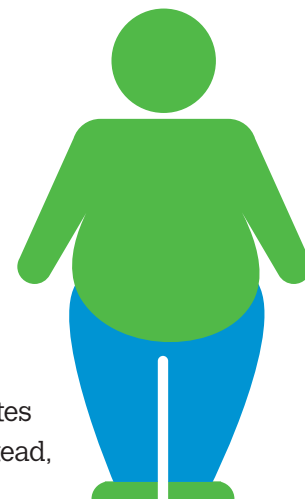




## Body mass index and obesity: Tips and tools for tackling a growing issue



For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called body mass index (BMI). BMI is used for most adults since it correlates with an individual's amount of body fat. However, BMI does not directly measure body fat; instead, it gives ranges of weight that show what is generally considered healthy for a given height.

The following list displays the ranges for adult BMI in relation to the corresponding clinical diagnosis per the Centers for Disease Control and Prevention (CDC):

BMI	
Less than 18.5	Underweight
18.5-24.9	Healthy weight
25.0-29.9	Overweight
30.0-39.9	Obese
40.0 or more	Morbidly obese

A child's weight status is determined by using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults since a child's body composition varies as he or she ages. BMI for pediatrics ages 2-20 is based on the growth charts published by the CDC.

The list below shows pediatric BMI in relation to the corresponding clinical diagnosis:

BMI	
Less than 5th	Underweight
5th-less than 85th	Healthy weight
85th-less than 95th	Overweight
At or above 95th	Obesity

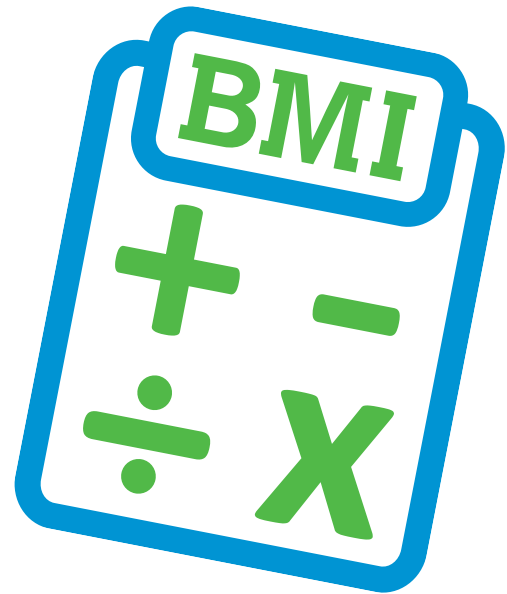
Obesity can have very harmful effects on the body. A 2007 study from the Journal of Pediatrics concluded that 70 percent of obese children had at least one cardiovascular risk factor such as high blood pressure or high cholesterol. Many health risks can be caused by obesity including diabetes, breathing issues, joint problems, fatty liver disease, gallstones and gastro-esophageal reflux (GERD, chronic heartburn). Providers should report the BMI on claims for patients with weight issues. While most providers have electronic medical records software that automatically calculates BMI for the patient, the CDC offers BMI calculators for children/teens and adults for those who do not.

### Obesity-related services

Obesity-related services are those services that help address unhealthy weight. Insurance plans and health programs may cover a range of services to prevent and reduce obesity including BMI screening, education and counseling on nutrition and physical activity, prescription drugs, and surgery.

Health care providers should conduct height, weight and nutrition assessments as part of all well-child visits and adult annual checkups. If primary care providers counsel patients regarding obesity, there are procedure codes that can be billed to report the services for reimbursement. Providers should ensure the correct diagnosis and BMI codes are billed that correlate to obesity to support the counseling. For questions about benefit levels and available coverage, contact Provider Services at 1-800-454-3730.

# Body mass index and obesity: Tips and tools for tackling a growing issue



## Documentation and coding

Obesity codes are located in the Endocrine, Nutritional and Metabolic Diseases chapter of ICD-9-CM. The codes are to be applied when documentation supports a clinical diagnosis from physician documentation.

The ICD-9 codes for reporting weight-related clinical diagnoses include:

<b>278.00</b>	Obesity unspecified
<b>278.01</b>	Morbid obesity
<b>278.02</b>	Overweight

A coding instructional note listed with category 278.0 states to code BMI using codes V85.0-V85.54. Assign both the clinical diagnosis and the BMI on your claim. ICD-9 Coding Guidelines define morbid obesity as BMI greater than 40.

