Provider Newsletter

https://providers.amerigroup.com/NJ

Amerigroup RealSolutions® in healthcare

2017
Quarter 2

Table of Contents

Medicaid:

CMS emergency preparedness rule	Page 2
Clinical Practice Guidelines	Page 3
Interactive Care Reviewer tool: Register and start using today!	Page 4
PCPs and behavioral health providers — working together to treat the whole person	Page 5
Clarification on the medical director peer-to-peer process	Page 7
Access to case management	Page 7
Claims tip of the month: verifying if a CPT and/or HCPCS code requires a prior authorization	Page 8
Availity Learning Center — Onboarding courses are now available	Page 8
Getting in front of substance abuse with screening, brief intervention and referral to treatment	Page 9
Utilization management	Page 11

Amerivantage:

CMS emergency preparedness rule	Page 12
New program offers benefits for end-stage renal disease patients	Page 13
Utilization Management affirmative statement	Page 14

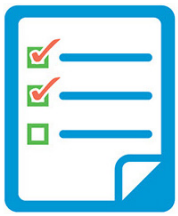
Reimbursement Policies:

Maternity Services	Page 15
Modifier 63: Procedure Performed on Infants Less Than 4 kg	Page 16
Modifier 22: Increased Procedural Service	Page 17
Inpatient Readmissions Update	Page 17
Multiple Radiology Payment Reduction	Page 18
Modifier FX and Reimbursement Policy Update	Page 18

CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, which includes providers with Amerigroup Community Care seeing Amerigroup Amerivantage (Medicare Advantage) and NJ FamilyCare members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicare and Medicaid participating providers and suppliers to meet the following best practice standards:

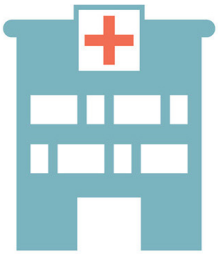
	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
	**2. Policies and procedures**	Develop and implement policies and procedures based on the plan and risk assessment.
	**3. Communication plan**	Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
	**4. Training and testing program**	Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:



The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

NJ-NL-0044-17

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are evidence-based guidelines known to be effective in improving health outcomes. CPGs are based on current research and national standards. Their effectiveness is determined through scientific evidence and/or expert opinion.

Amerigroup Community Care provides access to clinical care and preventive health guidelines on our website (https://providers.amerigroup.com/NJ > Provider Resources & Documents > *Clinical Practice Guidelines*). If you would like a paper copy of a guideline, contact Provider Services at 1-800-454-3730.

NJ-NL-0051-17

Interactive Care Reviewer tool: Register and start using today!

Your practice can initiate online preauthorization requests for NJ FamilyCare members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Web Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Web Portal. There are no changes to the preauthorization capabilities on the provider website (https://providers.amerigroup.com/NJ).

How do I gain access to the ICR?

You can access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select **Register** in the upper right-hand corner of the page. If your organization already has access to Availity, your Availity administrator can grant you access to "authorization and referral request" for submission capability and "authorization and referral inquiry" for inquiry capability. You can then find our tool under Patient Registration > Authorizations & Referrals. From this area, you can select the authorizations or authorization/referral inquiry option as appropriate.

Whom can I contact with questions?

For questions regarding our ICR tool, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY. Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

What benefits/efficiencies does the ICR provide?

- **You are automatically routed to our ICR.** Once the ICR is available, when you go to Authorizations in the Availity Web Portal, you are automatically routed to the ICR in order to begin your prior authorization request.
- **You can determine if prior authorization is needed.** For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- **You will have inquiry capability.** Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax, ICR or another online tool (for example, AIM Specialty Health®, OrthoNet LLC, eReview).
- **The ICR is easy to use.** You can submit outpatient and inpatient requests for services online using the same, easy-to-use functionality.
- **The ICR reduces the need to fax.** The ICR allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR is a no-cost solution that's easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- **You receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submitted online, including the status of your requests and specific views that provide case updates and a copy of associated letters.

