

Provider Newsletter



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

2015
Quarter 4

Centers for Disease Control and Prevention predicts another moderately severe flu season predominated by influenza A (H3N2)

The Centers for Disease Control and Prevention (CDC) released its report in June on influenza activity during last year's flu season and announced the composition of the 2015–16 influenza vaccine.

According to the CDC, the 2014–15 influenza season was moderately severe overall and especially severe in adults aged 65 years and older, with predominant circulation of influenza A (H3N2) viruses. Previous influenza A (H3N2)–predominant seasons have been associated with increased hospitalizations and deaths, especially among children under 5 years of age and adults 65 years of age and older.

Influenza activity peaked during late December, with influenza A (H3N2) viruses predominant early in the season. Influenza B became the predominant virus starting in late February, through the end of the flu season in May.

The Food and Drug Administration has recommended a change in the influenza A and influenza B components for the 2015–16 influenza vaccine, according to the report. Vaccine recommendations are based on several factors, including global influenza surveillance, genetic characterization, antigenic characterization, antiviral resistance and the candidate vaccine viruses available for production.

Since 2010, the CDC has recommended that everyone six months of age and older received a flu vaccine annually with rare exception.

Amerigroup Kansas, Inc. is launching our annual member outreach campaign to encourage high-risk members to visit their provider for a flu vaccine. Outreach includes automated

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outbound telephone calls, text messages and newsletter articles. Providers can expect an increase in phone calls and early appointments for the flu vaccine.

Antiviral drugs used to lessen flu duration and symptoms, as well as many cough and cold products, can be found on our provider website at providers.amerigroup.com/KS > Provider Resources & Documents > Pharmacy > Formulary. Please note, cough and cold products are only covered for members less than 20 years of age.

Flu vaccines are now available under the pharmacy benefit for members over 18 years of age. Pharmacies can bill ESI for the flu vaccines. In addition, flu surveillance and patient education materials are available at the [CDC website](http://www.cdc.gov). For more information about vaccine coverage, contact Provider Services at 1-800-454-3730.

Synagis (palivizumab)

Respiratory syncytial virus (RSV) season begins as early as September and runs through April. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. The American Academy of Pediatrics (AAP) recommends a maximum of five (15 mg/kg) monthly doses of palivizumab during the RSV season for high-risk infants who were born before 29 weeks, 0 days gestation, have chronic lung disease (CLD) of prematurity or have hemodynamically significant heart disease. Updated indications for prophylaxis can be found in the July 2014 AAP Policy Statement and on our provider website at providers.amerigroup.com.

The Synagis prior authorization form can be found on provider website at providers.amerigroup.com/KS > Provider Resources & Documents > Pharmacy > Pharmacy Prior Authorization Form. Only one request is needed for each patient throughout the RSV season. In a case where higher dosage is necessary due to weight gain, documentation of the patient's new weight must be provided.

You can also find additional drug information at providers.amerigroup.com/KS.

The importance of coordination of care

Coordination of care among providers is the key to good treatment and Amerigroup continues to stress the importance of regularly communicating and sharing medical records with your patients' other health care practitioners. This includes PCPs and medical specialists, as well as behavioral health practitioners. Remember, working together ensures appropriate diagnosis, treatment and referral.

What are KAN Be Healthy and early and periodic screening, diagnosis and treatment?

Early and periodic screening, diagnosis and treatment (EPSDT) is Medicaid's federally mandated comprehensive and preventive child health program for members younger than 21 years of age. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and requires states to cover all services within the scope of the federal Medicaid program. The intent of the EPSDT program is to focus attention on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services. Kansas' EPSDT program is called KAN Be Healthy and



includes additional member outreach activities and case management, as well as a provider preservice report.

