Provider Newsletter

providers.amerigroup.com

2015
Quarter 3

A message from President John Koehn

Amerigroup Community Care Providers:

Amerigroup Community Care is pleased to announce we will continue the Supplemental Incentive Program (SIP) in 2015. The SIP is intended to promote the following goals:

1) Timely completion of health care and preventive services
2) Improvement of the quality of care for our eligible members

The program will target specific primary care practices/providers and/or vendors; therefore, not all practices will qualify for SIP.

For those primary care practices and/or vendors that qualify, Amerigroup will pay your practice a SIP bonus payment of $50 for each claim submitted to the health plan by January 15, 2016, that includes a CPT4 code related to a SIP HEDIS® care gap measure for eligible members seen by the practice between August 1, 2015, and December 31, 2015. This is in addition to the compensation you receive under your Participation Agreement.

A list of your patients and the services they require will be mailed in late July to targeted practices. The mailing will also include an introductory letter and the program description that clearly defines every aspect of the program including what qualifies as an eligible member, time frames for delivering care and submitting your claims for payment.

We strongly encourage you to contact your patients and schedule time in your office to complete the listed service. You have from August 1, 2015, until December 31, 2015, to provide the services; eligible claims must be submitted by

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Medicaid

Amerivantage

At the conclusion of the program, a summary letter detailing the number of gaps closed will be mailed with your incentive payment.

John Koehn
President
Amerigroup Community Care

A message from Medical Director Dr. Geeta Sehgal

HEDIS is a tool used by Amerigroup to measure performance on important dimensions of care and service. One of those dimensions of care is ensuring that women receive a postpartum visit between 21 and 56 days after delivery.

Why is it important that your patients receive a postpartum visit?
Inter-conception care:

- The postpartum visit is a good time to take stock of the impact of the current pregnancy on the member physically, emotionally and medically.
- This is an opportunity to discuss reproductive health, including birth spacing and family planning.
- There is also an opportunity to optimize interim health, such as continued support for smoking cessation, continued glucose control or hypertension.

Closure for current pregnancy:

- This is an opportunity to address any newly identified medical issues that the pregnancy has unmasked, such as diabetes mellitus or hypertension, or to address any new problems that may have developed, such as medical or surgical issues.

We as providers can offer support to our patients in the transition from pregnancy to motherhood and parenting.

We can confirm with our patients that they have physically healed from this process and talk with them about what they can do to stay as healthy as they can as they now take care of their babies.

Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 years of age and older. Once a woman has had a fracture, she has a four times greater risk of another fracture, reports the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

Amerigroup asks that providers encourage women 67 to 85 who have had a fracture or may be a risk for a fracture to have a bone mineral density screening or be placed on osteoporosis medication if appropriate.

Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the Journal of Rheumatology.

Access to case management

Did you know that in addition to our disease management programs, we also offer a complex case management program for our high-risk members? Through claims and utilization data, we can identify the 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 the member, his or her family, physicians and other health care providers. They work with everyone involved in the member's care to help implement a case management plan based on the member's needs. We provide education and support to our members and their families to help improve health and quality of life. If you have a high-risk member you would like to refer to this program, please call us at 1-888-830-4300.

Quality overview: Special needs plan Model of Care

Commitment to our dual-special needs plan members' health and their satisfaction with the care and services they receive is the basis for the Amerigroup quality improvement program. Annually, the plan prepares a quality program description that outlines clinical quality and service initiatives. We strive to support the patient-physician relationship through our Model of Care program, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives.

Availity: New eligibility and benefits functionality and features

The Availity Web Portal launched new eligibility and benefits (E&B) functionality and features on June 27, 2015. These changes make finding eligibility and benefits 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 user's 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.
Clearer display of details	Users have a clearer and more complete view of specific benefit and financial information.
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.

