Provider Newsletter

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

2016
Quarter 2

KAN Be Healthy (KBH) – Early Periodic Screening, Diagnosis and Treatment (EPSDT) updates

Kansas Amerigroup, Inc. has adopted the Bright Futures/American Academy of Pediatrics periodicity schedule as a standard for pediatric preventive services through EPSDT programs. The KBH Program follows this periodicity schedule which is located on the Bright Futures website located at https://brightfutures.aap.org.

Medicaid KBH providers can continue to use forms from their electronic health records (EHRs) to submit for payment to Amerigroup as long as those forms follow the Bright Futures guidelines. These summary forms also satisfy the KBH requirement eliminating the use of the paper form. Providers may need to contact their EHR company to verify it follows the Bright Future guidelines.

For additional information and resources, refer to the KBH page on the Kansas Medical Assistance Program (KMAP) website. Recommended forms for KBH – EPSDT providers are now located on the Forms page. For answers to frequently asked questions (FAQ), refer to the FAQ page and click on KBH from the drop-down menu.

Update: Coverage of G-codes differentiating registered nurse and licensed practical nurse skilled nursing visits

Effective with dates of service on and after January 1, 2016, the following G-codes will be covered to differentiate registered nurse (RN) and licensed practical nurse (LPN) skilled nursing visits in the home

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Code descriptions and reimbursement		
G0299	Direct skilled nursing services of a RN in the home health or hospice setting	$35.00
G0300	Direct skilled nursing of a LPN in the home health or hospice setting	$35.00
T1002	RN services, up to 15 minutes	$15.00
T1003	Licensed vocational nurse (LVN)/LPN services, up to 15 minutes	$10.00

New claim reconsideration and appeal process

Providers will be able to request a reconsideration of a claim if the provider disagrees with the claim processing. If, after the reconsideration process has completed, the provider still disagrees, then a formal appeal can be submitted.

Providers will be required to request their claim be reconsidered. If the provider speaks to the Provider Service Unit (PSU) and still feels the claim was not processed correctly, or in certain situations where documentation is required, a provider may submit an appeal on line or in writing. Providers are allowed one appeal option per claim. The reconsideration process allows providers to have their claim reconsidered without using their appeal option.

Providers will be able to use our informal reconsideration process if they feel a claim was not processed correctly. Reconsiderations are accepted verbally by phone, online and in writing within 60 calendar days (plus three additional days if mailed) of the Explanation of Payment date. An appeal must be received within 30 calendar days (plus three additional days if mailed).

Reconsiderations can be requested through PSU verbally, online or in writing. PSU can be contacted at 1-800-454-3730 for a verbal reconsideration request. Online reconsiderations can be done through the Availity Web Portal. Mailed reconsiderations can be submitted to the following address:

Payment Reconsideration Unit
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

New Claims Status Listing Tool

On June 18, 2016, a new Claims Status Listing Tool will be offered on the Amerigroup Kansas, 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 now provide an added benefit with the Claims Status Listing Tool. With this tool, now 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, 7 a.m.-6 p.m., Central time.

Coverage of unlisted codes – additional codes

Effective with dates of service on and after May 1, 2016, the unlisted/miscellaneous codes shown below will be considered for coverage.

21299	Unlisted craniofacial and maxillofacial procedure	A6512	Compression burn garment noc	K0108	Other accessories
38129	Unlisted laparoscopy procedure spleen	A6549	Gradient compression stocking/sleeve nos	K0462	Temp repl pt owned equip being repr any type
38589	Unlisted laparoscopy px lymphatic system	A9150	Nonprescription drug	K0812	Power operated vehicle not otherwise classified

41899	Unlisted procedure dentoalveolar structures	A9270	Noncovered item or service	K0898	Power wheelchair not otherwise classified
43659	Unlisted laparoscopic procedure stomach	A9279	Monitor feature/devc stand-alone/integrated noc	L0999	Add to spinal orthotic not otherwise specified
44238	Unlisted laparoscopy px intestine xcp rectum	A9280	Alert or alarm device not otherwise classified	L1499	Spinal orthotic not otherwise specified
44979	Unlisted laparoscopy procedure appendix	A9300	Exercise equipment	L2999	Lower extremity orthoses not otherwise specified
45499	Unlisted laparoscopy procedure rectum	A9698	Non-radioactv contrst imag material noc per stdy	L3649	Orthoped shoe modification addition/transfer nos
47579	Unlisted laparoscopy procedure biliary tract	A9699	Radiopharmaceutical therapeutic noc **considered content of service	L3999	Upper limb orthosis not otherwise specified
49329	Unlisted laparoscopic px abd pertoneum and omentum	A9900	Dme sup/access/srv-compon/oth hcpcs	L5999	Lower extremity prosthesis nos
49659	Unlis laps px hrnap herniorrhaphy herniotomy	A9999	Miscellaneous dme supply or accessory nos	L7499	Upper extremity prosthesis nos
49999	Unlisted procedure abdomen peritoneum and omentum	B9998	Noc for enteral supplies	L8039	Breast prosthesis not otherwise specified
50549	Unlisted laparoscopy procedure renal	B9999	Noc for parenteral supplies	L8048	Uns maxillofce prosth br provided non-physician

