Provider NewsBlast

Amerigroup
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Amerigroup Community Care complies with all applicable federal and state civil rights laws, rules and regulations and does not discriminate against members/participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. To report a discrimination complaint or to request language, communication or disability assistance for a member/participant, call 1-800-600-4441. Information about civil rights laws can be found on our website and is available from the U.S. Department of Health and Human Services.

Medicaid:

Amerigroup Community Care expands work with AIM Specialty Health for outpatient genetic testing services authorizations

Effective February 1, 2019 AIM Specialty Health® (AIM) will provide health services review for prior authorization of genetic testing services.

If precertification is required, services will be provided through AIM Specialty Health. The clinical criteria used to review these service requests will not change with the transition of processing of prior authorizations for genetic testing to AIM. Clinical criteria used to determine medical necessity of these services can be found on our provider website.

You can also visit our provider website to determine if a specific code requires prior authorization: https://providers.amerigroup.com/TN > Quick Tools > Precertification Lookup Tool. The Precertification Lookup Tool allows you to search by CPT code, HCPCS code or code description.

For information on how to request prior authorization for genetic testing services, please read the following:

- The ordering provider is responsible for obtaining a health services review authorization. To obtain this authorization, you can access AIM at https://providerportal.com or https://www.availity.com. You can also can contact AIM toll free at 1-800-714-0040, Monday-Friday, 7 a.m.-7 p.m. CT.
    - The AIM ***Provider****Portal*$_{SM}$ is the fastest, easiest way to contact AIM. An online application, ***Provider****Portal* offers a convenient way to enter your order requests or check on the status of your previous orders. Go to https://providerportal.com to begin; registration is required.
- Fax requests will not be accepted for the services reviewed by AIM.
- Providers should verify that the necessary prior authorization has been obtained in advance of rendering the service. Failure to do so may result in nonpayment of your claim.
- Services performed as part of urgent/emergent care do not require prior authorization. Services provided as part of a planned inpatient admission may require prior authorization; however, they are not handled by AIM.

While prior authorization procedures for genetic testing services have changed as noted above, certain core services and capabilities, while subject to change independent of AIM's role in genetic testing prior authorization, remain unchanged at this time. These include:

- Claims processing.
- Clinical and coverage guidelines.
- The network of providers offering these services to our members.

Please note that adhering to these new policies and procedures is required to ensure appropriate payment of claims.

TN-NB-0066-18-A

Introducing the *New Amerigroup Professional Provider Market Master Fee Schedule*

Background: Effective January 1, 2019, Amerigroup Community Care will implement a new fee schedule. The new Amerigroup Professional Provider Market Master Fee Schedule will be frozen at current levels and will no longer be tied to CMS inflation indexes.

Why is this change necessary?
Amerigroup currently has a floating fee schedule tied to CMS that requires change to ensure full compliance with the Division of TennCare (TennCare) *Contractor Risk Agreement (CRA)*, which prohibits the TennCare MCOs from reimbursing providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare. The new Amerigroup Professional Provider Market Master Fee Schedule is compliant with the TennCare *CRA*.

Providers can access and read the *CRA* in its entirety by visiting the TennCare website.

Participating professional providers will receive an *Amendment by Notification* along with a cover letter setting out additional information about the new Amerigroup Professional Provider Market Master Fee Schedule within the next 30 days. Section 8.1 of the Amerigroup *Provider Agreement* permits *Amendment by Notification* for this purpose. In order to comply with Federal and state regulatory requirements, and in certain circumstances, those regulatory mandates may require Amerigroup to make changes to confidential portions of your *Provider Agreement*.

How does this affect behavioral health providers?
Only those rates and services tied to CMS will be moved to the new Amerigroup Professional Provider Market Master Fee Schedule. All fixed pricing, case rates and per-diems will remain the same.

How will this impact the way I am currently being paid?
This change will not cause any material change in a provider's reimbursement.

How will this impact the way I submit claims?
There will be no impact or change in the way providers submit claims.

What if I need assistance?
If you have additional questions, or to obtain a copy of the *new Amerigroup Professional Provider Market Master Fee Schedule*, please contact your local Provider Relations representative at 615-232-2160 or call Provider Services at 1-800-454-3730, or to receive a copy via email, please send request to TNproviderfeeschedulerequests@amerigroup.com.

Note, due to the size of the fee schedule document, you will not receive a copy by mail with the *Amendment by Notification*.