## AHA Coding Clinic advice

Per American Hospital Association's (AHA) Coding Clinic 2010, Q2, BMI itself may be retrieved from nonphysician documentation such as a dietician; however, the clinical diagnosis must come from physician documentation.

Per AHA Coding Clinic 2011, Q3, individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the BMI code meets the requirement for clinical significance when obesity is documented.

## Obesity and BMI coding in ICD-10

Document the type (i.e., morbid, obese, overweight) and cause of obesity for ICD-10 (e.g., excess calories, drugs, etc.).

ICD-10	Description
<b>E66.3</b>	Overweight
<b>E66.8</b>	Obesity, other causes
<b>E66.9</b>	Obesity, unspecified
<b>E66.01</b>	Morbid obesity due to excess calories
<b>E66.09</b>	Other obesity due to excess calories
<b>Z68</b>	Body mass index

Code category Z68 is a status code and requires 4th and/or 5th digits to fully report the BMI. The 4th and 5th digits describe the BMI measurement documented in the medical record. Adult BMI codes (Z68.1-Z68.45) are for use for persons 21 years of age or older. Pediatric BMI codes (Z68.51-Z68.54) are for use for persons 2-20 years of age.

## Resources

Centers for Disease Control and Prevention, [cdc.gov/obesity/childhood/index.html](http://cdc.gov/obesity/childhood/index.html)  
2012 ICD-9-CM Official Coding Guidelines  
American Hospital Association Coding Clinic

# Improving provider-member communication

An annual survey of Amerigroup Community Care members identified a need to improve provider-member communication.

Below are helpful steps to assist your office in communicating sometimes complex information to members, including services Amerigroup offers to facilitate provider-member communication.

## Health information can be confusing for anyone

Clear communication is an important part of a member's ability to understand and act upon health information. This can include a member's ability to follow instructions after a doctor's visit.

Patient compliance can also be related to the quality of the interaction between provider and member. Positive transactions with members should help them to feel empowered, cared about and encouraged to take an active role in their health care.

## Five steps to improve provider-member communication and improve member compliance:

1. **Greet the member** with a smile (for example, knock on door, make eye contact, introduce yourself if it's your first meeting and sit down with the patient instead of standing)
2. **Set a realistic agenda** with the member for the visit
3. **Listen** to and address the member's important health concerns
4. **Slow down** and use simple terms (without use of jargon or acronyms)
5. **Summarize the visit** by asking member, "Do you understand everything we've discussed" and "Would you like to repeat back to me what I just explained?"

Like many patients, Amerigroup members come from diverse cultural backgrounds. They have a wide variety of traditions, languages and ways of perceiving others and the world around them. Medicine has its own culture, with customs and mores that members must learn. Doctors interpret this set of cultural values by translating the member's health condition, illness or treatment in a way that the member can understand. Even if you are unfamiliar with a member's culture, there are still ways to have a meaningful interaction based on mutual respect.

## Amerigroup is here to help

Amerigroup policy is designed to ensure meaningful access to health care services for both members and providers.

Amerigroup provides training opportunities to staff and network providers regarding cultural sensitivity and ways to effectively interact with members. To schedule training for your office, call 732-452-6092 or 732-452-6007.

Upon request, written member materials are available in Braille, in large print, on tape and in languages other than English (dependent upon the population). Member materials are written at appropriate reading levels.

If you are serving an Amerigroup member with whom you cannot communicate, contact Member Services at 1-800-600-4441 to access an interpreter. For immediate needs, Amerigroup has Spanish language interpreters available without delay and can provide access to interpreters of other languages in minutes.

Additionally, for members with impaired hearing, providers are required to offer interpretive services to members who may need services. Amerigroup can help you telephonically communicate with patients via a translation device. In-office sign language assistance is available if requested in advance.

Call Member Services at **1-800-600-4441** to arrange for these services. Both the telephonic and in-office interpreter services are covered by Amerigroup.

# Adherence to access and availability standards improves access to care

Amerigroup 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.