Attention nursing home and assisted living providers: New state requirements regarding patient pay liability

Members in the managed long-term services and supports program who are in long-term care in a nursing home or receiving assisted living services in the community have Patient Pay Liability, also known as individual cost share. This amount is calculated by the County Welfare Agency and conveyed to the state of New Jersey for transmission to Medicaid managed care organizations like Amerigroup. Providers collect the member's cost share and Amerigroup deducts that amount when paying a claim for these services.

The state of New Jersey has recently begun a new process that updates Amerigroup when a retroactive change is made to the member's cost share. Amerigroup is finalizing a process to evaluate these changes and adjust claims previously paid in order to reflect any increase or decrease in the member's cost share.

- If the member's cost share was less than previously indicated, Amerigroup will reprocess the claim to add back the difference and the provider will reimburse the member.
- If the member's cost share was more than previously indicated, providers will need to collect this from the member. Amerigroup will send the provider a letter requesting reimbursement for the difference between the original and updated amounts.

Please note that Amerigroup does not calculate the amount of our members' cost share. Your Amerigroup Provider Relations representative can tell you the amount that was transmitted to Amerigroup from the state, but if you have questions about the calculation of the amount, you will need to call the member's County Welfare Agency.

If you have questions, please contact the following Amerigroup Provider Relations representative:

County	Representative	Email address	Phone number
Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Monmouth, Ocean and Salem	Carol DiPrisco	Carol.DiPrisco@amerigroup.com	732-623-5832
Somerset, Morris, Passaic, Sussex, Warren and Hunterdon	Sasha Pilgrim	Sasha.Pilgrim@anthem.com	732-623-5846
Bergen, Essex, Hudson, Mercer, Middlesex and Union	Alex Valentin	Alejandro.Valentin@amerigroup.com	732-623-5837

HEDIS updates

HEDIS is a core set of performance measures that health plans are required to collect and report on an annual basis. Results are included as part of a health plan's accreditation score from the National Committee for Quality Assurance (NCQA). Each year, health plan HEDIS scores impact maintenance of accreditation status. Depending on the accreditation status level, the status could go up or down a level based on the points achieved for HEDIS. The HEDIS data set includes measures which are administrative only (claims-based measures) and measures which are collected hybrid, meaning they are a combination of claims data and data collected via medical record review. The medical record review component is typically conducted from January through early May of each year. In this edition of our provider newsletter, we will highlight a selection of the HEDIS measures that Amerigroup reports on annually:

Pharyngitis

The percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. Eligible services include outpatient or emergency department visits with a diagnosis of pharyngitis.

Antibiotic medications

Description	Prescription	
Aminopenicillins	Amoxicillin	Ampicillin
Beta-lactamase inhibitors	Amoxicillin-clavulanate	
First generation cephalosporins	Cefadroxil Cefazolin	Cephalexin
Folate antagonist	Trimethoprim	
Lincomycin derivatives	Clindamycin	
Macrolides	Azithromycin Clarithromycin Erythromycin	Erythromycin ethylsuccinate Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	Erythromycin-sulfisoxazole	
Natural penicillins	Penicillin G potassium Penicillin G sodium	Penicillin V potassium
Penicillinase-resistant penicillins	Dicloxacillin	
Quinolones	Ciprofloxacin Levofloxacin	Moxifloxacin Ofloxacin
Second generation cephalosporins	Cefaclor Cefprozil	Cefuroxime
Sulfonamides	Sulfamethoxazole-trimethoprim	Sulfisoxazole
Tetracyclines	Doxycycline Minocycline	Tetracycline
Third generation cephalosporins	Cefdinir Cefixime Cefpodoxime	Ceftibuten Cefditoren Ceftriaxone

Source: HEDIS 2015, Volume 2, Technical Specifications

Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis can be validated through lab results; therefore, it serves as an indicator of appropriate antibiotic use. Reminder: Amerigroup covers the rapid strep test when you file a claim using CPT code 87880. This test should be completed for any child prescribed an antibiotic for pharyngitis.

Codes to identify pharyngitis: ICD-9-CM: 034.0, 462, 463.