Services include:

- Screening
- Diagnosis and treatment
- Transportation and scheduling assistance

Screening must include:

- Comprehensive health and developmental history (both physical and mental)
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory tests
- Lead toxicity screening
- Health education, including anticipatory guidance
- Vision services
- Dental services
- Hearing services
- Other necessary health care, including diagnostic services and treatment to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services

Use these schedules to determine when services are due:

- American Academy of Pediatrics Periodicity Schedule: brightfutures.aap.org/clinical_practice.html
- Advisory Committee on Immunization Practices Immunization Recommendations schedule: www.cdc.gov/vaccines/acip/index.html
- American Academy of Pediatric Dentistry: www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessmentChart.pdf

The Amerigroup EPSDT program supports individual state plans by:

- Providing a data repository to house EPSDT data
- Mailing annual preventive care recommendations to members
- Mailing reminders to members to make an appointment
- Mailing a letter to providers with a listing of members who may have missed services

Providers must bill Amerigroup using correct coding guidelines to ensure accurate reporting for EPSDT services. You can find more information about the KAN Be Healthy program on our provider website at providers.amerigroup.com/KS.



PCPs and behavioral health/substance use disorder providers: coordination of care

Is the patient you are treating for alcohol dependence taking his or her medications regularly? If diabetic, is he or she getting her HbA1c levels checked every three months? Did your patient who is taking an antipsychotic medication follow-up with his or her PCP after lab results indicated high cholesterol levels?

It often can be difficult to keep up with the rules and regulations of sharing information for specific healthcare specialties. But it is also extremely important to each individual's overall health that their care is coordinated. Substance use and mental illness impact not only the health of our members, but their ability to stay adherent to treatment for physical conditions. Many medications our members take for behavioral health conditions can impact physical health conditions and require close monitoring. Therefore, we encourage a high level of collaboration and coordination among providers.

Tips for collaboration and coordination:

- Gather information about the member's health conditions and treatment team, including specialists, PCPs and other prescriptive providers so you can coordinate care. If you are unsure of a specific provider's name or dates of prescriptions, you may access Provider 360 on the Amerigroup provider website at providers.amerigroup.com/KS.
- Disclosure about substance use disorder (SUD) treatment requires explicit written permission from our members. Therefore, it is important to take some time and explain to members who are in SUD treatment the purpose for and importance of sharing this critical health information.
- If you have a question about what information can be shared, always reference your internal policies and procedures related to privacy and confidentiality.
- If you order lab work, consider indicating on the order that the results be copied to the other provider(s).

HEDIS is just around the corner

What is the Healthcare Effectiveness Data and Information Set (HEDIS)?

- HEDIS is a set of standardized performance measures that compare the performance of managed health care plans. It compares how well a health plan performs in areas related to quality of care, access to care and member satisfaction. We use the HEDIS results to identify areas for improvement, measure results against our goals and to measure the effectiveness of actions we implemented to improve our results.

What are HEDIS measures?

- HEDIS measures address a broad range of important health issues, including immunizations, preventative care and screening, comprehensive diabetes care, medication management, controlling hypertension and access to care.

What is your role in HEDIS?

- Each year, Amerigroup reviews a sample of our members' medical records to measure the quality of care you provide. These records help us to validate the quality of care provided to our members. We appreciate your cooperation and timeliness in submitting the requested medical record information.
- No special authorization is required to share member medical record information with Amerigroup. The form you obtain from the patient permitting you to bill for care is sufficient under HIPAA regulations (Section §164.506) is sufficient for disclosures to carry out health care operations. Section §164.501 defines health care operations to include quality assessment and improvement activities.

Fraud, waste and abuse

As the recipient of funds from federal and state-sponsored health care programs, we have 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/KS. 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 at 757-518-3633
- Send an email to corpinvest@amerigroup.com
- Call our Provider Services team at 1-800-454-3730
- Reach out directly to our Chief Compliance Officer at 757-473--2711 or send an email to ethics@amerigroup.com

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

Examples of provider fraud, waste and abuse include:

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

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

- Medically necessary
- Documented accurately
- Billed according to guidelines



Examples of member fraud, waste and abuse include:

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

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
- Emailing corpinvest@amerigroup.com
- Contacting our Chief Compliance Officer at 757-473-2711
- Sending an anonymous report to amerigroup.silentwhistle.com

We will not retaliate against any individual who reports violations or suspected fraud, waste and abuse, and 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 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.