NJ-NL-0037-16

PCPs and behavioral health providers — working together to treat the whole person

PCPs and behavioral health (BH) providers should work together because:

- **Physical health (PH) and BH go hand in hand.** Comorbid conditions can complicate treatment of and recovery from both PH and BH issues. A member is more likely to stick to a medical treatment plan if their BH needs are properly met and vice versa.
- **Collaboration leads to well-informed decisions.** Providers working together to develop compatible courses of care increases the chances of positive health outcomes and prevents adverse interactions.
- **Sharing relevant case information in a timely, useful and confident manner is an Amerigroup Community Care policy.** We abide by standards set by the National Committee for Quality Assurance (NCQA) requiring health plans to ensure coordination of care between PCPs and BH providers.

PCPs and BH providers should exchange health information:

- When a member first accesses a PH or BH service.
- When a change in the member's health or care plan requires a change in another provider's care plan (e.g., when a member who has been taking lithium becomes pregnant).
- When a member discontinues care.
- When a member is admitted to or discharged from the hospital.
- When a member is admitted and a consultation is warranted.
- When a member has a physical exam and/or laboratory or radiological tests.
- Once a quarter, if not otherwise required.

Substance abuse and depression screening:

When doing an annual screening for substance abuse and depression, use standard screening tools. If your patient answers "yes" to any of the screening tool questions, refer the patient to a BH specialist for a complete BH assessment. Contact us if you need help making this referral. Screenings should be completed annually.

Brief screening questions

- In the last year, did you ever drink or use drugs more than you meant to?
- Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
- Over the past two weeks, have you felt down, depressed or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

Tips and tools for screening and follow-up care:

HEDIS® is a program developed by NCQA to measure how effectively health plans and providers deliver preventive care. Below are some things we can do together to keep our members healthy.

Antidepressant medication management

Depressive disorders can have a significant negative impact on a patient's quality of life and health care outcomes, and they are often diagnosed and initially treated by PCPs. You should regularly monitor patients you're treating with antidepressant medications. Patients should also be maintained on these agents to allow for adequate trials.

We strive to meet HEDIS goals by assessing the adequacy of medication trials for members 18 years of age and older who are diagnosed with a new episode of major depression and treated with (and kept on) an antidepressant medication:

- **Effective acute phase treatment** — the percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 12 weeks.
- **Effective continuation phase treatment** — the percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 6 months.

We are here to help you ensure an adequate medication trial for patients whose treatment plan includes medication. Please call Provider Services if you need assistance.

Follow-up visits after an ADHD diagnosis

ADHD is a complicated disorder in which treatment often involves a combination of counseling and medication. If treatment involves medication, it is very important to monitor this closely. We have adopted the following HEDIS goals for medication follow-up:

- At least one follow-up visit with a practitioner within a month of the first prescription of ADHD medication for all children 6-12 years old diagnosed with ADHD
- At least two follow-up visits in nine months for children who remain on ADHD medication for at least 210 days

We can help you arrange follow-up visits for children with ADHD — just give Provider Services a call.

We're here to help!

We encourage you to use the *Coordination of Care Form* so you cover all the bases when sharing information with fellow providers. You can access the form on our secure provider website.

Have more questions? Need help with a referral? Contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

NJ-NL-0061-17

Clarification on the medical director peer-to-peer process

Amerigroup Community Care knows your time is important, and we want to make the peer to peer process easy for you. Therefore, we now allow your office staff to call on your behalf to schedule a peer review with our medical director.

If you received a denial or notification that a case is under review and you would like to discuss the case with our medical director, please call 732-744-6304. Be ready to provide the following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB and Amerigroup member ID number

If you/your office staff reach our voicemail, please leave the name of the best contact person and his or her phone number so that our representatives can reach out for additional information.

Our medical director will make every effort to call you back within one business day.

Please note: If the notification you received indicates the case was denied, the case will need to follow the appeal process outlined in the denial letter.

NJ-NL-0063-17

Access to case management

In addition to disease management programs, Amerigroup Community Care offers a complex case management program for high-risk members. Using claims and utilization data as well as other triggers such as high utilization of services and health risk assessments, we can identify diseases for which members are most at risk and to which they are most susceptible.

