Provider NewsBlast

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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:

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 whom to contact for 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 uses the experience and expertise of the care coordination team to educate and empower our members by increasing self-management skills. The 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 by phone 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-NB-0159-19

Important information about utilization management

Our utilization management (UM) decisions are based on established medical necessity criteria, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Our *Medical Policies* are available on our provider website.

You can request a copy of our UM criteria at no cost to you from Provider Services at 1-800-454-3730. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the number listed below. Providers can access UM criteria online.

We are staffed with clinical professionals who coordinate our members' care and are available 24 hours a day, 7 days a week to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests via the methods below:

- Fax: 1-800-964-3627
- Phone: 1-800-454-3730
- Availity Portal

Have questions about utilization decisions or the UM process?
Call our Clinical team at 1-800-454-3730 Monday-Friday from 8 a.m.-5 p.m. Central time.

TN-NB-0159-19

2019 Utilization Management Affirmative Statement concerning utilization management decisions

All associates who make utilization management decisions are required to adhere to the following principles:

- Utilization management decision making is based on established medical necessity criteria, as well as the member's coverage according to their health plan.
- We do not reward practitioners or other individuals for issuing coverage or care denials. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support benefit denials.
- We do not offer financial incentives to decision makers for utilization management determinations that encourage decisions resulting in underutilization or create barriers to care and service.

TN-NB-0152-19

Members' Rights and Responsibilities Statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to participating practitioners and members in our system, Amerigroup Community Care has adopted a *Members' Rights and Responsibilities Statement*, which is located within the provider manual.

If you would like a physical copy of the statement sent to you, call Provider Services at 1-800-454-3730.

TN-NB-0159-19

New solution couples snapshot of high-risk patient information with decision support

Amerigroup Community Care is introducing *Opioid Risk Reports* to educate providers about their Amerigroup patients who are prescribed opioids. In collaboration with axialHealthcare, a company providing safe and effective pain care to our members, Amerigroup is excited to work with providers to offer focused patient information and decision support. The *Opioid Risk Report* alerts providers to individual risk factors for poor outcomes in a concise format that prioritizes patient notifications based on risk, summarizes your patient's critical diagnoses and recent prescription information, and offers tailored clinical considerations and next steps.

Receiving *Opioid Risk Reports*
These reports can be customized based on individual provider preference and are available by eFax, email or direct messaging to an electronic health record system in addition to being posted on the Pain Management Program Portal. You can view a sample *Opioid Risk Report* online.

In the coming weeks, axialHealthcare's Clinical Consult Services team will contact you to establish your communication preference and address any questions you may have. The team is readily available for consultation on pain management and opioid therapy and can answer any questions at providersupport@axialhealthcare.com.

TN-NB-0163-19

Hospice discharge planning update

Hospice benefits are intended for and available to members certified as terminally ill with a medical prognosis of six months or less to live if the illness runs its normal course. Hospice may discharge a member if it is determined they no longer meet the terminally ill certification. Once a member is no longer certified as terminally ill, coverage and payment for hospice care ceases.

Amerigroup Community Care does not anticipate a hospice member's sudden discharge. Rather, it is expected that the hospice interdisciplinary group is actively following the patient, and if there are indications of improvement in the individual's condition (such that hospice may no longer be appropriate), then discharge planning should begin.

If the patient seems to be stabilizing and/or the disease progression has halted, then we should prepare the member for alternative care. The discharge planning process should begin well before the date of discharge.

Discharge planning requirements when members are no longer certified as terminally ill:

- The hospice provider should have a discharge planning process in place.
- The discharge planning process should include planning for any necessary family counseling, patient education or other services before the member is discharged.
- If further discharge planning assistance is indicated, additional support is available through a referral to Case Management.

TN-NB-0155-19

National Provider Identifier
use for behavioral health practitioners

Amerigroup Community Care requires the use of the National Provider Identifier (NPI) or equivalent provider identification numbers when billing for behavioral health professional services.

What does this mean for me?

- All independently licensed clinicians rendering care to Amerigroup members must have a unique NPI and Medicaid ID number for the purpose of billing and payments.
- Providers are required to show and identify the licensed rendering provider when billing for professional services that are performed by an independently licensed clinician, as evidenced by the NPI in field 24j on the *CMS-1500* claim form or its electronic equivalent.
- When the rendering provider is an employee of a mental health outpatient facility (MHOF), the NPI of the supervising professional must instead be reported when billing for the services performed by a nonlicensed master level individual.
    - It is not appropriate to list the billing entity's NPI as the rendering provider when the rendering provider is a nonlicensed master level individual.
- The rendering provider must be an employee of a facility that is licensed as an MHOF by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS).
    - Additionally, the licensed MHOF should be contracted with the MCO in a manner (specified by the provider's agreement or contract) that allows the provider to render behavioral health professional services by a nonlicensed master level individual and, subsequently, bill such services under the NPI of the supervising professional.
- Claims not meeting the above requirements will be rejected.

