Provider Update

Amerigroup RealSolutions in healthcare

Reimbursement Policy Bulletin

July 2014, Issue #1

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 Kansas, Inc. 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 claims 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/quicktools/pages/reimbursementpolicies.aspx.

Policy Updates

Documentation Standards for Episodes of Care

(Policy 11-004, originally effective 12/07/2011)

Amerigroup requires that upon request for clinical documentation to support claims payment for services, the provided information should identify the member, be legible, and reflect all aspects of care.
To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Admission and discharge dates and instructions
- Preventive services provided or offered, appropriate to member's age and health status
- Evidence of coordination of care between primary and specialty physicians, when applicable
- Patient's identifying information
- Consent forms
- Health history including applicable drug allergies
- Physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician's orders
- Face to face evaluations
- Progress notes referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Working diagnoses consistent with findings and test results
- Treatment plans consistent with diagnoses

To view specific criteria, please refer to the policy at: providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx

Unlisted or Miscellaneous Codes (aka: Dump Codes)

(Policy 06-004, originally effective 03/02/2006)

Amerigroup allows reimbursement for unlisted or miscellaneous codes (a.k.a. dump codes). They should only be used when an established code does not exist to describe the service, procedure or item rendered.
Claims submitted with unlisted or miscellaneous codes must contain the following information and/or documentation for consideration during review:

- Include a written description, office notes, or operative report when describing the procedure or service performed
- Submit an invoice and written description for items and supplies
- Show the corresponding National Drug Code (NDC) number for an unlisted drug code

To view specific criteria, please refer to the policy at: providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx

Claims Submission – Required Information for Professional Providers

(Policy 06-029, originally effective 06/16/2006)

Professional providers of health care services are required to submit an original Centers for Medicare and Medicaid Services (CMS)-1500 health insurance claim form for payment of health care services. In addition to the required information, the CMS-1500 claim form must include the Clinical Laboratory Improvement Act (CLIA) certification number for applicable lab tests.
All claims must be legible. If any field on the claim is illegible the claim will be rejected or denied.

To view specific criteria, please refer to the policy at: providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx

Modifier CC

Corrected claims must be clearly marked. Failure to mark the claim appropriately may result in the denial of the claim as a duplicate. The use of Modifier CC is inappropriate to indicate a corrected claim. Modifier CC is not to be used by the provider community as it has been stipulated by CMS that the modifier be used by the contractor when the procedure code submitted was changed either for administrative reasons or because an incorrect code was used. Claims submitted with the Modifier CC will be rejected as it is an inappropriate modifier for provider use.

Obstetrics: New Condition Codes

Global Use of Condition Codes

Effective October 1, 2013, per the National Uniform Billing Committee Manual, new condition codes that indicate gestation and delivery must be reported on the delivery claim if required by the payer. These codes are listed below for your review:

Report condition code:

- 81 – C-sections or inductions performed at less than 39 weeks gestation for medical necessity
- 82 – C-sections or inductions performed at less than 39 weeks gestation electively
- 83 – C-sections or inductions performed at 39 weeks gestation or greater

Note: A number of state Medicaid fee-for-service plans are reducing payments for elective deliveries at less than 39 weeks gestation. Medically necessary deliveries are reimbursed the full rate. Retrospective reviews may be performed to verify the accuracy of the condition code reported. The implementation of ICD-10-CM may negate the need for these codes and the codes may be retired at that time.

This requirement is in addition to mandated modifier requirements.

CMS 1500: Appropriate Reporting for Place of Service

Services reported on a CMS-1500 Form require an accurate Place of Service (POS) consistent with the CPT or HCPCS code description. Providers are required to bill the appropriate POS for that claim to be eligible for reimbursement. In accordance with coding guidelines, physicians should not bill separately for performing administrative or clinical functions that are paid through the facility reimbursement.

For a complete list of reimbursement policies and clinical policy bulletins, visit providers.amerigroup.com and click on Quick Tools. Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative or our Provider Services team at 1-800-454-3730.