Provider NewsBlast

Amerigroup
An Anthem Company

https://providers.amerigroup.com/TN

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Medicaid:

What Matters Most: Improving the Patient Experience

Are you looking for innovative ways to improve your patients' experiences and earn continuing medical education credits?
Numerous studies have shown that a patient's primary health care experience and, to some extent, their health care outcomes are largely dependent upon health care provider and patient interactions. Amerigroup Community Care offers a new online learning course, *What Matters Most: Improving the Patient Experience,* to offer approaches to communication with patients. This curriculum is available at no cost to providers and their clinical staff nationwide and is acceptable for up to one prescribed continuing medical education credit by the American Academy of Family Physicians.

Through the use of compelling real-life stories that convey practical strategies for implementing patient care, providers learn how to apply best practices.

Did you know?
Substantial evidence points to a positive association between patient experience and health outcomes.

- Patients with chronic conditions, such as diabetes, demonstrate greater self-management skills and quality of life when they report positive interactions with their health care providers.
- Patients reporting the poorest-quality relationships with their physicians were three times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships.

How will this benefit you and your office staff?
You'll learn tips and techniques to:

- Improve communication skills.
- Build patient trust and commitment.
- Expand your knowledge of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

The course can be accessed at www.patientexptraining.com using your smartphone, tablet or computer, or use the QRC code below.

Like you, Amerigroup is committed to improving the patient experience in all interactions, and we are proud to work collaboratively with our provider network to provide support and tools to reach our goal.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

TN-NB-0022-18

Online registration processes for electronic remittance advices and electronic funds transfers

No action is required for providers already registered for electronic funds transfers (EFTs) and electronic remittance advices (ERAs). The information in this communication is applicable to both Medicaid and Medicare programs.

Effective September 1, 2018, our provider disbursement processes are changing. These changes include the following:

- New EFT enrollment: Go to EnrollHub™, a Council for Affordable Quality Healthcare (CAQH) Solutions™ enrollment tool.
- New ERA-only enrollment and change management for existing ERA-only enrollments: These will be managed through Availity. Go to https://www.availity.com and select **Enrollments Center** in the *My Account Dashboard* on the home page. Select **ERA Enrollment** in the *Multi-Payer Enrollments* section. Then, simply follow the wizard and submit. After submitting, you will be notified by email that enrollment is complete and start receiving *835s* through Availity.
- Change Healthcare and PaySpan will no longer be used for EFT/ERA enrollment.
- Providers now have access to *Explanation of Payment* letters through our secure self-service provider website.
- Medicaid and Medicare remittance advices have been consolidated.

These enhancements offer providers streamlined reimbursement registration tools.

The following chart summarizes information about the new processes to enroll in EFT or ERA or to update EFT and ERA transaction information after September 1, 2018.

Process to enroll or update electronic transactions after September 1, 2018		
Type of transaction	**How to enroll, update, change or cancel**	**Contact to resolve issues**
EFT only	Use the CAQH EFT EnrollHub tool available at http://www.caqh.org/solutions/enrollhub.	CAQH Provider Help Desk 1-844-815-9763
ERA only	Register for ERAs at https://www.availity.com.	Availity 1-800-282-4548

Is registration required?
Providers are not obligated to register for either EFT or ERA and will continue to receive a paper check and remittance advice.

Is there a cost to providers for the changes to the EFT and ERA?
There is no cost to providers from Amerigroup Community Care. Providers should inquire with trading partners and other vendors they work with to understand additional steps or any changes to services.

Information and changes to expect
Medicaid and Medicare claim payments and recoveries with claim adjudication beginning September 1, 2018, will be incorporated into one remittance advice for paper or electronic

payments. Checks and EFTs from Amerigroup will also be combined. Medicaid and Medicare will be grouped separately on the paper remittance in a section for each product line:

- The back of the remittance advice will contain specific instructions on how to file Medicare appeals.
- Medicaid and Medicare claims are identified in the Claim Filing Indicator Code (CLP06 segment) on the *ERA/835* for Medicaid with **MC** and Medicare with **MB**, **MA** or **16**.
- Effective September 1, 2018, we will discontinue the email notification providers currently receive when an EFT and ERA is issued.
- The PDF versions of paper remittances are available on the provider self-service website. Both provider and clearinghouse *835s* continue to be received through the EDI process.
- More information about retrieving copies of remittance advices is available online. To access our tutorial, *Remittance Inquiry Process Guide*, go to our provider website and select the **Tutorials** drop-down menu under *Provider Documents & Resources*.
- Starting in 2018, more claim payments and remittance advices issued by Amerigroup will be made on a **weekly basis** to providers. Additionally, non-Federal Employee Program payments under $5 will be held for a maximum of 14 days to allow additional claims to combine to increase the overall payment amount.
- This change will ensure efficiency and consistency between professional and facility claim payments.
- If you are a provider who receives paper claim checks or EFT payments from Amerigroup on a daily basis, you will be able to schedule posting on a weekly cycle after this change.
- The Automated Clearing House batch header is changing. The payee name that appears on the EFT statement is changing and will be easily identifiable. This change does not impact payment to you in any way. You will now see **Amerigroup TN5C**.

How do I access historical ERAs from Change Healthcare and PaySpan?

We are in the process of migrating all historical remittance advices to our self-service provider website. We will notify you when the migration is complete. Please continue to use Change Healthcare and PaySpan until that time.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at the toll-free phone numbers listed below:

- Medicaid providers call 1-800-454-3730.
- Medicare providers call 1-866-805-4589.

TN-NB-0029-18

Services requiring prior authorization

All programs require prior authorization (PA) for all covered specialty medications, where allowable by state. The scope of this notice will include both professional and facility requests for Medicaid business.