## Availability standards

The following standards apply:

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



## 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.

# Hypertensive diseases: Navigating the ups and downs of documentation and coding

**Blood pressure** is the force of blood against the walls of the arteries. Abnormally high pressure or hypertension damages blood vessels, causing them to become scarred, hardened and brittle. The damaged vessels are no longer able to adequately supply blood to the organs and tissues of the body. Hypertension can lead to strokes, organ failure, or heart attacks when not properly controlled.

## Treating hypertension

Hypertension is a chronic condition that requires lifelong treatment for most people. Treatment is aimed at controlling blood pressure and treating underlying or secondary conditions. The American Heart Association recommends blood pressure levels below 120/80 and screenings starting at 20 years of age. Hypertension is typically treated with medications, exercise/diet, managing stress and not smoking.

## Documentation and coding

The medical record documentation for patients with hypertension should include each of the following:

- **Type of hypertension** – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- **Complications** – body system such as heart or kidney that are affected by hypertension
- **Specific conditions** – details on the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)
- **Assessment/treatment** – all measures aimed at controlling the hypertension or treating symptoms of complication(s)

Diagnosis code assignment is based on provider documentation and the medical record must support the codes submitted on the claim.

## Essential (primary) hypertension 401

Code assignment is based on the type of hypertension documented (benign, malignant or unspecified). Statements such as high blood pressure, hypertension and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign code 796.2 elevated blood pressure reading without diagnosis of hypertension. Terms such as controlled and uncontrolled indicate the status of the condition and do not have a bearing on code assignment for hypertension.

## Hypertensive heart disease 402

Assign category 402 hypertensive heart disease when a cardiac condition is stated (due to hypertension) or implied (hypertensive). The physician must document cause and effect between the two conditions. Category 402 is further specified based on the presence of heart failure. Use additional codes from (428.0-428.43) to specify type of heart failure if known.

## Hypertensive chronic kidney disease 403

ICD-9 coding guidelines assume a cause and effect relationship when both hypertension and chronic kidney disease are documented. Assign codes from category 403 hypertensive chronic kidney disease along with additional codes for the stage of CKD from category 585 chronic kidney disease.

## Hypertensive heart and chronic kidney disease 404

When documentation supports heart and kidney complications with hypertension, the rules of cause and effect are as follows:

- Assumed cause and effect for hypertension and chronic kidney disease.
- Requires documented cause and effect for hypertension and heart disease.

Instructional notes state to use additional codes from 428.0 to 428.43 to specify the type of heart failure (if known) and the stage of CKD from category 585 chronic kidney disease. ICD-10 equivalent code category: I13 hypertensive heart and chronic kidney disease.

## Secondary hypertension 405

Hypertension caused by underlying conditions such as adrenal gland disorders, kidney disease, and drugs is called secondary hypertension. Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

## AHA Coding Clinic advice

When the provider establishes a linkage or relationship between two conditions, they should be coded as such. The entire record for the date of service should be reviewed to determine whether a relationship between the

two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean that they are related. A different cause may be documented by the provider. If it is not clear whether or not two conditions are related, coders should query the provider (AHA Coding Clinic Q3, 2012.)

### Hypertensive diseases in ICD-10

An important change for hypertension is that ICD-10 does not require documentation of the type of hypertension for correct code assignment. Providers will need to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

ICD10	Description
I10	<b>Essential (primary) Hypertension</b>
I11	<b>Hypertensive Heart Disease (with or without heart failure).</b> Use an additional code from I50 to specify type of heart failure (if present).
I12	<b>Hypertensive Chronic Kidney Disease.</b> Use an additional code from N18 to identify stage of chronic kidney disease.
I13	<b>Hypertensive Heart and Chronic Kidney Disease.</b> Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease.
I15	<b>Secondary Hypertension.</b> Requires two codes, one for underlying cause and one from category I15 to identify secondary hypertension. Sequencing is based on circumstances of visit and documentation.

# Availity: Registration information and reminders

Amerigroup Community Care recently introduced Availity Web Portal, a tool to help reduce costs and administrative burden for our physicians and hospitals.

Whether you work with one managed care organization (MCO) or hundreds, Availity can help you quickly and easily file claims, check eligibility, process payments, and more. For your convenience, Availity also offers a link back to the Amerigroup provider self-service site for all other transactions.

