Provider Newsletter

Amerigroup Kansas, Inc.
providers.amerigroup.com/KS
Provider Services: 1-800-454-3730

2016
Quarter 1

Human papillomavirus (HPV): important information about vaccinations

Human papillomavirus (HPV) is the most common sexually transmitted virus in the United States, and the highest prevalence is found in sexually active adolescents and young adults. The Centers for Disease Control and Prevention (CDC), American Academy of Family Physicians, American Academy of Pediatrics and society for Adolescent Health and Medicine recommend the vaccination series. Please read the information below regarding HPV and the vaccine series, and share with your patients. There are more than 40 types of HPV and 14 million people, including teens, become infected with HPV every year.

- When HPV persists, individuals are at risk for cancer. Every year, 17,600 women and 9.300 men are affected by cancers caused by HPV. HPV infections contribute to development of cancers of the cervix, vagina, anus, vulva, mouth/throat and penis.
- There are two vaccines licensed by the FDA. The vaccine is safe; no serious safety concerns have been confirmed in large studies since [2006]. Vaccine is has not demonstrated any serious safety concerns – mild side effects that are common include arm pain, redness and swelling where injection given, fever, dizziness, headache and nausea.
  - It is recommended that the vaccine series is administered to boys and girls at ages 11 and 12 years to protect them prior to exposure to virus. It is important to have this sometimes difficult discussion with parents to help them understand that it is best to vaccinate before their child is exposed to virus.
  - The vaccine can still be given after adolescent has been sexually active.
  - All girls and women 13-26 years of age who have not been immunized previously or have not completed the full vaccine series should complete the series.

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

- Men 22-26 years of age who have not been immunized previously or have not completed the full vaccine series may receive HPV4 vaccine.
    - The vaccine is not recommended for pregnant females.
- HPV vaccines provide long-lasting protection.
    - In the four years since the vaccine was recommended in 2006, the amount of HPV infections in teen girls has decreased by 56%.
    - It is known to work in the body for at least 10 years and data suggests protection by the vaccine will continue beyond ten years.
- Kansas ranked last in the nation on HPV vaccination results for adolescents.
- Medicaid and uninsured adolescents can receive the vaccine through the Vaccines for Children (VFC) program – it is important to note that for those with Medicaid please submit claim to include the administration charge and the vaccine with a charge amount of $0 to indicate the vaccine from the VFC was given. This helps to capture data from claims to help demonstrate member compliance.

The CDC flyer, "Tips and Timesavers for Talking with Parents About HPV Vaccines," is also a helpful resource when talking to parents about the vaccine.

Intensity modulated radiation therapy (IMRT) codes require prior authorization (PA)

Effective May 1, 2016, two intensity modulated radiation therapy (IMRT) codes that previously did not require PA will now require PA. IMRT requests must be reviewed by Amerigroup Kansas, Inc. for PA for dates of service on or after May 1, 2016.

Amerigroup will require PA for the following IMRT codes beginning May 1, 2016:

- 77385: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 : Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

PA request may be submitted by either of the following methods:

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

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

More than a score: working together to achieve better health outcomes while meeting HEDIS measures

We know you've heard of HEDIS, established by the National Committee for Quality Assurance (NCQA). We send you report cards, letters and reminders about members overdue for services related to HEDIS measures — you might even be eligible for incentive payments when helping members get these important services.

But it's not just about the scores. It's about the woman whose Pap smear led to early detection and

treatment of her cervical cancer. Or the toddler who didn't get whooping cough during last year's outbreak because he got his shot on time. Or the grandfather who kept up with cholesterol screenings and avoided another heart attack.

We thank you for giving our members the highest quality care possible. Working together to meet these benchmarks, we have the best chance of improving our members' health outcomes and, ultimately, their quality of life.