Specialty medications that are reported with not otherwise classified (NOC) designation codes and C codes may also require PA before services are provided.

Regardless of whether PA is required, all services must be medically necessary to be covered. Even if PA is not required, to avoid a claim denial based on medical necessity, Amerigroup Community Care encourages providers to review our medical necessity criteria prior to rendering nonemergent services. Medical necessity criteria can be accessed by visiting https://providers.amerigroup.com/TN to view the most current *Medical Policies* and *Clinical Utilization Management Guidelines*.

If no specific policy is available, the medical necessity review of a drug may be conducted using *Medical Policy ADMIN.00006: Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy* or *Clinical Utilization Management Guideline* and/or *Clinical Utilization Management Guideline CG-DRUG-01: Off-Label Drug and Approved Orphan Drug Use*.

Clinical review of specialty medications is in addition to services currently requiring PA. Providers are responsible for verifying eligibility and benefits for Amerigroup members before providing services. We recommend providers visit https://providers.amerigroup.com/TN to review the list of services and service categories currently requiring PA, with a reminder that the list of services requiring PA will be updated as needed. For clarification regarding whether a specific code or service requires PA, call the number listed below. Except in an emergency, failure to obtain PA may result in denial of reimbursement.

Again, please be reminded that the list of services requiring PA will be updated as needed.

Requesting PA

To request PA, report a medical admission or for questions regarding PA, providers may use one of the following methods:

- Web: https://www.availity.com
- Fax: 1-800-964-3627
- Phone: 1-800-454-3730

Providers are strongly encouraged to revisit the *Government Business Division Reimbursement Policy Unlisted or Miscellaneous Codes* policy, which states NOC codes must be submitted with the correct national drug code (NDC) for proper claim payment. If the required NDC data elements are missing or invalid for the procedure code on a claim line, the claim will be denied.

Prior authorization requirements for Darzalex (daratumumab)

Effective August 1, 2018, prior authorization (PA) requirements will change for the injectable drug Darzalex (daratumumab) for Medicaid members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines (including definitions and specific contract provisions/exclusions) take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to:

- J9145 — injection, Darzalex (daratumumab), 10 mg

To request PA, you may use one of the following methods:

- Interactive Care Reviewer: https://www.availity.com
- Fax: 1-800-964-3627
- Phone: 1-800-454-3730

Not all PA requirements are listed here. PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at https://providers.amerigroup.com > **Login**. Contracted and noncontracted providers may also call Provider Services at 1-800-454-3730 for assistance with PA requirements.

TN-NB-0017-18

Miscellaneous durable medical equipment billing guidelines

Reminder: Miscellaneous durable medical equipment (DME) procedure codes (such as E1399) cannot be used as an alternative to specific identified codes. Amerigroup Community Care conducts postpayment reviews to ensure the right codes for the right services are used. This applies to all claims for TennCare and Amerigroup Amerivantage (Medicare Advantage) members.

In an effort to improve the provider experience, we continually evaluate coding and billing patterns. Recently, we identified trends related to the use of E1399 — DME, miscellaneous. This code is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.

We continue to require prior authorization for the use of miscellaneous code E1399. To request PA, you may use one of the following methods:

- Web: https://www.availity.com
- Fax: 1-800-964-3627
- Phone: 1-800-454-3730

As it is not our policy to inform providers of proper billing processes within prior authorization responses, authorization responses do not include code-specific details. If your service was

approved but your claim was denied payment when billed using E1399, the incorrect code was used. You will need to update the authorization and the claim with the appropriate *HIPAA*-compliant HCPCS code.

Amerigroup will conduct postpayment reviews of code E1399 to ensure proper use. If it is determined a more appropriate code should have been used, we will notify you in writing and advise you of your appeal rights.

You can find additional information related to miscellaneous codes in the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Coding > Unlisted, Unspecified or Miscellaneous Codes.

TN-NB-0019-18

Provider Refund Notification Form

The *Provider Refund Notification Form* is located on our provider website available at https://providers.amerigroup.com/ProviderDocuments/TNTN_RefundNotificationForm.pdf. This new form should be utilized for future unsolicited provider refunds.

If you have additional questions or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-434-3730.

TN-N-0032-18

Provider surveys

Each year we reach out to you to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers.

Thank you for participating in our network, for providing quality health care to our members and for your timely completion of any surveys you receive.

TN-NL-0141-17

Use Availity to update your information

We continually update our provider directories to ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice — including updating your address and/or phone number, adding or deleting a physician from your practice, closing your practice to new patients, etc. — please notify us by updating your information in Availity via https://www.availity.com. Thank you for your help and continued efforts in keeping our records up to date.

TN-NL-0141-17

Complex Case Management program

Managing illness can be a daunting task for our members. It is not always easy to understand test results or know how to obtain essential resources for treatment or who to contact with questions and concerns.

Amerigroup Community Care is available to offer assistance in these difficult moments with our Complex Care Management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals there to support members, families, primary care physicians and caregivers. The Complex Care Management process utilizes the experience and expertise of the Care Coordination team to educate and empower our members by increasing self-management skills. The Complex Care Management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Customer Service number located on their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can contact us by email at hcmref@anthem.com or by phone at 1-800-454-3730. Case Management business hours are Monday-Friday from 8 a.m.-5 p.m. Central time.

TN-NL-0141-17

Makena®

Effective January 1, 2018, Makena (codes J1726 and J1729) will no longer require prior authorization. Makena is covered under the medical benefit only. In order to receive timely medication, please submit Makena order forms to Caremark Medical Specialty (Monroeville, PA), Entrust Rx or proceed using the "buy and bill" process.