TNPEC-2466-18-G

Place of service code 09 — prison/correctional facility

Effective February 1, 2019, Amerigroup Community Care will reject or deny claims that have a place of service code of 09 — prison/correctional facility.

Any *CMS-1500* claim form with a place of service code of 09 will be rejected or denied as a billing error.

Claims, including corrected claims, received after the applicable timely filing deadlines will be denied.

TN-NB-0111-18

Update: noncovered codes

Summary: Effective December 1, 2018, Amerigroup Community Care considers Resource Base Relative Value Scale (RBRVS), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that are not listed on the current CMS fee schedules as not covered for both professional and institutional claims.

What this means to you:
To avoid claim denials, please ensure you are billing with the most current, applicable RBRVS, CPT and HCPCS codes. All of the codes in the below table are **noncovered**.

What is the impact of this change?
Amerigroup follows CMS guidelines and has identified codes that are not payable that should either be billed with a more appropriate code, bundled (not separately reimbursed) or not listed in your provider agreement.

Amerigroup encourages the submission of claims electronically through electronic data interchange. Providers must submit claims so that they are received by Amerigroup within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Amerigroup receives notification from the Division of TennCare of the member's eligibility/enrollment.

A corrected claim or replacement claim may be submitted within 120 calendar days of Amerigroup payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

Claims, including corrected claims, received after the applicable filing deadlines will be denied.

Listed below are codes that will no longer be reimbursed and will deny as of December 1, 2018.

A0380	A0390	S9126	S9128	S9129	38214	78350	80300	80301	80329
A0382	A0398	20930	20936	22841	77387	80325	80326	80327	80342
S9083	S9110	38204	38207	80323	80324	80338	80339	80341	80354
V5364	37216	76140	76390	80336	80337	80351	80352	80353	80364
36416	74263	80320	80321	80348	80349	80361	80362	80363	80374
69710	80304	80334	80335	80359	80360	80371	80372	80373	92314
80303	80332	80346	80347	80369	80370	90389	90889	92310	92921
80331	80345	80357	80358	89322	90384	92606	92630	92633	98943
80344	80356	80367	80368	92532	92534	97010	97014	99058	99070
80355	80366	89320	89321	95131	95133	99051	99053	99243	99244
80365	80377	92342	92370	99001	99002	99241	99242	99359	99363
80375	92341	95120	95125	99135	99140	99340	99358	A4207	A4208
92340	98961	98962	99000	99254	99255	99485	A4206	S0612	A4209
92929	99080	99100	99116	99374	99380	Q0144	S0201	S2083	A4213
98960	99251	99252	99253	C9113	L7600	S0119	S0610	V5363	A4215
99078	99366	99367	99368	G0168	S9452	V5269	V5362	36000	A4230
99245	A0422	A4262	A6549	S9131	27216	27217	27218	58970	A4231
99364	A0424	A4913	A9270	27215	44799	55400	58770	80302	A4232
A4245	A4248	A4570	A4616	A4627	A6250	A6533	A6540	B4104	E0265
A4246	A4250	A4611	A4617	A5200	A6260	A6534	B4102	E0190	E0266
A4247	A4550	A4615	A4620	A6229	A6530	A6539	B4103	E0244	E0637
E0640	E0971	E0990	E1140	E1353	E2331	L0984	L2750	L2820	L2840
E0641	E0973	E0995	E1260	E2300	E2367	L2275	L2780	L2830	L2861
L3215	L3216	L3221	L3222	L3230	L3252	L4398	L7900	L8010	S8451
S8999									

TN-NB-0078-18-B

Urine drug screens limit change effective January 1, 2019

Effective January 1, 2019, the limits for the urine drug screens represented by codes 80305 and 80306 will be changed from a limit of 12 per member, per calendar year to 24 per member, per calendar year.

Description	Codes	Codes description	Policy
Urine Drug Screens	80305 Or	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Limit of 24 per member, per calendar year
	80306	Drug tests, presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	(Any combination of 80305 and 80306 combined limited to a total of 24)
	80307	Drug tests, presumptive, any number of drug classes; any number of devices or procedures by instrumental chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MA LDI, LDTD, DES I, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Limit of 4 per member, per calendar year Limits do not apply in the emergency department (Note: this includes urine drug screens that are sent to an independent lab on the same date of service for the same enrollee on the same day of an emergency department visit.)

TN-NB-0103-18

My Diverse Patients — a website to support your diverse patients

While there's no single, easy answer to the issue of health care disparities, the vision of My Diverse Patients is to harness the power of data and identify ways to bridge gaps often experienced by diverse populations.