Our case managers use evidence-based guidelines to coordinate care with members, their families, physicians and other health care providers. They work with everyone involved in the members' care to help implement a case management plan based on members' individual needs. We provide education and support to our members and their families to help our members improve their health and quality of life. If you have a high-risk member you would like to refer to this program, please call us at 1-800-454-3730 or 1-800-452-7101, ext. 66097. You may also encourage your patients to self-enroll in the program.

NJ-NL-0065-17

Claims tip of the month: verifying if a CPT and/or HCPCS code requires a prior authorization

To verify if/when a CPT and/or HCPCS code will require prior authorization (PA), start your research with the Precertification Lookup Tool (PLUTO) (https://providers.amerigroup.com/NJ > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool) prior to performing services.

Complete the three drop-down boxes as applicable for your state, product and code:

Field:	Selection:
Market * Select Market	New Jersey
Line of Business *	Medicaid/SCHIP/Family Care
CPT / HCPCS Code or Description *	Enter code and/or written description

When using PLUTO, please remember the tool is designed to advise you if a code requires PA; the tool does not provide covered versus noncovered CPT and/or HCPCS coding. Please note that obtaining PA is not a guarantee of payment.

NJ-NL-0064-17

Availity Learning Center — Onboarding courses are now available

New onboarding courses are now available in the Availity Learning Center to support users as they begin to use the Availity Web Portal. The courses are good resources for new users as well as current users who would like a refresher.

The Availity Web Portal is a multipayer portal and does not go into payer-specific information. The courses address payer-specific scenarios, and all payers/regions may not have the same features/transactions available to them. Your local Provider Relations representative is knowledgeable on the features/transactions available in the Availity Web Portal as well as other resources and tools within *Payer Spaces* and our provider self-service website.

Accessing the onboarding courses

1. Navigate to the Availity Learning Center (https://www.availity.com > LOGIN > Help > Get Trained).
   - Note, the Availity Learning Center displays in a new browser window.
2. In the *Catalog*, search by keyword for **onboarding**.
3. Click **Enroll** for the course(s) you would like to take:
   - Onboarding program: for Availity users — get up and going quickly
   - Onboarding program: for Availity administrators — a great place to start your admin journey
4. Once enrolled, go the *Dashboard* tab to launch and complete the course(s) as well as download a completion certificate.

NJ-NL-0060-17

Getting in front of substance abuse with screening, brief intervention and referral to treatment

About screening, brief intervention and referral to treatment (SBIRT)

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and screening for individuals with risky alcohol and drug use. For these patients who are at a high-risk of developing a substance use disorder or who are already dependent upon substances, SBIRT helps get patients to more intensive substance abuse treatment quickly.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SBIRT as:

- Brief (typically 5-10 minutes for brief intervention and 5-12 minutes for brief treatment).
- Universal.
- Targeting one or more behaviors regarding risky alcohol and drug use.
- Delivered in a public health, nonsubstance abuse treatment setting.
- Comprehensive — comprising of screening and referral.
- Involving research, evaluation and collection of experiential evidence to assess the model's effectiveness.

Screening	■ Conduct a 5-10 minute consultation to identify the right amount of treatment. ■ Use common screening tools such as the *Alcohol Use Disorders Identification Test (AUDIT)*, the *CAGE Questionnaire* and the *Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)*. ■ Bill with code H0049.
Brief intervention	■ Provide 1-5 sessions with each session lasting five minutes to one hour. ■ Educate patients and increase motivation to reduce risky behavior. ■ Bill with code H0050.

