Provider Newsletter

https://providers.amerigroup.com/IA
Provider Services: 1-800-454-3730

2016
Quarter 3

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Amerigroup
An Anthem Company

Vascular embolization or occlusion services to require prior authorization

Effective October 1, 2016, vascular embolization or occlusion services will require prior authorization (PA).

Vascular embolization or occlusion services requests must be reviewed by Amerigroup Iowa, Inc. for PA for dates of service on and after October 1, 2016. To request PA, use one of the following methods:

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

For a list of Amerigroup reimbursement policies and more information on PA requirements, please visit our website at https://providers.amerigroup.com/ia and under Provider Resources & Documents, select Quick Tools.

- For reimbursement policies, select Reimbursement Policies.
- For authorization requirements, select Precertification Lookup Tool.

If you have questions about this communication or need assistance with any other item, call Provider Services at 1-800-454-3730.

PCP Change Request form now available on provider website

Amerigroup Iowa, Inc. has implemented a new way to perform PCP changes for its members. You may now download the PCP Change Request Form from the provider website and fax it to the number provided.

- Download the form at the Amerigroup provider website (https://providers.amerigroup.com/ia).
- Ensure the form is completed in its entirety by the member. Forms will not be processed unless all fields are completed.
- Fax form to 1-866-840-4993.
- Allow 24-72 hours for processing.

Please note: PCP changes are effective the date the fax is received. *PCP Change Request* forms are not retroactive.

Effective November 1, 2016 ClaimsCheck® upgrade to ClaimsXten™

Amerigroup Iowa, Inc. 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 ClaimCheck10.2, 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 type 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.

Rule	Provider type	Description
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.
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. Thank you for your support.

Coverage of Vaccinations for *hawk-i* Members

Amerigroup Iowa, Inc. will cover the cost of the vaccine and the administration of vaccines to ***hawk-i*** members. Providers should not use the Vaccine for Children Program as this is for children on Medicaid only.

AIM Specialty Health® (AIM) to conduct medical necessity reviews for vascular and radiology modalities

Amerigroup Iowa, Inc. is collaborating with AIM to conduct medical necessity reviews for vascular and radiology modalities for our individual IA Health Link and ***hawk-i*** members.

Effective June 1, 2016, AIM will accept prior authorization (PA) requests for the following modalities:

- Computed tomography (CT), also includes (CTA)
- Magnetic resonance imaging and angiogram (MRI, MRA, magnetic resonance spectroscopy [MRS], magnetic resonance microscopy [MRM])
- Nuclear cardiology
- Positron emission tomography (PET)
- Functional magnetic resonance imaging (fMRI)
- Stress echocardiography (SE)
- Resting transthoracic echocardiography (TTE)
- Transesophageal echocardiography (TEE)

To submit your request, go to the AIM provider portal at Availity.com or https://providers.amerigroup.com.

Access through https://providers.amerigroup.com:

If you are navigating to the new secure Amerigroup provider website from providers.amerigroup.com:

- Click *Login*
- Enter your Availity ID and password

PA requirements also can be reviewed online at Availity.com.

If you have questions, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730. For additional assistance, you may also call AIM at 1-800-714-0040, Monday through Friday, 7 a.m. to 7 p.m. Central time.

Enhanced Availity eligibility and benefits inquiry

Users now have the added benefit to query for multiple members at one time through the Availity eligibility and benefits inquiry.

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.

What if I need assistance?

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. PT.

If you have questions about the tools and resources available on the Amerigroup Iowa, Inc. 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.

Reimbursement Policies

New Policy
Reimbursement for Maximum Units Per Day
(Policy 15-003, effective 01/01/2017)

Amerigroup Iowa, Inc. allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

For additional information, refer to the Reimbursement for Maximum Units Per Day policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Iowa.

New Policy
Durable Medical Equipment (Rent to Purchase)
(Policy 06-052, effective 01/01/2017)

Amerigroup Iowa, Inc. allows reimbursement for Durable Medical Equipment (DME). Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of Rental DME
Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances Affecting Rental Reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days
- If a member changes suppliers during the rental period, a new rental period will not start over

Amerigroup allows reimbursement for oxygen equipment for a maximum of 36 months; however, Amerigroup will continue to reimburse for oxygen contents.

For additional information, refer to the Durable Medical Equipment (Rent to Purchase) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Iowa.

Policy Update

DME Modifiers for Rented and Used Equipment

(Policy 06-053, effective 3/14/16)

Amerigroup Iowa, Inc. allows reimbursement for rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary
or first modifier field to determine appropriate reimbursement:

- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics, and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier RR or UE may be denied.

For additional information, refer to the DME Modifiers for New, Rented and Used Equipment policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Iowa.