We've heard it all our lives: in order to be fair, you should treat everybody the same. But the challenge is that everybody is *not* the same — and these differences can lead to critical disparities not only in how patients access health care, but in their outcomes as well.

The reality is that burden of illness, premature death and disability disproportionately affects certain populations.[1] My Diverse Patients features robust educational resources to help support you in addressing these disparities, such as:

- Continuing medical education about disparities, potential contributing factors and opportunities for you to enhance care.
- Real life stories about diverse patients and the unique challenges they face.
- Tips and techniques for working with diverse patients to promote improvement in health outcomes.

Accelerate your journey to becoming your patients' trusted health care partner by visiting https://mydiversepatients.com today. You may also access the site with the QR code provided.

1 Centers for Disease Control and Prevention. (2013, Nov 22). CDC Health Disparities and Inequalities Report — United States, 2013. *Morbidity and Mortality Weekly Report*. Vol 62 (Suppl 3); p3.

TN-NB-0095-18

Reducing the overuse of imaging studies: lower back pain

Background: The HEDIS® measure Use of Imaging Studies for Low Back Pain (LBP) looks at members between the ages of 18-50 years with a primary diagnosis of lower back pain who have not had an imaging study within 28 days of the diagnosis. The cases of those who did not receive an imaging study immediately after diagnosis indicate appropriate treatment of uncomplicated lower back pain.

The National Committee for Quality Assurance (NCQA) and American Academy of Family Physicians recommend decreasing the number of these studies. Reducing unnecessary imaging studies saves your practice money and limits patient exposure to radiation. Help us ensure quality care by decreasing the number of imaging studies ordered, except when an exclusion or secondary diagnosis is present.

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

Guidelines for diagnostic studies:

- Consider appropriate treatment options prior to ordering diagnostic imaging studies immediately or in the first few weeks of new onset back pain if there are no red flags such as cancer, recent trauma, neurologic impairment, HIV, spinal infections, organ transplant, prolonged use of corticosteroid or intravenous (IV) drug abuse.
- When ordering an imaging study for a red flag or other reason, use the correct exclusion or secondary diagnosis code.
- If you order a study specifically to diagnose lower back pain, bill using the correct CPT or ICD-10 diagnosis codes.

CPT and ICD-10 diagnosis codes for diagnostic imaging studies:

Description	CPT and HCPCS codes
Outpatient visit	98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
ED visit	99281–99285 (Do not include if visit resulted in inpatient stay.)
Observation visit	99217–99220 (Do not include if visit resulted in inpatient stay.)
Imaging study	72010, 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220
Osteopathic and chiropractic manipulative treatment visit	98925-98929, 98940-98942
PT visits	97110, 97113, 97124, 97140, 97161-97164
HCPCS codes	G0402, G0438, G0439, G0463, T1015

Description	ICD-10 diagnosis codes
Uncomplicated lower back pain	M47.26-M47.28, M47.816-M47.818, M47.896-M47.898, M48.06, M48.061, M48.062, M51.16, M51.17, M51.36, M51.37, M51.86, M51.87, M53.2X6-M53.2X8, M53.3, M53.86-M53.88, M54.16-M54.18, M54.30-M54.32, M54.40-M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.73, M99.83, M99.84, S33.100A, S33.100D S33.100S, S33.110.A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120D, S33.120S, S33.130A, S33130D, S33130S, S33.140A, S33.140D, S33140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.92XA, S39.92XS

ICD-10 exclusion codes:

Description	ICD-10, CPT and HCPCS codes
Cancer	V10, Z85, Z86.000, Z86.008, Z86.03, 140.x–209.XX, 230.X–239.X, C00.0-C96.9, D00.0-D09.9, D37.01-D48.9, D49.0-D49.9 (Benign tumor codes are not exclusions.)
Trauma	S02, S03, S06, S12, S13, S14, S21, S22, S23, S24, S26, S27, S31, S32, S33, S34, S36, S37, S38, S42, S43, S49, S52, S53, S59, S62, S63, S72, S73, S79, S82, S83, S89, S92, S93, S99 (Please note, not all the codes associated with the 3-digit categories listed are related to trauma and exclusions.)

IV drug abuse	F11.10-F15.29
Neurologic impairment	G83.4
HIV	B20, Z21, V08
Organ transplant	50300, 50320, 50340, 50365, 50370, 50380, 32850-32856, 33933, 33940, 33944, 33945, 44132, 44133, 44135-44137, 44715, 44720, 44721, 47133, 47135, 47136, 47140—47147, 48160, 48550-48552, 48554, 48556, S2065, S2053-S2055, S2060, S2061, S2152, Z94.0 (ICD-10 PCS and UBREV codes in relation to organ transplants not shown on this list are exclusions as well.)