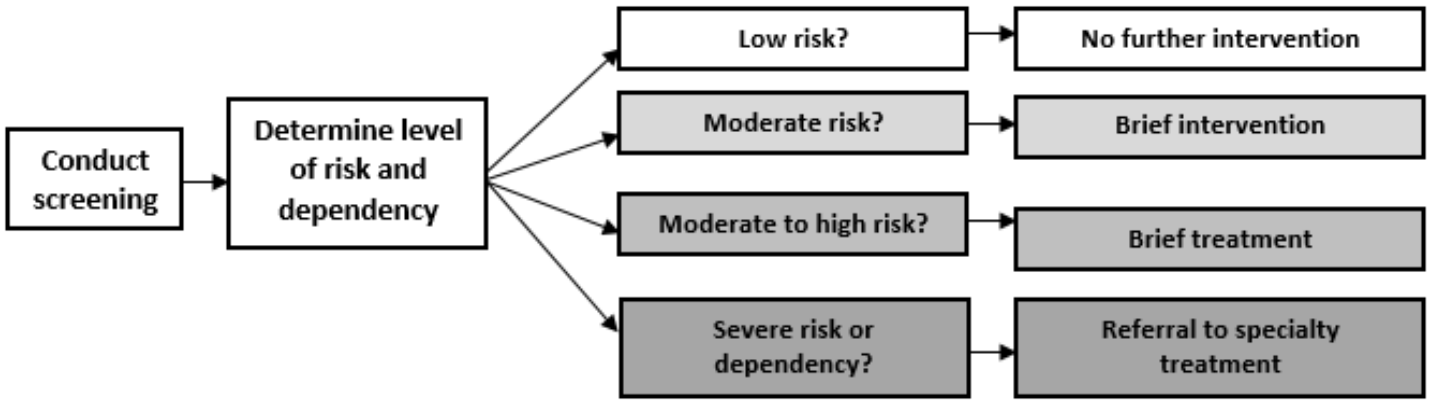
Brief treatment	■ Provide 5-12 sessions.
	■ During the session:
	  ■ Change the immediate behavior or thoughts about a risky behavior.
	  ■ Address long-standing problems with harmful drinking and drug misuse.
	  ■ Help patients with higher levels of disorder obtain more long-term care.
	■ Bill with code 99409.

Referral to treatment	■ If a patient meets the diagnostic criteria for substance dependence or a mental illness as defined by the *Diagnostic and Statistical Manual of Mental Disorders — Fourth Edition*, we recommend you refer the patient to a specialty provider. ■ Referrals can be complex and involve coordination across different types of services, and we can help! Call us at 1-888-830-4300.

Delivering SBIRT services

Primary care centers, hospital ERs, trauma centers and community health settings have the best chance to intervene early with at-risk substance users and prevent more severe consequences. PCPs and physician assistants as well as behavioral health providers play a role in SBIRT.

SBIRT process flow



Implementing SBIRT into care management

- **Choose a screening tool.** We recommend the *AUDIT*, *CAGE Questionnaire*, *TWEAK scale*, *4P's Plus©* *Screening Tool* or *CRAFFT Screening Tool*. More information about these tools can be found on our website, https://providers.amerigroup.com.
- **Decide who will conduct the screening and intervention and when it will occur.** It can be as simple as a nurse performing a brief screening while taking a patient's blood pressure.
- **If needed, refer patients for further treatment.**

Referral assistance

Call us at 1-888-830-4300. We're glad to help you get our members this important kind of care.

Resources

- SBIRT: https://www.SAMHSA.gov > Programs & Campaigns > SBIRT
- American Public Health Association and Education Development Center, Inc. (2008). Alcohol screening and brief intervention: A guide for public health practitioners. Washington DC: National Highway Traffic Safety Administration, U.S. Department of Transportation.

NJ-NL-0066-17

Utilization management

Utilization management (UM) criteria

Amerigroup Community Care uses nationally recognized criteria to assist medical management staff in making decisions concerning the medical necessity of:

- In-hospital level of care and lengths of stay.
- Admissions.
- Outpatient services.
- Behavioral health services.
- Pharmacy services.