Specialty pharmacy contact information

Caremark Medical Specialty, Monroeville, PA:

- NPI: 1043382302
- Fax: 1-866-336-8479
- Phone: 1-877-254-0015

Entrust Rx:

- Fax: 1-855-273-3925
- Phone: 1-855-273-3924

TN-NB-0018-18

Lower extremity vascular intervention codes require prior authorization

Effective July 1, 2018, lower extremity vascular intervention codes will require prior authorization (PA) from Amerigroup Community Care. Federal and state law, as well as state contract language including definitions, and specific contract provisions and exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with these requirements may result in denied claims.**

PA requirements will be added to the following codes:

- **37220** — revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- **37221** — revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- **37224** — revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty
- **37225** — revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed
- **37226** — revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- **37227** — revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
- **37228** — revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty
- **37229** — revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed
- **37230** — revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- **37231** — revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

Please use one of the following methods to request PA:

- **Web:** https://www.availity.com
- **Fax:** 1-800-964-3627
- **Phone:** 1-800-454-3730

Please refer to the Precertification Lookup Tool for detailed PA requirements by visiting https://providers.amerigroup.com/TN, choosing **Quick Tools** from the *Provider Resources & Documents* menu, and then selecting **Precertification Lookup Tool**.

TN-NB-0008-18

Coding Spotlight — Pregnancy
A provider's guide to diagnose and code for pregnancy

Pregnancy demonstrates a woman's amazing creative and nurturing powers while providing for the future. Early and regular prenatal care is vital to the health of the baby and the mother.

Pregnancy facts

- In 2016, 7.2 percent of women who gave birth smoked cigarettes during pregnancy. Prevalence of smoking during pregnancy was highest for women aged 20-24 (10.7 percent), followed by women aged 15-19 (8.5 percent) and 25-29 (8.2 percent).[1]
- Hypertensive disorders affect up to 10 percent of pregnancies in the United States.[2]
- Ectopic pregnancy affects 1-2 percent of all pregnancies and is responsible for 9 percent of pregnancy-related deaths in the United States.[3]

Risk factors

- **Existing health conditions:** Pregnant women with high blood pressure, diabetes or who are HIV-positive may experience a complicated pregnancy.[4]
- **Overweight and obesity:** According to the American College of Obstetricians and Gynecologists (ACOG), more than 50 percent of pregnant women in the United States are overweight or obese.[5] Being obese raises the risk for cardiac problems, sleep apnea, pre-eclampsia, gestational diabetes and venous thromboembolism (VTE).[5]
- **Multiple births:** Women with more than one fetus face a higher risk of complications. Typical issues include pre-eclampsia, premature labor and preterm birth.[4]
- **Young or old maternal age:** The age of the mother is one of the common factors. Those who are in their teens or age 35 or over have a higher risk for pre-eclampsia and gestational high blood pressure.[4]
- **Previous fetal loss:** Previous fetal death poses a risk for subsequent pregnancy.[4]
- **History of complications with previous pregnancies:** Complications experienced during a previous pregnancy are more likely to recur.[4]

HEDIS® quality measures for prenatal and postpartum care

Prenatal and postpartum care is a measure that focuses on women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year.[6]

Timeliness of prenatal care: the percentage of deliveries that received a prenatal care visit as a member in the first trimester on the enrollment start date or within 42 days of enrollment as a member[6]

Documentation of when prenatal care was initiated or the date of the member's first prenatal visit should be reflected in the medical record documentation. Evidence of at least one of the following needs to be documented:[6]

- A basic physical obstetrical exam (auscultation for fetal heart tone, pelvic exam with obstetric observations, measurement of fundus height)

- Prenatal care visits with screening test/obstetric panel, TORCH antibody panel alone, a rubella antibody test/titer with an Rh incompatibility blood typing, ultrasound/echography of a pregnant uterus
- Last menstrual period or estimated due date with either prenatal risk assessment and counseling/education or complete obstetrical history[6]

Postpartum care: a percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery[6]

Documentation must indicate visit date and evidence one of the following:

- Pelvic exam
- Evaluation of weight, blood pressure, breasts and abdomen (Notation of breastfeeding is acceptable for the evaluation of breasts component.)
- Notation of postpartum care (e.g., six-week check, postpartum care, PP care, PP check)[6]

Tips for providers

- The ACOG recommends a minimum of 14 prenatal visits for a 40-week pregnancy. To ensure regular care, members need to get reminders to schedule all required visits, including:
    - One visit every four weeks until 28 weeks' gestation (at least six visits)
    - One visit every two weeks until 36 weeks' gestation (at least four visits)
    - One visit every week after 36 weeks until delivery (at least four visits)[6]
- If the patient comes in one or two weeks after delivery for an incision check, the patient needs to be educated on the importance of coming back for a visit 21-56 days after discharge from the hospital. The visit needs to be scheduled, and the purpose should be explained.
- A follow-up cesarean section postoperative visit 1-2 weeks after delivery does not count as a postpartum visit.[6]
- Patients should get phone calls about scheduling the postpartum visit and should also get reminders about the date and time of the appointment.
- Appointments that were missed need to be rescheduled.
- All services should be documented using the ACOG forms.[6]

ICD-10-CM: general coding and documentation

- Conditions that affect the management of pregnancy, childbirth and the puerperium are classified in categories O00 through O9A in Chapter 15 of the ICD-10-CM.
- If the pregnancy is incidental to an encounter for a different reason, code Z33.1 (pregnant state, incidental) is assigned in place of any Chapter 15 codes.
- When treating the pregnant member, the codes in Chapter 15 of the ICD-10 codes set are applied before codes from other chapters. However, codes from other chapters may be used to report additional conditions when needed to provide more specificity.
- Codes from Chapter 15 refer to the mother only and are assigned only on the mother's record. They are never assigned on the newborn's record.[7]

