

Provider Newsletter



Amerigroup Community Care
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Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 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 Community Care asks that providers encourage women 67 to 85 who have had a fracture or may be at 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.

Disease modifying 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.

Encourage Medicare Advantage members to control high blood pressure

According to the Centers for Disease Control (CDC), almost one in three American adults have high blood pressure but only about half 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.

Table of contents

During member visits

1. Osteoporosis screening, medication encouraged for women
2. Disease modifying anti-rheumatic drugs help prevent long-term disability
3. Encourage Medicare Advantage members to control high blood pressure
4. Quality overview: Special needs plan Model of Care
5. Amerigroup, Optum deliver reports to ensure members received regular exams

Policies, updates, and reminders

6. Availability: New eligibility and benefits functionality and features
7. CMS requirements: Annual medication, supplement review for special needs plan members
8. Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Business operations

9. Provider requirements and Medicare notices
10. ICD-10 documentation and diagnosis coding tips
11. ICD-10-CM: HIV status

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

Quality overview: Special needs plan Model of Care

Commitment to our dual eligible—special needs plans 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 to highlight the outcomes of these initiatives.

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)/healthcare quality patient assessment form 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 health care quality patient assessment form program, please call the Optum Provider Support Center at 1-877-751-9207.

Availity: New eligibility and benefits functionality and features

The Availity Web Portal launched new eligibility and benefits 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](#).

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

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

SNP members age 66 or older also should have one functional status assessment each year. According to Healthcare Effectiveness Data and Information Set (HEDIS[®]) guidelines, notations for a complete functional status assessment should include one of the following:

- Notation that activities of daily living were assessed, including bathing, dressing, eating, transferring, using toilet, walking
- Notation that instrumental activities of daily living were assessed, including 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 instrumental activities of daily living 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 (e.g., 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.

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

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

Amerigroup follows the 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/gr_immun_bill.pdf for specifics on institutional billing.

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 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 health plan 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, 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 the 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](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html)
- IM notice: [cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html)

Important update: Quality improvement organizations (QIOs) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see [gioprogram.org](https://www.gioprogram.org) or contact 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 1-212-476-2908.

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 ulcers
- 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 Excludes1 and 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 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <i>I15 Secondary hypertension</i>. • Transient – Temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code <i>R03.0 Elevated blood pressure reading without a diagnosis of hypertension</i>. • Controlled/uncontrolled – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is <i>I10 Essential (primary) hypertension</i>. • 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: <ul style="list-style-type: none"> – I11 Hypertensive heart disease – Use additional code from category <i>I50 Heart failure</i> if present. 	I10 – I15.9

Chronic condition:	Provider documentation required for correct coding:	ICD-10 code
Hypertension	<ul style="list-style-type: none"> – I12 Hypertensive chronic kidney disease – Use additional code from category <i>N18 Chronic kidney disease</i> to identify the stage. – I13 Hypertensive heart and chronic kidney disease – Requires use of additional code from category <i>I50 Heart failure</i> if present and use additional code from category <i>N18 Chronic kidney disease</i> to identify the stage. – I60 – I69 Hypertensive cerebrovascular disease – Code also <i>I10 Essential (primary) hypertension</i>. – H35.0 Hypertensive retinopathy – Code also <i>I10 Essential (primary) hypertension</i>. 	I10 – I15.9
Diabetes mellitus (DM)	<ul style="list-style-type: none"> • Type – Providers must document the type of diabetes in ICD-10-CM: <ul style="list-style-type: none"> – 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 – Code 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)
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 (CMS): [Provider Resources](#)
- American Academy of Professional Coders: [AAPC ICD-10 Resources](#)
- World Health Organization: [WHO ICD-10 Training](#)