50949	Unlisted laparoscopy procedure ureter	C9399	Unclassified drugs or biologicals	L8699	Prosthetic implant not otherwise specified
51999	Unlisted laparoscopy procedure bladder	D0999	Unspecified diagnostic procedure by report	L9900	Ortho and pros spl acss and/srvc cmpnt oth hcpcs l code
54699	Unlisted laparoscopy procedure testis	E0625	Patient lift bathroom or toilet noc	Q018 1	Uns oral dosage anti-emetic not >48 hr dose reg
55559	Unlisted laproscopy procedure spermatic cord	E0769	Estim/electromagn etic wound treatment devc noc	Q050 7	Misc supply or accessory use with external vad
58578	Unlisted laparoscopy procedure uterus	E1229	Wheelchair pediatric size nos	Q050 8	Misc supply or accessory use with implanted vad
58679	Unlisted laparoscopy procedure oviduct/ovary	E1239	Power wheelchair pediatric size nos	Q050 9	Misc spl/acss impl vad no payment Medicare prt a
59897	Unlisted fetal invasive px w/ultrasound	E1399	Durable medical equipment miscellaneous	Q405 1	Splint supplies miscellaneous **considered content of service
59898	Unlisted laparoscopy px maternity care and delivery	E1699	Dialysis equipment not otherwise specified	Q408 2	Drug or biological noc part b drug cap
60659	Unlisted laparoscopy procedure endocrine system	E2599	Accessory for speech generating device noc	Q410 0	Skin substitute not otherwise specified
87999	Unlisted microbiology	J3490	Unclassified drugs	Q500 9	Hospice/home health care provided in place nos **Considered content of service

Amerigroup RealSolutions in healthcare

KanCare

88749	Unlisted in vivo laboratory service	J3590	Unclassified biologics	S2409	Rep congn malform fetus proc prfrm utero noc
93998	Unlisted noninvasive vascular diagnostic study	J7199	Hemophilia clotting factor noc	S5131	Homemaker service nos; per diem
94799	Unlisted pulmonary service/procedure	J7599	Immunosuppressive drug not otherwise classified	S5497	Home infus tx cath care/maint noc; per diem
96379	Unlisted therapeutic proph/dx iv/ia njx/nfs	J7699	Noc drugs inhalation solution admined thru dme	S8301	Infection control supplies nos
96549	Unlisted chemotherapy procedure	J7799	Noc rx oth than inhalation rx admined thru dme	S9379	Home infusion therapy infusion therapy noc; diem
A4335	Incontinence supply; miscellaneous	J8498	Antiemetic drug rectal/suppository nos	T5999	Supply not otherwise specified
A4421	Ostomy supply; miscellaneous	J8499	Prescription drug oral nonchemotherapeutic nos	V5274	Assistive learning device nos

Provider education

Remember to register for upcoming training opportunities using the following address and selecting Training Programs: https://providers.amerigroup.com/KS.

Enhanced Availity eligibility and benefits inquiry

Beginning in Q2 2016, users will have the added benefit to query for multiple members at one time through the Availity eligibility and benefits inquiry. You can check up to 50 members' eligibility and benefits during one system transaction. You no longer have to request eligibility information one member at a time, and you can download the results of all your eligibility and benefits inquiries across multiple payers.

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 his or her 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.

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. Pacific time.

If you have questions about the tools and resources available on the Amerigroup Kansas, Inc. or Availity websites, please visit https://providers.amerigroup.com.

KAN Be Healthy program – use of Bright Futures website

Kansas Department of Health and Environment (KDHE) is updating the KAN Be Healthy (KBH) program manual, screening forms, website and all related materials for use by KBH providers.

