Provider Newsletter

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Amerigroup RealSolutions® in healthcare

2017
Quarter 2

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Amerigroup Community Care of New Mexico, Inc. is an HMO plan with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.

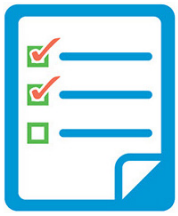
NM-NL-0019-17

June 2017

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, which includes providers with Amerigroup Community Care of New Mexico, Inc. seeing Amerigroup Amerivantage (Medicare Advantage) 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 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).

NM-NL-0015-17

Utilization Management affirmative statement

Amerigroup Community Care of New Mexico, Inc., 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
Modifier 63: Procedure Performed on Infants Less Than 4 kg
(Policy 06-015, effective 09/15/2017)

Currently, Amerigroup Community Care of New Mexico, Inc. 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.

SSO-NL-0005-16

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

Amerigroup Community Care of New Mexico 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.

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.

SSO-NL-0011-17

Policy Update
Modifier 22: Increased Procedural Service
(Policy 07-020, effective 11/01/17)

Amerigroup Community Care of New Mexico, Inc. 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
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 of New Mexico, Inc. 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
Multiple Radiology Payment Reduction
(Policy 12-002, effective 09/15/2015)

Amerigroup Community Care of New Mexico, Inc. 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
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 of New Mexico, Inc. 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 Amerigroup only. For additional information, refer to Modifier Usage Reimbursement Policy (Exhibit A) at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

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