# Provider Newsletter

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2016
Quarter 2

## Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

**Additional coverage information**

As previously communicated, routine screening Pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine Pap testing for women 66 and older, with prior negative screening results, will be denied.

**Screening method and intervals**

The U.S. Preventive Services Task Force[1], the American College of Obstetricians and Gynecologists[2], the American Cancer Society[3], the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

| Population | Recommended screening |
|---|---|
| Women younger than 21 years | No screening |
| Women aged 21-29 years | Cervical Pap alone every three years |
| Women aged 30-65 years | Human Papillomavirus (HPV) and cervical Pap co-testing every five years or cervical Pap alone every three years |

### Table of contents

1. Routine cervical cancer screening
2. New claims status listing tool
3. ICD-10 coding for diabetes

### Reimbursement Policies

4. Medical Recalls

| Population | Recommended screening |
| --- | --- |
| Women older than 65 years | No screening is necessary after adequate negative prior screening results |
| Women who underwent total hysterectomy (with no residual cervix) | No screening is necessary |

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.


1. United States Preventive Services Task Force. Cervical Cancer. March 2012.
2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:el-20.
3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.


## New Claims Status Listing Tool

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

**Here's 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 passwords should not be shared.

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.

## ICD-10 and coding for diabetes

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

**Diabetic complications in ICD-10**

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

- Type of diabetes (i.e., Type 1, Type 2, secondary)
- Complications and body systems affected (i.e., diabetic neuropathy)
- Control status (document how well diabetes is controlled over time)
- Long term use of insulin (report additional code Z79.4 on the claim)

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

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

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

**Accurately reporting uncontrolled diabetes**

Previously, diabetes mellitus codes were classified as controlled or uncontrolled. In ICD-10-CM diabetes described as not being controlled is classified as hyperglycemia which is considered a complication.

When documentation contains terms such as *inadequately controlled, out of control and poorly controlled, the index leads to* diabetes with hyperglycemia (see example below). Assign as many codes that are needed to accurately describe the patient's diabetic condition(s).

| Documentation | Correct code(s) |
|---|---|
| Male patient is seen and evaluated for diabetes mellitus type 2 poorly controlled. | E11.65 Type 2 diabetes mellitus with hyperglycemia |
| Female patient is seen and evaluated for shooting pain and numbness in toes and feet. The provider diagnosis type 1 diabetic neuropathy inadequately controlled. | E10.40 Type 1 diabetes mellitus with diabetic neuropathy<br>E10.65 Type 1 diabetes mellitus with hyperglycemia |

**Documenting to support accurate coding**

Since diagnosis coding is based on provider documentation, it is critical that providers include all known details about coexisting and chronic conditions (i.e., diabetes) in the medical record for each patient encounter. Details such as the provider's assessment/evaluation of the condition, medications prescribed, recommendations, referrals and even patient noncompliance help support accurate coding. Supporting documentation for all current medical conditions improves quality of care and ensures coding guidelines are followed. ICD-10-CM Official Guidelines for Coding and Reporting, Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services state:

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

**Documenting cause and effect for diabetic complications**

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

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

If documentation does not properly link the condition(s), a diabetes combination code should not be assigned. Each condition must be coded separately when documentation does not establish a causal link (see example on following page).

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

For complete ICD-10-CM Official Guidelines for Coding and Reporting, please refer to the front of the current ICD-10-CM coding manual.

## Reimbursement Policies

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

Amerigroup Iowa, Inc. 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.