Provider Newsletter

providers.amerigroup.com

2016
Quarter 1

B'More Fit: free weight loss support

B'more Fit is a free weight loss and exercise program for women who receive public assistance and have young children, through the Family League of Baltimore.

A recent study from the Centers for Disease Control and Prevention (CDC) found that nearly half of American women are gaining more than the recommended amount of weight during pregnancy. You can help your postpartum clients lose their baby weight by providing information about B'more Fit, a free evidence-based group support program.

Offered in Spanish and English, B'more Fit offers Take Off Pounds Sensibly (TOPS) education, exercise classes led by professional trainers, tips on budgeting and food preparation, and more. To minimize barriers, we also offer transportation and childcare at no cost.

Since 2012, over 600 women have enrolled in the B'more Fit intervention. Over half of participants who have attended the program for at least 12 weeks have lost five percent or more of their body weight. Nearly one in five lost 10 percent or more of their body weight - the point at which clinical health benefits can be seen.

For more information and referrals, please contact B'more Fit Project Coordinator Donnica Fife-Stallworth at 1-410-662-5500, ext. 243.

Health education materials available

At Amerigroup Community Care, we believe prevention is a key to good health. Our Health Promotion department offers a variety of resources to help educate and empower members through educational materials, health education workshops, member incentive programs and outreach assistance to community resources. To learn more, please contact Health Promotion at MDoutreach@amerigroup.com or 1 800 600 4441, ext. 44120.

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Access to Case Management

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 Provider Services 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.

Pharmacy education – respiratory step therapy, quantity limits and prior authorization (PA) edit

Amerigroup would like to provide you with information on the respiratory step therapy (ST), quantity limited (QL) and PA edit requirements for our suite of respiratory medications referenced on our formulary. Some medications may be prescribed without ST or PA while other medications have edits. There are two medications that require prior authorization.

Please review the information in the grid below to be informed when prescribing respiratory medications for our members.

Medication	ST (Y/N)	ST edits	Quantity limits
Advair*	Y	Inhaled corticosteroid (i.e. Qvar, Flovent, Aerospan)	1 inhaler per 27 days or 2 inhalers per 45 days
Aerospan	N	None	None
Asmanex	N	None	None
Dulera	Y	Inhaled corticosteroid (i.e. Qvar, Flovent, Aerospan)	1 inhaler per 27 days or 2 inhalers per 45 days
Flovent HFA	N	None	1 inhaler per 27 days or 2 inhalers per 45 days
Montelukast	N	None	1 tablet per day
Pulmicort Flexhaler	N	None	1 inhaler per 27 days or 2 inhalers per 45 days

Medication	ST (Y/N)	ST edits	Quantity limits
Qvar	N	None	3 inhalers per 27 days or 6 inhalers per 45 days
Symbicort	Y	Inhaled corticosteroid (i.e. Qvar, Flovent, Aerospan)	1 inhaler per 27 days or 2 inhalers per 45 days
Zafirlukast	N	None	2 tablets per day

* Advair is non-preferred status for members 12 years and older. Dulera and Symbicort are preferred.

XOLAIR	PA is required
SINGULAR (brand name)	PA is required

If you have questions, contact your local Provider Relations representative or call Provider Services at 1-800-964-2112.

PA required for H.P. Acthar Gel, Prialt and Retisert

Amerigroup is adding the following drugs to the 2016 Medicaid list of injectable or infusible drugs requiring PA. As of May 1, 2016, providers must call for PA of the drugs listed below:

- H.P. Acthar Gel (Repository Corticotropin Injection) for the treatment of infantile spasms and corticosteroid-responsive conditions where there is clear documentation of why all other well-established routes for corticosteroid therapy cannot be used.
  - Amerigroup Clinical Utilization Management Guideline CG-DRUG-24: (J0800=Injection, corticotropin, up to 40 units)
- Prialt (Ziconotide Intrathecal Infusion) for the management of severe chronic pain when intrathecal therapy is warranted and when intolerant or refractory to other treatment.
  - Amerigroup Medical Policy Drug.00027: (J2278=Injection, ziconotide, 1 microgram)
- Retisert (Fluocinolone acetonide intravitreal implant) for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.
  - Amerigroup Medical Policy DRUG.00032: (J7311=Fluocinolone acetonide, intravitreal implant)

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

Intensity modulated radiation therapy (IMRT) codes require PA

Effective May 1, 2016, two intensity modulated radiation therapy (IMRT) codes that previously did not require PA will now require PA. IMRT requests must be reviewed by Amerigroup for PA for dates for service on or after May 1, 2016.