Codes to identify visit type:

Description	CPT	UB revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455, 99456	
Emergency department	99281-99285	0450-0452, 0456, 0459, 0981
Observation	99217-99220	

Upper respiratory infection

The percentage of our members 3 months to 18 years of age who were given a diagnosis of upper respiratory

infection (URI) and were not dispensed an antibiotic prescription.Using antibiotics when they're not needed can be harmful and cause antibiotic resistance. Clinical Practice Guidelines suggests that antibiotics are not indicated for a non-specific URI (Source: Center for Disease Control and Prevention).

Codes to identify URI: 460, 465.0, 465.8, 465.9

Codes to identify visit type:

Description	CPT	UB revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455, 99456	
Emergency department	99281-99285	0450-0452, 0456, 0459, 0981
Observation	99217-99220	

Anti-depressant medication management

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant treatment. Two rates are reported.

- Effective acute phase treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective continuation phase treatment. The percentage of members who remained on antidepressant medication for at least 180 days (6 months).

Antidepressant medications which qualify for this measure

Description	Prescription		
Miscellaneous antidepressants	Bupropion	Vilazodone	
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine	Selegiline Tranylcypromine	
Phenylpiperazine antidepressants	Nefazodone	Trazodone	
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide Amitriptyline-perphenazine	Fluoxetine-olanzapine	
SSNRI antidepressants	Desvenlafaxine Duloxetine	Venlafaxine	
SSRI antidepressants	Citalopram Escitalopram	Fluoxetine Fluvoxamine	Paroxetine Sertraline
Tetracyclic antidepressants	Maprotiline	Mirtazapine	
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine	Desipramine Doxepin (>6 mg) Imipramine	Nortriptyline Protriptyline Trimipramine

Source: HEDIS 2015, Volume 2, Technical Specifications

The measure allows for 30 gap days in the acute phase and 51 in the continuation phase. This would include days when medication would not be taken due to medication being changed or refilled.

A diagnosis of major depression can be identified through inpatient, outpatient, emergency department, intensive outpatient or partial hospitalization settings.

Codes

AMM stand alone visit codes to be reported with the major depression code	AMM stand alone visit-CPT: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411-99412, 99510 HCPCS: G0155, G0176-G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, M0064, S0201, S9480, S9484-S9485 UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900-0905, 0907, 0911-0917, 0919, 0982-0983	Major depression (ICD-9): 296.20-296.25, 296.30-296.35, 298.0, 311
AMM visits combined with AMM POS and major depression code	AMM visits (CPT): 90791-90792, 90801-90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90867-90870, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99251-99255	AMM POS: 03, 05, 07, 09, 11-15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 AND: Major depression (ICD9): 296.20-296.25, 296.30-296.35, 298.0, 311

Source: HEDIS 2015, Volume 2, Technical Specifications

If services are provided in the emergency department, include the emergency department code with any diagnosis of major depression.

If services are provided inpatient (acute or non-acute), include ICD-9 for any diagnosis of major depression.

Description	**CPT**	**UB revenue**
Acute inpatient	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99291	UBREV: 0100-0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159-0160, 0164, 0167, 0169, 0200-0204, 0206-0214, 0219, 0720-0724, 0729, 0987

Description	CPT	UB revenue
Nonacute inpatient	99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524-0525, 0550-0552, 0559, 0660-0663, 0669
Emergency department	99281-99285	0450-0452, 0456, 0459, 0981

Rationale

According to the American Psychiatric Association (APA) (2000), successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode. Patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse (APA, 2000).

Follow-up care for children prescribed ADHD medication (ADD):

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had a least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- Initiation phase. The percentage of members 6 to 12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase.
- Continuation and maintenance (C&M) phase. The percentage of members 6 to 12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

ADHD medications which qualify for this measure

Description	Prescription		
CNS stimulants	Amphetamine-dextroamphetamine Dexmethylphenidate	Dextroamphetamine Lisdexamfetamine Methamphetamine	Methylphenidate
Alpha-2 receptor agonists	Clonidine	Guanfacine	
Miscellaneous ADHD medications	Atomoxetine		

Source: HEDIS 2015, Volume 2, Technical Specifications

The measure allows for gaps in medication treatment during the continuation phase. Continuous treatment must cover at least 210 days out of the 300 day period after the IPSD. Gaps in medication treatment up to a total of 90 days during the 300 day (10 month) period for changes in medication or treatment gaps to refill the same medication are allowed.

