Provider Newsletter

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

2017
Quarter 1

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Reimbursement Policies:

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Kansas, Inc. previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP*) or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-800-454-3730.

ClaimCheck and ClaimsXten are registered trademarks of McKesson Technologies Inc. and McKesson Health Solutions LLC, respectively.

KS-NL-0038-17

Do you know your Provider Relations representative?

Your designated Provider Relations representative can help answer your questions or concerns, resolve more complex issues, and help you meet your training needs. To identify your Provider Relations representative, refer to the list of Provider Relations representatives on our provider website (https://providers.amerigroup.com/KS > Provider Resources & Documents > Find your Provider Representative > List of Provider Representatives). For ease of identification, the list is organized by county and includes a full range of contact options including phone numbers and email addresses.

KS-NL-0033-16

KHIN
Kansas Health Information Network

Kansas Heath Information Network

The mission of the Kansas Heath Information Network (KHIN) is to improve health care quality, coordination and efficiency through the exchange of health information at the point of care. The exchange of health information at the point of care is accomplished using a secure electronic network provided through a collaborative effort of health care organizations and KHIN. Amerigroup Kansas, Inc. actively participates in the KHIN and is exploring additional data exchange opportunities to further the mission of KHIN and to provide comprehensive health information about KanCare members. Amerigroup encourages participation in the KHIN network as part of the Amerigroup Health Information Exchange (HIE) initiatives and in support of Kansas HIE strategies. For more information on the KHIN, visit their website at http://khinonline.org.

KS-NL-0033-16

Cost Containment

If you receive a letter from Cost Containment requesting back claims payment and you have questions or want to dispute it, you may contact Cost Containment using one of the methods listed below.

- Contact the Cost Containment representative listed in the signature line of your letter.
- Fax your inquiry and any supporting documentation to 1-866-920-1874.
- Mail your inquiry and any supporting documentation to the following address:
  Cost Containment
  Amerigroup Kansas, Inc.
  P.O. Box 62427
  Virginia Beach, VA 23466-2437

If you receive a recoupment letter and would like the money to be recovered from future claim payments, you may contact Cost Containment using one of the methods listed below.

- Fax your request to 1-866-920-1874.
- Mail your request to the following address:
  Cost Containment
  Amerigroup Kansas, Inc.
  P.O. Box 62427
  Virginia Beach, VA 23466-2437

KS-NL-0033-17

Secure file transfer protocol

A secure file transfer protocol (SFTP) is a tested and secure electronic path used to upload files that has the ability to track who has viewed the records. Using a safe SFTP is a more efficient and cost-effective way to forward medical records for required audits and reviews — particularly HEDIS®* medical record requests. Amerigroup Kansas, Inc. is using this technology with great success.

Benefits to your organization:

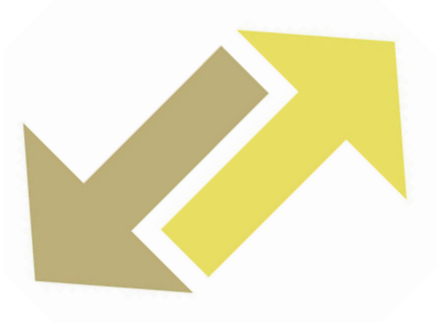
- SFTP eliminates the need for a medical record vendor; therefore, one less organization has access to your records.
- You control which records are loaded to the secure site and the amount of time the records are available.
- There is no cost to implement or maintain the SFTP process.

Only HEDIS-experienced, Amerigroup-registered nurses review the records on the SFTP. Our nurses work diligently to find the required data elements for passing the various HEDIS measures. We work to make sure your office has the highest HEDIS quality scores possible.

For more information, please contact Julie Nicolle, RN, at 913-749-5955, ext. 50510 or julie.nicolle@amerigroup.com.

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

KS-NL-0033-17



HEDIS

Each year, as part of the HEDIS quality study, Amerigroup Kansas, Inc. reviews a sample of our members' medical records to measure performance on important dimensions of care and service. We are pleased to participate in this study as a means of pursuing continuous improvement of the quality of care and services and to see where we need to focus our improvement efforts. Your assistance is crucial to ensure that our data is statistically valid, auditable and accurately reflects quality performance.