Amerigroup will require PA for the following IMRT codes beginning May 1, 2016:

- 77385: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 : Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

PA request may be submitted by either of the following methods:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627

If you have questions, call Provider Services at 1-800-454-3730.

ICD-10 and coding for diabetes

Below is some helpful information regarding ICD-10 and how to properly bill for diabetes.

Diabetic complications in ICD-10

A benefit of ICD-10 codes is that providers can now report more clinical details concerning diabetic complications than they could in ICD-9. The increased specificity is possible because ICD-10 contains expanded combination codes for diabetic complications. A combination code describes two or more conditions within a single code. The ICD-10 code categories E08-E13 contain the combination codes for diabetic complications. The codes include type of diabetes mellitus, body system affected and complications affecting that body system. Combination codes may require additional diagnosis codes to escribe all associated conditions. Reporting all documented conditions to the highest level of

fully describe all associated conditions. Reporting all documented conditions to the highest level of specificity on the claim form helps to promote quality and continuity of patient care. To ensure coding specificity for diabetic complications in ICD-10, medical record documentation should include:

- Type of diabetes (i.e., Type 1, Type 2, secondary)
- Complications and body systems affected (i.e., diabetic neuropathy)
- Control status (document how well diabetes is controlled over time)
- Long term use of insulin (report additional code Z79.4 on the claim)

Some examples of ICD-10-CM type 2 diabetes combination codes include:

Complication type	Correct code category
Kidney and renal	E11.2- Type 2 diabetes with kidney complications
Ophthalmic (eye/retinal)	E11.3- Type 2 diabetes with ophthalmic complications
Neurologic (nervous system)	E11.4- Type 2 diabetes with neurological complications

Complication type	Correct code category
Circulatory (arteries)	E11.5- Type 2 diabetes with circulatory complications
Other specified (arthropathy, skin, ulcerations, oral, hypoglycemia and hyperglycemia)	E11.6- Type 2 diabetes with other specified complications

Note: Not an all-inclusive list. For a complete list consult the current ICD-10-CM coding manual.

Accurately reporting uncontrolled diabetes

Previously, diabetes mellitus codes were classified as controlled or uncontrolled. In ICD-10-CM diabetes described as not being controlled is classified as hyperglycemia which is considered a complication. When documentation contains terms such as *inadequately controlled, out of control* and *poorly controlled,* the index leads to diabetes with hyperglycemia (see example below). Assign as many codes that are needed to accurately describe the patient's diabetic condition(s).

Documentation	Correct code(s)
Male patient is seen and evaluated for diabetes mellitus type 2 poorly controlled.	E11.65 Type 2 diabetes mellitus with hyperglycemia
Female patient is seen and evaluated for shooting pain and numbness in toes and feet. The provider diagnosis type 1 diabetic neuropathy in adequately controlled.	E10.40 Type 1 diabetes mellitus with diabetic neuropathy E10.65 Type 1 diabetes mellitus with hyperglycemia

Documenting to support accurate coding

Since diagnosis coding is based on provider documentation, it is critical that providers include all known details about coexisting and chronic conditions (i.e., diabetes) in the medical record for each patient encounter. Details such as the provider's assessment/evaluation of the condition, medications prescribed, recommendations, referrals and even patient noncompliance help support accurate coding. Documenting support for all current medical conditions improves quality of care and ensures coding guidelines are followed.

ICD-10 Coding Guidelines, Section IV Diagnostic coding and Reporting Guidelines for Outpatient Services

- .I *Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions.*
- .J *Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management*.

Documenting cause and effect for diabetic complications

When diabetic complications are present, it is important that medical record documentation support the cause and effect relationship between diabetes and the other conditions with linking verbiage. Examples of linking verbiage include:

- Diabetic
- Due to diabetes
- Secondary to diabetes
- Caused by diabetes

If documentation does not properly link the condition(s), a diabetes combination code should not be assigned. Each condition must be coded separately when documentation does not establish a causal link (see example below).

