Provider Newsletter

providers.amerigroup.com
Provider Services: 1-800-454-3730

2015
Quarter 3

Case management programs and care coordination

Because you asked for more information about our case management programs and care coordination, below is a list of available programs and services available to help you provide quality care to our members.

Case Management program

Our Case Management (CM) program is a 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 receiving optimal care.

CM services are for children and adults with special health care needs, pregnant and postpartum women and persons with developmental disabilities. Our case managers can assist with:

- Coordination of 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

High-Risk Maternity program

- Goal: Engage pregnant women in timely prenatal care and aim for delivery of a healthy, term infant without complications
- One interactive contact per month of pregnancy (more frequent contact, if needed):
  - Comprehensive clinical assessment to include behavioral health and substance abuse
  - Information on tobacco cessation, support and referrals to cessation services
  - Support and follow-up on patient self-management
  - Ensure member is established with a provider and receives prenatal and postpartum visits and postpartum depression screening

Table of contents

- Referrals to community-based resources and follow-up for these referrals
- Provide prenatal educational packets, regardless of risk level
- Follow-up to ensure pregnant women who are screened get a prenatal visit
- Follow up all eligible postpartum members and assist as needed

Taking Care of Baby and Me®

- This program helps pregnant members with complex health care needs. Nurse case managers work closely with these members to help teach them about these needs. They give emotional support and help members to follow their primary care provider's (PCP's) care plan. They can also help with other services members may need. The goal of this program is to promote better health for members and the birth of healthy babies.

Special needs populations

Amerigroup Community Care case management provides health care services to enrollees who are members of special needs populations. As identified by COMAR 10.09.65.04, special needs populations consist of the following non-mutually exclusive populations:

1. Children with special health care needs
2. Individuals with a physical disability
3. Individuals with a developmental disability
4. Pregnant and postpartum women
5. Individuals who are homeless
6. Individuals with HIV/AIDS
7. Children in state-supervised care

Amerigroup has a special needs coordinator who:

- Serves as a point of contact for health care services information and referral for members of special needs populations
- Is skilled in communications with, and sensitive to, the unique needs of members of special needs populations, their families, guardians and caregivers
- Participates on the managed care organizations' (MCO) consumer advisory board as a representative of special needs populations
- Serves as a resource to MCO providers and enrollees

Although the health plan has limited ability to impact programs administered by the state, Amerigroup will make the effort to collaborate with Maryland's State Public Mental Health System for members with behavioral health and/or substance use disorders as warranted.

Complex Case Management

- Promotes optimal levels of health and well-being for members by providing timely coordination of quality services and self-management support
- Offers community outreach and home visits to conduct comprehensive clinical assessments of member needs
- Provides interactive contacts to provide individual self-management support

Sickle Cell Disease Care Management

- Physician directed care management program at Johns Hopkins University Hospital that includes a comprehensive array of medical and care services:
  - Care management and member outreach

- Physician office visits
- Outpatient infusion services
- Pain management
- Urgent care
- Care coordination

Disease Management

This program helps members better understand and manage their chronic health problem. Licensed nurses or social workers called disease management case managers provide telephonic care to members. Case managers also help providers better understand their condition and will work with members to develop a custom plan to meet their health care needs. Disease Management includes:

- Asthma
- Bipolar disorder
- Diabetes
- Chronic obstructive pulmonary disease
- Congestive heart failure
- HIV/AIDS
- Hypertension
- Coronary artery disease
- Schizophrenia
- Major depressive disorder
- Substance use disorder

To refer a member to our Case Management program, call our Provider Services unit at 1-800-454-3730. You can learn more about our Disease Management Centralized Care Unit by calling 1-888-830-4300. Ask to speak to a case manager.

For Pediatric Case Management, Special Needs Case Management, OB Case Management and Adult Case Management, call 1-800-600-4441.