ADD stand-alone visits	ADD stand-alone visits-CPT: 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411-99412, 99510 HCPCS: G0155, G0176-G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, M0064, S0201, S9480, S9484-S9485 UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982-0983	
ADD visits group 1 with ADD POS group 1	ADD visits group 1: 90791-90792, 90801-90802, 90816-90819, 90821-90824, 90826-90829, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	ADD POS group 1: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72
ADD visits group 2 with ADD POS group 2	99221-99223, 99231-99233, 99238-99239, 99251-99255	52-53

Rationale
Diagnosis and management of children and youth with ADHD may require more time for the physician than the other conditions they treat. This could require more time with patients and families, developing a system of contacts with school and other personnel, providing continuous and coordinated care, all of which is time demanding.

The high prevalence of ADHD and limited mental health resources require primary care pediatricians to play a significant role in the care of their patients with ADHD so that children with this condition receive the appropriate diagnosis and treatment. Treatments available have shown good evidence of efficacy and lack of treatment results in a risk for impaired outcomes.

Education of parents is an important component in the chronic illness model to ensure their cooperation in efforts to reach appropriate titration of medication (remembering that the parents themselves might be challenged significantly by ADHD). The primary care clinician should alert parents and children that changing medication dose and occasionally changing medication might be necessary for optimal medication management, that the process might require a few months to achieve optimal success, and that medication efficacy should be systematically monitored at regular intervals.

Source: American Academy of Pediatrics, ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics Volume 128, Number 5, November 2011.

Follow-up after hospitalization for mental illness (FUH):
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected

mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days of discharge.
- The percentage of discharges for which the member received follow-up within seven days of discharge.

Codes

FUH stand-alone visit with a mental health practitioner	FUH stand-alone visits-CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411-99412, 99510 HCPCS: G0155, G0176-G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039-H0040, H2000-H2001, H2010-H2020, M0064, S0201, S9480, S9484-S9485	
FUH visits group 1 with FUH POS group 1 with a mental health practitioner	FUH visits group 1: 90791-90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875- 90876	FUH POS GROUP 1: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
FUH visits group 2 with FUH POS group 2 with a mental health practitioner	99221-99223, 99231-99233, 99238-99239, 99251-99255	52-53
FUH rev codes group 1 – visit to behavioral health facility	0513, 0900-0907, 0911-0917, 0919	
FUH rev codes group 2 – visit to a non-behavioral health facility with a mental health practitioner	0510, 0515-0517, 0519-0523, 0526-0529, 0982-0983	
FUH rev codes group 2 - visit to a non-behavioral health facility with a diagnosis of mental illness	0510, 0515-0517, 0519-0523, 0526-0529, 0982-0983	Mental illness - ICD-9-CM: 295.00-295.05, 295.10-295.15, 295.20-295.25, 295.30-295.35, 295.40-295.45, 295.50-295.55, 295.60-295.65, 295.70-295,75, 295.80-295.85, 295.90-295.95, 296.00-296.06, 296.10-296.16, 296.20-296.26, 296.30-296.36, 296.40-296.46, 296.50-296.56, 296.60-296.66, 296.7, 296.80-296.82, 296.89, 296.90, 296.99, 297.0-297.3, 297.8-297.9, 298.0, 298.1-298.4,

Codes (continued)