Documentation	Correct code
Female patient evaluated for type 1 diabetes and stage 1 chronic kidney disease. (Cause and effect not documented)	E10.9 Type 1 diabetes mellitus *without complications* N18.1 Chronic kidney disease, stage 1
A male patient is seen and evaluated for diabetic chronic kidney disease-stage 3, he takes insulin on a daily basis	E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease N18.3 Chronic kidney disease, stage 3 (moderate) Z79.4 Long-term (current) use of insulin

For complete instructions and guidelines, please refer to the current ICD-10-CM coding manual.

HEDIS is coming

It's that time of year again! As a part of the Healthcare Effectiveness Data and Information Set (HEDIS) quality study, Amerigroup reviews a sample of our members' medical records to measure the quality of care you provide. We are pleased to participate in this study as a means of pursuing continuous improvements in the services you provide to our members. Your assistance is crucial to ensuring that our data is statistically valid, auditable and accurately reflects quality performance.

No special authorization is required to share member medical record information with Amerigroup. The form you obtain from your patients permitting you to bill for care is sufficient under HIPAA regulations.

- Pursuant to 45 CFR §164.506, the routine form you have the member sign is sufficient to permit disclosure of protected health information to carry out health care operations.
- In addition, 45 CFR §164.501 defines health care operations to include quality assessment and improvement activities.

NCQA rates Amerigroup one of the top plans in Maryland

National Committee for Quality Assurance (NCQA)'s Medicaid Health Insurance Plan Ratings 2015-2016 rated Amerigroup four out of five, placing it among the highest rated plans in the state. Amerigroup earned the ratings from the National Committee for Quality Assurance, a nonprofit organization dedicated to improving health care quality.

"Being identified by the NCQA as one of the highest performing health plans in the state is a testament to the hard work and passion our team embodies here in Maryland," said Vince Ancona, plan president. "We take tremendous pride in being recognized, but we also look forward to building on this achievement, and improving as a health plan and trusted resource for our members."

All plans were evaluated based on three areas -- consumer experience, prevention and treatment. Amerigroup received identical scores of three for consumer experience and treatment and a 3.5 in prevention.

The clinical quality measures include prevention and treatment measures, which are a subset of the NCQA HEDIS one measures. Prevention measures assess the proportion of eligible members who received preventive services, like prenatal and postpartum care, immunizations and cancer screenings. Treatment measures assess the proportion of eligible members who received the recommended care for conditions such as diabetes, heart disease and mental illness.

Consumer satisfaction measures come from the HEDIS survey measurement set—Consumer Assessment of Healthcare Providers and Systems (CAHPS)—a validated survey overseen by the Agency for Health Care Quality. Consumer satisfaction measures assess patient experience with care, including their experiences with doctors, services and customer service.

Amerigroup CAHPS scores increased in 2015, resulting in an increase in our overall NCQA accreditation score. At 84.22 of 100 possible points, Amerigroup maintains its Commendable NCQA accreditation score.

About NCQA

NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes clinicians in key clinical areas. NCQA's HEDIS is the most widely used performance measurement tool in health care. NCQA's website at ncqa.org contains information to help consumers, employers and others make more informed health care choices.

About Amerigroup

Amerigroup has provided health care coverage in Maryland since 1999. Statewide, we serve approximately 266,000 members in the Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) programs. Amerigroup is the state's largest managed care organization (MCO) and is one of the largest MCOs in Baltimore City and the counties of Baltimore, Montgomery, Prince George's and Anne Arundel. Employees share genuine pride in making a

difference in the lives of people who might need a little extra help.

The CCU claim collection life cycle will include three phases:

- A standard recovery process requesting refunds from providers
- An escalated recovery process which attempts to obtain check refunds from the providers for any offsets not satisfied by the 60th day following a negative balance adjustment
- Lastly, a third party recovery process initiated by LHA if claims are not successfully fulfilled during the escalated recovery process

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Reimbursement Policy updates

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.

Locum Tenens
(Policy 06-063, originally effective 08/23/2006)

Amerigroup allows reimbursement of locum tenens physicians in accordance with the CMS guidelines. Amerigroup will reimburse the member's regular physician or medical group for all covered services provided by a locum tenens physician during the absence of the regular physician in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis.