Final character for trimester

- The majority of codes in Chapter 15 of ICD-10-CM have a final character indicating the trimester of pregnancy. It is the provider's responsibility to document the number of weeks of gestation and/or trimester in the medical record. The time frames for the trimesters are indicated at the beginning of Chapter 15 and are defined by ICD-10 as follows:

Trimester	Length in weeks
First trimester	less than 14 weeks, 0 days
Second trimester	14 weeks, 0 days less than 28 weeks, 0 days
Third trimester	28 weeks, 0 days until delivery

- Assignment of the final character for trimester is based on the provider's documentation for the current encounter (number of weeks or trimester). Not every single code in Chapter 15 has a trimester component. If trimester is not a component of a code, it is because the condition always occurs in a specific trimester or the concept of trimester of pregnancy is not applicable.[8]

Seventh character

Many codes in Chapter 15 of ICD-10-CM require a seventh character. If the pregnancy is a single gestation, the seventh character *0* is reported. However, when there is more than one fetus, the documentation needs to indicate which specific fetus is having a problem. For example:

- O41.03x4 — Oligohydramnios, third trimester, fetus 4[8]

Normal pregnancy

When coding routine visits for the pregnant member who has no complications, Z codes are assigned from Chapter 21 of ICD-10-CM. These codes are only chosen when a healthy, pregnant woman has neither a current illness nor a current injury. For example:

- Z34.01 — encounter for supervision of normal first pregnancy, first trimester
- Z34.82 — encounter for supervision of other normal pregnancy, second trimester[8]

Supervision of high-risk pregnancy

Codes from category O09 (supervision of high-risk pregnancy) are intended for use only during the prenatal period.[8]

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09 (supervision of high-risk pregnancy) should be reported as the first listed diagnosis on the claim.

ICD-10-CM provides codes for the supervision of the following types of high-risk pregnancies:

ICD-10 code categories	Code descriptions
O09.00-O09.03	Pregnancy with history of infertility
O09.10-O09.13	Pregnancy with history of ectopic pregnancy
O09.A0-O09.A3	Pregnancy with history of molar pregnancy
O09.211-O09.299	Pregnancy with other poor reproductive or obstetric history
O09.30-O09.33	Pregnancy with insufficient antenatal care
O09.40-O09.43	Pregnancy with grand multiparity
O09.511-O09.529	Elderly primigravida and multigravida
O09.611-O09.629	Young primigravida and multigravida

ICD-10 code categories	Code descriptions
O09.70-O09.73	High-risk pregnancy due to social problems
O09.811-O09.899	Other high-risk pregnancies (includes pregnancy resulting from assisted reproductive technology O09.81- and pregnancy with history of in utero procedure during previous pregnancy O09.82-)

Fetal conditions affecting management of pregnancy

Codes from categories O35 (maternal care for known or suspected fetal abnormality and damage) and O36 (maternal care for other fetal problems) are assigned only when the fetal condition is actually responsible for modifying the mother's care. These codes are used when the listed condition in the fetus is the reason for hospitalization or other obstetric care to the mother or for termination of pregnancy.[8]

Other conditions complicating pregnancy, childbirth or the puerperium

Certain categories in Chapter 15 of the ICD-10-CM distinguish between conditions of the mother that existed prior to pregnancy and those that are a direct result of pregnancy:

- Conditions such as edema; proteinuria; and hypertensive disorders in pregnancy, childbirth and the puerperium are classified in categories O10-O16.
- Other maternal disorders, such as hemorrhage, hyperemesis gravidarum, venous complications, genitourinary infections, diabetes mellitus, malnutrition and liver disorders are classified in categories O20-O29.
- Certain infectious diseases such as HIV disease, viral hepatitis, viral diseases (Zika infection), tuberculosis and venereal disease are classified in category O98.[8]

Hypertension

Pre-existing hypertension is classified in category O10 as follows:

ICD-10 codes	Conditions
O10.01-O10.03	Pre-existing essential hypertension
O10.111-O10.13	Pre-existing hypertensive heart disease
O10.211-O10.23	Pre-existing hypertensive chronic kidney disease
O10.311-O10.33	Pre-existing hypertensive heart and chronic kidney disease
O10.411-O10.43	Pre-existing secondary hypertension
O10.911–O10.93	Unspecified pre-existing hypertension

When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of hypertensive heart disease (category I11), heart failure (category I50), chronic kidney disease (category I12), or hypertensive heart and chronic kidney disease (category I13).[7]

Gestational or pregnancy-induced hypertension is coded to category O13 (gestational pregnancy-induced hypertension without significant proteinuria).

Diabetes

Category O24 distinguishes between pre-existing diabetes mellitus (type 1, type 2, other, unspecified), gestational diabetes and unspecified diabetes as follows:

ICD-10 codes	Conditions
O24.011-O24.03	Pre-existing type 1 diabetes mellitus
O24.111-O24.13	Pre-existing type 2 diabetes mellitus
O24.311-O24.319	Unspecified pre-existing diabetes mellitus
O24.410-O24.439	Gestational diabetes mellitus
O24.811-O24.83	Other pre-existing diabetes mellitus
O24.911-O24.93	Unspecified diabetes mellitus

Codes for gestational diabetes are in subcategory O24.4 (gestational diabetes mellitus). No other code from category O24 (diabetes mellitus in pregnancy, childbirth and the puerperium) should be used with the code from O24.4.[7]

Code Z79.4 (long-term current use of insulin) should be assigned if the pre-existing or unspecified diabetes mellitus is being treated with insulin. Code Z79.84 (long-term current use of oral hypoglycemic drugs) should be assigned if the pre-existing or unspecified diabetes mellitus is being treated with oral hypoglycemic drugs. However, neither code Z79.4 nor code Z79.84 should be assigned with codes from subcategory O24.4 (gestational diabetes).[8]

HIV infection

During pregnancy, childbirth or the puerperium, a patient with HIV-related illness should receive a principal diagnosis from subcategory O98.7- (human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium) followed by the code(s) for the HIV-related illness(es). Patients with asymptomatic HIV infection status should receive codes O98.7- and Z21 (asymptomatic human immunodeficiency virus [HIV] infection status). For example:

- O98.711 + B20 + Z3A.00 — first trimester pregnant female with AIDS
- O98.713 + Z21 + Z3A.30 — 30-weeks pregnant female with complicating asymptomatic HIV status[8]

Alcohol and tobacco use

When the mother uses alcohol during the pregnancy or postpartum, codes from subcategory O99.31 (alcohol use complicating pregnancy, childbirth and the puerperium) should be assigned. A secondary code from category F10 (alcohol related disorders) should also be assigned to identify manifestations of the alcohol use.