What is the impact of this change?

If the billing entity and rendering provider are the same (e.g., when billing for nonprofessional services such as psychosocial rehabilitation, supported housing, IMR, etc.), the rendering provider should not be reported in NPI field 24j on the *CMS-1500* claim form or its electronic equivalent.

In order to facilitate quality and uniformity for claims adjudication, all providers must complete the claim form as outlined above.

TN-NB-0160-19

Medicare Advantage:

Fall prevention tips

Each year, falls result in more than 2.8 million ER visits; 800,000 hospitalizations; and 27,000 deaths. One-third of older Americans fall each year.

Older adults who are eligible for both Medicare and Medicaid experience high rates of chronic conditions and are particularly vulnerable to falls. Evidence shows that two or more health care providers who jointly manage an individual's medical care can double the rates of individuals receiving recommended assessments and care for falls.

Facts about falls:

- Falls are the leading cause of fatal and nonfatal injuries.
- 20-30 percent of those who fall suffer moderate to severe injuries (for example, hip fracture, head trauma).
- Risk of fall-related injuries increases with age, especially those over 75 years of age.
- Fewer than 50 percent of members discuss their falls with their primary care provider.
- Past falls predict the likelihood of fractures independently of osteoporosis risk.

Fall risk factors	
• Environmental hazards • Fall risk increasing drugs (FRID) • Fear of falling • Gait deficit* or balance impairment • Irregular heart rate/rhythm • Pain (any)*	• Parkinson's disease* or other cognitive/neurologic impairment • Polypharmacy • Poor visual acuity • Postural hypotension • Prior falls** • Use of walking aid*

* Risk more than doubled.

FRID medications	
• Alcohol/drugs • Anticonvulsants • Benzodiazepines (for example, Valium, Ativan) • Blood pressure medication (alpha blockers, beta blockers) • First generation antihistamines (for example, Benadryl)	• Long-acting hypoglycemic agents (for example, Glyburide) • Pain medication (opiate and non-opiate) • Skeletal muscle relaxants (for example, Soma) • Tertiary tricyclic antidepressants (for example, Elavil)

Fall screening

Ask these questions and document in the medical record:

- Have you fallen and hurt yourself in the past year?
- Have you fallen two or more times in the past year?
- Do you fear falling because of balance or gait?

Additionally, perform the Timed Up and Go (TUG) test and assess ambulation/gait.

ICD-10-CM coding rules:

- W00-W19: Slipping, tripping, stumbling and falls
- Z91.81: History of falling
- R29.6: Repeated falls

Fall assessment

Complete fall assessments for members at risk for falls based on the above screening:

- Medication reconciliation/reduction
- Neurologic exam
- Heart rate/rhythm
- Orthostatic blood pressure

Care plan

Addressing more than one fall risk factor is more effective than single interventions. Care plans should be individualized, monitored and revised. Consider the below interventions when creating care plans:

- Screening of bone density for treatment of osteoporosis
- Medication adjustments
- Manage foot and footwear problems
- Manage irregular heart rate and orthostatic hypotension
- Eye exam — encourage cataract surgery and proper lens prescription
- Gait, balance and strength evaluation
- Cognition evaluation
- Home hazard evaluation — remove or modify identified hazards
- Education on self-management strategies
- Assistive device for balance disorder
- Exercise programs* that challenge balance in addition to strength such as:
    - Tai chi
    - Otago exercise program (reduces falls and related injury by 35 percent)

* Exercise is the only intervention that has been found to reduce injurious falls when used on its own.

Resources:

- National Council on Aging — Falls Prevention
- TUG test
- Otago exercises for fall prevention

AGPCRNL-0011-19

Prior authorization requirements for DME repair and portable oxygen concentrators

Effective July 1, 2019, prior authorization (PA) requirements change for DME repair and portable oxygen concentrators to be covered by Amerigroup Community Care for Amerigroup Amerivantage (Medicare Advantage) members. Federal and state law, as well as state contract language and CMS 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 the following:

- K0739 — repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes
- E1392 — portable oxygen concentrator, rental

To request PA, use the Availity Portal.