If an Amerigroup medical director denies a service request, both provider and member will receive a *Notice of Action Letter* that will include the reason for the denial and the criteria/guidelines used for the decision as well as explain the appeal process and provider and member rights. To speak with UM about the service request denial, call Provider Services at 1 800-454-3730. To request a copy of the specific criteria/guidelines used for the decision, fax 1-877-271-2409, call 1-800-600-4441 or send a written request to the address below:
Medical Management
Amerigroup Community Care
101 Wood Ave. S., Suite 800
Iselin, NJ 08830

Access to UM staff

We are staffed with clinical professionals who coordinate our members' care and are available 24 hours a day, 7 days a week to accept precertification requests or other UM related issues.

Language assistance including TDD/TTY services is available to the members as needed.

You can submit precertification requests using any of the methods below:

- Phone: 1-800-454-3730
- Availity Web Portal: https://www.availity.com
- Provider website: https://providers.amerigroup.com/NJ > Provider esources & Documents > Quick Tools > Precertification Lookup Tool

If you have questions about UM decisions or the UM process in general, call our Clinical team at 1 800 454-3730 anytime Monday-Friday between 8:30 a.m.-5:30 p.m. ET.

Utilization Management affirmative statement

Amerigroup Community Care, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

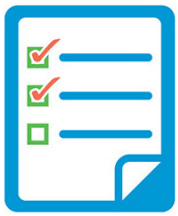
- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not reward practitioners or other individuals for issuing denials of coverage or care.
- Decisions about hiring, promoting or terminating practitioners or other staff are not based on 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 result in underutilization or create barriers to care and service.

NJ-NL-0062-17 and NJ-NL-0048-17

CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, which includes providers with Amerigroup Community Care seeing Amerigroup Amerivantage (Medicare Advantage) and NJ FamilyCare members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicare and Medicaid participating providers and suppliers to meet the following best practice standards:

	**1. Emergency plan**	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
	**2. Policies and procedures**	Develop and implement policies and procedures based on the plan and risk assessment.
	**3. Communication plan**	Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
	**4. Training and testing program**	Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

Important dates:

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

NJ-NL-0044-17

New program offers benefits for end-stage renal disease patients

This year, Amerigroup Community Care began offering Amerivantage ESRD (HMO-POS SNP) — a Medicare Advantage chronic care-special needs plan specifically designed for members with end-stage renal disease (ESRD). The plan offers medical coverage (Parts A and B), prescription drug coverage (Part D) tailored to ESRD patients and an out-of-network option. Additional benefits include:

- Preventive and comprehensive dental coverage.
- Transportation to medical appointments (48 one-way trips).
- Annual eyewear allowance.
- Over-the-counter allowance.

Note, Amerivantage ESRD (HMO-POS SNP) is an open-access plan, so there is no requirement to receive a referral. However, for coordination of overall care and referral guidance, Amerigroup encourages members to talk to their primary physician. Amerigroup does require prior authorization for some services.

DaVita VillageHealth* is working with Amerivantage ESRD (HMO-POS SNP) members to help coordinate care and medical services among their health care providers. All members are assigned a registered nurse or nurse practitioner who will facilitate communication between you, the member's other doctors, the member's family and the member.

Paper claims submissions for Amerivantage ESRD (HMO-POS SNP) members should be sent to the address below:
Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

If you have any questions regarding Amerivantage ESRD (HMO-POS SNP), please call our dedicated line (1-844-887-6350).

** DaVita VillageHealth, an independent company, is a subsidiary of DaVita Inc. and provides case management services on behalf of Amerigroup.*

SSO-NL-0015-17

Utilization Management affirmative statement

Amerigroup Community Care, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not reward practitioners or other individuals for issuing denials 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 result in underutilization or create barriers to care and service.

SSO-PEC-0880-17

Policy Update — Medicaid Maternity Services

(Policy 14-001, effective 11/01/17)

Amerigroup Community Care allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. You can elect reimbursement for Maternity Services on either a global basis or as individual services.

Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

What's New?

We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

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

NJ-NL-0039-17

Policy Update — Amerivantage Maternity Services

(Policy 14-001, effective 11/01/17)

Amerigroup Community Care allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

What's New?