		298.8-298.9, 299.00-299.01, 299.10-299.11, 299.80-299.81, 299.90-299.91, 300.3-300.4, 301.0, 301.10-301.13, 301.20-301.22, 301.3-301.4, 301.50-301.51, 301.59, 301.6-301.7, 301.81-301.84, 301.89, 301.9, 308.0, 308.1-308.4, 308.9, 309.0-309.1, 309.21-309.24, 309.28-309.29, 309.3-309.4, 309.81-309.83, 309.89, 309.9, 311, 312.00, 312.01-312.03, 312.10-312.13, 312.20-312.23, 312.30-312.35, 312.39, 312.4, 312.81-312.82, 312.89, 312.9, 313.0-313.1, 313.21-313.23, 313.3, 313.81-313.83, 313.89, 313.9, 314.00-314.01, 314.1-314.2, 314.8-314.9
Transitional care management services where the date of service on the claim is 29 days after the date the member was discharged with a principal diagnosis of mental illness	7-day follow-up visit: CPT: 99496 30-day follow-up visit: CPT: 99495	

Rationale

Regular follow-up care with a mental health practitioner post discharge is important to ensure a smooth transition for the member back to their home and/or work environment. It also benefits monitoring of medications for side effects and ensures continuity of care.

Source: Agency for Healthcare Research and Quality.

Low back pain

The percentage of members 18 to 50 years of age with a primary diagnosis of low back pain who did not have an imaging study such as plain X-ray, MRI, CT scan within 28 days of the diagnosis.

Codes

Imaging study codes with a diagnosis of low back pain	Imaging study - CPT: 72100, 72110, 72114, 72120, 72131-72133, 72141-72142, 72146-72149, 72156, 72158, 72200, 72202, 72220 UBREV: 0320, 0329, 0350, 0352, 0359, 0610, 0612, 0614, 0619, 0972	Low back pain: 721.3, 722.10, 722.32, 722.52, 722.93, 724.02-724.03, 724.2- 724.3, 724.5-724.6, 724.70-724.71, 724.79, 738.5, 739.3- 739.4, 846.0-846.3, 846.8-846.9, 847.2.

Codes to identify visit type

Description	CPT	UB revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455, 99456	
Emergency department	99281-99285	0450-0452, 0456, 0459, 0981
Observation	99217-99220	
Osteopathic manipulative treatment	98925-98929, 98940-98942	

Rationale

Uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The majority of these patients are back to their usual activities in 30 days.

Source: According to the American College of Radiology.

COPD

COPD (short for chronic obstructive pulmonary disease) is an obstructive lung disease that over time makes it hard to breathe. COPD is a disease that involves inflammation and thickening of the airways. It also involves destruction of the tissue of the lung where oxygen is exchanged.

According to American Lung Association, COPD is the third leading cause of death in the United States. Sometimes referred to as either chronic bronchitis or emphysema and most people will have symptoms of both conditions.

Diagnosis

If you are at risk for COPD or have symptoms of COPD, you should be tested through spirometry.

Description

The percentage of COPD exacerbations for members 40 years of age or older who had an acute inpatient discharge or Emergency Department visit and who were dispensed appropriate medication.

Two rates are reported

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Treatments

Systemic corticosteroids

Description	Prescription			
Glucocorticoids	Betamethasone Dexamethasone	Hydrocortisone Methylprednisolone	Prednisolone Prednisone	Triamcinolone

Bronchodilators

Description	Prescription		
Anticholinergic agents	Albuterol-ipratropium Aclidinium-bromide	Ipratropium Tiotropium	
Beta 2-agonists	Albuterol Arformoterol Budesonide-formoterol Fluticasone-salmeterol	Fluticasone-vilanterol Formoterol Indacaterol Levalbuterol	Mometasone-formoterol Metaproterenol Pirbuterol Salmeterol
Methylxanthines	Aminophylline Dyphylline-guaifenesin Guaifenesin-theophylline	Dyphylline Theophylline	

Source: HEDIS 2015, Volume 2, Technical Specifications

Codes to identify visit type

Description	CPT	UB revenue
Emergency department	99281-99285	0450-0452, 0456, 0459, 0981
Acute inpatient		UBREV: 0100-0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159-0160, 0164, 0167, 0169, 0200-0204, 0206-0214, 0219, 0720-0724, 0729, 0987

Diagnosis codes ICD-9-CM

COPD:	493.20-493.22, 496
Emphysema:	492.0, 492.8
Chronic bronchitis:	491.0, 491.1, 491.20-491.22, 491.8-491.9

Spirometry

- Spirometry is a simple test of how well your lungs work.
- The percentage of members 40 years of age and older with a new diagnosis COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. The intake period captures the first COPD diagnosis.

