asthma medication are a few factors in the asthma guideline. Providers can provide enhanced follow-up care.

For an example of an asthma action plan, please visit the Centers for Disease Control and Prevention (CDC) website at cdc.gov/asthma/tools_for_control.htm.

Providers should become familiar with these guidelines and can access them on our website at providers.amerigroup.com/GA under Provider Resources and Documents > Clinical Practice Guidelines.

Distribution of clinical practice and preventive health guidelines

Evidence-based guidelines are CPGs known to be effective in improving health outcomes. Guideline effectiveness is determined through scientific evidence, professional standards or expert opinion. Amerigroup provides clinical care and preventive health guidelines to our network physicians. These guidelines are based on current research and national standards. The following guidelines are available on our website at providers.amerigroup.com/GA:

- Attention deficit hyperactivity disorder Adult preventive health recommendations
- Asthma
- Management of bipolar disorder in adolescents
- Management of bipolar disorder in adults
- Child preventive health recommendations
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Diabetes mellitus
- Management of HIV/AIDS
- Childhood and adolescent hypertension
- Management of major depression
- Management of obesity in children and adolescents
- Postpartum care
- Management of schizophrenia
- Adult hypertension
- Congestive heart failure

We also suggest you refer to the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care guidelines at aap.org for children up to 21years of age.

You can find immunization schedules at aap.org/immunization/izschedule.html. For the Bright Futures Periodicity schedule, visit brightfutures.aap.org.

If you would like a paper copy of any of the guidelines noted, call Provider Services at 1-800-454-3730.

Provider satisfaction

Each year, we conduct a provider satisfaction survey. Analysis of survey responses helps us to identify aspects of performance that do not meet provider expectations and initiate an action plan to improve performance. A positive working relationship with our contracted providers is important to the delivery of health care to our members. The objective of the survey is to measure overall provider satisfaction with, and loyalty to, Amerigroup and to identify areas of strength and opportunities for improvement. The survey also assesses provider satisfaction in the following categories:

- Customer service at the call center
- Local health plan provider services
- Communication and technology
- Claims processing and provider reimbursement
- Network
- Utilization management
- Quality management
- Pharmacy and drug benefits
- Disease Management Centralized Care Unit
- Continuity and coordination of care

We distributed our latest survey in 2014. The overall Amerigroup satisfaction ranking was 86 percent, which was a slight increase from 84 percent in 2013. For key drivers, we have made improvements in case management, utilization management, HEDIS® data and disease management.

Thank you for participating in our network, for providing quality health care to our members and for cooperating in our annual review process.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Improvement program

The Amerigroup Quality Improvement (QI) program is committed to excellence in the quality of service and care our members receive and the satisfaction of our network providers. We are always looking for ways to refine our comprehensive QI program, which includes:

- Adherence to federal, state and Georgia Families program standards
- Objectively monitor and evaluate the care and services provided to members
- Plan studies across the continuum of care to ensure ongoing, proactive evaluation and refinement of the program
- Reflect the demographic and epidemiological needs of the population served

- Encourage both members and providers to weigh-in with recommendations for improvement
- Identify areas where we can promote and improve patient safety
- Measure our progress to meet annual goals

We would like to share with you our annual quality improvement summary of goals, processes and outcomes related to clinical performance and service satisfaction. Throughout the year, we evaluate data trends related to how our members receive health care and preventive care services, and then we compare our findings to national practice guidelines. You — our network physicians and office staff — are the key to helping us collect this information and improve our quality performance.

Clinical performance and service satisfaction are based upon results from:

Performance measures — HEDIS is a program developed by the National Committee for Quality Assurance (NCQA) to measure important dimensions of care and service performance. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided to and health outcomes of children in Medicaid and CHIP programs and include a core measure set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs . These measures evaluate a broad range of important health issues, including: immunizations, preventive care and screening, comprehensive diabetes care, asthma medication use, controlling hypertension and access to care.