Our benchmarks for clinical performance and service satisfaction
Healthcare Effectiveness Data and Information Set (HEDIS) — A program developed by the NCQA to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 80 measures across five domains of care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) — A survey evaluating member satisfaction with care and services received over the past six months by questioning a random sample of plan members on their doctors and the health plan.

Provider Satisfaction Survey — An annual survey to find out what you, our providers, think we're doing well and what we can do better in several capacities, including communication and technology, claims processing, and customer service.

HEDIS, CAHPS and the Provider Satisfaction Survey 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
- Determine the effectiveness of actions we implemented to improve our results

Our Quality Improvement Program
When it comes to quality, we're guided by:
- Results-based studies conducted by our Quality Improvement program team
- Sound advice from internal and external experts
- National standards set by NCQA
- Current research that informs the criteria we use
- First-hand experience of case managers who know our members' needs

Our comprehensive program:
- Adheres to HEDIS standards and measures our progress to meet annual goals
- Objectively monitors and evaluates the care and services our members receive
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of our program

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

- Reflects the demographic and epidemiological needs of each population served
- Encourages both members and providers to recommend improvements
- Identifies ways we can promote and improve patient safety

Precertification lookup tool

If you have questions about precertification, please visit our provider self-service website at providers.amerigroup.com/KS and use the Precertification Lookup Tool located under Provider Resources & Documents > Quick Tools. From here, you can check the status of existing precertification requests, find information on how to submit a new request and learn more about which services require precertification.

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: 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 is 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 in adequately controlled.	E10.40 Type 1 diabetes mellitus with diabetic neuropathy 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. Documenting support for all current medical conditions improves quality of care and ensures coding guidelines are followed.

ICD-10 Coding Guidelines, Section IV Diagnostic coding and Reporting Guidelines for Outpatient Services:

- *.I 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.*
- *.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* 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 N18.3 Chronic kidney disease, stage 3 (moderate) Z79.4 Long-term (current) use of insulin

For complete instructions and guidelines, please refer to the current ICD-10-CM coding manual.

Reimbursement policies

Reimbursement policies serve as a guide to assist you with accurate claim submissions and outline the basis for reimbursements when services are covered by the member's Amerigroup plan.

Remember that the determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as the member's state of residence.

Reimbursement policies are reviewed and updated throughout the year by Amerigroup. To view the most up-to-date version of the Reimbursement Policies, go to providers.amerigroup.com > Quick Tools > Reimbursement Policies > Select the appropriate product.

Availity: Registration information and reminders

Amerigroup recently introduced Availity Web Portal, a tool to help reduce costs and administrative burden for our physicians and hospitals. Whether you work with one managed care organization (MCO) or hundreds, Availity can help you quickly and easily file claims, check eligibility, process payments and more. For your convenience, Availity also offers a link back to the Amerigroup provider self-service site for all other transactions.

How to register

To initiate the registration process, your primary controlling authority (PCA) – the individual in your organization who is legally entrusted to sign documents – must first complete registration at www.Availity.com. Once your PCA completes this initial process, your primary access administrator (PAA) – the individual in your organization who is responsible for maintaining users and organization information – will receive a temporary password that will allow him or her to add users, providers, and additional

enrollments for the organization. Each staff member should register with his or her own login credentials to avoid business disruptions.

For additional training, visit www.Availity.com and select Availity Learning Center under Resources in the top bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

For any questions or additional registration assistance, contact Availity Client Services at 1-800-282-4548, Monday through Friday, 8 a.m. – 7 p.m., Eastern time.

Reimbursement Policy Updates

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

Locum Tenens
(Policy 06-063, originally effective 08/23/2006)

Amerigroup allows reimbursement of locum tenens physicians in accordance with the CMS guidelines. Amerigroup will reimburse the member's regular physician or medical group for all covered services provided by a locum tenens physician during the absence of the regular physician in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis.