Share it with your team

The provider newsletter contains important information for you, as a provider, as well as members of your team. When you receive the latest edition, please take a moment to share the information with your staff. Recent editions of the provider newsletter are available online on the provider website at providers.amerigroup.com/KS under Provider Resources & Documents > Newsletters.



Coverage of unlisted codes

Effective with processing dates June 1, 2015, and after, the following unlisted/miscellaneous codes will be considered for coverage:

01999	15999	17999	19499	20999	21089	21499	21899
22899	22999	23929	24999	25999	26989	27299	27599
27899	28899	29799	29999	30999	31299	31599	31899
32999	33999	36299	37501	37799	38999	39499	39599
40799	40899	41599	42299	42699	42999	43499	43999
44799	44899	45999	46999	47399	47999	48999	53899
55899	58579	58999	59899	60699	64999	66999	67299
67399	67599	67999	68399	68899	69399	69799	69949
69979	76496	76497	76498	76499	76999	77299	77399
77499	77799	78099	78199	78299	78399	78499	78599
78699	78799	78999	7999	81099	84999	85999	86849
86999	88199	88299	88399	89240	90899	91299	92499
92700	93799	95199	95999	96999	97039	97799	99199
99499	A0999	G6021	L8499				

If a claim contains one of the above unlisted procedure codes, it must include a complete description. For surgical procedures, the claim must contain an operative report. Documentation supporting medical necessity must also accompany the claim. All supporting documentation must accompany the claim so that appropriate coverage and reimbursement can be determined.

An unlisted procedure code can only be used when there is not a pure code to use. If an unlisted procedure code is billed and there is an appropriate pure code to use, the charges for the unlisted code will be denied and the claim must be resubmitted with the appropriate pure code for consideration of payment within the provider's timely filing period according to contract.

New corrected claim requirement for CMS 1500

Effective June 15, 2015, professional corrected claims billed on CMS 1500 forms must be submitted to Amerigroup in their entirety. As of June 15, 2015, when submitting a correction for a previously billed claim on a CMS 1500 forms, you must include all services on the new submission. If any previously submitted charges or services are not billed on the corrected claim form, they will be removed in the adjustment.

In order to ensure all claims accurately reflect the services performed providers will no longer be permitted to submit individual lines for correction on a CMS 1500 form. Adjustments to the previously processed claim will reflect exactly what is shown on the new corrected claim submission. The updated process for CMS 1500 corrected claims will mirror the current process for institutional replacement claims submitted on CMS 1450 (UB-04) claim forms.



By making this change, we will be able to remove possible discrepancies between the intention of the correction and the way the claim is actually adjusted in our systems. The process for submitting facility replacement claims billed on a CMS 1450 form is not affected by this change. Standard timely filing guidelines apply to all corrected and replacement claims.

If you submit a claim correction and fail to include services that were correctly paid on your original submission, they will be removed on the adjusted claim. Any reduction in payment amount would result in a negative account balance and/or a refund request. If you have questions, call Provider Services at 1-800-454-3730 or contact your local Provider Relations representative.

Pharmacy Dose Optimization program

Effective September 7, 2015, Amerigroup is implementing our Dose Optimization or Consolidation program on some brand-name and generic drugs. This program is designed to increase patient adherence with drug therapy.