The code and measure tips listed above are for informational purposes only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state and provider contract(s), Medicaid, member benefits, and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing the appropriate care decreases the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members.

Please note: The information provided is based on HEDIS 2019 technical specifications and is subject to change based on guidance given by the NCQA, CMS and state recommendations. Please refer to the appropriate agency for additional guidance.

TN-NB-0107-18

Medical Policies **and** ***Clinical Utilization Management Guidelines*** **update**

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. For markets with carved-out pharmacy services, the applicable listings below are informational only.

Please share this notice with other members of your practice and office staff.

To search for specific policies or guidelines, visit https://medicalpolicies.amerigroup.com/search.

Medical Policies

On September 13, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care.

Publish date	*Medical Policy #*	*Medical Policy* title	New or revised
10/17/2018	MED.00125	Biofeedback and Neurofeedback	New
10/17/2018	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Revised

Clinical UM Guidelines

On September 13, 2018, the MPTAC approved the following *Clinical UM Guidelines* applicable to Amerigroup. This list represents the guidelines adopted by the medical operations committee for the Government Business Division on September 27, 2018.

Publish date	*Clinical UM Guideline #*	*Clinical UM Guideline* title	New or Revised
10/17/2018	CG-DME-46	Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs	New
10/17/2018	CG-SURG-90	Mohs Micrographic Surgery	New
9/20/2018	CG-DRUG-94	Rituximab (Rituxan®) for Non-Oncologic Indications	Revised
10/17/2018	CG-DRUG-107	Pharmacotherapy for Hereditary Angioedema	Revised
9/20/2018	CG-SURG-40	Cataract Removal Surgery for Adults	Revised

TN-NB-0099-18

Coding spotlight: diabetes — provider information guide to coding the diagnosis and treatment of diabetes

Diabetes mellitus is a chronic disorder caused by either an absolute decrease in the amount of insulin secreted by the pancreas or a reduction in the biologic effectiveness of the insulin secreted.

Facts

- According to the 2017 *Diabetes Report Card*, the rates of new cases of diabetes among adults living in the U.S. has decreased, and the rates of new cases among children and adolescents has increased.[1]
- Diabetes is the seventh leading cause of death in the United States.[2]
- Diabetes is the leading cause of new cases of blindness in adults.**Error! Bookmark not defined.**

Risk factors

- Age
- Obesity or being overweight
- Sedentary lifestyle
- Family history
- Ethnic background
- Impaired glucose intolerance

- Gestational diabetes
- Polycystic ovary syndrome[3]

Diagnosis and treatment

The American Diabetes Association (ADA) has recommended screening for the following people:

- Anyone with a body mass index higher than 25 (regardless of age), who has additional risk factors such as high blood pressure, a sedentary lifestyle, high cholesterol levels, a history of heart disease, a history of polycystic ovary syndrome, or having delivered a baby who weighted more than nine pounds
- Anyone over the age of 45.

Diabetes tests:

- Glycated hemoglobin (HbA1c) test
- Random blood sugar test
- Fasting blood sugar test
- Oral glucose tolerance test
- Screening test for gestational diabetes in pregnant patients:
    - For high-risk patients: given at the first prenatal visit
    - For average-risk patients: given between 24-28 weeks of pregnancy
    - For patients on antipsychotic medications: regular metabolic screening (including A1C testing) is recommended

Diabetes treatment and management:

- Maintaining a healthy weight through diet and exercise
- For type 1 diabetes, insulin injections or the use of an insulin pump, frequent blood sugar checks and carbohydrate counting
- For type 1 diabetes, a pancreas transplant may be an option
- For type 2 diabetes, monitoring the blood sugar along with diabetes medications
- For gestational diabetes, controlling blood sugar levels to avoid complications during delivery[4]

HEDIS® quality measure for diabetes

Comprehensive Diabetes Care (CDC) is a measure that evaluates members ages 18-75 with type 1 or type 2 diabetes. Each year, members with type 1 or type 2 diabetes should have:

- HbA1c testing and result
- Blood pressure monitoring
- Medical attention to nephropathy (micro/macro urine, angiotensin-converting enzyme/angiotensin receptor blockers therapy) in the measurement year
- Retinal eye exam performed by an ophthalmologist or optometrist in measurement year or year prior.[5]

Tips for providers:

- Evaluate diabetes services needed at each visit.