## HOW TO register

To initiate the registration process, your primary controlling authority (PCA) – the individual in your organization who is legally entrusted to sign documents – must first complete registration at [www.Availity.com](http://www.Availity.com).

Once your PCA completes this initial process, your primary access administrator (PAA) – the individual in your organization who is responsible for maintaining users and organization information – will receive a temporary password that will allow him or her to add users, providers, and additional enrollments for the organization.

Each staff member should register with his or her own login credentials to avoid business disruptions.

## ADDITIONAL training

For training, visit [www.Availity.com](http://www.Availity.com) and select Availity Learning Center under Resources in the top bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

## If you need assistance

For any questions or additional registration assistance, contact Availity Client Services at **1-800-282-4548**, Monday through Friday, 8 a.m.-7 p.m. Eastern time.

# Pharmacy benefit manager conversion to Express Scripts, Inc.

As of April 1, 2015, Amerigroup Community Care began using Express Scripts (ESI) as its pharmacy benefit manager (PBM) for covered prescription drugs for Amerigroup members. This change affects the processing information for your claims.

Claims submitted to Express Scripts as of April 1, 2015, should use the following BIN/PCN/Group Rx information:

**BIN:** 003858

**PCN:** MA

**Group:** WKPA



Please continue to refer to our preferred drug list (PDL) and formulary when prescribing medications for your Amerigroup patients. You will be able to access these on our provider website at [providers.amerigroup.com/quicktools/pages/pharmacytools.aspx](http://providers.amerigroup.com/quicktools/pages/pharmacytools.aspx).

While drugs on the PDL are covered, some medications will **require prior authorization**.

To request either the PDL or an authorization form, go online to [providers.amerigroup.com/Help/Pages/login.aspx](http://providers.amerigroup.com/Help/Pages/login.aspx).

## Our pharmacy online prior authorization tool allows you to:

Verify member eligibility

Attach clinical documentation

Utilize our drug lookup

Enter multiple requests for multiple drugs at one time

Appeal denied requests

Upload supporting documents and review appeal status

Request medical injectables for those medications obtained for onsite infusion or administration

You may also submit a pharmacy prior authorization request by calling our Pharmacy department at 1-800-454-3730 or faxing your request to 1-800-359-5781.

To search for pharmacies participating in the ESI network, use the pharmacy locator tool. The link will be posted on our provider website at [providers.amerigroup.com/NJ](http://providers.amerigroup.com/NJ) under Vendor/Partner Links & Information > ESI Pharmacy Locator Tool.



# Top HEDIS<sup>®</sup> providers

Amerigroup recently honored its top quality network physicians. These physicians achieved the highest overall quality scores – **above the 75th percentile** – based on 2013 HEDIS results.

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The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across five domains of care.

Congratulations to the below physicians on their achievement. **We thank you** for the care and service you provide to our members.

Daniel J. Abraham, MD  
Nael A. Abutabikh, MD  
Jesus R. Alfonso, MD  
Julia Bakshiyev, MD  
Leonard K. Berkowitz, DO  
Maury Buchalter, MD  
Rosa L. Calderon, MD  
Rodrigo I. Castillo, MD  
Mansoor Chaudry, MD  
Stephen R. Cronin, MD  
Paul DeMuro, DO  
Angel R. De La Cruz, MD  
Vijaya S. Desai, MD  
Amina Elkassir, MD  
Fredy A. Fernandez, MD  
Durga C. Gaviola, MD  
Irina Girshovich, MD  
Louis A. Goyco, MD  
Tadeusz Jedlinski, MD  
Malgorzata M. Kortowska, MD  
Amy M. Kotler, MD  
Jual J. Latorre, MD  
Gamil L. Makar, MD

Omana R. Mathew, MD  
Deepali Mattoo, MD  
Gladibel Medina, MD  
Maria G. Mena, MD  
Rodulfo P. Moises, MD  
Norma J. Murray, MD  
Suprema D. Naim, MD  
Jack Needleman, MD  
Maria C. Obleada, MD  
Beatrice O. Onyeador, MD  
Sylvia M. Piezas, MD  
Tehsin R. Qudsi, MD  
Robert A. Rizzo, MD  
Imad K. Saedeldine, MD  
Amarjit K. Saini, MD  
Elliott Samet, MD  
Paresh P. Shukla, MD  
Luba Stein, MD  
Paul V. Sunkavalli, MD  
Rao V. Vinnakota, MD  
Elizabeth Wong, MD  
Faye C. Wong, MD