Post-hospital care coordination

Transitional model of care

- This offers a structured approach to the short-term management of services and access for members discharged from the hospital.
- The goal is to facilitate the transition back into the community and avoid an unnecessary readmission.
- Members work with care managers who maintain contact for 30 days at intervals appropriate for the member's level of need.
- The program is based on the Eric A. Coleman, MD, MPH model and includes four pillars: PCP follow up within seven days of hospital discharge, medication self-management, patient-centered medical record and red flag management.
- Facilities with transitional care managers include University of Maryland Medical System, University of Maryland Midtown Campus, Bon Secours, Johns Hopkins, Sinai, St. Agnes and GBMC.

The Right Care, Right Place, and Time (RCPT) program and utilization management

The Right Care, Place and Time (RCPT) program was developed as a joint effort between Health Care Management Services and the Provider Services Organization to address emergency room (ER) utilization. Its objective is for members to receive care in settings that are best aligned to meet their needs. Initiatives seek to impact member utilization. Several support clinical intervention, while others promote access alternatives.

Clinical interventions

- The ER Triage Predictive Model was developed by Health Care Economics to identify those members who are at high risk for frequent ER utilization. It assigns scores to members for CM evaluation.
- Members are monitored more closely for ER utilization and are reached out to with additional education.

Access alternatives

- 24-hour Nurse HelpLine: 24 hours a day, 7 days a week, 365 days a year availability of registered nurses to assist members with health care concerns via the toll-free telephone number for Member Services
- Amerigroup On Call: Offers more intensive outreach to members by providing them with a toll-free telephone number direct to the Nurse HelpLine as well as the option for the Nurse HelpLine to make referrals to Physician Teleconsult
- Network access: Optimizes performance of PCP networks by reviewing data with providers on member ER visits made during regular office hours; encourages after-hours availability on weekdays and weekends
- Urgent care/retail clinic strategies: Increase access opportunities and member awareness of these care locations

Availity: New eligibility and benefits functionality and features

The Availity web portal launched new eligibility and benefits functionality and features on June 27, 2015. These changes make finding edibility and benefits E&B easier and faster for you. Here's a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes users' most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list displays all service types and benefits returned from the health plan.
Patient snap shot	The summary of patient information is easily found at the top of the page.
Advanced printing	By selecting which sections to print, users save paper and can customize prints to target necessary information.
Real-time feedback	Feedback buttons on each returned eligibility allows users to provide instant feedback of missing or inaccurate information.

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

Looking for answers? Check your provider manual

The provider manual contains everything you need to know about us, our programs and how we work with you. For the most up-to-date information, we encourage use of the manual available at providers.amerigroup.com/MD > Provider Resources & Documents > Manuals and Referral Directories.

Reminder! Reimbursement for well and sick visits on the same day

When a child presents for a sick visit and is due for a preventive visit, complete a well-child assessment in addition to rendering care for the presenting problem, using the appropriate Current Procedural Terminology (CPT) preventive code.

When both sick care and preventive care are provided on the same day, use the evaluation and management (E&M) CPT codes for the level of complexity combined with the age-appropriate CPT preventive medicine codes for billing early Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Bill the age-appropriate EPSDT visit codes (99381-99385 and 99392-99395) using one of the appropriate sick visit E&M codes with modifier 25. Modifier 25 must be billed with the applicable E&M code for the allowed sick visit. When modifier 25 is not billed appropriately, the sick visit is denied. Appropriate diagnosis codes must also be billed for both wellness and sick visits, and appropriate diagnosis codes must be billed for respective visits. Same day wellness visits are not applicable to the After-Hours Care program – after-hours care is for sick visits only.

For a full description of the procedures, visit www.dhmh.state.md.us/epsdt/healthykids – the Department of Health and Mental Hygiene Healthy Kids program website.

Pharmacy management

Need up-to-date pharmacy information?
Log on to our website at providers.amerigroup.com/MD to access our formulary, prior authorization form, processes, preferred drug list and more.

Have questions about the formulary or need a paper copy?
Call our Pharmacy department at 1-800-454-3730.

Prescription mail order

WellPartner works with Express Scripts to provide mail order pharmacy services to Amerigroup members. There is free standard shipping for all prescription orders. Orders arrive about seven to ten business days after receipt by WellPartner. Extra time should be allowed for new prescriptions. Amerigroup members receive instructions on how to order prescriptions through WellPartner. Members can also call our Member Services line at 1-800-600-4441 (TTY 711) for assistance.