Dose optimization quantity limits			
Brand name	Generic name	Strengths	Number of units per day
Abilify	Aripiprazole	2mg	2
Abilify	Aripiprazole	5mg	1.5
Abilify	Aripiprazole	10mg, 15mg	1
Adderal XR	Amphetamine/Detroam phetamine	5mg, 10mg, 15mg	1
Concerta	Methylphenidate	18mg, 27mg	1
Effexor XR	Venlafaxine HCl	37.5mg, 75mg	1
Focalin XR	Dexmethylphenidate HCl	5mg, 10mg, 15mg	1
Intuniv	Guanfacine HCl	1mg, 2mg	1
Invega	Paliperidone	1.5mg, 3 mg	1
Latuda	Lurasidone	20mg, 40mg, 60mg	1
Metadate CD	Methylphenidate	10mg, 20mg, 30mg	1
Paxil CR	Paroxetine HCl	12.5mg	1
Pristiq	Desvenlafaxine Succinate	50mg	1
Remeron Rapid Dissolve	Mirtazapine	15mg	1
Ritalin LA	Methylphenidate	10mg, 20mg	1
Seroquel XR	Quetiapine Fumarate	50mg	2
Seroquel XR	Quetiapine Fumarate	150mg, 200mg	1
Viibryd	Vilazodone	10mg, 20mg	1
Vyvanse	Lisdexamfetamine	10mg, 20mg, 30mg	1
Zyprexa	Olanzapine	2.5mg, 7.5mg, 10mg	1



Reimbursement Policy: updates and reminders

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.

Policy updates

Preadmission Services for Inpatient Stays

(Policy 07-017, originally effective 09/28/2007)

Amerigroup allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window). For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three days prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses. For critical access hospitals, outpatient diagnostic services are not subject to either the three- day- or one-day-payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

Please note, the three day payment window does not apply to outpatient diagnostic services included in the rural health clinic or federally qualified health center all-inclusive rate.

Applicable preadmission services consist of all diagnostic outpatient services (including nonpatient laboratory tests) and clinically related nondiagnostic (e.g., therapeutic) services that are related to the inpatient stay and are included in the inpatient reimbursement. A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately.

Prosthetic and Orthotic Devices

(Policy 06-084, originally effective 09/06/2006)

Reimbursement is allowed for prosthetic and orthotic devices when provided as part of a physician's services or ordered by a physician and used in accepted medical practice. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the prosthetic or orthotic device dispensed. The design, materials, measurements, fabrications, testing, fitting and training in the use of the device are included in the reimbursement of the device and are not separately reimbursable expenses. In instances of theft, a police report is required for consideration of replacements.



Split-Care Surgical Modifiers

(Policy 11-005, originally effective 05/04/2006)

Reimbursement of surgical codes appended with split-care modifiers is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code.

Amerigroup Kansas, Inc., in accordance with Kansas Medical Assistance Program, reimburses Modifier 54 at 80 percent, Modifier 55 at 10 percent and Modifier 56 at 10 percent (used only with global surgery indicator of YYY).

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

Reminder:

Modifier 54 is used to indicate that a surgeon performed only the surgical component of a global surgical package (i.e., another physician provides postoperative care).

Modifier 55 is used to indicate that a physician other than the surgeon performed only the postoperative management component of a global surgical package.

Modifier 56 is used to indicate that a physician other than the surgeon performed only the preoperative evaluation component of a global surgical package.

Transportation Services: Ambulance and Nonemergent Transport

(Policy 07-036, originally effective 02/26/2008)

Amerigroup allows reimbursement for transport to and from covered services or other services mandated by contract. Due to the complex nature of transportation services, Amerigroup recommends that providers also review individual state guidelines for coverage requirements.

Please note, Amerigroup does not allow reimbursement for mileage when the transport service has been denied or is not covered.

For additional information and/or nonreimbursable services, refer to the Transportation Reimbursement Policy at providers.amerigroup.com.



Policy reminder

Reimbursement of Sanctioned and Opt-Out Providers

(Policy 10-002, originally effective 10/11/2010)

Reimbursement is not allowed for providers who are excluded, debarred or who opt out from participation in state and federal health care programs. Reimbursement is also not allowed for providers who have rendered services to members enrolled in any Medicare program if such provider has opted out from participation in Medicare. Services that are rendered by a provider who is sanctioned or who has opted out of participation in Medicare may only be reimbursed in urgent or emergent situations. Claims received for services other than emergency services submitted by sanctioned or opt-out providers as provided herein will be denied. Amerigroup screens providers through all applicable state and federal exclusion lists.

