Provider Newsletter

providers.amerigroup.com

2016
Quarter 2

Over-the-counter (OTC) pharmacy benefits start with you!

Amerigroup Community Care covers up to $15 worth of certain OTC generic drugs every three months. Quantity limits and safety restrictions apply. Providers need to write a prescription for these drugs for the member to submit to their pharmacy. Some examples of covered OTC products are:

- Analgesics (pain relief)
- Cough/cold/decongestants (age limits may apply)
- Medical supplies
- Skin/topical
- Vitamins/minerals

For a listing of many OTC products we cover, check the pharmacy formulary benefit located at https://providers.amerigroup.com/QuickTools/Pages/FormularyCare11.aspx or contact our Pharmacy Help Desk at 1-800-454-3730.

Harvoni hepatitis C medication coverage

Prior authorization (PA) requests for Harvoni, require providers to submit a completed PA form and include copies of the patient's medical history summary, lab and genetic test reports. The PA form must be filled out completely before therapy is approved. The PA form can be located at: https://mmcp.dhmh.maryland.gov/pap/docs/Hepatitis%20C%20PA%20form%20July%201%202015.pdf

Clinical criteria will be applied to all Harvoni requests. The criteria can be found at: https://mmcp.dhmh.maryland.gov/pap/docs/Clinical%20Criteria%20for%20Hepatitis%20.pdf. If there are questions or need for assistance, contact the Pharmacy Helpdesk at: 1-800-454-3730.

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Step therapy for asthma and controlling inhalers

Make sure you are prescribing asthma and controlling inhalers correctly. Some controllers need a PA. Visit the Precertification Lookup Tool at https://providers.amerigroup.com/Pages/PLUTO.aspx for more information.

Changes to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program schedule

The Maryland Healthy Kids Program requires an EPSDT exam to include a complete health history, including mental and physical development, a complete physical exam, health education/anticipatory guidance, labs and up to date immunizations per the periodicity schedule. Refer to the Healthy Kids manual website address to come for more information regarding the required components of the EPSDT exam. Sports physicals are a great time to complete an EPSDT exam!

Some helpful reminders

Below is a list of helpful tips and reminders on a number of topics, from billing procedures to where you can locate a list of member rights and responsibilities.

1. **Member ID cards on smartphones**
   If our members show you their ID cards using the Amerigroup Community Care mobile app on their smartphone, you should accept that as valid proof of insurance coverage. The Amerigroup mobile app shows an electronic version of a member's real ID card. It has the same information and is proof of coverage. You can easily view their ID card and get all of the information you need.

2. **Ambulatory surgery center (ASC) – site of service**
   To insure care is provided in the most cost effective setting, procedures for certain specialties should be performed at a participating ASC unless medical necessary criteria are met for the procedure to be performed in a hospital setting. Amerigroup reviews site of service and medical necessity for certain gastroenterology, ophthalmology, urology and podiatry outpatient surgery. Please refer Amerigroup members to a participating specialist who has admitting privileges at a participating ASC.

3. **Billing tip for family planning services**
   For providers who bill on a CMS 1500 form for family planning services, a valid NDC number is required on the claim when billing a Depo Provera Injection (J1050, Medroxyprogesterone acetate, 1 mg). Unit value of the dosage must be specified. For example, NDC 59762-4538-02, 150, UN having J1050 as the HCPC and the 150 in the unit field of the 1500 form. When giving the 104 mg dosage, the format should be the same, but with the 104 in place of the 150.

4. **Affirmative statement about incentives**
   As a corporation and as individuals involved in utilization management (UM) decisions, we are governed by the following statements:
   - UM decision making is based only on appropriateness of care and service and existence of coverage.
   - Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
   - Financial incentives for UM decision-makers do not encourage decisions that promote denials, result in underutilization, or create barriers to care and service.

5. **Distribution of clinical practice and preventive health guidelines**
   Evidence-based guidelines are clinical practice guidelines known to be effective in improving health outcomes. Guideline effectiveness is determined through scientific evidence, professional standards, or expert opinion. Amerigroup provides clinical and preventive health guidelines to our network physicians. These guidelines are based on current research and national standards. Members and providers may request a paper copy of a guideline by calling Provider Services at 1-800-454-3730. They are also available on our website at https://providers.amerigroup.com/MD.