Important to remember:

- All prescription orders are limited to a 60-day supply
- All medications shipped using mail order must have a valid, written prescription either faxed or mailed to WellPartner
- Standard formulary requirements apply such as prior authorization, quantity limits and step therapy

Quality Improvement program

The Amerigroup Quality Improvement (QI) program is committed to excellence in the quality of service and care our members receive and the satisfaction of our network providers. We are always on the lookout for ways to refine our program.

Our comprehensive QI program:

- Adheres to Maryland program standards
- Objectively monitors and evaluates the care and services provided to members
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of the program
- Reflects the demographic and epidemiological needs of the population served
- Encourages both members and providers to weigh in with recommendations for improvement
- Identifies areas where we can promote and improve patient safety
- Measures our progress to meet annual goals

Healthcare Effectiveness Data and Info Set (HEDIS®) – A program developed by the National Committee for Quality Assurance (NCQA) to measure performance on important dimensions of care and service. HEDIS measures address a broad range of important health issues including immunizations, preventive care and screening, comprehensive diabetes care, asthma medication use, controlling hypertension, and access to care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – Surveys evaluating member satisfaction with care and services received over the past six months; a random sample of plan members answers questions about their doctors and health plan.

HEDIS and CAHPS results help us identify areas of strength and where we need to focus our improvement efforts. We use the results to measure our performance against our goals, and to determine the effectiveness of actions we implemented to improve our results. To review the current QI program summary, please call Provider Services at 1-800-454-3730. We'll be glad to send you a copy.

We'd like to share with you our annual QI summary of goals, processes and outcomes related to clinical performance and service satisfaction. Throughout the year, we evaluate data trends related to how our members receive health care and preventive care services and compare our findings to national practice guidelines. You – our network physicians and office staff – are the key to helping us collect this information and improve our quality performance.

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 (e.g., commercial, Medicaid fee-for-service), the claim 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 is 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.

ICD-10: From compliance to medical policies

Below is an overview of the ICD-10 update and key information you need to know.

Compliance

- The current implementation date of ICD-10 is October 1, 2015, as mandated by HIPAA.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis for correct coding.
- Providers should submit all known conditions on the claim using ICD-10-CM diagnosis codes.

Claims processing

The following information explains the claims processing procedures for claims according to dates of services. Amerigroup is committed to ensuring providers understand the correct code set to use. The following information applies to claims processing:

- No mixed claims: Consistent with CMS guidelines, mixed claims (claims filed with ICD-9 and ICD-10 codes on the same claim) will not be accepted.
- ICD-10 codes: Claims with ICD-10 codes for dates of service (DOS) or dates of discharge (DOD) prior to October 1, 2015 will not be accepted.
- ICD-9 codes: HIPAA will not allow the use of ICD-9 codes for claims with DOS or DOD on or after October 1, 2015.
- Resubmitting claims: When resubmitting claims, providers should utilize the code set that is valid for the DOS/DOD.

Update to prior authorizations process

Amerigroup has updated prior authorization procedures to accommodate the transition to ICD-10-CM. The updates will ensure that providers understand how to submit prior authorizations according to the date that services are scheduled to be performed. The following information details the process for prior authorizations:

- Starting June 1, 2015, we will begin accepting and processing prior authorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015.
- ICD-9 codes must continue to be used to prior authorize services scheduled through September 30, 2015.
- Existing approved prior authorizations coded in ICD-9 whose effective period spans the ICD-10 date of October 1, 2015, do not need to obtain another authorization that is coded in ICD-10.
- Prior authorizations that span the October 1, 2015, compliance date will be valid for claims submitted using ICD-10 codes.
  - Example: If a DME wheelchair rental authorization coded with ICD-9 was approved for the effective period of April 1, 2015 – April 1, 2016, this authorization will still be valid for claims filed using ICD-10 diagnosis codes with beginning dates of service of October 1, 2015, and later.