CAHPS — Consumer Assessment of Health Providers & Systems (CAHPS) surveys evaluate member satisfaction related to care and services received over the past six months. Plan members are randomly sampled and answer questions about their doctors and the health plan

HEDIS and CAHPS results help us identify areas of strength and areas where we need to focus our improvement efforts. We use the results to measure our performance against our goals and to determine the effectiveness of plans we implemented to improve our results.

Amerigroup's QM accomplishments in 2014:

- Achieved #1 ranking for Medicaid health plans in Georgia and #32 ranking nationally according to the National Committee for Quality Assurance (NCQA). Amerigroup was only one of two plans in the Southeast region in the top 35 health plans nationally. In 2014, NCQA ranked 136 Medicaid health plans, placing Amerigroup in the top quartile.
- Ensured continuous activities were in place to increase HEDIS rates from the previous year, resulting in improved rates for measurement year 2013 (reported in 2014) for several measures, including well-child visits in the 3rd, 4th, 5th and 6th years of life, lead screening, adolescent well-care visits, BMI percentile, counseling for nutrition and physical activity, adult BMI, controlling high blood pressure, follow-up after hospitalization for mental illness and appropriate treatment for children with URI.
- Maintained continuous NCQA health plan accreditation. Our score for HEDIS and CAHPS rates submitted to the National Committee for Quality Assurance (NCQA) accreditation review in 2014, resulted in a commendable rating for our health plan.
- Rated in the 90th percentile for health plan and customer service on 2014 CAHPS survey.
- Expanded plan-wide training and engagement in quality improvement initiatives.
- Increased provider engagement activities including assisting additional primary care practices with NCQA patient centered medical home designation.

- Expanded number of physician practices participating in pay-for-performance programs.
- Increased our community health promotions activities in 2014 conducting 163 events resulting in arranging more than 3,000 well-child visits.
- Provided oversight of delegated vendor activities.
- Performed member and provider education and outreach activities to increase preventive screening rates.
- Submitted the required performance improvement projects to DCH.

QM direction for Amerigroup in 2015:
- Continue collaboration with DCH and CMIS on quality improvement initiatives
- Execute on rapid-cycle improvement projects to identify effective interventions to spread to our network
- Ensure continuous survey readiness for NCQA reaccreditation in 2016
- Complete a successful 2015 EQR audit
- Continue PCP medical record reviews for Clinical Practice Guideline adherence and monitoring health check compliance for early and periodic screening, diagnosis and treatment (EPSDT) program screening rates to meet required targets
- Continue focus on health promotion and education
- Increase collaboration with physicians on quality improvements and continue to improve Provider Satisfaction
- Take actions to reduce racial and ethnic disparities in health care
- Collaborate with the network to improve member satisfaction
- Increase provider and member involvement on our Health Advisory Committees

To review or receive a copy of the current Quality Improvement program documents or if you would like more information about our QM program, data results and progress toward meeting our goals, please call our office at 678-587-4840 and ask for Charmaine Bartholomew.

Availability of utilization management criteria

We use nationally recognized Amerigroup criteria to assist our Medical Management staff in making decisions concerning the medical necessity of:
- In-hospital level of care and length of stay
- Admissions
- Outpatient services
- Behavioral health services
- Pharmacy services

If an Amerigroup medical director denies a service request, both provider and member will receive a notice of action letter which will include the reason for the denial, note the criteria/guidelines used for the decision, as well as explain the appeal process and provider/member rights. To speak with a medical director about the service request denial, call Provider Services at 1-800-454-3730 or the local health plan. To request a copy of the specific criteria/guidelines used for the decision, please call 1-800-600-4441 or write to:

Medical Management
Amerigroup Community Care
303 Perimeter Center North, Suite 400
Atlanta, GA 30346

ICD-10: From compliance to medical policies

Below is an overview of the ICD-10 update and key information you need to know:

Compliance

- The current implementation date of ICD-10 is October 1, 2015, as mandated by HIPAA.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' or hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s). The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis for correct coding.
- Providers should submit all known conditions on the claim using ICD-10-CM diagnosis codes.