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal. Providers who are unable to access Availity may call the Provider Services number on the back of the member's ID card for PA requirements.

AGPCRNL-0008-19

Why do patients stop taking their prescribed medications, and what can you do to help them?

You want what's best for your patients' health. When a patient doesn't follow your prescribed treatment plan, it can be a challenge. Approximately 50 percent of patients with chronic illness stop taking their medications within one year of being prescribed.* What can be done differently?

The missed opportunity may be that you're only seeing and hearing the *tip of the iceberg*, that is, the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline — the giant, often invisible patient self-talk that may not get discussed aloud — can create a misalignment between patient and provider.

We've created an online learning experience to teach the skills and techniques that can help you navigate these uncharted patient waters. After completing the learning experience, you'll know how to see the barriers, use each appointment as an opportunity to build trust and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence — and you'll earn continuing medical education credit along the way.

Take the next step. Go to MyDiversePatients.com > *The Medication Adherence Iceberg: How to Navigate What You Can't See to Enhance Your Skills*. The course is approximately one hour and accessible by smart phone, tablet or desktop at no cost.

* Centers for Disease Control and Prevention. (2017, Feb 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm.

AGPCRNL-0007-19

Medical records request for risk adjustment

Amerigroup Community Care is working with Optum CiOX Health (CiOX) to request medical records for risk adjustment. Risk adjustment is the process by which CMS reimburses Medicare Advantage plans based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost

expenditures of members by adjusting payments based on demographics (age and gender), as well as health status.

In 2019, Amerigroup will work with Optum, using their copy partner CiOX, to request medical records with dates of service for the target year 2018 through present day, then review and code the record.

Jaime Marcotte, retrospective risk program lead, is managing this initiative. if you have any questions regarding this program, contact Jaime at Jaime.Marcotte@anthem.com or 843-666-1970.

History of risk adjustment
As a part of risk adjustment implementation, CMS initially collected hospital inpatient diagnoses for determining payment to Medicare Advantage plans. In 2000, Congress mandated a change to include ambulatory data. This change took place gradually, with full implementation in 2007. CMS selected a payment model that included diagnosis data reported from physician office, hospital inpatient and hospital outpatient settings — the CMS-Hierarchical Condition Category (CMS-HCC) payment model.

Physician's role
Physician data is critical for accurate risk adjustment as physicians are the largest source of ambulatory data for the risk adjustment model. The CMS-HCC model relies on ICD-10-CM coding specificity.

What is the provider notification process?
Optum, using the copy partner CiOX, will initiate the record retrieval process. The process begins with phone/fax outreach to the provider, which is followed by a written request, to include:

- Role of the vendor.
- Purpose of the medical record retrieval request.
- Action being requested (for example, submission of the entire medical record).
- Name of the member.
- Date range of service being requested.

The provider should supply the medical records within two weeks of receipt of the request. If the provider did not see the member during the requested dates of service, the provider should return the request to the vendor with an explanation that no information relative to the request appears on the patient's medical record

How does risk adjustment impact physicians and members?
It's important to keep in mind that the risk adjustment process also benefits you and your patients. Increased coding accuracy helps Amerigroup identify patients who may benefit from disease and medical management programs. More accurate health status information can be used to match health care needs with the appropriate level of care.

Risk adjustment also helps you meet your CMS provider responsibilities regarding reporting ICD-10-CM codes, including:

- Secondary diagnoses, to the highest level of specificity.
- Maintaining accurate and complete medical records. (ICD-10-CM codes must be submitted with proper documentation.)
- Reporting claims and encounter data in a timely manner.

With your help in providing accurate and timely coding for risk adjustment, we can avoid unnecessary and costly administrative revisions and provide your patients and our members with superior customer service.

Why is medical record documentation important for risk adjustment?

- Accurate risk adjusted payment relies on complete medical record documentation and diagnosis coding.
- CMS conducts risk adjustment data validation by medical record review.
- Specificity of the ICD-10 diagnosis coding is substantiated by the medical record.

Importance of ICD-10-CM diagnosis coding

- ICD-10-CM is the official diagnosis code set for Medicare and is used for risk adjusted payment.
- Medical record documentation dictates what code is assigned.
- Appropriate coding requires use of the most specific code available.