Please note that, Amerigroup requires the regular physician or medical group to identify the locum tenens physician by entering their Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

For market-specific information, refer to the Locum Tenens reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Professional Providers
(Policy 06-029, originally effective 06/16/2006)

Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original CMS-1500 Health Insurance Claim Form to us for payment of health care services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include specific information outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Professional Providers reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Facilities
(Policy 06-030, originally effective 06/16/2006)

Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original CMS UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to us for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and Amerigroup can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Facilities reimbursement policy at providers.amerigroup.com.

Documentation Standards for Episodes of Care
(Policy 11-004, originally effective 12/07/2011)

Amerigroup requires that documentation for all episodes of care must meet the following criteria:
- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated and timed.
- Documentation must reflect all aspects of care.
- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

For a complete list of minimum documentation requirements, refer to the Documentation Standards of Episodes of Care reimbursement policy at providers.amerigroup.com.

Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative. Medicaid providers can call Provider Services at 1-800-454-3730.

Billing process for Money Follows the Person transitional services

Effective with dates of service December 1, 2015, and after, Money Follows the Person (MFP) transitional services will be reimbursed by Amerigroup. These services will be used for members residing in facilities to assist in transition planning as they move back into the community.

What services are affected by this change?

H2015 U3 Transition coordination services (TCS) – Transition coordination will work with the resident in pre-transition planning to evaluate suitability for the MFP demonstration. TCS will identify the individual's hopes and dreams and work to assist the individual in realizing their goal of moving into a community-based setting. Activities will include helping the consumer to identify and eliminate potential barriers that would prohibit transitioning to the community; helping to facilitate and develop natural support systems; and providing technical information to concerned family and friends upon the consumer's request/release of information.

Fifteen minutes will equal one unit. Reimbursement will be $11.25 per 15 minutes. This service is limited to 192 units per lifetime (i.e., 365 days of MFP transition). Some TCS billable time can/does occur prior to the MFP transition (365 days): initial consultation with provider to see if there is interest in the program, seek housing options, etc.

H2016 U3 Transition funds – Transition funds are funds for direct costs incurred by the member accessing the MFP demonstration project. Transition funds are related to costs incurred when the member begins to access community residential housing. Such costs would be identified as (but not limited to): housing and utility deposits (rent/lease/purchase costs not allowed); the purchase of basic furnishings (linens, cooking and eating equipment/utensils); and other basic living costs. There is a $2,500 lifetime maximum for this service code. All services must receive prior authorization by Amerigroup in order to be considered for payment. More information will be forthcoming regarding a member's eligibility for the MFP demonstration project and the provider's requirements.

If you have any questions, contact your local Provider Relations representative or Provider Services at 1-800-454-3730.

Electronic funds transfers (EFTs) and electronic remittance advices (ERAs) available

We encourage you to enroll in the electronic funds transfers (EFTs) and electronic remittance advices (ERAs) available from Emdeon and PaySpan.

The benefits of enrolling in EFT/ERA include the ability to:

- Receive ERAs and import information directly into your practice management or patient accounting system
- Route EFTs to the bank account of your choice
- Create your own custom reports within your office
- Access reports 24 hours a day, 7 days a week

All ERT/ERA services are free. You can access EOBs/remits easily and when you use these services, you never have to wait on the postal service for delivery or worry about missing or lost checks.

You will receive information on how to enroll in EFT and ERA in a separate mailing from the clearinghouse partner.

New collection agency partnership

The Amerigroup Kansas, Inc. Cost Containment Unit (CCU) has partnered with a third party collection agency, Lamont, Hanley & Associates, Inc. (LHA) to assist in the recovery of overpayment refunds.