Update to medical policies

Amerigroup has worked diligently to ensure that medical policies and clinical utilization management (UM) guidelines have been updated to include proposed ICD-10 coding. We want to ensure that providers understand where to locate medical policies and UM guidelines. Preparing policies and processes for ICD-10 helps ensure providers operate smoothly after October 1, 2015. The updated medical policies are available on the Amerigroup provider website at providers.amerigroup.com. For specific questions regarding medical policies, please contact Provider Services at 1-800-454-3730.

Coding updates and resources for providers

Amerigroup is committed to helping providers transition smoothly to the new ICD-10-CM code set. The resources below provide valuable information in terms of assessment, planning and training to help providers at any stage in the ICD-10-CM implementation process.

- Amerigroup provider home page: This site offers the latest news on ICD-10 and links to industry resources. Visit our provider website at providers.amerigroup.com/MD and look for the ICD-10 news link.
- The Amerigroup newsletter: This communication provides documentation and coding information on ICD-10 and HEDIS® in addition to important network updates. Find our newsletter online at providers.amerigroup.com/MD.
- Road to 10: CME Online Tool for Small Practices: This online resource built with the help of providers in small practices is intended to help small medical practices jumpstart their ICD-10 transition. It includes specialty references, access to free Medscape education modules and CME credits for physicians and nurses who complete the learning modules. Use this tool at www.roadto10.org/.
- ICD-10 Monitor: This online news and information source was created to help healthcare providers make informed decisions as they transition to ICD-10. The ICD-10 Monitor hosts weekly live broadcasts where relevant ICD-10 topics are discussed with industry experts called Talk Ten Tuesdays. Visit the site at .icd10monitor.com.

ICD-10 documentation and diagnosis coding tips

ICD-10-CM diagnosis codes

- Contain anywhere from three to seven characters (seventh character extension)
- Character one is alpha
- Character two is numeric
- Characters three to seven are alpha or numeric (alpha digits are not case sensitive)
- Decimal appears after the third digit
- The first three characters make up the ICD-10 category
- Characters four to seven are driven by clinical concepts in documentation

Understanding ICD-10-CM coding

- The current implementation date of ICD-10 is October 1, 2015. Providers and staff should be engaged in ICD-10 coding training now.
- Dates of service or dates of discharge that occur on or after October 1, 2015, must be reported using ICD-10-CM/PCS.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about patient condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis in order to allow the most specific code(s) to be assigned.

ICD-10-CM official coding guidelines for outpatient services

The outpatient coding guidelines for ICD-10-CM are the same as those found in ICD-9-CM. For guidelines, visit the CDC website at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2015.pdf. Listed below are some of the ICD-10-CM guidelines pertinent to outpatient and office visit encounters.

- **ICD-10-CM Section IV.C, Accurate reporting of ICD-10-CM diagnosis codes.** For accurate reporting of ICD-10 diagnosis codes, the documentation should describe the patient's diagnoses, symptoms, problems, or reasons for the encounter. It is acceptable to report the appropriate unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.
- **ICD-10-CM Section IV.F. 1-2, Level of detail in coding.** Codes with only three characters are used as the heading of categories in ICD-10-CM and may be further subdivided (require additional characters). Providers must report ICD-10-CM diagnosis codes to the highest number of characters available. Incomplete and/or invalid diagnoses codes are not acceptable for reporting.
- **ICD-10-CM Section IV.I, Chronic diseases.** 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. Chronic conditions do not go away and typically always impact care provided. They should be assessed and reported at each visit.
- **ICD-10-CM Section IV.J**, **Code all documented conditions that co-exist**. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do no code conditions that were previously treated and that no longer exist.

Clinical concepts in documentation

Certain clinical concepts appear in ICD-10 coding which may or may not be present in ICD-9. Providers should become familiar with these concepts and ensure that documentation includes all known pertinent details for accurate code assignment in ICD-10. Examples of clinical concepts include:

- Cause and effect
- Laterality
- Timing
- Associated conditions
- Remission status
- Severity
- Episode of care
- Trimester of pregnancy
- Agent and/or organism
- Anatomical location
- Comorbidities
- Depth/stage for wounds and ulcer
- Late effects

New coding conventions

ICD-10-CM has some new coding conventions that are not included in the ICD-9-CM code set. A brief explanation of those follows:

- **Seventh character extension** is required for certain categories in ICD-10 and must always appear in the seventh character field.
- The **dummy placeholder X** may be used in the fifth or sixth character field to ensure that a seventh character is added correctly.