- Adjust therapy to improve HbA1c and blood pressure levels.
- Consider ordering labs prior to scheduled patient appointment times.
- Screen yearly for nephropathy and treat if necessary.
- Evaluate eye exam results.
- Document any reasons why the above-listed exams were not done.
- Educate members on medication adherence and healthy diet and exercise.

ICD-10-CM information

General coding and documentation

In ICD-10-CM, diabetes is classified in categories E8-E13. The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected and the complications affecting the body system.

The ICD-10-CM presumes a causal relationship between diabetes and several acute and chronic conditions. The term "with" means "associated with" or "due to" when it appears in a code title, the alphabetic index or an instructional note in the tabular list. However, if the physician documentation specifies that diabetes is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication. The documentation should indicate if the two conditions are related or not.[6]

ICD-10-CM diabetes categories:

- E08 Diabetes mellitus due to an underlying condition
- E09 Drug or chemical induced diabetes mellitus
- E10 Type 1 diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus[7]

ICD-10-CM tips:

- If the medical record documentation does not specify the type of diabetes, the default is category E11 type 2 diabetes mellitus according to the ICD-10-CM *Official Coding Guidelines*.
- Secondary diabetes due to an underlying condition is coded to category E08 with the underlying condition coded first. Underlying conditions include congenital rubella (P35.0), Cushing's syndrome (E24.-), cystic fibrosis (E84.-), malignant neoplasm (C00-C96), malnutrition (E40-E46), and pancreatitis and other diseases of the pancreas (K85-, K86.-).
- Secondary diabetes mellitus that is due to pancreatectomy is coded to E89.1, postprocedural hypoinsulinemia. A code from category E13 should be assigned and either code Z90.410 acquired total absence of pancreas or code Z90.411 acquired partial absence of pancreas as additional diagnoses.[6]
- Secondary diabetes drug-induced or chemically induced is coded to category E09. For example, steroid-induced diabetes mellitus due to prolonged use of prednisone for an unrelated condition is coded as E09.9 drug or chemical induced diabetes mellitus without complications followed by code T38.0X5- adverse effect of glucocorticoids and synthetic analogs.

- Type 1 diabetes mellitus (category E10) can also be described as ketosis-prone, juvenile-onset, idiopathic diabetes or brittle diabetes.
- Type 2 diabetes mellitus (category E11) may also be described as insulin-resistant. Code Z79.84 long-term (current) use of oral hypoglycemic drugs is assigned when the patient requires oral hypoglycemic medication. When a patient with type 2 diabetes routinely uses insulin, assign code Z79.4 long-term (current) use of insulin. If the patient is treated with both oral medications and insulin, only the code for insulin should be assigned.

Patients with diabetes often suffer several complications concurrently, in which case multiple codes from categories E08-E13 are assigned to identify all the associated diabetic conditions.

- **Renal complications:** Diabetic renal complications are coded to E08-E13 with .21 for diabetic nephropathy, .22 for chronic kidney disease, and .29 for other kidney complication.
- **Diabetic eye complications:** Diabetic eye complications are coded to E08-E13; the fourth and fifth characters indicating unspecified retinopathy, nonproliferative diabetic retinopathy and proliferative diabetic retinopathy. The sixth character provides an information to identify the presence or absence of macular edema. The seventh character designates the laterality of the condition.

ICD-10-CM presumes a causal relationship between diabetes and cataracts. Diabetes and cataracts should be coded as related even when the provider is not specifically linking them, unless the documentation clearly states that the conditions are not related.

Diabetic neurological complications

Peripheral, cranial and autonomic neuropathy are chronic manifestations of diabetes mellitus. The subclassification for neurological complication is the following:

- E08-E13 with .40 unspecified diabetic neuropathy
- E08-E13 with .41 diabetic mononeuropathy
- E08-E13 with .42 diabetic polyneuropathy
- E08-E13 with .43 diabetic autonomic (poly)neuropathy
- E08-E13 with .44 diabetic amyotrophy
- E08-E13 with .49 other diabetic neurological complication[7]

Diabetic circulatory complications

- Diabetic peripheral vascular disease without gangrene is coded as E08-E13 with .51.
- Diabetic peripheral vascular disease with gangrene is coded as E08-E13 with .52.
- Diabetes with other circulatory complications is coded to E08-E13 with .59.

