Provider Newsletter

https://providers.amerigroup.com/NJ

Amerigroup RealSolutions® in healthcare

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Quarter 4

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Elective one and two vessel coronary artery bypass graft to require prior authorization

Effective January 1, 2017, elective one and two vessel coronary artery bypass graft (CABG) will require prior authorization (PA).

Amerigroup Community Care will require PA for the elective one and two vessel CABG beginning January 1, 2017. Please refer to the provider self-service website for detailed PA requirements (https://providers.amerigroup.com/NJ > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- 33510 — coronary artery bypass, vein only; single coronary venous graft
- 33511 — coronary artery bypass, vein only; two coronary venous grafts
- 33517 — coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for primary procedure)
- 33518 — coronary artery bypass, using venous graft(s) and arterial graft(s); two venous grafts (list separately in addition to code for primary procedure)
- 33530 — reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (list separately in addition to code for primary procedure)
- 33533 — coronary artery bypass, using arterial graft(s); single arterial graft
- 33534 — coronary artery bypass, using arterial graft(s); two coronary arterial grafts

To request PA, contact us via phone (1-800-454-3730), fax (1-800-964-3627) or the provider website.

The Utilization Review team will utilize the InterQual Procedures criteria for CABG requests.

Provider Website Survey

Amerigroup Community Care relies on your feedback to improve and strengthen our processes and operations. Our *Provider Website Survey* is a new tool to evaluate the effectiveness of our Medicaid provider websites. Input about your experience with our website is essential to our goal of efficient and effective provider resources. We will use your survey responses to better understand your experiences and continue to improve our site. Providing exceptional service to our providers is one of our strongest commitments.

Thank you in advance for taking the time to complete this brief survey. To access the survey, go to https://www.surveymonkey.com/r/7PHY5BL.

Prior authorization requirements for new injectable/infusible drugs: Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb)

Effective February 1, 2017, Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb) will require prior authorization (PA) under the medical benefit.

For dates of service on or after February 1, 2017, PA will be required for five injectable/infusible drugs covered by Amerigroup Community Care for NJ FamilyCare members. These drugs are Istodax (romidepsin), Ixempra (ixabepilone), Doxil (doxorubicin), Torisel (temsirolimus) and Inflectra (infliximab-dyyb). Noncompliance with new requirements may result in denied claims.

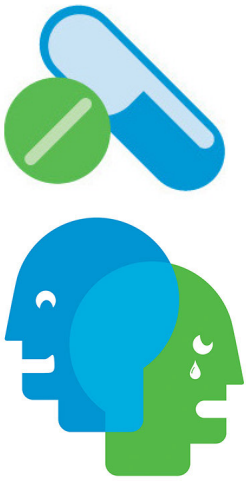
PA requirements will be added to the codes below:

- Istodax (romidepsin) — J9315
- Ixempra (ixabepilone) — J9207
- Doxil (doxorubicin) — Q2049 and Q2050
- Torisel (temsirolimus) — J9330
- Inflectra (infliximab-dyyb) — Q5102

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/NJ > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Providers may also call Provider Services at 1-800-454-3730 for PA requirements if they are not able to access the website.

Behavioral Health Medication Management program



The Amerigroup Community Care Behavioral Health (BH) Medication Management program addresses the specific needs of NJ FamilyCare members using medications prescribed for their BH. Our goal is to improve the quality of care provided to our members and promote medication adherence. We focus on age appropriate use of medications, thus reducing the use of unnecessary medications.

The outreach and education programs also support providers and members on BH-related HEDIS®* measures that use medication utilization as a quality measurement tool such as:

- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

If you have questions, please call Pharmacy Operations at 1-800-719-4871. Note, calls will be answered and/or returned Monday-Friday from 8:30 a.m.-4 p.m. ET.

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

Adherence to access and availability standards improves access to care

Amerigroup Community Care has established access and availability standards to ensure timely health services are accessible to all members. These standards comply with regulatory requirements and are periodically measured through member satisfaction surveys, member complaint analysis, provider office-site visits and special surveys.