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

Send claims medical attachments through Availity

Amerigroup partners with Availity to offer providers the ability to check patients' eligibility and claims status, as well as submit claims and access multiple payer information with a single, secure Availity Web Portal login.

The medical attachments feature is now available to providers. You can now use your billing National Provider Identifier (NPI) number to register and submit attachments, with or without a claim, through Availity. This service enables you to submit attachments (e.g., medical records, itemized bills, etc.) prior to claims submissions, with claims submission or as requested by Amerigroup.

To access this new feature, primary access administrators (PAAs) should register today by logging in at availity.com. Click on the Amerigroup medical attachments registration link under your PAA dashboard and you can then assign access to appropriate office staff.

As an Amerigroup provider, you can now send up to 10 unsolicited attachments through the web portal. You may submit up to 10 attachments for each claim, with a maximum file size of 10MB per attachment. This service includes attachments for secondary claims or even attachments that are not related to a claim at all. Availity rejects any individual files larger than 10MB and requests that you split larger files into smaller files. Files can be submitted as TIFFs (.tif), JPEGs (.jpg) and PDFs (.pdf). This new feature allows your team to submit supporting medical documentation for claims without prompting by Amerigroup.

Unsolicited attachments streamline the claims process and can improve your revenue cycle by capturing required documentation needed to adjudicate a claim up front. Plus, the Availity captures, transmits, stores and retrieves your medical attachments, providing an electronic history that's easily accessible, now or in the future.



To access additional training about this new Availity feature:

1. Log in to the Availity Web Portal at availability.com. To do this:
 - a. Go to www.availability.com.
 - b. Click the **Web Portal Users Login** link in the upper right corner.
 - c. On the Availity portal login page, enter your Availity user ID and password.
 - d. Click **Log in**.
 2. At the top of any Availity portal page, click **Help | Get Trained**. *(Make sure you do not have a pop-up blocker turned on or the next page may not open.)*
 3. In the new window a list of available topics will open. Locate and click **Medical Attachments**.
 4. Under the **Recordings** section, click **View Recording** (next to Amerigroup Medical Attachments).
- If you have questions contact your local Provider Relations representative or call our Provider Services team at 1-800-454-3730.

Using Patient360

Quickly retrieve detailed records about your Amerigroup patients through our provider self-service website using Patient360. This real-time dashboard gives you a robust picture of a patient's health and treatment history and will help you facilitate care coordination

Drill down to specific patient details:

- Demographic information
- Care summaries
- Claims details
- Authorization details
- Pharmacy information
- Care management activities

With this level of detail at your fingertips, you'll:

- Immediately retrieve a complete medical history for new patients
- Spot utilization and pharmacy patterns
- Avoid service duplication
- Identify care gaps and trends
- Coordinate care more effectively
- Reduce the number of communications needed between PCPs and case managers

To access Patient360:

1. Log in to our secure provider website at providers.amerigroup.com/KS.
2. Select Members from the left navigation.
3. Choose Patient360.
4. Enter a specific Amerigroup member's information.

If you have questions about Patient360, call our Provider Services team at 1-800-454-3730.



Provider Self-Service tools make it easy to do business with our organization

The Provider Self-Service (PSS) web portal offers 24/7 access to update basic provider demographic information like practice address information, practice roster, or termination of a provider in the practice by simply attaching supporting documentation.

Other available tools on the secure PSS site include, but are not limited to:

- Access to PCP member panels
- Patient 360 tool to quickly retrieve detailed records about your patients
- Member eligibility and benefits
- The ability to submit and check status of:
 - Authorizations
 - Claims

You must be a registered user to access the secure PSS tool at providers.amerigroup.com with your Availity username and password. If you do not have a login, go to www.availity.com, select the *Register Now* option and follow the Availity registration process instructions. Once you have your Availity username and password and have logged in, you may take an online tutorial under *Provider Education* to guide you through the process to make provider updates.

If you experience any difficulty, contact your local Provider Relations representative or call our Provider Services team at 1-800-454-3730, from 8 a.m. to 5 p.m., Monday through Friday for assistance.