About HEDIS

- HEDIS is a performance measurement tool coordinated and administered by the National Committee for Quality Assurance (NCQA) and used by CMS for monitoring the performance of managed care organizations (MCOs).
- All NCQA-accredited MCOs perform HEDIS reviews the same time each year.
- A subset of HEDIS measures are collected and reported for the marketplace (health care exchanges) product lines.
- HEDIS is a retrospective review of services and performance of care.
- HEDIS results are used to measure performance, identify quality initiatives, and provide educational programs for providers and members.

What is your role in HEDIS?

Amerigroup appreciates your cooperation and timeliness in submitting or providing access to requested medical record information. You play a central role in promoting the health of our members. The records you provide during this process help us validate the quality of care provided to our members.

You and your office staff can help facilitate the HEDIS process by:

- Providing the appropriate care within the designated time frames.
- Documenting all care in the patient's medical record.
- Accurately coding all claims.
- Responding to our requests for medical records within 10 business days.

HIPAA

Under the HIPAA privacy rule *45 CFR §164.506* and *45 CFR §164.501*, data collection for HEDIS is permitted and the release of information does not require special patient consent or authorization since the disclosure is part of quality assessment and improvement activities. Please be assured the personal health information of KanCare members is maintained in accordance with all federal and state laws. Data is reported collectively without individual identifiers.

Medicaid-hybrid HEDIS measures:

- ABA — Adult Body Mass Index Assessment
- AWC — Adolescent Well-Care Visits
- CBP — Controlling High Blood Pressure
- CCS — Cervical Cancer Screening
- CDC — Comprehensive Diabetes Care
- CIS — Childhood Immunization Status
- FPC — Frequency Of Ongoing Prenatal Care
- HPV — Human Papillomavirus Vaccine For Female Adolescents
- IMA — Immunizations For Adolescents
- LSC — Lead Screening In Children
- PPC — Prenatal And Postpartum Care
- WCC — Weight Assessment/Counseling For Nutrition And Physical Activity For Children/Adolescents
- W15 — Well-Child Visits In The First 15 Months Of Life
- W34 — Well-Child Visits In The 3rd, 4th, 5th And 6th Years Of Life

KS-NL-0033-17

Address and/or practice status changes

For providers directly contracted with Amerigroup Kansas, Inc.:

To maintain the quality of our provider data and to assure timely notification and payment, please advise Amerigroup immediately, or with as much advance notice as possible, of any demographic/information updates. Submit changes/updates such as, but not limited to, your practice contact information, service site or payment address, phone or fax numbers, and the information of participating providers within your practice as well as TIN changes.

Notify Amerigroup of changes by using the *Practice Profile Update Form* found on our provider website (https://providers.amerigroup.com/KS > Provider Resources & Documents > Forms > *Practice Profile Update Form*).

Completed *Practice Profile Update Forms* may be sent to Amerigroup using one of the following methods:

- Fax: 1-866-494-5632
- Mail:
  Provider Relations Department
  Amerigroup Kansas, Inc.
  9225 Indian Creek Parkway, Building 32
  Overland Park, KS 66210
- Email: ks1provrel@amerigroup.com

For providers credentialed/contracted through MultiPlanSM*:

Reach out to MultiPlan directly if you have questions regarding:

- Your plan participation status or provider contract.
- Claim questions related to the fee schedule where the source cannot be identified on the Medicaid website, through the Amerigroup resources or in the Multiplan contract.
- Changes in physician/provider demographic information including deletions, additions and changes to TIN (*W-9* form copies are required for TIN changes) as well as NPI numbers.
- Credentialing including current credentialing criteria and application submissions.