Claims processing

The following information explains the claims processing procedures for claims according to dates of services. Amerigroup is committed to ensuring providers understand the correct code set to use. The following information applies to claims processing:

- No mixed claims: Consistent with CMS guidelines, mixed claims (claims filed with ICD-9 and ICD-10 codes on the same claim) will not be accepted.
- ICD-10 codes: Claims with ICD-10 codes for dates of service (DOS) or dates of discharge (DOD) prior to October 1, 2015 will not be accepted.
- ICD-9 codes: HIPAA will not allow the use of ICD-9 codes for claims with DOS or DOD on or after October 1, 2015.
- Resubmitting claims: When resubmitting claims, providers should utilize the code set that is valid for the DOS/DOD.

Update to prior authorizations process

Amerigroup has updated prior authorization procedures to accommodate the transition to ICD-10-CM. The updates will ensure that providers understand how to submit prior authorizations according to the date that services are scheduled to be performed. The following information details the process for prior authorizations:

- Starting June 1, 2015, we will begin accepting and processing prior authorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015.
- ICD-9 codes must continue to be used to prior authorize services scheduled through September 30, 2015.
- Existing approved prior authorizations coded in ICD-9 whose effective period spans the ICD-10 date of October 1, 2015, do not need to obtain another authorization that is coded in ICD-10.
- Prior authorizations that span the October 1, 2015, compliance date will be valid for claims submitted using ICD-10 codes.
  - Example: If a durable medical equipment wheelchair rental authorization coded with ICD-9 was approved for the effective period of April 1, 2015 – April 1, 2016, this authorization will still be valid for claims filed using ICD-10 diagnosis codes with beginning dates of service of October 1, 2015, and later.

Update to medical policies

Amerigroup has worked diligently to ensure that medical policies and clinical utilization management (UM) guidelines have been updated to include proposed ICD-10 coding. We want to ensure that providers understand where to locate medical policies and UM guidelines. Preparing policies and processes for ICD-10 helps ensure providers operate smoothly after October 1, 2015. The updated medical policies are available on the Amerigroup provider website at providers.amerigroup.com/GA. For specific questions regarding medical policies, please contact Provider Services at 1-800-454-3730.

Coding updates and resources for providers

Amerigroup is committed to helping providers transition smoothly to the new ICD-10-CM code set. The resources below provide valuable information in terms of assessment, planning and training to help providers at any stage in the ICD-10-CM implementation process.

- Amerigroup provider home page: This site offers the latest news on ICD-10 and links to industry resources. Visit our provider website at providers.amerigroup.com and look for the ICD-10 news link.
- The Amerigroup newsletter: This communication provides documentation and coding information on ICD-10 and HEDIS in addition to important network updates. Find our newsletter online at providers.amerigroup.com/GA.
- Road to 10: CME Online Tool for Small Practices: This online resource built with the help of providers in small practices is intended to help small medical practices jumpstart their ICD-10 transition. It includes specialty references, access to free Medscape education modules and CME credits for physicians and nurses who complete the learning modules. Use this tool at www.roadto10.org/.
- ICD-10 Monitor: This online news and information source was created to help healthcare providers make informed decisions as they transition to ICD-10. The ICD-10 Monitor hosts weekly live broadcasts where relevant ICD-10 topics are discussed with industry experts called Talk Ten Tuesdays. Visit the site at .icd10monitor.com.

ICD-10 documentation and diagnosis coding tips

ICD-10-CM diagnosis codes

- Contain anywhere from 3-7 characters (seventh character extension)
- Character 1 is alpha
- Character 2 is numeric
- Characters 3-7 are alpha or numeric (alpha digits are not case sensitive)
- Decimal appears after the third digit
- The first three characters make up the ICD-10 category
- Characters 4-7 are driven by clinical concepts in documentation

Understanding ICD-10-CM coding

- The current implementation date of ICD-10 is October 1, 2015. Providers and staff should be engaged in ICD-10 coding training now.
- Dates of service or dates of discharge that occur on or after October 1, 2015, must be reported using ICD-10-CM/PCS.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis in order to allow the most specific code(s) to be assigned.