Codes from subcategory O99.33 (tobacco use disorder complicating pregnancy, childbirth and the puerperium) should be assigned for a pregnancy case where a mother uses any type of tobacco product during the pregnancy or postpartum. A secondary code from category F17 (nicotine dependence) should also be assigned to identify the type of nicotine dependence.[8]

Other maternal diseases

ICD-10-CM provides category O99 to describe other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium:

ICD-10 codes	Conditions
O99.0-	Anemia complicating pregnancy, childbirth and the puerperium
O99.1-	Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy, childbirth and the puerperium
O99.2-	Endocrine, nutritional and metabolic diseases complicating pregnancy, childbirth and the puerperium
O99.3-	Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium
O99.4-	Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium
O99.5-	Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium
O99.6-	Diseases of the digestive system complicating pregnancy, childbirth and the puerperium
O99.7-	Diseases of the skin and subcutaneous tissue complicating pregnancy, childbirth and the puerperium
O99.8-	Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium

Malignant neoplasms complicating pregnancy, childbirth and the puerperium are classified to subcategory O9A.1, with additional code(s) to identify the specific neoplasm.

Normal delivery

Code O80 (encounter for full-term uncomplicated delivery) is used when the delivery is entirely normal with a single liveborn outcome; the completed weeks of gestation code is also assigned. There can be no postpartum complications. Code O80 cannot be used if any other code from Chapter 15 is needed to describe a current complication.[8]

Complications of labor and delivery

Complications of labor and delivery are classified to categories O60-O77.

- Category O60 (preterm labor) is defined in ICD-10-CM as the onset (spontaneous) of labor before 37 completed weeks of gestation. This category includes codes for cases with delivery as well as without delivery.
- Failed induction of labor is classified to category O61.
- Abnormalities of forces of labor are classified to category O62.
- For patients with long labor, ICD-10-CM provides category O63 codes.
- ICD-10-CM provides categories O64, O65 and O66 for obstructed labor due to different etiologies (due to malposition and malpresentation of fetus, due to maternal pelvic abnormality).
- ICD-10-CM also provides the following categories for labor and delivery caused by different conditions:

- O67.0-O67.9 — intrapartum hemorrhage
- O68 — abnormality of fetal acid-base balance
- O69.0-O69.9 — umbilical cord complications[8]

Fetal stress

ICD-10-CM provides different codes related to fetal problems complicating labor and delivery, such as the following:

- O68 (labor and delivery complicated by abnormality of fetal acid-base balance) — used to describe fetal academia, fetal alkalosis or fetal metabolic academia when these conditions complicate labor and delivery
- O76 (abnormality in fetal heart rate and rhythm complicating labor and delivery) — includes fetal problems such as bradycardia, heart rate decelerations, heart rate irregularity and tachycardia
- Category O77 (other fetal stress complicating labor and delivery)[8]

Routine postpartum care

Routine postpartum care, just like routine prenatal care, is reported with Z codes from Chapter 21 of ICD-10-CM. For example:

- Z39 — encounter for maternal postpartum care and examination
- Z39.0 — encounter for care and examination of mother immediately after delivery
- Z39.1 — encounter for care and examination of lactating mother
- Z39.2 — encounter for routine postpartum follow-up[7]

Sequelae of complication of pregnancy, childbirth or the puerperium

Code O94 (sequelae of complication of pregnancy, childbirth and the puerperium) is assigned when an initial complication of the obstetric experience develops a sequela that requires care or treatment of a later date. For example:

- A patient presents with fatigue and cold intolerance. Her history indicates that she had a severe hemorrhage during delivery of a normal liveborn seven months earlier. She was diagnosed with Sheehan's syndrome and treated with replacement hormones. Code E23.0 (hypopituitarism) is assigned for Sheehan's syndrome, followed by code O94 (sequelae of complication of pregnancy, childbirth and the puerperium).[8]

Abortive outcomes

Abortive outcome is classified by type in ICD-10-CM as follows:

- O03 — spontaneous abortion
- O04 — complications following (induced) termination of pregnancy
- O07 — failed attempted termination of pregnancy

Category Z3A codes (weeks of gestation) should not be assigned for pregnancies with abortive outcomes (O00-O08).[8]

Ectopic and molar pregnancies

Ectopic and molar pregnancies and other abnormal products of conception are classified to the following categories with an additional code from category O08 when any complication occurs:

- O00 — ectopic pregnancy
- O01 — hydatidiform mole
- O02 — other abnormal product of conception[8]

Patients with a history of an ectopic or molar pregnancy have an increased risk of having another tubal pregnancy. Assign code O09.1- for an encounter involving supervision of an obstetric patient with a previous history of ectopic pregnancy. Codes from subcategory O09.A are assigned during the prenatal period for pregnant women who are high risk because of a previous history of molar pregnancy.[8]

Resources

1 Cigarette Smoking During Pregnancy: United States, 2016. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db305.htm.