MultiPlan may be reached in the following ways:

- Phone: 1-866-971-7427
- Fax: 630-799-3587
- Mail:
  MultiPlan
  Attn: GBSC
  6116 Shallowford Road, Suite 109B
  Chattanooga, TN 37421
- Email: govtcoordinator@multiplan.com

** MultiPlan is a registered service mark of MULTIPLAN INC.*

KS-NL-0033-17

Synagis and the RSV season

Respiratory syncytial virus (RSV) season begins in November and runs through March. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. The American Academy of Pediatrics recommends a maximum of five (15 mg/kg) monthly doses of Synagis during the RSV season for high-risk infants who were born before 29 weeks, 0 days gestation; have chronic lung disease of prematurity; or have hemodynamically significant heart disease. To view the state-approved Synagis prior authorization criteria, visit www.kdheks.gov > Health Care Finance > KanCare > Kansas Medicaid Pharmacy > Clinical Prior Authorization Criteria > Palivizumab (Synagis®).*

Please note, when submitting Synagis administration claims, there are different claims submission forms depending on the process by which Synagis is obtained — buy and bill process or retail pharmacy process.

Medical buy and bill process

Buy and bill is when a provider office uses Synagis from their stock to administer to a child. Providers must send in the Synagis Enrollment Form (https://providers.amerigroup.com/KS > Provider Resources & Documents > Pharmacy > Synagis Enrollment Form) to provide the clinical information needed to obtain prior authorization (PA) for the member. Once the form is complete, it may be faxed to Amerigroup Kansas, Inc. at 1-800-359-5781. For questions, contact the Pharmacy Prior Authorization Help Desk at 1-800-454-3730.

Retail pharmacy claim process

Pharmacy PA is when a pharmacy supplies Synagis to the member and the member brings it to their appointment at the provider's office to be administered. Providers must send in the Synagis (palivizumab) Prior Authorization of Benefits (PAB) Form (https://providers.amerigroup.com/KS > Provider Resources & Documents > Pharmacy > Pharmacy Prior Authorization Forms > Synagis) to provide the clinical information needed to obtain PA for the member. For questions, contact the Express Scripts PA Help Desk by phone at 1-855-201-7170 or by fax at 1-800-601-4829.

** Synagis is a registered trademark of MEDIMMUNE, LLC.*

KS-NL-0033-16

Notification process reminder

Effective April 24, 2017, failure to obtain precertification for KanCare members and failure to notify Amerigroup Kansas, 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.

What is the impact of this change?

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

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)

Notification process reminder continued

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

** Availity is a registered trademark of Availity, L.L.C.*

KSPEC-1457-16

Intracardiac electrophysiological studies and catheter ablation to require prior authorization

Effective April 1, 2017, intracardiac electrophysiological studies and catheter ablation will require prior authorization (PA). All requests with dates of service beginning on or after April 1, 2017, must be submitted for PA.

Please refer to the provider self-service tool for detailed authorization requirements. To locate the provider self-service tool:

- Go to https://providers.amerigroup.com and select your state
- Under Provider Resources & Documents, select Quick Tools and then select Precertification Lookup Tool.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

Please use one of the following methods to request PA:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: https://providers.amerigroup.com

Federal and state law, state contract language, CMS guidelines and definitions, as well as specific contract provisions and exclusions take precedence over these PA rules and must be considered first when determining coverage.

KS-NL-0031-16

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 *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 *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 continued**

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.

KSPEC-1460-16

New Policy

Modifier 26 and TC: Professional and Technical Component

(Policy 15-004, effective 07/01/17)

Amerigroup Kansas, Inc. allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC when appropriate.

Professional Component (Modifier 26)

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

Technical Component (Modifier TC)

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable X-ray suppliers should bill only for the technical component by appending Modifier TC.

Global Procedure

In the absence of Modifier TC and Modifier 26, the physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Amerigroup does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only, or global test only of a selected diagnostic test

Amerigroup reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

For additional information and to view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

KS-NL-0021-16

Policy Update

Modifier Usage

(Policy 06-006, effective 08/01/16)

Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

KS-NL-0017-16

Policy Update

Modifier 91: Repeat Clinical Diagnostic Laboratory Test

(Policy 06-020, effective 07/01/17)

Amerigroup Kansas, Inc. allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100 percent of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

KS-NL-0018-16