Codes

Diagnosis	CPT code
Spirometry	94010, 94014, 94015, 94016, 94060, 94070, 94375, 94620

Codes to identify visit type:

Description	CPT	UB revenue
Outpatient	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455, 99456	

Codes to identify visit type:

Description	CPT	UB revenue
Emergency department	99281-99285	0450-0452, 0456, 0459, 0981
Observation	99217-99220	
Acute inpatient		UBREV: 0100-0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159-0160, 0164, 0167, 0169, 0200-0204, 0206-0214, 0219, 0720-0724, 0729, 0987

Diagnosis codes ICD-9-CM

COPD:	493.20-493.22, 496
Emphysema:	492.0, 492.8
Chronic bronchitis:	491.0, 491.1, 491.20-491.22, 491.8-491.9

Breast cancer screening

- The percentage of women 50 to 74 years of age who have had a mammogram in the prior two years.
- The focus of this measure is primary screening for breast cancer. Biopsies, breast MRIs or ultrasounds would not count for HEDIS compliance.

Codes to identify mammogram

Diagnosis	CPT	ICD-9	HCPCS	UBREV
Mammogram	77055, 77056, 77057	87.36, 87.37	G0202, G0204, G0206	0401, 0403

Please include any documentation of bilateral mastectomy as this is an exclusion for the measure.

Chlamydia screening in women

- The percentage of sexually active women ages 16 to 24 year of age who had one test for chlamydia in the measurement year.
- Women are identified as sexually active per two methods: claim/encounter data and pharmacy data.

Codes indicating a chlamydia test

Diagnosis	CPT	LOINC
Chlamydia	87110, 87270, 87320, 87490, 87491, 87492, 87810	14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8

Tips for working with members

- Follow up with members to schedule preventive care and order any needed testing.
- Review medications at each visit to ensure members understand the importance of taking their medications properly.
- Routinely ask members to update their contact information (i.e., phone number, address, Amerigroup ID number).
- Engage member in their treatment plan, and gain their understanding of the treatment plan.
- Engage family members as needed in the treatment plan. This is particularly important with members who may not be able to communicate their understanding of the plan or who need additional assistance.

Thank you for taking the time to appropriately code and document the care you provide our members. We appreciate your efforts to maintain their health and well-being.

HEDIS 2015 Volume 2 Technical Specifications for Health Plans - This information may be subject to change.

Billboard campaign

Have you seen our billboards? Amerigroup recently ran an advertising campaign in Atlantic, Ocean, Burlington and Camden Counties. The campaign included outdoor billboards, bus shelter and bus interior posters as well as a digital ad campaign on Facebook.

The campaign ran from July 1, 2015, through August 31, 2015. This campaign is part of a broader initiative to increase our brand awareness and marketing presence in the southern part of the state.

Marketing representatives are working with community organizations and providers' offices in these counties, too. If you are interested in having marketing materials available, contact your Provider Relations representative. Certain restrictions may apply.

Distribution of clinical practice and preventive health guidelines

Evidence-based guidelines are clinical practice guidelines known to be effective in improving health outcomes and are based on current research and national standards. Effectiveness of guidelines is determined by scientific evidence, professional standards or expert opinion. Amerigroup provides access to clinical care and preventive health guidelines to our participating network physicians on our website at providers.amerigroup.com/NJ > Clinical Practice Guidelines. If you would like a paper copy of a guideline, call our Provider Services team at 1-800-454-3730.