Type of care:	Standard:
Emergency care	Immediately; otherwise, refer to an emergency room
Urgent care	Within 24 hours
Routine care/preventive care (well-visits)	Within 28 days of request
Symptomatic acute care (nonurgent, symptomatic conditions or chronic problems)	Within 72 hours of request
Specialty care	Within four weeks of referral, based on severity of condition
Urgent specialty care	Within 24 hours of referral
Early and Periodic Screening, Diagnosis and Treatment (ESPDT)	In accordance with the Bright Futures/American Academy of Pediatrics periodicity schedule for well-child examinations and the Centers for Disease Control and Prevention immunizations schedule
Initial health visit – adult	Within 180 days of enrollment
Initial health visit — child and adult Division of Developmental Disabilities clients	Within 90 days of enrollment or in accordance with ESPDT periodicity schedule
After-hours care	Answering servie or telephone message with directions on how to obtain urgent care must be available 24 hours a day, 7 days a week
Prenatal care — initial visit	Within three weeks of positive pregnancy test
Prenatal care — high-risk visit	Within three days of identification of high risk
Prenatal care — visit in first and second trimester	Within seven days of request
Prenatal care — visit in third trimester	Within three days of request
Laboratory/radiology services	• Within three weeks for routine appointments. • Within 48 hours for urgent services.
Dental services	• Within 48 hours for emergency • Within three days of referral for urgent care services
Behavioral health/substance abuse	• Immediately for emergency services • Within 24 hours for urgent care • Within 10 days of request for routine care

Adherence to access and availability standards improves access to care continued

Access standards

Participating providers are responsible for offering members access to covered services 24 hours a day, 7 days a week. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. The covering provider may not sign members out of the emergency room during his or her shift.

Additional access standards include:

- Member in-office wait times for an appointment must be within 45 minutes
- Provider response time for telephone call-back wait time, including:
  - After regular business hours, within 30 to 45 minutes for nonemergent, symptomatic issues
  - Same-day call-back for nonsymptomatic concerns
  - Call-back within 15 minutes for crisis situations

Provider offices must have telephone protocols in place to ensure the following situations are handled appropriately:

- Answering telephone inquiries in a timely manner
- Prioritizing appointments
- Scheduling a series of appointments and follow-ups as needed
- Identifying and rescheduling missed appointments
- Identifying special member needs while scheduling appointments (for example, wheelchair-bound members and members with interpretive linguistic needs)
- Triage noncompliant individuals with behavioral health issues for medical and dental conditions and special behavioral needs

Noncompliance

In the event a provider's office is found noncompliant with our standards, the provider's office is notified and resurveyed approximately six months later. If, upon resurvey, the provider's office remains noncompliant, a Provider Relations representative will visit the office to review the standards and to discuss corrective actions.

Update to the ClaimsCheck® upgrade to ClaimsXten™

Earlier this year, Amerigroup announced plans for an upgrade from ClaimsCheck to McKesson's next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

With the new software functionality, edits will be applied with greater accuracy. The new software functionality will also allow for greater flexibility with rule development and configuration.

For additional details regarding this software update, please refer to the original communication posted at https://providers.amerigroup.com/NJ > Provider Resources & Documents > Newsletters > Provider News Issue 2 2016.

Continuous interstitial glucose monitoring to require prior authorization

Effective March 1, 2017, continuous interstitial glucose monitoring will require prior authorization (PA).

For dates of service on or after March 1, 2017, PA will be required for continuous interstitial glucose monitoring covered by Amerigroup Community Care for NJ FamilyCare members. Federal and state law as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- 95250: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording
- 95251: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — interpretation and report

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/NJ > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

Intracardiac electrophysiological studies and catheter ablation to require prior authorization

Effective April 1, 2017, intracardiac electrophysiological studies and catheter ablation will require prior authorization (PA). All requests with dates of service beginning on or after April 1, 2017, must be submitted for PA.

Please refer to the provider self-service tool for detailed authorization requirements. To locate the provider self-service tool:

- Go to https://providers.amerigroup.com and select your state
- Under Provider Resources & Documents, select Quick Tools and then select Precertification Lookup Tool.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

Please use one of the following methods to request PA:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: https://providers.amerigroup.com

Federal and state law, state contract language, CMS guidelines and definitions, as well as specific contract provisions and exclusions take precedence over these PA rules and must be considered first when determining coverage.

Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) updates

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the DSM-5.

When transitioning from the DSM-IV-TR to the DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in DSM-5.

Although formatted differently, the same information is found within the DSM-5 diagnostic system. DSM-5 combines DSM-IV-TR axes I-III diagnoses into one list, as shown in Table 1.