2 Hypertension in pregnancy. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Hypertension-in-Pregnancy.

3 Barash J.H., Buchanan E.M., Hillson C. Diagnosis and Management of Ectopic Pregnancy. Retrieved from https://www.aafp.org/afp/2014/0701/p34.html.

4 High-risk pregnancy – ICD-10 Coding Changes in 2017. *Medical Coding News* (April 27, 2017). Retrieved from http://www.outsourcestrategies.com/resources/high-risk-pregnancy-icd-10-coding-changes-2017.html.

5 Ob-Gyns Continue to Fight Obesity Epidemic, Promote Exercise during Pregnancy and the Postpartum Period. Retrieved from https://www.acog.org/About-ACOG/News-Room/News-Releases/2015/Ob-Gyns-Continue-to-Fight-Obesity-Epidemic.

6 Quality Reporting and Performance Measures. Amerigroup RealSolutions in healthcare. Retrieved from http://providers.amerigroup.com.

7 ICD-10-CM Expert for Physicians: the complete official code set. (2017). Optum 360, LLC.

8 Leon-Chisen N. (2017). ICD-10-CM and ICD-10-PCS Coding Handbook 2018. Chicago, IL: American Hospital Association.

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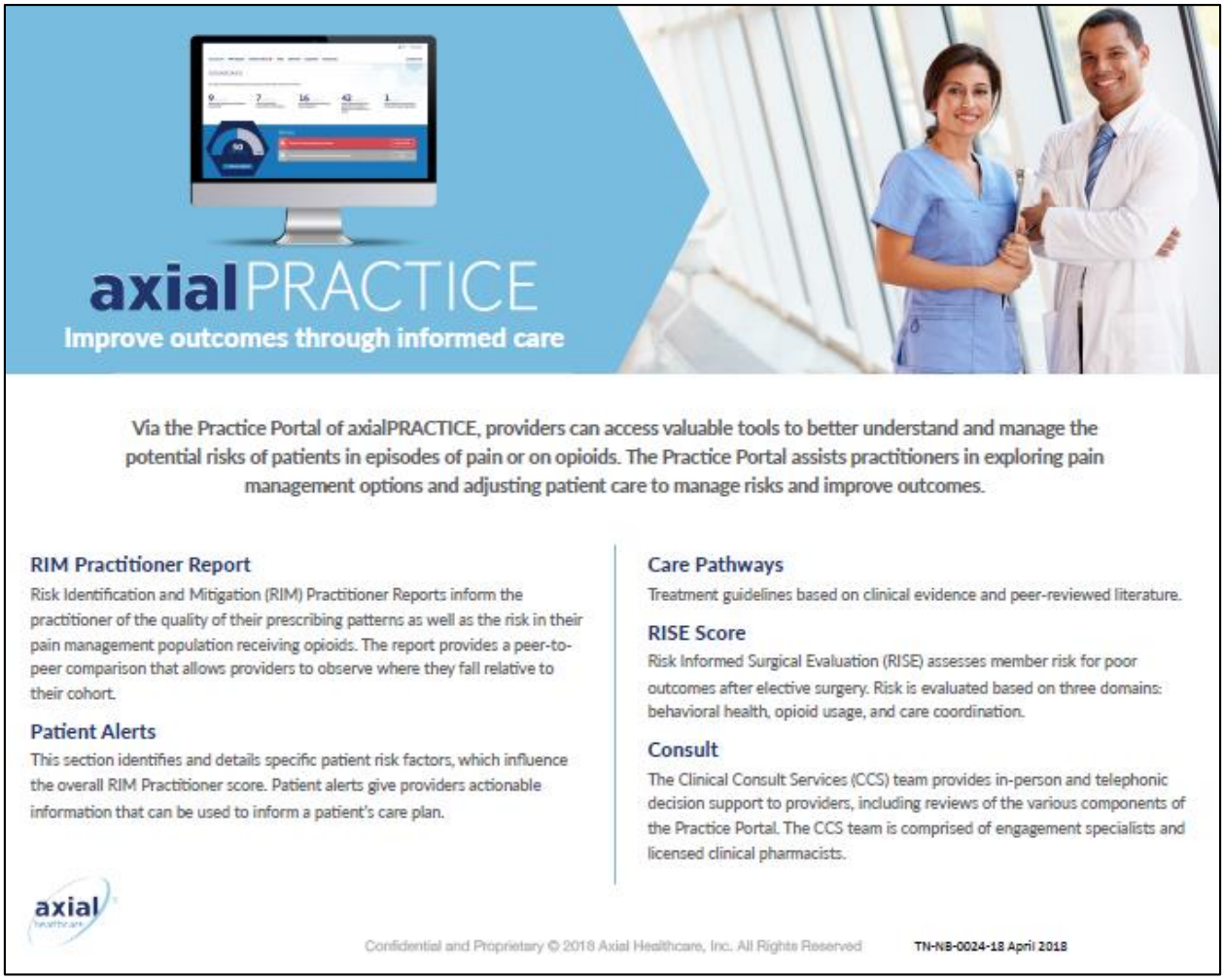

TN-NB-0024-18

Amerivantage:

Miscellaneous durable medical equipment billing guidelines

Please view the full article included in the Medicaid section.

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

Home modification provider update

In an effort to ensure minor home modifications are completed in a timely manner, meet standards set by the *Americans with Disabilities Act*, and comply with all local laws and building codes, Amerigroup Community Care is changing the process for bids submissions, tracking outstanding projects and documentation requirements for completed projects.