Other manifestations of diabetes mellitus

Common chronic complications of diabetes, besides renal, ophthalmic, neurological or circulatory, are classified to E08-E13 with the following:

- E08-E13 with .61 diabetic arthropathy
- E08-E13 with .62 diabetic skin complications
- E08-E13 with .63 diabetic oral complications[7]

Diabetes and skin ulcers
When a patient has diabetes with skin ulcer, the ICD-10-CM classification presumes a causal relationship between the conditions unless the documentation clearly states that the two conditions are not related.

The code for the diabetic foot ulcer complication (E08-E13 with .621) is assigned first with an additional code of L97.4-, L97.5- indicating the specific site of the ulcer. If gangrene is present, code E08-E13 with .52 should be assigned as an additional code. Other diabetic skin ulcers are coded to E08-E13 with .622 and an additional code to identify the site of the ulcer (L97.1-L97.9, L98.41-L98.49).

Complications due to insulin pump malfunction
Failure or malfunction of the pump may result in underdosing or overdosing of insulin. Both of these situations are mechanical complications and are assigned a code from subcategory T85.6 mechanical complication of other specified internal and external prosthetic devices, implants and grafts. The appropriate T85.6- code is selected depending on the type of malfunction as the following:

- T85.614 Breakdown (mechanical) of insulin pump
- T85.624 Displacement of insulin pump
- T85.633 Leakage of insulin pump[7]

In addition, codes are assigned to specify underdose (T38.3x6-) or overdose (T38.3x1-) as well as the code for the type of diabetes mellitus and any associated complications.

Uncontrolled Diabetes
There is no default code for uncontrolled diabetes in ICD-10-CM. Uncontrolled diabetes is classified by type and whether it is hyperglycemia or hypoglycemia.

Type 2 diabetic ketoacidosis
Codes E11.10 type 2 diabetes mellitus with ketoacidosis without coma and E11.11 type 2 diabetes mellitus with ketoacidosis with coma were created to identify ketoacidosis in patients with type 2 diabetes.

Diabetes complicating pregnancy
Diabetes mellitus complicating pregnancy, delivery or the puerperium is classified in chapter 15 of ICD-10-CM. Pregnant women who have diabetes mellitus should first be assigned a code from category O24 diabetes mellitus in pregnancy, childbirth and puerperium followed by an appropriate diabetes code(s) (E08-E13) from chapter 4 of ICD-10-CM to indicate the type of diabetes.

Gestational diabetes
Subcategory O24.4 gestational diabetes is assigned for this condition. No other code from category O24 should be assigned with a code from category O24.4.

Subcategory O24.4 is subdivided whether the gestational diabetes is controlled by diet, insulin or oral hypoglycemic drugs and whether it occurs in pregnancy, childbirth or the puerperium.

An abnormal glucose tolerance in pregnancy, without a diagnosis of gestational diabetes, is assigned a code from subcategory O99.81 abnormal glucose complicating pregnancy, childbirth and the puerperium.[7]

1 *Diabetes Report Card*. CDC. https://www.cdc.gov/diabetes/library/reports/reportcard.html
2 *Diabetes: What is it?* https://www.cdc.gov/diabetes/diabetesatwork/pdfs/DiabetesWhatIsIt.pdf
3 *What increases my risk of diabetes?* https://www.webmd.com/diabetes/guide/risk-factors-for-diabetes#1
4 *Diabetes: Diagnosis and treatment*. https://www.mayoclinic.org/diseases-conditions/diabetes/diagnosis-treatment/drc-20371451
5 *HEDIS Benchmarks and Coding Guidelines for Quality Care*. Developed by Amerigroup Community Care.
6 Leon-Chisen N. (2017). ICD-10-CM and ICD-10-PCS Coding Handbook 2018. American Hospital Association: Chicago, IL
7 *ICD-10-CM Expert for Physicians: the complete official code set*. (2018). Optum 360.

TN-NB-0094-18

Amerivantage:

Prior authorization for genetic testing for Medicare Advantage members effective February 1, 2019

Effective with dates of service on or after Feb. 1, 2019, Amerigroup Community Care will transition the medical necessity review of all genetic testing services for individual Medicare Advantage members to AIM Specialty Health® (AIM). Additionally, this review will now take place as a **prior authorization**.

Beginning Feb. 1, please submit genetic testing prior authorization requests to AIM through one of the following ways:

- Access AIM ***Provider****Portal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at https://www.availity.com.
- Call the AIM Contact Center toll-free number at 800-714-0040, Monday-Friday, 7 a.m.-7p.m. CT.