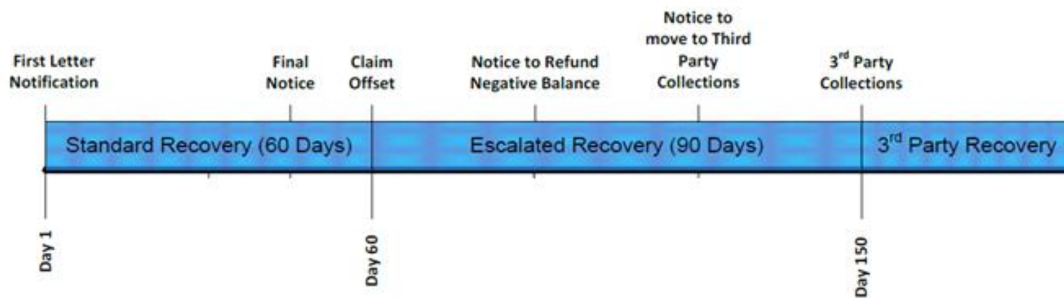
Lamont, Hanley & Associates, Inc. is a New Hampshire-based, nationwide debt collection agency with a long history of providing excellent collection services for Anthem, the parent company of Amerigroup Kansas, Inc. LHA was chosen due to its philosophy of a "customer service approach to collections," a value we identify with. This value and philosophy is also critical in ensuring a successful partnership with our providers and understanding the sensitivity of releasing a collection agency in our provider networks.

A brief excerpt from LHA…

Our methodology incorporates sales techniques with financial guidance to provide your customers with a program that results in clearing their balance in a non-confrontational, business-like manner. This process results in a higher liquidation and maintains a professional image for our company and our clients. We combine this with our collectors' abilities to resolve disputes and expedite files, making us unique in the collection industry.

The CCU claim collection life cycle will include three phases:

- A standard recovery process requesting refunds from providers
- An escalated recovery process, which attempts to obtain check refunds from the providers for any offsets not satisfied by the [60th day] following a negative balance adjustment
- Lastly, a third-party recovery process initiated by LHA if claims are not successfully fulfilled during the escalated recovery process



Your market is already live, and this notification is to inform you of the role LHA plays in the collection process.

If you have questions about this communication, received it in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at 1-800-454-3730.

Fraud, waste and abuse

As the recipient of funds from federal and state-sponsored health care programs, Amerigroup has a duty to help prevent, detect and deter fraud, waste and abuse. Our corporate compliance program, code of business conduct and ethics, and our fraud, waste and abuse policies are available for review on our provider website at providers.amerigroup.com.

As part of the requirements of the Federal Deficit Reduction Act, you are required to adopt our policies on fraud, waste and abuse.

Methods to report fraud, waste and abuse

- Make anonymous reports to amerigroup.silentwhistle.com
- Make anonymous reports by leaving a message on the Medicaid Fraud Reporting Hotline at 1-877-660-7890
- Send an email to medicaidfraud@anthem.com
- Call our Provider Services team

Remember, you are the first line of defense against fraud, waste and abuse.

Examples of provider fraud, waste and abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

To help prevent fraud, waste and abuse, make sure your services are:

- Medically necessary
- Documented accurately
- Billed according to guidelines

Examples of member fraud, waste and abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

Methods to help prevent member fraud, waste and abuse

- Educate members
- Be observant
- Spend time with members and review their prescription record
- Review their Amerigroup member ID card
- Make sure the cardholder is the person named on the card
- Encourage members to protect their ID cards like they would credit cards or cash
- Encourage them to report any lost or stolen card to us immediately

We also encourage our members to report any suspected fraud, waste and abuse by calling our Member Services team at 1-800-600-4441 (TTY 711).

We will not retaliate against any individual who reports violations or suspected fraud, waste and abuse. We will make every effort to maintain anonymity and confidentiality.

In the event that Amerigroup identifies and validates an incident of fraud, waste or abuse, we disclose that information to the Kansas Department of Health and Environment, apply a statistical sample and extrapolation method to estimate overpayments and pursue recoveries consistent with commonly accepted practices. Providers are required to repay all identified overpayments – this is addressed within the Patient Protection and Affordable Care Act.

If you have questions, please contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.