What this means for providers:

- The bidding process will no longer be handled by the Clinical Coordination team. This process will now be handled by our Operations Team (Ops). The Ops team will be your primary point of contact for questions or concerns.
- The *Minor Home Modification Bid Form* must be filled out in its entirety each time you submit a bid request. Include specifications for the projected work needed.
- After the bid has been awarded, you will receive follow-up from Ops at milestone dates to check on the status of project completion.
- A *Certification of Completion* and *Final Inspection Form* must be submitted upon completion of each job. Include contractor signature, homeowner or member signature, and pictures showing the details of work completed.
- If work has been completed according to the service order, authorization for job completion will be sent to you within 2-3 business days.

Key contact information
Amerigroup Operations Team
Phone: 1-866-840-4991
Fax: 1-888-762-3203
Email: LTCProvReq@amerigroup.com

TNPEC-2261-18

Home delivered meals provider update

Holiday/inclement weather/office closure meals
In an effort to ensure providers are able to bill in a timely manner for meals delivered due to holiday/inclement weather/office closures, an additional authorization with a U2 modifier has been created. This method will allow the provider to generate a schedule as needed for any unforeseen reason a meal would need to be delivered ahead of schedule, outside of a hot meal delivery.

What this means for providers:

- The process for requesting a cold meal authorization due to a holiday, inclement weather or an office closure will no longer need to be sent to the managed care organization.
- An authorization that spans the calendar year will be loaded into HealthStar for those individuals who receive hot meals. This authorization will include a U2 modifier with 24 visits when entered in the beginning of the year. Authorizations entered after the beginning of the year will include fewer visits.
- The authorization will be available within the member's record on your dashboard.
- The **Build HDM Schedule** option will allow you to create a schedule for the day the meal will be consumed by the individual. This date should reflect the consumption date, not the delivery date.
- A schedule will be created for the consumption date that was selected and will be reflected within the appointment dashboard. Once the visit has been confirmed, the appointment will be available to export on the dashboard and will follow the normal claims process, paying at the cold meal rate.

Please contact the electronic visit verification (EVV) or authorization team with any questions or concerns:

- Phone: 1-866-840-4991
- Fax: 1-888-762-3203
- Email: LTCProvReq@amerigroup.com
- EVV email: tn1ltcevvcs@amerigroup.com

TNPEC-2261-18

Electronic visit verification provider update: electronic acknowledgement and signature via DocuSign

To ensure a more streamlined and efficient acknowledgement and signing process, Amerigroup Community Care will begin sending the *Person-Centered Support Plans* (*PCSPs*) and other authorizations via DocuSign® effective January 31, 2018.

The *PCSP* will continue to be available in HealthStar for electronic acknowledgement and signature (electronic visit verification EVV) services. Non-EVV providers will be required to sign and acknowledge the *PSCP* via DocuSign. By using DocuSign, providers will be able to access current and historical authorizations and *PCSP* documentation. All providers will receive authorizations via DocuSign.

In order to use DocuSign, you must have an active email address with Amerigroup. You can validate your current email address with us by sending an email to ltcprovreq@amerigroup.com. As a best practice, Amerigroup recommends using a group email box so multiple users have access to the documents. Person-specific email is not recommended. All email validations must be completed by January 31, 2018.
Upon receiving your first DocuSign email, you will be prompted to set up an account with your signature. All signatures must contain the following information or they will be rejected:

- Name of person acknowledging the *PCSP*
- Title of person acknowledging the *PCSP*
    - Example: John Smith, intake coordinator

Your signature will be electronically returned to Amerigroup once you select the signature section of a *PCSP*/authorization.

If you have any questions or would like assistance using DocuSign, please let us know at ltcprovreq@amerigroup.com or call 1-866-840-4991.

TNPEC-2261-18

Electronic visit verification provider update: manual confirmations — reminder about timesheet requirements

All providers submitting manual confirmations in HealthStar for services that require timesheets must include the following information in order for a request to be reviewed:

- Name of the individual receiving services
- Signature of the individual or an authorized representative
- Time services were rendered/duration of care — a.m./p.m. designation should be included
- Date services were rendered
- Tasks performed
- Name of caregiver performing services
- Name and/or logo of provider submitting timesheet

Should you have questions regarding this requirement, please feel free to contact our team inbox at TN1LTCEVVCS@amerigroup.com.

TNPEC-2261-18

Electronic visit verification provider update: exporting *PCSP* from HealthStar

Did you know that you can now export the *Person-Centered Support Plan* (*PCSP*) from HealthStar? Effective April 2, 2018, providers will no longer be emailed copies of the *PCSP*.

TNPEC-2261-18

Community living supports provider updates

Effective March 9, 2018, there are four new community living supports (CLS) transitional services for Employment and Community First CHOICES.

1. **T2016 U7, UA (revenue code 960) = CLS Community Stabilization and Transition (CLS-CST) — period up to 90 days ($245/day)**
    - CLS-CST is for people who have been in highly structured (or supports-intensive) settings but do not have co-occurring serious mental health conditions and challenging behaviors that will require the integration of BH treatment services into the person's daily life. The purpose of this higher rate is to allow time for stabilization, assessment and planning, and transition to the appropriate ongoing level of CLS. This rate will be the same as the rate for Level 4 CLS — $245/day for a period of up to 90 days.
2. **T2016 U8, UA (revenue code 960) = CLS Behavioral Health Community Stabilization and Transition (CLS-BHCST) 2a — for no more than 90 days ($450/day)**
3. **T2016 U9, UA (revenue code 960) = CLS-BHCST 2b — for no more than 90 additional days ($395/day)**
    - CLS-BHCST are for people with co-occurring serious mental health conditions who require intensive integrated BH treatment services as part of the day-to-day provision of CLS. This rate will cover the provision of short-term intensive 24 hours a day, 7 days a week community-based behavioral-focused transition and stabilization services and supports to assist individuals aged 18 years and older with intellectual and/or developmental disabilities (I/DD) and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.
4. **T2016 U7, UB (revenue code 960) = CLS Emergency Placement Community Stabilization and Transition (CLS-EPCST) — authorized for 30 days and in exceptional circumstances an ability to request an additional 30 days maximum ($245/day)**
    - CLS-EPCST is for people who are referred by Adult Protective Services and need immediate housing supports because their home is uninhabitable or they have

been subject to abuse and neglect to the degree that their immediate safety, health and welfare is in jeopardy.