SSO-NL-0055-18 73404TNPENAGP 08/10/2018

Transportation and Translation services:

Helping members get no-cost rides to their appointments

We understand that transportation can often be a huge hurdle for members getting the care they need. That's why Amerigroup Community Care has developed a handy brochure that explains how members can get easy access to transportation services.

TN-NB-0106-18

Amerigroup
An Anthem Company

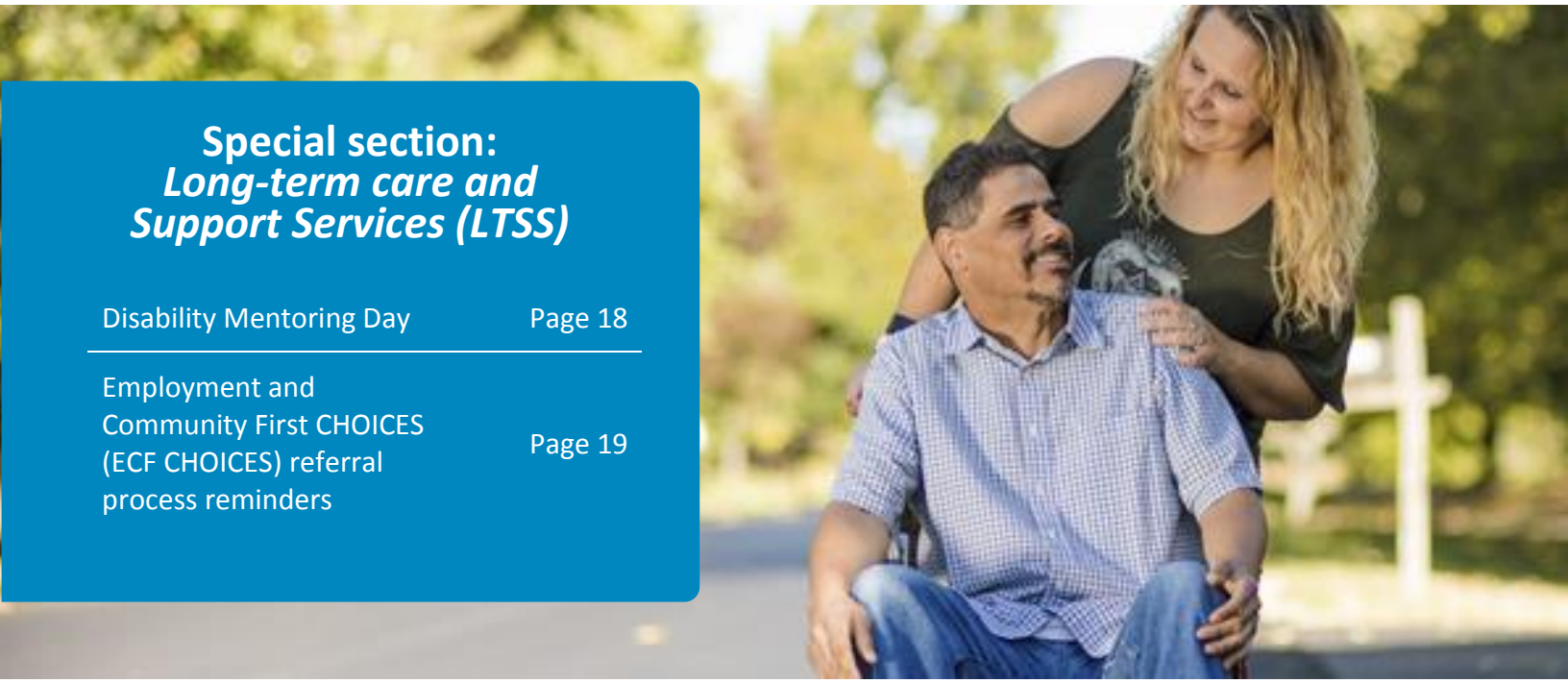
https://providers.amerigroup.com

Translator Request Form

Fax to: 1-888-642-4011

Member TennCare ID:	
Member last name, first name:	
Appointment date:	
Appointment time:	
Appointment location:	
Physician name:	
Vendor name:	
Language requested:	
Date of request:	
Requester name:	
Requester phone number:	

TN-NB-0105-18



Special section: *Long-term care and Support Services (LTSS)*

Disability Mentoring Day

Amerigroup Community Care was pleased to be a host for Disability Mentoring Day (DMD) in October 2018. As part of October's celebration of disability employment awareness month, DMD is a national movement designed to bring individuals with disabilities into the workplace where they learn about various career opportunities within a host site. The theme for DMD 2018 was *America's Workforce: Empowering All*. Amerigroup hosted 14 individuals for DMD this year; we were pleased to host nine mentees in the Nashville office and five in the West office, with plans to expand to the East region next year.