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

# Questions?

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

# Recovery look-back period to align with CMS

To align with the Centers for Medicare & Medicaid Services (CMS) guidelines, Amerigroup Community Care will begin recovering Medicare Advantage claim overpayments within four years of the claim payment date. Currently, Amerigroup recovers overpayments within three years of the claim payment date.



## What this means to you

As of May 1, 2015, providers have been notified in writing of any Medicare Advantage claim overpayments identified with good cause within four years of the claim payment date consistent with the CMS guidance below unless a different time frame is specifically noted for Medicare Advantage plans in the provider's contract.

## CMS guidance

42 CFR § 405.980 gives guidance to Payors that overpayment recoveries can occur:

- 1 **Within one year** from the date of the initial determination or redetermination for any reason.
- 2 **Within four years** from the date of the initial determination or redetermination for good cause as defined in § 405.986.
- 3 **At any time** if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.
- 4 **At any time** if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.
- 5 **At any time** to effectuate a decision issued under the coverage appeals process.

In addition, CMS' Medicare Integrity program employs Recovery Audit Contractors (RAC) to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

## Overpayment examples

- Billing errors, such as deviation from National Correct Coding Initiative guidelines and improper use of billing modifiers
- Payment errors, such as an incorrect fee schedule applied to the claim or identification of a member's other health insurance that would be primary

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## The appeals process remains unchanged.

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If you have any questions, please call the Provider Services Unit at **1-866-805-4589** or contact your Provider Relations representative. We appreciate your care for our Medicare Advantage members.

Amerivantage is an HMO plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Amerivantage depends on contract renewal.

# Distinct procedural service coding update

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers to define subsets of the -59 modifier used to define a distinct procedural service.

## How is the coding for this modifier changing?

Currently, the -59 modifier is used when a code for a service, which would usually be bundled, is being considered separate and distinct from another service.

CMS has defined four new HCPCS modifiers to selectively identify subsets of distinct procedural services (-59 modifier). These modifiers, collectively referred to as -X{EPSU} modifiers, are as follows:

- **XE separate encounter** – A service that is distinct because it occurred during a separate encounter
- **XP separate practitioner** – A service that is distinct because it was performed by a different practitioner
- **XS separate structure** – A service that is distinct because it was performed on a separate organ/structure
- **XU unusual nonoverlapping service** – The use of a service that is distinct because it does not overlap usual components of the main service

Amerigroup Community Care will begin accepting CMS Modifiers for distinct procedural services. We will continue to recognize the -59 modifier; however, CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the -59 modifier; it would be incorrect to include both modifiers on the same line.

Amerigroup will be accepting the -X{EPSU} modifiers prior to the National Corrective Coding Initiative (NCCI) edits update. We will require the use of selective modifiers in lieu of the general -59, when the -X{EPSU} modifiers provide more clarity for the service/procedure performed.

## ICD-10 made easy

We know that ICD-10 can often look daunting. But there is no need to memorize all of the new ICD-10 diagnosis and inpatient procedure codes.

If you are not an inpatient facility, you only need to be concerned with the most common ICD-10 PCS diagnosis codes your practice uses today. For example:

- If you are a cardiologist and only treat cardiac patients, focus only on those diagnoses related to your specialty during the course of your ICD-10 remediation work.
- If you practice general or pediatric medicine and therefore treat patients with a wide range of medical conditions, use the 80/20 rule to determine which ICD-10 codes are most pertinent.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record. You only need to have enough clinical detail in your clinical documentation to determine the code in your ICD-10 coding tool, whether it is a book or online.

For more information, visit our ICD-10 web page at [providers.amerigroup.com/Pages/ICD10.aspx](http://providers.amerigroup.com/Pages/ICD10.aspx).

# ProviderNews

## 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 [providers.amerigroup.com/NJ](http://providers.amerigroup.com/NJ) under Provider Resources and Documents > Newsletters.