ICD-10-CM official coding guidelines for outpatient services

The outpatient coding guidelines for ICD-10-CM are completely similar to those found in ICD-9-CM. For guidelines, visit the CDC website at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2015.pdf. Listed below are some of the ICD-10-CM guidelines pertinent to outpatient and office visit encounters.

- **ICD-10-CM Section IV.C, Accurate reporting of ICD-10-CM diagnosis codes.** For accurate reporting of ICD-10 diagnosis codes, the documentation should describe the patient's diagnoses, symptoms, problems, or reasons for the encounter. It is acceptable to report the appropriate unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

- **ICD-10-CM Section IV.F. 1-2, Level of detail in coding.** Codes with only 3 characters are used as the heading of categories in ICD-10-CM and may be further subdivided (require additional characters). Providers must report ICD-10-CM diagnosis codes to their highest number of characters available. Incomplete and/or invalid diagnoses codes are not acceptable for reporting.
- **ICD-10-CM Section IV.H, Uncertain diagnosis**. Do not code diagnoses documented as probable, suspected, questionable, rule out, working, consistent with or other similar terms that indicate uncertainty. Instead, code the conditions to the highest degree of certainty for the encounter/visit.
- **ICD-10-CM Section IV.I, Chronic diseases.** 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. Chronic conditions do not go away and typically always impact care provided. They should be assessed and reported at each visit.
- **ICD-10-CM Section IV.J**, **Code all documented conditions that co-exist**. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do note code conditions that were previously treated and that no longer exist.

Clinical concepts in documentation

Certain clinical concepts appear in ICD-10 coding which may or may not be present in ICD-9. Providers should become familiar with these concepts and ensure that documentation includes all known pertinent details for accurate code assignment in ICD-10. Examples of clinical concepts include:

- Cause and effect
- Laterality
- Timing
- Associated conditions
- Remission status
- Severity
- Episode of care
- Trimester of pregnancy
- Agent and/or organism
- Anatomical location
- Comorbidities
- Depth/stage for wounds and ulcer
- Late effects

New coding conventions

ICD-10-CM has some new coding conventions that are not included in the ICD-9-CM code set. A brief explanation of those follows:

- **Seventh character extension** is required for certain categories in ICD-10 and must always appear in the seventh character field.
- The **dummy placeholder X** may be used in the 5th or 6th character field to ensure that a seventh character is added correctly.

Example: T15.12XS Foreign body in conjunctival sac, left eye, sequel (late effect)

Locating the correct diagnosis code in the ICD-10 code book

- First, locate the documented term in the alphabetic index and then verify the code in the tabular list.
- Use a current ICD-10 code book. Become familiar with the Official ICD-10-CM Coding Guidelines and follow all instructions for the chapter and category related to specific codes including Excludes1and Excludes2 notes.
  - Excludes1 – Not coded here. The codes should never be used at the same time.
  - Excludes2 – Not typically included here, but a patient may have both conditions at the same time.
- Reliance on coding software, EHR systems, and cheat sheets alone can lead to coding errors.

Locating official coding advice

- The *American Hospital Association (AHA) Coding Clinic*™ is the CMS approved resource for clarification of ICD-10-CM. Volumes are published quarterly and contain new and/or updated information on the use of ICD-10-CM as well as clarification of previously published coding advice.
- Additional advice on ICD-10-CM can be located on CMS website at http://cms.hhs.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10.

Documenting specificity for accurate ICD-10 coding

Specificity in documentation allows the most accurate ICD-10 codes to be assigned. Accurate and complete coding shows a true picture of each member's health status. As the October 1, 2015, compliance date draws near, health care providers should begin incorporating additional documentation into patient encounters. The table below shows some common chronic conditions and the documentation requirements for accurate ICD-10 code assignment.