The Kansas Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, known as KAN Be Healthy, will utilize the resources of the American Academy of Pediatrics (AAP) Bright Futures website: brightfutures.aap.org/Pages/default.aspx. All KBH Forms on the Kansas Medicaid Assistance Program website will no longer be utilized.

The KBH program will utilize resources that are produced by the Bright Futures program, as funded by the US Department of Health and Human Services resources and services administration, Maternal Child health bureau and the AAP. KBH follows the Bright Futures periodicity schedule for the EPSDT program. Bright Futures is CMS approved and nationally recognized resource based on the AAP uniform set of recommendations for health care professionals. Use of the Bright Futures materials and resources will provide consistent and universal screening procedures and risk assessment. Core tenants include delivering health care services that recognizes the partnership of the child, family, health care professional and community. In addition to provider resources, Bright Futures offers educational information about child health and wellness to families.

Implementation of CPT category II code

Why use CPT category II codes?

CPT category II codes can relay important information related to health outcome measures such as

- BMI
- CVD cholesterol management
- Controlling blood pressure
- Comprehensive diabetes care

What do we hope to achieve?

Amerigroup Kansas, Inc. strives to ensure that we promote the most efficient processes for our providers while continuously improving the quality of care and services that our members receive.

By increasing the use of CPT level II codes, we hope to:

- Improve the health status of our members
- Monitor and ensure our members receive seamless, continuous and appropriate care throughout the continuum of care

What are CPT II codes?

CPT Category II codes are tracking codes that facilitate data collection for the purposes of performance measurement.

How are CPT II codes developed?

The tracking codes are adopted and reviewed by the Performance Measures Advisory Group (PMAG). PMAG is made up of experts in performance measurement from organizations, including the AMA, NCQA, CMS, AHRQ and JCAHO.

Where can I find a list of CPT II codes?

CPT II codes are released annually as part of the full CPT code set and are updated semi-annually in January and July by the AMA. The current listing of CPT II codes can be found on the AMA website at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page.

Why should my organization use CPT II codes?

CPT II codes ease the administrative burden that many providers experience related to chart reviews for many health outcome measures. Use of these codes enables more effective monitoring of quality and service delivery.

How should my organization bill CPT II codes?

CPT category II codes are arranged according to the following categories and are comprised of four digits followed by the letter F:

- Composite measures 0001F – 0015F
- Patient management 0500F – 0575F - 0584F
- Patient history 1000F – 1220F – 1505F
- Physical examination 2000F – 2050F – 2060F
- Diagnostic/screening processes/results 3006F – 3573F – 3763F
- Therapeutic, preventive or other interventions 4000F – 4306F – 4563F
- Follow-up or other outcomes 5005F – 5100F – 5250F
- Patient safety 6005F – 6150F
- Structural measures 7010F – 7025F
- Non-measure code listing 9001F – 9002F – 9003F – 9004F – 9005F – 9006F – 9007F

Urinalysis restrictions for pregnancy related diagnosis codes

Urinalysis procedure codes 81000 through 81020 will not be covered for pregnancy related diagnosis codes when submitted as a primary or secondary diagnosis.

Effective with dates of service on and after November 1, 2015, procedure codes 81000 through 81020 will not be covered for pregnancy-related diagnosis codes when submitted as a primary or secondary diagnosis. If the urinalysis is related to the pregnancy diagnosis, reimbursement is included in the global pregnancy payment. If a pregnant woman is treated for a condition not related to pregnancy, these restrictions do not apply and a diagnosis code for the condition classifiable elsewhere can be used

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 https://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.

New Reimbursement Policy

Medical Recalls

(Policy 06-111, effective 10/01/2016)

Amerigroup Kansas, 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.

Reimbursement Policy Reminders

Unlisted or Miscellaneous Codes

(Policy 06-004, originally effective 07/29/2013)

Amerigroup Kansas, Inc. allows reimbursement for unlisted or miscellaneous codes in accordance with specified guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on review of the unlisted or miscellaneous code(s) on an individual claim basis.

For additional information, refer to the Unlisted or Miscellaneous Codes policy at https://providers.amerigroup.com.

Facility Take Home DME and Medical Supplies

(Policy 06-081, originally effective 12/22/2009)

Amerigroup does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Amerigroup allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

For additional information, refer to the Facility Take Home DME and Medical Supplies reimbursement policy at https://providers.amerigroup.com.

Effective November 1, 2016 ClaimsCheck® upgrade to ClaimsXten™

Amerigroup Kansas, 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 ClaimCheck 10.2, 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 types 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.
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).

Rule	Provider type	Description
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.