Example: T15.12XS Foreign body in conjunctival sac, left eye, sequel (late effect)

Locating the correct diagnosis code in the ICD-10 code book

- First, locate the documented term in the alphabetic index and then verify the code in the tabular list.
- Use a current ICD-10 code book. Become familiar with the Official ICD-10-CM Coding Guidelines and follow all instructions for the chapter and category related to specific codes including Excludes1and Excludes2 notes.
  - Excludes1 – Not coded here. The codes should never be used at the same time.
  - Excludes2- Not typically included here, but a patient may have both conditions at the same time.
- Reliance on coding software, electronic health records (HER) systems, and cheat sheets alone can lead to coding errors.

Locating official coding advice

- The *American Hospital Association (AHA) Coding Clinic*™ is the CMS approved resource for clarification of ICD-10-CM. Volumes are published quarterly and contain new and/or updated information on the use of ICD-10-CM as well as clarification of previously published coding advice.
- Additional advice on ICD-10-CM can be located on CMS website at http://cms.hhs.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

Documenting specificity for accurate ICD-10 coding

Specificity in documentation allows the most accurate ICD-10 codes to be assigned. Accurate and complete coding shows a true picture of each member's health status. As the October 1, 2015 compliance dates draws near, health care providers should begin incorporating additional documentation into patient encounters.

The table on the following pages shows some common chronic conditions and the documentation requirements for accurate ICD-10 code assignment.

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Asthma	• **Severity** – Document asthma severity as either intermittent, mild persistent, moderate persistent or severe persistent. • **Type** – Exercise-induced or cough-variant are other types of asthma, documentation should specify type. • **Acute exacerbation** – Documentation should state if the asthma is in acute exacerbation. • **Status asthmaticus** – An acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators. • **Infection** – A superimposed infection may be present. This should clearly be documented by the provider.	J45.20 – J45.998
Hypertension	• **Primary or secondary** – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension — one to identify the underlying etiology and one from category *I15 Secondary hypertension*. • **Transient** – A temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code *R03.0 Elevated blood pressure reading without a diagnosis of hypertension.*	I10 – I15.9

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Hypertension	• **Controlled/uncontrolled** – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is *I10 Essential (primary) hypertension.* • **Complications** – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive or caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following coding guidance applies to hypertensive complications: – **I11 Hypertensive heart disease** – Use additional code from category *I50 Heart failure* if present. – **I12 Hypertensive chronic kidney disease** – Use additional code from category *N18 Chronic kidney disease* to identify the stage. – **I13 Hypertensive heart and chronic kidney disease** – Requires use of additional code from category *I50 Heart failure* if present and use additional code from category *N18 Chronic kidney disease* to identify the stage. – **I60 – I69 Hypertensive cerebrovascular disease** – Code also *I10 Essential (primary) hypertension.* • **H35.0 Hypertensive retinopathy** – Code also *I10 Essential (primary) hypertension.*	I10 – I15.9
Diabetes mellitus (DM)	• **Type** – Providers must document the type of diabetes in ICD-10-CM: – **E08 Diabetes mellitus** – Due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc. – **E09 Drug or chemical induced diabetes mellitus** – Code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect if applicable, to identify drug. – **E10 Type 1 diabetes mellitus** – Due to pancreatic islet B cell destruction. Also known as juvenile diabetes. – **E11 Type 2 diabetes mellitus** – Use for diabetes not otherwise specified. – **E13 Other specified diabetes mellitus** – Includes that due to genetic defects and secondary diabetes not classified elsewhere. • **Body system affected** – Diabetes may affect multiple body systems. Providers should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented.	E08 – E13

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Diabetes mellitus (DM)	• **Complications affecting that body system** – Providers must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include diabetes with neuropathy, diabetic retinopathy and nephropathy due to diabetes. • **Insulin use** – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term, apply code Z79.4 (long term, current use of insulin).	E08 – E13