DMD provides valuable opportunities for career exploration, and we feel our DMD activities this year were a great success based on the feedback we received from our mentors and mentees. Additionally, we have had two individuals who participated this year apply for positons with Amerigroup in our National Call Center in the Nashville office.

This year's DMD activities included an overview of the company, the types of employment opportunities that are available at Amerigroup, an employability skills workshop, some one-on-one time with a mentor in their area of interest, as well as information about possible internships such as Project SEARCH! Many thanks to the associates who volunteered to mentor this year. We had associates from several departments including Long-Term Services and Supports (LTSS), Provider Relations, Compliance, Health Care Management Services — Case

Management (HCMS-CM), Credentialing, HCMS-CHOICES, Medical Management, and Behavioral Health.

Please contact Tina Jones at 865-214-0765 or Tina.Jones3@amerigroup.com for additional information.



TN-NB-0113-18

Employment and Community First CHOICES (ECF CHOICES) referral process reminders

ECF CHOICES referrals from Amerigroup Community Care:

- Come in a secure format from tnecfreferrals@anthem.com.
- Contain secure message access, which expires 72 hours after reception if the secure message is not successfully accessed.
- Contain a PDF attachment that includes the services being referred and detailed information about the person including contact information for meet-and-greets, preferences, identified risks, etc.
- Contain the email and phone number of the person's assigned support coordinator.
- Are sent to the designated referral email address of assigned Provider Relations representative the provider has indicated.

If there are issues opening the secure email, please reach out to the help desk at **1-888-268-4361** to work through accessing the message.

Expectations:

- Providers should respond with their acceptance or rejection of each ECF CHOICES service indicated in the PDF attachment within 48 business hours of receipt and ensure tnecfreferrals@anthem.com is included as a recipient on the response email.
    - If **accepted**, please indicate your current staffing situation:
        - Staff trained and ready to perform the service(s) — indicates you have trained staff with capacity to begin services immediately
        - Staff in training nearing completion to provide service(s) — indicates you have staff hired, but they are going through training and will take some time before they are ready to serve

        - No staff trained and would need to hire staff to provide service(s) — indicates you need to hire and train staff to provide services
    - If **rejected**, please tell us why you are rejecting the referral (e.g., no staff, distance too far, risks too great, etc.).
    - If **additional information** is needed, please indicate what that information is and ensure the assigned support coordinator is included as a recipient on your response email.
- Providers are not expected to communicate their acceptance/rejection for services they are not contracted to provide.
- Providers are not expected to have to accept all service needs in a PDF referral but should respond with their acceptance rejection of each identified service need based on capacity.
    - Due to continuity of care, providers who can deliver multiple service needs will more than likely receive first preference from the person served.
- Providers should let the assigned support coordinator know when a meet-and-greet is scheduled with a person.
- Providers can and should reach out to the indicated support coordinator if challenges arise in scheduling a meet-and-greet and/or contacting the person.

General rules

Authorizations to a provider will not be granted unless:

- A meet-and-greet has taken place between the provider and person.
- The provider agrees to provide the service to the person.
- The person chooses the provider for their service.
- Staffing has been worked out, and expectations are set between the person and provider regarding a start date for the service:
    - This includes setting realistic time frames for having staff hired and trained to perform the service.

ECF CHOICES organizational updates

The ECF CHOICES team would like to share some organizational updates:

- Hollie Campbell has assumed the role of ECF CHOICES director for Amerigroup. Hollie has worked in the field supporting individuals with intellectual/developmental disabilities (IDD) for 23 years and began with Amerigroup prior to the launch of ECF CHOICES. She can be reached at Hollie.Campbell@amerigroup.com or at 615-882-8213.
- We would also like to introduce you to the support coordination management team that manages the support coordinators throughout the state of Tennessee. Please feel free to contact them with any questions or concerns:
    - Kathryn Kranitzky is the support coordination manager for the East region and can be reached at 615-417-7082 or Kathryn.Kranitzky@amerigroup.com.
    - Allison Cumming is the support coordination manager for the Middle region and can be reached at 615-306-9712 or Allison.Cumming@amerigroup.com.
    - Raven Oliver is the support coordinator for the West region and can be reached at 901-623-4517 or Raven.Oliver@amerigroup.com.