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Asthma	• **Severity** – Document asthma severity as either intermittent, mild persistent, moderate persistent or severe persistent. • **Type** – Exercise induced or cough variant are other types of asthma; documentation should specify type. • **Acute exacerbation** – Documentation should state if the asthma is in acute exacerbation. • **Status asthmaticus** – Acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators. • **Infection** – Superimposed infection may be present this should clearly be documented by the provider.	J45.20 – J45.998
Hypertension	• **Primary or secondary** – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension, one to identify the underlying etiology and one from category *I15 Secondary hypertension*. • **Transient** – Temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code *R03.0 Elevated blood pressure reading without a diagnosis of hypertension.* • **Controlled/uncontrolled** – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is *I10 Essential (primary) hypertension.*	I10 – I15.9

Hypertension	• **Complications** – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive, caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following coding guidance applies to hypertensive complications: – **I11 Hypertensive heart disease** – Use additional code from category *I50 Heart failure* if present. – **I12 Hypertensive chronic kidney disease** – Use additional code from category *N18 Chronic kidney disease* to identify the stage. **I13 Hypertensive heart and chronic kidney disease** – Requires use of additional code from category *I50 Heart failure* if present and use additional code from category *N18* Chronic kidney *disease* to identify the stage. – **I60 – I69 Hypertensive cerebrovascular disease** – Code also *I10 Essential (primary) hypertension.* – **H35.0 Hypertensive retinopathy** – Code also *I10 Essential (primary) hypertension.*	I10 – I15.9
Diabetes mellitus (DM)	• **Type** – Providers must document the type of diabetes in ICD-10-CM: – **E08 Diabetes mellitus** – Due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc. – **E09 Drug or chemical-induced diabetes mellitus** – Code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect if applicable, to identify drug. – **E10 Type 1 diabetes mellitus** – Due to pancreatic islet B cell destruction. Also known as juvenile diabetes. – **E11 Type 2 diabetes mellitus** – Use for diabetes not otherwise specified. – **E13 Other specified diabetes mellitus** – Includes that due to genetic defects and secondary diabetes not classified elsewhere. • **Body system affected** – Diabetes may affect multiple body systems. Providers should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented. • **Complications affecting that body system** – Providers must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include: diabetes with neuropathy, diabetic retinopathy, and nephropathy due to diabetes. • **Insulin use** – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term then apply code Z79.4 (Long term, current use of insulin).	E08 – E13

Amerigroup RealSolutions® in healthcare

ICD-10-CM: HIV status

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015.

The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient's human immunodeficiency virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

The table below reflects the crosswalk from ICD-9 to ICD-10.

ICD-9 Code(s)	ICD-10 Code(s)
• **V08** – Asymptomatic human immunodeficiency virus (HIV) infection status • **042** – Human immunodeficiency virus (HIV) • **079.53** – Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified sit	• **Z21** – Asymptomatic human immunodeficiency virus [HIV] infection status • **B20** – Human immunodeficiency virus (HIV) disease • **B97.35** – Human immunodeficiency virus, type 2 (HIV 2) as the cause of diseases classified elsewhere

To further assist in preparation for ICD-10, please see the following resources:

- Centers for Medicare & Medicaid Services (CMS): Provider Resources
- American Academy of Professional Coders: AAPC ICD-10 Resources
- World Health Organization: WHO ICD-10 Training

Disease modifying anti-rheumatic drugs help prevent long-term disability

The American College of Rheumatology recommends that persons with rheumatoid arthritis (RA) are prescribed a disease modifying anti-rheumatic drug (DMARD) to prevent long-term disability and damage. To help ensure your Medicare Advantage RA patients have these important prescriptions, we will review medical and pharmacy claims looking for members who have an RA diagnosis and do not appear to have a claim for a DMARD. Providers who have members with a diagnosis of RA and not on a DMARD may receive a monthly fax reminder. Please be sure to use correct diagnosis codes for RA and be careful not to use a RA code for ruling out RA, osteoarthritis and joint pain.

Encourage Medicare Advantage members to control high blood pressure

According the Centers for Disease Control and Prevention (CDC), almost one in three American adults has high blood pressure but only about half have their blood pressure under control. Amerigroup joins you in encouraging our Medicare Advantage members to know and control their blood pressure to lower their risk of heart attack, heart disease, stroke and kidney disease.

Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Amerigroup follows CMS Medicare Part B immunization billing guidelines. Please use the following forms when filing flu, pneumonia or hepatitis B claims for Amerigroup individual and group-sponsored Medicare Advantage members.

- Professional claims should be filed on the CMS 1500 form with the appropriate current procedural terminology code and/or health care procedural code for the vaccine and administration.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes.
  - Revenue codes (except rural health clinics and federally qualified health centers):
    - 0636 – vaccine (and CPT or HCPC)
    - 0771 – administration (and HCPC)
  - Rural health clinics and federally qualified health clinics – 052X revenue code series

Please refer to page three of the Medicare Part B immunization billing http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf for specifics on institutional billing.

CMS requirements: Annual medication, supplement review for special needs plan members

Medicare requires that primary care providers (PCPs) review all prescription and nonprescription drugs, vitamins, herbals and other supplements at least once per year for members in a special needs plan (SNP).

SNP members 66 years of age or older should also have one functional status assessment each year. According to Healthcare Effectiveness Data and Information Set (HEDIS®) guidelines, notations for a complete functional status assessment should include one of the following:

• Notation that activities of daily living were assessed – includes bathing, dressing, eating, transferring (i.e., getting in and out of chairs), using toilet, walking

Notation that instrumental activities of daily living were assessed – includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances

• Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - Assessment of living skills and resources
  - Barthel ADL index physical self-maintenance scale

- Bayer activities of daily living scale
- Barthel index
- Extended activities of daily living scale
- Independent living scale
- Katz index of independence in activities of daily living
- Kenny self-care evaluation
- Klein-Bell activities of daily living scale
- Klein-Bell activities of daily living scale
- Kohlman evaluation of living skills
- Lawton & Brody's instrumental activities of daily living scales

- Notation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Sensory ability (including hearing, vision and speech)
  - Other functional independence (i.e., exercise, ability to perform job)

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

Provider requirements and Medicare notices

The Centers for Medicare and Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the Important Message from Medicare About Your Rights (IM) notice to every Medicare beneficiary within two calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than two calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, Amerigroup periodically conducts IM and NOMNC audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

Our audit findings show providers would benefit from focusing in on the following elements required by CMS:
NOMNC notices:

- Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
- Include the beneficiaries health care identification number or medical record number on page one
- Include the specific type of services ending on page one
- Include the health plan's contact information on page two
- Have the beneficiary or authorized representative sign and date page two at least two days prior to the end of services
- Retain a copy of the signed notice, both page one and page two

IM notices:

- Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
- Include the physician's name on page one
- Have the beneficiary or authorized representative sign and date page one within two calendar days of the date of an inpatient hospital admission
- Call the authorized representative to deliver the IM when the beneficiary is unable to sign
- Deliver the IM, or copy of the IM again, no sooner than two calendar days before discharge
- Retain a copy of the signed notice, both page one and page two.

To download the standardized IM/NOMNC notices required by CMS, along with accompanying instructions, go to CMS website at cms.hhs.gov/bni or refer to the specific links below:

- NOMNC notice: cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
- IM notice: cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Important update: Quality improvement organizations (QIO) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see qioprogram.org to locate your QIO.

For more information on compliance with the Notice of Medicare Non-Coverage or the Important Message from Medicare, contact Mary Heapes, RN, BSN in the Federal Clinical Compliance Department at 212-476-2908.

Amerigroup, Optum deliver reports to ensure members receive regular exams

Amerigroup collaborates with Optum to educate our individual and group-sponsored members on the importance of annual wellness exams and improvement of chronic conditions.

The patient assessment form (PAF)/health care quality patient assessment form are used to ensure individual and group-sponsored Medicare Advantage members receive a complete and comprehensive assessment at least once a year. The PAF is always sent when an appointment is scheduled with an Amerigroup member. Some providers, depending on volume, will receive a PAF for all members regardless of an appointment being scheduled.

The members without office visit report identifies patients who have not visited a provider in 12 months. Optum will work with a practice to ensure a patient schedules an updated office visit.