We have updated the Maternity Services Reimbursement Policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

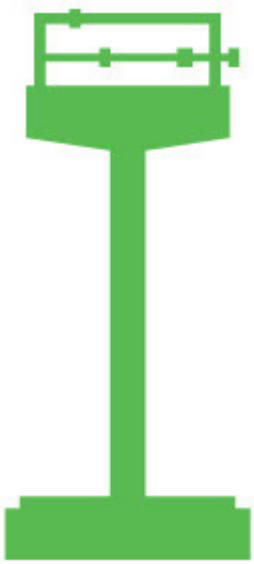
For additional information, refer to the Maternity Services Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

PEC-ALL-2382-17

Policy Update — Medicaid and Amerivantage

Modifier 63: Procedure Performed on Infants Less Than 4 kg

(Policy 06-015, effective 09/15/2017)



Currently, Amerigroup Community Care allows additional reimbursement of 120 percent for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, Amerigroup will allow reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100 percent of the applicable fee schedule or contracted/negotiated rate. Please note, the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

Key Definition

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding Modifier 63 to the procedure.

In applicable circumstances, Amerigroup does **not** allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants Less Than 4 kg Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

NJ-NL-0032-16

Policy Update — Medicaid Modifier 22: Increased Procedural Service

(Policy 07-020, effective 11/01/17)

Amerigroup Community Care allows reimbursement for procedure codes appended with Modifier 22. Beginning November 1, 2017, reimbursement will be based on 100 percent of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure.

Refer to Modifier 22: Increased Procedural Service Reimbursement Policy for more information at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

NJ-NL-0038-17

Policy Update — Amerivantage Modifier 22: Increased Procedural Service

(Policy 07-020, effective 11/01/17)

Amerigroup Community Care allows reimbursement for procedure codes appended with Modifier 22. Reimbursement is based on 120% of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure.

Refer to Modifier 22: Increased Procedural Service Reimbursement Policy for more information at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-NL-0010-17

Policy Update — Amerivantage Inpatient Readmissions Update

(Policy 13-001)

In an effort to identify clinically related readmissions to the same facility, licensed clinical staff will review at the time of an inpatient authorization the clinical information submitted regarding the medical treatment and management of an admission that occurred within 2 30 days from a previous admission to the same facility. If an admission is believed to be related, a medical director will contact the admitting physician to confirm that the clinical information is accurate. If the second admission is determined to be clinically related, we will not reimburse for an additional admission as this is considered a continuation of the episode of care. This process will be implemented June 2017.

Based on the information above, the Inpatient Readmissions Reimbursement Policy has been updated. Amerigroup Community Care will utilize information indicating clinically related readmissions, clinical criteria and/or licensed clinical medical review for readmissions from day 2-day 30 for the second admission determination.

For additional information, please refer to the Inpatient Readmissions Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-NL-0016-17

Policy Update — Amerivantage Multiple Radiology Payment Reduction

(Policy 12-002, effective 09/15/2015)

Amerigroup Community Care allows reimbursement for multiple diagnostic imaging procedures. Multiple diagnostic imaging procedures with the exception of CT scan services will be subject to a Multiple Procedure Payment Reduction when services are performed by the same physician or health care professional with the same NPI on the same date of service during the same patient encounter.

The global and technical component (TC) of certain diagnostic imaging procedures will reimburse at 100 percent of the physician fee schedule or negotiated amount for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day.

A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59.

For additional information, please refer to the Multiple Radiology Payment Reduction Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-PEC-0873-17

Policy Update — Amerivantage Modifier FX and Reimbursement Policy Update

CMS has added a new Modifier FX, used to indicate X-rays that are taken using film. Reimbursement will be subject to a 20 percent reduction of the applicable fee schedule and/or contracted/ negotiate rate. Amerigroup Community Care will begin following CMS Modifier FX reimbursement guidelines effective September 15, 2017.

Modifier FX (X-ray taken using film) has been added to our reimbursement modifiers list. This modifier is applicable to Medicare Advantage Plans only. For additional information, refer to Modifier Usage Reimbursement Policy (Exhibit A) at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-NL-0017-17