Availability of utilization management criteria

If an Amerigroup medical director denies your service request, both you and the member will receive a notice of action letter which includes:

- The reason for the denial
- The criteria/guidelines used for the decision
- Explanation of the appeal process and appeal rights

If you'd like to speak with a medical director about the service request denial, call our Provider Services team at 1-800-454-3730 or your local health plan at 732-452-6000. To request a copy of the specific criteria/guidelines used for the decision, please call 1-800-454-3730.

Management 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. You can submit precertification requests by:

- Calling us at 1-800-454-3730
- Faxing to 1-800-964-3627
- Logging on to providers.amerigroup.com/NJ and using the Precertification Lookup tool

Have questions about utilization decisions or the utilization management process in general? Call our clinical team at 1-800-454-3730, Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

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 Community Care 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 durable medical equipment 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/NJ. 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/NJ 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/NJ.
- 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 3-7 characters (seventh character extension)
- Character 1 is alpha
- Character 2 is numeric
- Characters 3-7 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 4-7 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 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 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 completely similar to 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 3 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 their highest number of characters available. Incomplete and/or invalid diagnoses codes are not acceptable for reporting.
- **ICD-10-CM Section IV.H, Uncertain diagnosis**. Do not code diagnoses documented as probable, suspected, questionable, rule out, working, consistent with or other similar terms that indicate uncertainty. Instead, code the conditions to the highest degree of certainty for the encounter/visit.
- **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 not 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 5th or 6th 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, EHR 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, healthcare providers should begin incorporating additional documentation into patient encounters. The table below 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** – Defined as an acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators. • **Infection** – 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** – 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.* • **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, 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.	I10 – I15.9

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Hypertension	– **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** – **C**ode 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. • **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, then apply code Z79.4 (long term, current use of insulin).	E08 – E13

ICD-10-CM: HIV status

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015.

The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient's human immunodeficiency virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient

has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

The table below reflects the crosswalk from ICD-9 to ICD-10.

ICD-9 Code(s)	ICD-10 Code(s)
• **V08** – Asymptomatic human immunodeficiency virus (HIV) infection status • **042** – Human immunodeficiency virus (HIV) • **079.53** – Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site	• **Z21** – Asymptomatic human immunodeficiency virus (HIV) infection status • **B20** – Human immunodeficiency virus (HIV) disease • **B97.35** – Human immunodeficiency virus, type 2 (HIV 2]) as the cause of diseases classified elsewhere

To further assist in preparation for ICD-10, please see the following resources:

- Centers for Medicare & Medicaid Services: Provider Resources
- American Academy of Professional Coders: AAPC ICD-10 Resources
- World Health Organization: WHO ICD-10 Training

Disease management anti-rheumatic drugs help prevent long-term disability

The American College of Rheumatology recommends that persons with rheumatoid arthritis (RA) are prescribed a disease modifying anti-rheumatic drug (DMARD) to prevent long-term disability and damage. To help ensure your Medicare Advantage RA patients have these important prescriptions, we will review medical and pharmacy claims looking for members who have an RA diagnosis and do not appear to have a claim for a DMARD. Providers who have members with a diagnosis of RA and not on a DMARD may receive a monthly fax reminder. Please be sure to use correct diagnosis codes for RA and be careful not to use a RA code for ruling out RA, osteoarthritis and joint pain.

Amerigroup, Optum deliver reports to ensure members receive regular exams

Amerigroup collaborates with Optum to educate our individual and group-sponsored members on the importance of annual wellness exams and improvement of chronic conditions.

The patient assessment form (PAF)/health care quality patient assessment form (HQPAF) are used to ensure individual and group-sponsored Medicare Advantage members receive a complete and comprehensive assessment at least once a year. The PAF is always sent when an appointment is scheduled with an Amerigroup member. Some providers, depending on volume, will receive a PAF for all members regardless of an appointment being scheduled.

