MARYLAND
ProviderNews
2015 • Quarter 1

ICD-10 coded prior authorizations

The transition from ICD-9 to ICD-10 goes into effect on October 1, 2015.

Amerigroup Community Care will begin accepting ICD-10 coded authorizations beginning June 1, 2015. These will only be for those authorization requests where the dates of service are October 1, 2015, or later. Authorization requests for dates of service prior to October 1, 2015, will continue to be coded using ICD-9.

Getting ready to transition to ICD-10

To help ensure you are ready, here are some additional things to remember:

- Make sure your practice management system and/or billing system is ICD-10 ready. Talk with your vendor about the support and services you might need to be compliant for ICD-10.
- There is no need to memorize all of the new ICD-10 diagnosis codes. If you are not an inpatient facility, you only need to be concerned with the most common medical conditions your practice sees today and understand how ICD-10 impacts them.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record.
- If your practice treats a wide range of medical conditions, use the 80/20 rule to determine which ICD-10 diagnosis codes are most pertinent. This would include family practice, pediatric medicine or internal medicine.

The Centers for Medicaid & Medicare Services (CMS offers the "Road to ICD-10" – a comprehensive tool where you can explore common codes, primers for clinical documentation, clinical scenarios and additional resources associated by specialty.

Visit www.roadto10.org to find information for:

- Family Practice
- Pediatrics
- OB-GYN
- Cardiology
- Orthopedics
- Internal Medicine
- Other Specialties

Did you know you also have the opportunity to earn continuing medical education (CME) credits while preparing for ICD-10?

CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition. The video lectures are specifically for physicians, while the article covers more general topics for all health care providers. CME credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion.

The modules are free and can be found at www.cms.gov/Medicare/Coding/ICD10.

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Amerigroup **2014 HEDIS® data collection** is underway

Healthcare Effectiveness Data and Information Set (HEDIS®) data collection is a nationwide, joint effort among employers, health plans and physicians. To aid in this effort, we must regularly send member diagnosis data to the Centers for Medicare & Medicaid Services (CMS) for our Amerigroup plans. The goal is to monitor and compare health plan performance as the National Committee for Quality Assurance (NCQA) specifies. We collect most of the data from claims and encounters, though we also gather diagnosis codes from member medical records.

What we need from you

Our staff or a contracted representative may contact your office to collect medical record information on behalf of our members' 2015 visits. If you're contacted, we ask that you cooperate with our request. We'll need timely access to our members' medical records by a specific due date. Our representatives will work with you and give you options for sending medical records.

Meeting HIPAA guidelines

Our representatives serve us in a role that Health Insurance Portability and Accountability Act (HIPAA) defines and covers. As HIPAA defines, Amerigroup is a Covered Entity and our representative's role is a Business Associate of a Covered Entity. Giving medical record information to us or our contracted representatives meets HIPAA regulations.

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

Lead testing **options**

Remember, it is important to follow the lead testing schedule as it applies to Medicaid recipients.

Per federal and Maryland state law, it is the responsibility of health care providers to ensure that eligible children receiving Medicaid receive:

- A blood lead level performed at age 12 months and 24 months
- A lead risk assessment survey completed at every well-child visit from age 6 months to 6 years
- A blood level check for any patient with any item positive on a lead risk assessment survey

Children who have lead levels above five milligrams per deciliter are to be retested within three months. In addition, the family should receive lead and nutritional education along with an assessment for other likely causes of lead exposure.

In order to help providers meet these mandates, LabCorp, Quest Diagnostic and MedTox Laboratories may be used to conduct lead levels testing. Amerigroup has a contract with MedTox Laboratories to provide physicians with a fast, noninvasive filter paper screening method that can be used while the child is in your office.

Please code your services correctly – providers receive an **increased reimbursement of $10** for billing CPT code 36416, collection of capillary blood specimen, when drawing blood in the office.

Questions?

If you have questions about this newsletter or need assistance with any other item, call Provider Services at **1-800-454-3730** or contact your local Provider Relations representative.

IMPROVING YOUR EXPERIENCE:
Availity eligibility and benefits (E&B) updates

Availity is launching new eligibility and benefits features for their Web Portal during the second quarter of 2015. These enhancements will make finding eligibility and benefits easier and faster for you.

View the chart below for more information on what's coming:

New Request page	The new Request page design makes it faster for you to submit member inquiries. Now, you can submit multiple inquiries without having to wait for individual results to show before starting another request.
Patient history list	The results list summarizes your most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only the information relevant to that member is displayed.
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list includes key coverage elements and only shows information returned from the payer.
Organization-wide view of E&B transactions	You can now see transactions by other users within your organization (shared history) – resulting in less duplication of work already completed by your peers.
Organization dropdown menu	Users responsible for more than one organization can switch organizations while staying on the same page, providing a convenient, streamlined workflow.
Payer section	In this section, value-added services were consolidated so you can access these services (e.g., a patient care summary) from the same page.

To learn more about these time-saving features, go to **www.availity.com** and take a quick tour, view the recorded webinar or join Availity for a live webinar.