6. **Availability of UM criteria**
   If an Amerigroup physician reviewer denies your service request due to medical necessity, both you and the member will receive a notice of action letter that will include the reason for denial, note the criteria/guidelines used for the decision and explain the provider/member appeal process and rights. If you would like to arrange to speak with a physician reviewer about a medical necessity determination within 24 hours /one business day of the initial notice of action about the service request denial, call the MD Peer-to-Peer line at 1-866-696-2709. Administratively denied requests must follow the appeal process only. To request a copy of the specific criteria/guideline used for the decision, please call 1-800-600-4441 or write to:

   Attn: UM Medical Management
   Amerigroup Community Care
   7550 Teague Road, Suite 500
   Hanover, MD 21076

7. **Access to utilization staff**
   Providers have access to clinical professionals who coordinate member care and are available 24 hours a day, 7 days a week to accept precertification requests. You can submit a precertification request by:
   - Calling 1-800-474-3730
   - Faxing to 1-800-964-3627
   - Logging in to https://providers.amerigroup.com/MD and using the precertification lookup tool

   If you have questions about utilization decisions or the UM process, call the clinical team at 1-800-454-3730, Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

8. **Member rights and responsibilities**
   Our members have defined rights and responsibilities. These can be found in your provider manual and on our website, https://providers.amerigroup.com/MD. If you would like a paper copy mailed to you, call Provider Services at 1-800-454-3730.

9. **Pharmacy benefit manager change**
   Effective April 1, 2015, Amerigroup began using Express Scripts as our pharmacy benefit manager. Please continue to refer to our preferred drug list (PDL) and formulary when prescribing medications for your patients. You can access these on our provider website at https://providers.amerigroup.com/quicktools/pages/pharmacytools.aspx.

   Although most drugs on the PDL are covered, some medications require prior authorization. To request authorization, go to https://providers.amerigroup.com/Help/Pages/login.aspx. You may also submit a pharmacy prior authorization request by calling our Pharmacy department at 1-800-454-3730 or faxing your request to 1-800-363-0728.

Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

Additional coverage information

As previously communicated, routine screening pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective October 30, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine pap testing for women 66 and older, with prior negative screening results, will be denied.

Screening method and intervals

The U.S. Preventive Services Task Force[1], the American College of Obstetricians and Gynecologists[2], the American Cancer Society[3], the American Society for Colposcopy and Cervical

Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical pap alone every three years
Women aged 30-65 years	Human papillomavirus (HPV) and cervical pap co-testing every five years or cervical pap alone every three years
Women older than 65 years	No screening is necessary after adequate negative prior screening results
Women who underwent total hysterectomy (with no residual cervix).	No screening is necessary

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.

1. United States Preventive Services Task Force. Cervical Cancer. March 2012.
2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:e1-20.
3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.

New Claims Status Listing Tool

On May 21, 2016, a new Claims Status Listing Tool will be offered on the Amerigroup Community Care 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 provide an added benefit with the Claims Status Listing Tool. With this tool, 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, 5 a.m.-4 p.m., Pacific time.

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 https://providers.amerigroup.com/MD > Newsletters.

New Reimbursement Policies

Medical Recalls
(Policy 06-111, effective 10/01/2016)
Amerigroup Community Care 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.

Multiple Procedure Payment Reduction
(Policy 15-002, effective 10/01/2016)
We allow reimbursement for multiple procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

When services are performed on the same date of service during the same patient encounter, and are performed by the same physician or health care professional with the same National

Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, "always therapy" services will be subject to Procedure Payment Reductions (MPPR).

The Practice Expense (PE) component of "always therapy" services will reimburse at the following rates:

- 100 percent of the applicable fee schedule or contracted/negotiated rate for the service with the highest PE payment
- 50 percent of the applicable fee schedule or contracted/negotiated rate for the PE of subsequent therapy services

Amerigroup Community Care in Maryland does not recognize Modifier TC for cardiovascular and ophthalmology procedures; therefore, does not apply Multiple Procedure Payment Reductions to these procedures.

For additional information regarding reimbursement for these services and procedures, refer to the Multiple Procedure Payment Reduction policy at https://providers.amerigroup.com.

Reimbursement Policies Updates

Unlisted or Miscellaneous Codes
(Policy 06-004, originally effective 07/29/2013)
We allow reimbursement for unlisted or miscellaneous codes in accordance with specified guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Unlisted or miscellaneous codes should be used only when an established code does not exist to describe the service, procedure, or item rendered.

Reimbursement is based on review of the unlisted or miscellaneous code(s) on an individual claim basis. Claims submitted with unlisted or miscellaneous codes must include documentation for consideration during review except for unlisted maternity care and delivery codes submitted by free-standing birth center facilities.

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

Reimbursement Policies Reminder

Facility Take Home DME and Medical Supplies

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

Amerigroup Community Care 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, 2016ClaimsCheck® upgrade to ClaimsXten™

Amerigroup Community Care 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.