Please note that, Amerigroup requires the regular physician or medical group to identify the locum tenens physician by entering their Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

For market-specific information, refer to the Locum Tenens reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Professional Providers
(Policy 06-029, originally effective 06/16/2006)

Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original CMS-1500 Health Insurance Claim Form to us for payment of health care services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include specific information outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Professional Providers reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Facilities
(Policy 06-030, originally effective 06/16/2006)

Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original Centers for Medicare and Medicaid Services UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to us for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and Amerigroup can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Facilities reimbursement policy at providers.amerigroup.com.

Documentation Standards for Episodes of Care
(Policy 11-004, originally effective 12/07/2011)

Amerigroup requires that documentation for all episodes of care must meet the following criteria:

- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated and timed.
- Documentation must reflect all aspects of care.
- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

For a complete list of minimum documentation requirements, refer to the Documentation Standards of Episodes of Care reimbursement policy at providers.amerigroup.com.

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

New 2016 provider collaboration initiative

You asked and we heard you! Based on the results of our provider survey we are building a new clinical focused provider collaborative in 2016. This initiative will be focused on building and in some cases enhancing our relationship with some of our key providers. Our goal is to understand our provider practices including the needs, barriers and day to day struggles of our provider network and how we can assist providers with management of some of our most complex membership. This relationship will focus on bridging communication, clinical rounds to discuss complex members, providing internal resources and support for member management and in coordination with our Provider Solutions team help our providers improve their quality of care and meet their Value-Based Purchasing and HEDIS goals.

New collection agency partnership

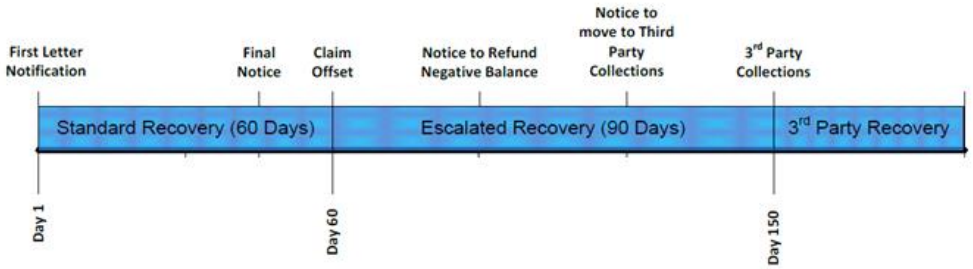
The Amerigroup Cost Containment Unit (CCU) has partnered with third party collection agency, Lamont, Hanley & Associates, Inc. (LHA) to assist in the recovery of overpayment refunds.

Lamont, Hanley & Associates, Inc. is a New Hampshire-based, nationwide debt collection agency with a long history of providing excellent collection services for Anthem, parent company of Amerigroup. LHA was chosen due to its philosophy of "customer service approach to collections," a value we identify with and one that is critical in ensuring a successful partnership, understanding the sensitivity of releasing a collection agency in our provider networks.

A brief excerpt from LHA…
Our methodology incorporates sales techniques with financial guidance to provide your customers with a program that results in clearing their balance in a non-confrontational, business-like manner. This process results in a higher liquidation and maintains a professional image for our company and our clients. We combine this with our collectors' abilities to resolve disputes and expedite files, making us unique in the collection industry.

The CCU claim collection life cycle will include three phases:

- A standard recovery process requesting refunds from providers
- An escalated recovery process which attempts to obtain check refunds from the providers for any offsets not satisfied by the 60th day following a negative balance adjustment
- Lastly, a third party recovery process initiated by LHA if claims are not successfully fulfilled during the escalated recovery process



Amerigroup RealSolutions in healthcare

Your market is already live and this notification is to inform you of the role LHA plays in the collection process.

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

Scion Dental contact information

Please use the information below if you need to contact Scion Dental directly.

Provider Services

- Phone: 844-275-8753
- Email: providerservices@sciondental.com
- Web portal: www.provider.MDhealthysmiles.com

Claims mailing address

Maryland Healthy Smiles: Claims
P.O. Box 2186
Milwaukee, WI 53201

Grievances/Appeals mailing address

Maryland Healthy Smiles: Grievances/Appeals
P.O. Box 393
Milwaukee, WI 53201
Please note: This address is the same for members.

Member Services

- Phone: 855-934-9812
- TDD: 855-934-9816
- Web portal: www.member.MDhealthysmiles.com

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 their 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 8 a.m. to 7 p.m. Eastern time.

If you have questions about the tools and resources available on the Amerigroup or Availity websites, please visit providers.amerigroup.com. If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.