Transition of care – **pediatric to adult**

The transition from pediatric to adult care is an important one, and we ask that you remember in particular pregnant adolescents as they transition from pediatrician to an adult primary care provider, obstetrician or gynecologist, family practitioner or internist. Upon request, Amerigroup customer service can provide a list of providers to help the members plan for the transition. As it is important to maintain coordination and continuity of care as they move between providers, we ask that you forward copies of requested medical records in a timely fashion. If assistance is needed with the transition process, please contact us. We have trained customer service personnel, as well as licensed nurses and social workers, available to help.

Member and provider **safety**

At Amerigroup, we take our commitment to safety seriously and work hard to implement policies and procedures to support that goal. We have a comprehensive quality management plan that includes monitoring metrics such as quality of care, attitude and service, access, pharmacy, billing and finance, as well as quality of office site. We also monitor complaints and grievances and take action to resolve any issues in a timely manner.

To promote a culture of safety, a variety of classes on topics such as emergency preparedness and safety in the home are provided to the communities we serve. Please contact Quality Management at 410-981-4582 for further information.

ClaimCheck®

Version 55 upgrade effective July 2015

In 2015, Amerigroup will complete two upgrades to newer versions of ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in Version 55 of the upgrade are effective July 2015. The changes included in Version 56 of the upgrade are effective August 2015.

What this means to you

No actions required; for your information only

Background information

Amerigroup uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to industry standards.

Why is this change necessary?

ClaimCheck is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes.

Amerigroup uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- 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 billed with inappropriate modifiers

New corrected claim requirement for CMS 1500

Effective June 15, 2015, professional corrected claims billed on CMS 1500 forms must be submitted to Amerigroup Community Care in their entirety.

What does this mean to you?

As of June 15, 2015, when submitting a correction for a previously billed claim on a CMS 1500 form, 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 that 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.

How will this change affect you?

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.

Avoid timely filing denials

A clean claim must be received by Amerigroup within 180 days (six months) from the date of service. After 180 days, any claim submitted will be denied as untimely and the claim will not be paid.

If the claim is first submitted to another insurance carrier (Commercial, Medicaid fee-for-service, for example), claims must be submitted within 180 days (six months) from the date of the Explanation of Benefits (EOB) of the primary carrier. It is required that the provider submit the EOB with the claim.

It is critical that providers retain their EOB as proof of timely filing. This the only acceptable proof that a claim has been filed – Amerigroup does not accept billing system printouts as proof that a claim was filed in a timely manner.

Providers should make every effort to submit claims as soon as possible. This allows providers additional time to submit corrected new claims within the six-month time frame.

Need help with smoking cessation?

Visit MDQuit.org/Cessation-Programs.

Maryland's 1-800 QUIT NOW

OB-GYNs:

Be sure to remind your patients to visit the dentist during pregnancy

We know oral health can have serious effects on overall health – this is especially true during a pregnancy. During this time, women have a higher risk of developing periodontal (gum) disease and that can seriously affect the health of the baby, possibly leading to premature labor and low birth weight. It's important that OB-GYNs remind their patients to see the dentist before, during and after pregnancy.

The dentist can ensure that teeth and gums are in good shape so that any oral health problems your patient may have can be taken care of before she gets pregnant. During pregnancy, the dentist should be aware of all medications and vitamins the expectant mother is taking, as these can affect how certain conditions are treated. Also, although X-rays are much safer today than in the past, they should not be done for pregnant patients except in the case of an emergency. If this should arise, the dentist can take special precautions to keep mother and baby safe.

Dental and periodontal treatment should be avoided as much as possible during certain times in the baby's development,

specifically the first trimester and the final six weeks before delivery. Routine care is okay during the second trimester, but patients should wait, when possible, to have major dental work done until after the baby is born.

Pregnancy can cause hormonal changes that make the patient more susceptible to gum disease. This can lead to bleeding of the gums, a condition known as pregnancy gingivitis. Any form of gum disease can affect the baby, so if the patient notices any bleeding, swelling or tenderness of the gums, she should let her dentist know immediately.

Of course, expectant mothers should always follow good oral hygiene habits – brushing and flossing daily. If the taste of the toothpaste is too intense during pregnancy, the dentist can recommend one with a blander flavor. Soon after the baby is born, she should have another cleaning and oral health exam to have her periodontal health evaluated, particularly if she had any issues with her gums during the pregnancy.

Most of the services described here are covered if your patient has dental insurance. Generally, preventive services such as exams and X-rays are covered 100 percentand major services are partially covered.

Amerigroup RealSolutions in healthcare

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ProviderNews

Case management PROGRAM

Our Case Management (CM) program is part of a comprehensive Health Care Management Services program that offers a continuum of services including CM, disease management and care coordination. Since many members have complex needs that require services across multiple providers and systems, a potential for gaps may occur in the health care delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our CM program helps reduce these barriers by identifying the unmet needs of members and assisting them in finding solutions to those needs.

Our case managers can assist in:

- Coordinating care
- Accessing community services
- Providing disease-specific education
- Facilitating any number of interventions to improve the quality of life and functionality of members along with efficiently using health care resources

If you need to refer a member to our Case Management program, call National Customer Care at

1-800-454-3730.

If you would like to learn more about our Disease Management Centralized Care Unit, call

1-888-834-4300

and ask to speak to a care manager.