Provider Newsletter

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

2017
Quarter 2

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IA-NL-0054-17

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Amerigroup An Anthem Company

Genetic testing services to require prior authorization

Effective May 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 May 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 Iowa, Inc. for IA Health Link 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 at 1-800-454-3730 or by fax at 1-800-964-3627.

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/ia > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

IA-NL-0034-16

Host a Clinic Day at your location

Amerigroup Iowa, Inc. is launching a quality initiative designed to improve compliance rates for preventive health care services.

What is Clinic Day?

Clinic Day is an opportunity to bring members and providers together to improve patient compliance and member access to care. In partnership with our network providers, we will host a series of Clinic Days for Amerigroup members who haven't received recommended preventive screenings and services within the calendar year.

Clinic Days target members due for well-child visits, childhood immunizations, diabetes care, postpartum care or other preventive services (depending on the provider type and member panel). Members will be directed to the office of the provider identified as their primary care physician.

What support will Amerigroup provide?

If you are interested in collaboration by hosting a Clinic Day, we will:

- Provide a list of members due for targeted preventive care services.
- Work with your office to schedule and confirm appointments with members.
- Provide additional needed support for members and providers to encourage the completion of recommended preventive health care services.
- Be present on the day of the event to distribute giveaways and health information.

How can my practice take advantage of this opportunity?

To receive further information, please contact your Practice Consultant.

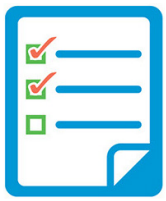
We appreciate your participation in the Amerigroup network and your dedication to serving our members. We look forward to working with you to improve the health outcomes of our members.

IAPEC-0591-16

CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Amerigroup Iowa, Inc. seeing IA Health Link members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following best practice standards:

	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
	**2. Policies and procedures**	Develop and implement policies and procedures based on the plan and risk assessment.
	**3. Communication plan**	Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
	**4. Training and testing program**	Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

IA-NL-0043-17

Notification process reminder

Effective May 17, 2017, failure to obtain precertification for IA Health Link members and failure to notify Amerigroup Iowa, Inc. of a member's admission or transfer within established time frames (as outlined below) will result in your claims being administratively denied, and you will not receive payment for the service(s). For participating providers, this is a contractual obligation and has been in effect since the execution of your contract. As a reminder, providers cannot balance bill members for services that are administratively denied. Members who are retroactively enrolled into the plan by the state are deemed out of scope.

If your claim is administratively denied, you may file an appeal in accordance with rules and regulations. As part of the appeal, you must demonstrate that you notified or attempted to notify Amerigroup within the contractually established time frame and that the service(s) are medically necessary.

Notification requirements:

Amerigroup must be notified of all member admissions or transfers within one business day of admission or transfer. Ideally notification should occur the day of admission or transfer; however, you have one business day to notify Amerigroup without penalty. A business day is considered Monday-Friday and does not include weekends or weekdays that fall on federal holidays.

Notification for all post-stabilization admissions including transfers should occur within one business day of admission. The following clinical scenarios are excluded:

- Admission to a Neonatal Intensive Care Unit (NICU) level III
- Admission to an Intensive Care Unit (ICU)
- Direct admission to an operating room (OR)/ recovery room
- Direct admission to a telemetry floor
- Involuntary behavioral health admission

Notification process reminder (cont.)

Note, admission to a general ward is considered in scope for our notification requirements. Failure to notify us within one business day of admission to the general ward or NICU level I or II is considered failure to notify, and administrative denial applies. Once the member has been downgraded to a general ward from the NICU level III, ICU, OR/recovery or telemetry, the requirement for notification within one business day applies.

Notification of OB antepartum/postpartum admissions that do not result in a delivery should occur within one business day.

Precertification requirements:

Precertification is required for the following:

- Nonemergent inpatient transfers between acute facilities
- Elective inpatient admissions
- Rehabilitation facility admissions
- Long-term acute care admissions
- Skilled nursing facility admissions
- Behavioral health levels of care (as outlined in the provider handbook and precertification documents)
- Out-of-area/out-of-network services
- Outpatient services (as outlined within the Precertification Lookup Tool on the website)
- Outpatient durable medical equipment purchases and rentals (as outlined within the Precertification Lookup Tool on the website)

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

To obtain precertification or to verify member eligibility, benefits or account information, follow instructions outlined on the provider website or in the quick reference guide, provider manual, interactive voice response system or Availity® Web Portal where applicable.

For additional information and/or detailed precertification requirements, refer to the provider website (https://providers.amerigroup.com/ia > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

IAPEC-0583-16

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: *DSM-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 (cont.)**

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.

IAPEC-0587-16

Policy Update
Maternity Services
(Policy 14-001, effective 11/01/17)

Amerigroup Iowa, Inc. allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

What's New?
We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

For additional information, refer to the Maternity Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Iowa.

IA-NL-0037-17

Policy Update
Modifier 22: Increased Procedural Service
(Policy 07-020, effective 11/01/17)

Amerigroup Iowa, Inc. allows reimbursement for procedure codes appended with Modifier 22. Reimbursement will be based on 110 percent of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure.

Refer to Modifier 22: Increased Procedural Service Reimbursement Policy for more information at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Iowa.

IA-NL-0035-17