Table 1: DSM-5 diagnosis:

DSM-IV multiaxial system	DSM-5 nonaxial system
Axis I: clinical disorder (d/o) and other conditions that are focus of treatment **Axis II:** personality d/o and mental retardation Axis III: general medical conditions	Combined attention to clinical disorders, including personality disorders and intellectual disability, other conditions that are the focus of treatment, and medical conditions.
Axis IV: psychosocial and environmental stressors	Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.
Axis V: Global Assessment of Functioning (GAF)	Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis V GAF was removed from DSM-5. Alternatively, WHODAS 2.0 is included in section III of DSM-5.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

***Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®)* updates continued**

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at http://psychiatryonline.org. Select **View the DSM-5® Update (September 2016)**.

Table 2:

Disorder	Codes effective October 1, 2016
Avoidant/Restrictive Food Intake Disorder	F50.89
Binge-Eating Disorder	F50.81
Disruptive Mood Dysregulation Disorder	F34.81
Excoriation (Skin-Picking) Disorder	F42.4
Gender Dysphoria in Adolescents and Adults	F64.0
Hoarding Disorder	F42.3
Obsessive-Compulsive Disorder	F42.2
Other Specified Depressive Disorder	F32.89
Other Specified Feeding or Eating Disorder	F50.89
Other Specified Obsessive-Compulsive and Related Disorder	F42.8
Pica, in adults	F50.89
Premenstrual Dysphoric Disorder	F32.81
Social (Pragmatic) Communication Disorder	F80.82
Unspecified Obsessive-Compulsive and Related Disorder	F42.9

Some resources that may best help you include:

- *American Medical Association, Professional Edition CPT* (current procedural terminology), 2016.
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA, American Psychiatric Association, 2013.
- *ICD-10-CM and ICD-10-PCS Coding Handbook 2016*.

Clarification — requesting authorization for certain arterial duplex imaging procedures

Amerigroup Community Care is collaborating with AIM Specialty Health (AIM) to conduct medical necessity reviews for vascular ultrasound management for Amerigroup Amerivantage (Medicare Advantage) members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request a clinical appropriateness review no later than 10 business days after you perform these procedures and before you submit a claim.

Please note, failure to contact AIM for review within the 10-day postservice window will result in a denial of payment.

Impacted codes are as follows:

CPT code	Brief description
93925	Dup-scan lxtr art/artl bpgs compl bi study
93926	Dup-scan lxtr art/artl bpgs uni/lmtd study
93930	Dup-scan uxtr art/artl bpgs compl bi study
93931	Dup-scan uxtr art/artl bpgs uni/lmtd study

To submit a review request, visit the AIM website (aimspecialtyhealth.com).

For additional assistance, contact AIM at 1-800-714-0040, Monday-Friday from 7 a.m.-7 p.m. CT.

HCPCS codes required for rural health clinic claims

All claims for Amerigroup Amerivantage (Medicare Advantage) members from rural health clinics with dates of service on or after April 1, 2016, must contain an appropriate HCPCS code for each service line along with a revenue code. This pertains to contracted and noncontracted providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including dual special needs plans and Medicare-Medicaid plans.

Update to the ClaimsCheck® upgrade to ClaimsXten™

Earlier this year, Amerigroup Community Care announced plans for an upgrade from ClaimsCheck to McKesson's next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

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New Policy - Medicaid

Corrected Claims

(Policy 16-001, effective 05/15/2017)

Amerigroup Community Care allows reimbursement for a Corrected Claim when received within 365 calendar days from the date of service. Providers resubmitting paper claims for corrections must clearly mark the claim "**Corrected Claim**." Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

For additional information, refer to the Corrected Claims reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

New Policy - Amerivantage

Corrected Claims

(Policy 16-001, effective 05/15/2017)

Amerigroup Community Care allows reimbursement for a Corrected Claim when received within the applicable timely filing requirements of the original claim. The Corrected Claim must be received within the timely filing limit due to the initial claim not being considered a clean claim. Amerigroup follows the standard of:

- Within 12 months during the timely filing period for participating and nonparticipating providers and facilities

Providers resubmitting paper claims for corrections must clearly mark the claim "**Corrected Claim**." Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

For additional information, refer to the Corrected Claims reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.