If you have additional questions, please reach out to your assigned long-term services and supports Provider Relations consultant.

TNPEC-2261-18

General CLS best practices/requirements

Community living supports (CLS) providers must:

- Be contracted with an MCO and licensed by the Department of Intellectual and Developmental Disabilities (DIDD) for service they are providing.
- Be contracted (not just licensed) with DIDD in order to administer medications in the CLS home.
    - The only exception to this is when a provider has an RN on staff to administer or delegate authority to administer medications.
- Maintain adequate administrative structure.
- Demonstrate financial solvency.
- Maintain an adequate number of trained staff.
- Comply with all background check requirements.
- Comply with all critical incident reporting.
- Cooperate with quality monitoring and oversight activities.
- Notify individuals in the home when permanent staff changes will be made and give them a voice in the decision.
- Ensure medications are administered by appropriately trained staff.
- Assist with community transportation to activities of choice. If local, non-medical transport is not available in the area, it is the provider's responsibility to provide for transportation of some kind (Uber, Access Ride, bus, personal staff vehicle, etc.).
- Assist the individual in scheduling medical appointments and obtaining medical services, including accompanying the individual to the medical appointment if the member wishes. The provider must provide transportation or assist in scheduling of nonemergency medical transportation through Tennessee carriers.
- Manage acute and chronic health conditions, including nursing oversight and monitoring, administration of meds, and skilled nursing services as needed for routine and ongoing health care tasks.

TNPEC-2261-18

Employment and Community First CHOICES (ECF CHOICES) employment webinars

In February 2018, Amerigroup Community Care began conducting bimonthly webinars/training on ECF CHOICES employment services.

These webinars are prerecorded and sent out to providers to view as their schedules allow. A live Q&A is held the week after the webinars are distributed so that providers have an opportunity to watch the webinar and ask any questions they may have regarding the specific topic covered in the webinar.

TNPEC-2261-18

TennCare CHOICES and Employment and Community First CHOICES provider focus groups

As part of an effort to better support our providers, long-term services and supports Provider Relations will be leading provider focus groups throughout 2018.

What is a provider focus group?
A provider focus group is where a select number of specific provider types are invited to participate in a brief training and discussion surrounding a specific service or topic. Subject matter experts from Amerigroup Community Care will be on-hand to conduct the training and lead the discussions surrounding the topics and services that will be covered.

The goal of the focus group is to better understand the questions and concerns of our provider network as well as what supports and training needs they may have.

TNPEC-2261-18

Employment and Community First CHOICES (ECF CHOICES) — employment success stories

Kelly (Andrea) (Middle)
Prior to her enrollment in ECF CHOICES, Andrea lived a very secluded and lonely life with her mother and only dreamt of a job, friends and a place of her own. She received Discovery services through Best Buddies, where they found out she had great organizational skills, artistic talent and a love for Predators hockey. She was able to secure a job at Health Stream, working in the Human Resources department organizing files. They noticed her creativity and now have her working on drawings for their newsletters. She also has a second job at Bridgestone Arena, working during the Predators games. She loves this side job because she gets to watch the games and meet other fans (and even mingle with some of the cheerleaders and players). She recently moved into an apartment and is learning independent living skills and how to use Uber to get to work and meet up with her friends. Her life has changed significantly for the better.

Joshua (East)
Josh moved to Tennessee from Florida. He moved to Anderson County and lives with his mother. He completed Discovery with Emory Valley, where his first work experience resulted in a job offer. The work was janitorial, and Josh did not want to work janitorial, but through the process of Discovery, he learned that he enjoyed working in the food industry. He works at The Soup Kitchen in Oak Ridge, and his job coach has completely faded out. He is well-liked by his co-workers and supervisors. He uses consumer-directed transportation (a taxi service) to and from work and is working to get his driver's license in May when he hits his two-year mark of being seizure-free. He intends to move out from his mother's home in May as well. He has received benefits counseling and is working between 20-25 hours a week.

TNPEC-2261-18

Workforce challenges

We recognize the challenge associated with workforce development and recruitment. We also recognize the effort taken on behalf of providers to acquire additional staff. Despite the efforts, there is still a need for additional supports. In response, we offer some best practices as follows:

- Recognize areas for improvement.
- Offer incentives.
- Ensure sufficient training.
- Be vocal with your local government.
- Advertise different; interview different; hire different.
- Be flexible.
- Analyze "What's working, and what's not working?"
- Be aware of where the needs are.
- Trend your staffing data (disability support providers and frontline supervisors). It will tell a story.
- Conduct satisfaction surveys.
- Share success stories.
- Change the culture.

TNPEC-2261-18

Spotlight on claims

Based on provider feedback (TennCare CHOICES, Employment and Community First CHOICES) from the *2017 Provider Satisfaction Survey*, Amerigroup Community Care is working to identify improvement opportunities to simplify the billing/claims process and to support the provider community in an effort to reduce the overall denial rate.

In response to your feedback, Amerigroup will distribute a follow-up Survey Monkey questionnaire. We ask that providers help us to examine our billing and claims tools as well as our software platforms (Availity, HealthStar, Amerigroup self-service site) from their perspective to provide a window to better understand their challenges as our valued providers.

Once the survey is ready, we will provide notification to the network to include instructions for accessing online.

By participating, you will be making an important contribution in helping Amerigroup to continually improve and to serve you better. As a network provider, your opinion is valued.

TNPEC-2261-18