Provider Newsletter

https://providers.amerigroup.com/NM

Amerigroup RealSolutions® in healthcare

2017
Quarter 1

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Reimbursement Policies:

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.

NM-NL-0016-17

March 2017

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Community Care of New Mexico, Inc. previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-866-805-4589 and select the appropriate prompt.

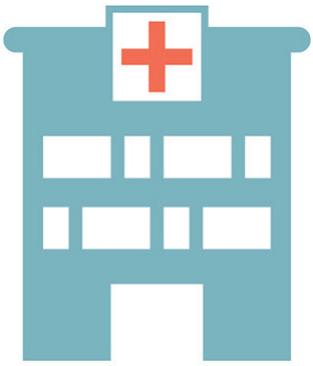
ClaimCheck and ClaimsXten are registered trademarks of McKesson Technologies Inc. and McKesson Health Solutions LLC, respectively.

SSO-NL-0013-17

Hospital observation service limits

This is a correction to the previous hospital observation service limits newsletter article published in September 2016. Observation services with less than eight hours will be considered a bundled service. Observation services billed over 72 hours will be considered as exceeding limits. This pertains to both contracted and noncontracted providers.

An Amerigroup Amerivantage (Medicare Advantage) member's time in observation (and hospital billing) begins with the member's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. The billed units of service should equal the number of hours the patient receives observation services.



Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.

Additional information and discussion regarding hospital observation services can be found in the *Medicare Claims Processing Manual*, Chapter 4 — Part B Hospital, 290.2.2.

SSO-NL-0008-16

Launch of the Retrospective Medical Record Review Program

Risk adjustment is the method used by CMS to adjust the capitated payment made to Amerigroup Community Care of New Mexico, Inc. based on demographic characteristics and health status (represented by diagnosis data and disease interactions) of each Amerigroup Amerivantage (Medicare Advantage) member. Risk adjustment relies on the timely and accurate collection and submission of member diagnosis data each year. All diagnosis data must be supported by the member's medical record documentation. Federal regulations require Amerigroup to review and validate medical records to avoid underpayments and overpayments.

Program details:

Our retrospective medical record review initiative is a risk adjustment program intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations.

Amerigroup contracts with Verscend Health (formerly Verisk) to conduct outreach to providers as well as collect, review and code medical records with dates of service for the 2017 target year through present day.

What if I need assistance?

The Retrospective Risk Program Lead, Jaime Marcotte, is managing this initiative. For more information on this program, please contact Jaime at 314-925-6094.

FAQ — Retrospective Medical Record Review Program

Q. What is the Retrospective Medical Record Review Program?

A. The program is intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations. We exclusively contract with Verscend Health (formerly Verisk) for this initiative.

Q. What services is Verscend performing on behalf of Amerigroup?

A. Verscend is contracted to retrieve the medical records of targeted members as well as review these records and code them based on ICD-10-CM coding guidelines and requirements. Additionally, Verscend sends a data extract including the coded conditions to us.

Q. Is the retrospective medical record review an audit?

A. This is not a retrospective claims validation audit.

Q. What dates of service are included for the 2017 initiative?

A. The scope for this initiative includes 2016 dates of service through present day.

Q. Are all Amerigroup Amerivantage (Medicare Advantage) members targeted?

A. No, Amerigroup conducts a complex effort synthesizing claims and pharmacy data with enrollment data. Due to the high probability of identifying undocumented data and/or new diagnosis information, persistent members are targeted for this initiative.

Launch of the Retrospective Medical Record Review Program continued

Q. What is the provider notification process?

A. Beginning in early May, Verscend will initiate the record retrieval process. The process begins with phone/fax outreach to the provider that is followed by a written request. The written request includes:

- Role of Verscend
- Purpose of the medical record retrieval request
- Action being requested (e.g., submission of the entire medical record)
- Name of the member
- Date(s) of service being requested

Q. When do I need to submit the requested medical records?

A. You should supply the medical records within two weeks of receipt of the request. If the volume is large, Verscend will work with you throughout 2017 to obtain the requested records.

Q. What should I do if I did not actually see the member during the requested date(s) of service?

A. You should return the request to Verscend and include an explanation stating you do not have information relative to the request in the patient's medical record.

Q. How do I submit a medical record? Are there different submission options?

A. Medical records should be returned to Verscend using one of the following methods:

- Mail with prepaid postage
- Electronic medical record (EMR) integration (Verscend requires remote access to the provider's EMR system.)
- Secure file transfer protocol
- Secure Provider Upload Portal (Contact Jaime Marcotte for details regarding this option.)
- On-site scanning (reserved for providers with large record requests)

Q. I received a request for a large number of medical records; can special arrangements be made?

A. Verscend offers on-site scanning services for providers who receive a request for a large number of medical records.

Q. Am I required to comply with the request for medical records?

A. In accordance with the language in the Terms and Conditions of Payment section of your Provider Agreement, you are required to comply with requests from Amerigroup for medical records.

Q. Do I need HIPAA authorization or a release from the patient in order to supply their medical records?

A. No, the collection of risk adjustment data as well as the request for medical records to validate payment made to Medicare Advantage organizations is considered a health care operation and, as such, does not violate the privacy provisions of HIPAA (CFR 164.502).

Q. Whom can I contact if I have questions?

A. Verscend Retrospective Program Manager, Jaime Marcotte, is managing this initiative. She can be reached by phone at 314-925-6094.

SSO-NL-0009-16

Policy Update

Reimbursement for Reduced and Discontinued Services

(Policy 10-003, effective 04/27/2015)

Amerigroup Community Care of New Mexico, Inc. allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Modifiers 52, 53, 73 and 74 can be appended for reduced and discontinued services, if applicable.

Modifier 52 indicates procedures for which services performed are significantly less than usually required. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Do not report Modifier 52 on Evaluation & Management (E&M) and consultation codes.

Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing, and is not valid when billed with E&M or time-based codes.

Modifier 73 indicates the physician cancelled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

Modifier 74 indicates a procedure was stopped after the administration of anesthesia or after the procedure was started. Reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

NM-NL-0010-16

Policy Update

Claims Timely Filing

(Policy 06-050, effective 08/01/16)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 12 months for participating and nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

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

Reimbursement Policy Disclaimer

These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. To view the Reimbursement Policy Disclaimer, please visit https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Policy Disclaimer.

SSO-PEC-0006-16

Policy Reminder

Split-Care Surgical Modifiers

(Policy 11-005, effective 08/01/16)

Reimbursement of surgical codes appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 20 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-PEC-0722-16