The members without office visit report identifies patients who have not visited a provider in 12 months. Optum will work with a practice to ensure a patient schedules an updated office visit. Should you have any questions about Optum's relationship with Amerigroup please call 1-317-287-0719. For questions about the Healthcare Quality Patient Assessment Form program, please call the Optum Provider Support Center at 1-877-751-9207.

Encourage Medicare Advantage members to control high blood pressure

According the Centers for Disease Control and Prevention (CDC), almost one in three American adults has high blood pressure, but only about half of them have their blood pressure under control. Amerigroup joins you in encouraging our Medicare Advantage members to know and control their blood pressure to lower their risk of heart attack, heart disease, stroke and kidney disease.

Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Amerigroup follows Centers for Medicare & Medicaid Services' (CMS') Medicare Part B immunization billing guidelines.

Please use the following forms when filing flu, pneumonia or hepatitis B claims for Amerigroup individual and group-sponsored Medicare Advantage members:

- Professional claims should be filed on the CMS 1500 form with the appropriate current procedural terminology code and/or health care procedural code for the vaccine and administration.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes
  - Revenue codes (except rural health clinics and federally qualified health centers):
    - 0636 – vaccine (and CPT or HCPC)
    - 0771 – administration (and HCPC)
  - Rural health clinics and federally qualified health clinics – 052X revenue code series

Please refer to page three of the Medicare Part B immunization billing http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf for specifics on institutional billing.

CMS requirements: Annual medication, supplement review for special needs plan members

Medicare requires that primary care providers review all prescription and nonprescription drugs, vitamins, herbals and other supplements at least once per year for members in a special needs plan (SNP).

SNP members 66 years of age or older should also have one functional status assessment each year. According to HEDIS guidelines, notations for a complete functional status assessment should include one of the following:

- Notation that activities of daily living (ADL) were assessed – includes bathing, dressing, eating, transferring (i.e., getting in and out of chairs), using toilet, walking
- Notation that instrumental activities of daily living (IADL) were assessed – includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - Assessment of living skills and resources
  - Barthel ADL index physical self-maintenance scale
  - Bayer activities of daily living scale
  - Barthel index
  - Extended activities of daily living scale
  - Independent living scale
  - Katz index of independence in activities of daily living
  - Kenny self-care evaluation
  - Klein-Bell activities of daily living scale
  - Kohlman evaluation of living skills
  - Lawton & Brody's IADL scales
- Notation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Sensory ability (including hearing, vision and speech)
  - Other functional independence (i.e., exercise, ability to perform job)

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

Provider requirements and Medicare notices

CMS requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the Important Message from Medicare About Your Rights (IM) notice to every Medicare beneficiary within two calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than two calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, Amerigroup periodically conducts IM and NOMNC audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.
Our audit findings show providers would benefit from focusing in on the following elements required by CMS:

- NOMNC notices:
  - Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
  - Include the beneficiaries health care identification number or medical record number on page one
  - Include the specific type of services ending on page one
  - Include the health plan's contact information on page two
  - Have the beneficiary or authorized representative sign and date page two at least two days prior to the end of services
  - Retain a copy of the signed notice, both page one and page two.
- IM notices:
  - Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
  - Include the physician's name on page one
  - Have the beneficiary or authorized representative sign and date page one within two calendar days of the date of an inpatient hospital admission
  - Call the authorized representative to deliver the IM when the beneficiary is unable to sign
  - Deliver the IM, or copy of the IM again, no sooner than two calendar days before discharge
  - Retain a copy of the signed notice, both page one and page two

To download the standardized IM/NOMNC notices required by CMS, along with accompanying instructions, go to CMS website at cms.hhs.gov/bni or refer to the specific links below:

- NOMNC notice: cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
- IM notice: cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Important update: Quality improvement organizations (QIO) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see qioprogram.org to locate your QIO.

For more information on compliance with the Notice of Medicare Non-Coverage or the Important Message from Medicare, contact Mary Heapes, RN, BSN in the Federal Clinical Compliance Department at 212-476-2908.