Medical record documentation

- Documentation should be clear, concise, consistent, complete and legible.
- Document coexisting conditions at least annually.
- Use standard abbreviations.
- Use problem lists. (Ensure they are comprehensive, show evaluation and treatment for each condition relating to an ICD-10 code on the date of service, and are signed and dated by the physician or physician extender.)
- Identify patient and date on each page of the record.
- Authenticate the record with signature and credentials.

Major points

Federal regulations require Medicare and its agents to review and validate medical records to avoid underpayments or overpayments.

It is important for the physician's office to fully code each encounter; the claim should report the ICD-10-CM code of every diagnosis that was addressed and should only report codes of diagnoses that were actively addressed.

Contributory (comorbid) conditions should be reported if they impact the care and are, therefore, addressed at the visit but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses that were addressed were reported.

Requests for medical records
Amerigroup continually conducts medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding.

In addition, if CMS conducts an annual data validation audit, the provider will be required to assist Amerigroup by providing medical record documentation for members included in the audit.

Concerned about *HIPAA* privacy?
The collection of risk adjustment data and request for medical records to validate payment made to Medicare Advantage organizations is considered a health care operation and, as such, does not violate the privacy provisions of *HIPAA* (*45 CFR 164.502*).

CMS data validation
Data validation ensures the integrity and accuracy of risk-adjusted payment. It is the process of verifying that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member.

Medicare Advantage plans are selected for data validation audits annually.

It is important for physicians and their office staff to be aware of risk adjustment data validation activities because medical record documentation may be requested by the Medicare Advantage organization. Accurate risk-adjusted payment relies on the diagnosis coding derived from the member's medical record.

Additional risk adjustment information is available at http://csscoperations.com.

Additional information, including frequently asked questions and answers, is available at https://providers.amerigroup.com > Important Medicare Advantage Updates.

AGPCRNL-0010-19

2019 *Utilization Management Affirmative Statement* concerning utilization management decisions

All associates who make utilization management decisions are required to adhere to the following principles:

- Utilization management decision making is based on established medical necessity criteria, as well as the member's coverage according to their health plan.We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

AGPCRNL-0016-19

Submitting corrected claims

Amerigroup Community Care treats corrected claims as replacement claims. When you submit a corrected claim, it is important that you clearly identify that the claim is a correction rather than an original claim. Refer to the instructions below for information on submitting *CMS-1500* and *UB-04* claims forms.

Electronic *CMS-1500* claims
Enter Claim Frequency Type code (billing code) 7 for a replacement/correction. Enter 8 to void a prior claim in the 2300 loop of CLM*05 03. Enter the original claim number in the 2300 loop of the REF*F8*.

Paper *CMS-1500* claims
Amerigroup accepts:

- *Corrected claim* written on the face of the *CMS-1500* claim.
- The *Provider Adjustment Request Form* clearly identifying the information being corrected.
- Entry in box 22 of the claim:
    - Use resubmission code 7 to notify us of a corrected or replacement claim.
    - Insert an 8 to let us know you are voiding a previously submitted claim.
    - Enter the original claim number in the Original Ref. No. field. If that information is not available, enter the original document control number (DCN).

Electronic or paper *UB-04* claims

- Amerigroup continues to accept the *Provider Adjustment Request Form* clearly identifying the information being corrected.
- When submitting a corrected claim, ensure the type of bill is xx7 (correction/replacement) or xx8 (void) when the correction is made within the initial claim one-year timely filing limitation.

When you need to correct a claim and it is <u>beyond</u> the timely filing limit of one calendar year from the through date on claim, you should resubmit a reopening request (type of bill XXQ) to correct the error. Reopenings are typically used to correct claims with clerical errors, including minor errors and omissions, and are conducted at the discretion of the plan. Therefore, it is not appealable and the original initial determination stands as a binding decision. Appeal rights are retained on the original initial determination. Omissions do not include failure to bill items or services such as late charges.

Note: For adjustments and reopenings that result in higher weighted diagnosis-related groups, there is a congressionally mandated time frame of 60 days from the initial claim determination.

AGPCRNL-0015-19

Update: 2019 risk adjustment provider trainings

The Medicare Risk Adjustment Regulatory Compliance team at Amerigroup Community Care offers two provider training series regarding Medicare risk adjustment guidelines. Information for each training is outlined below.

Medicare Risk Adjustment and Documentation Guidance (General) training

- **Series**: Offered the first Wednesday of each month from 1 p.m.-2 p.m. ET
- **Learning objective**: Provide an overview of Medicare risk adjustment, including the risk adjustment factor and the hierarchical condition category (HCC) model, with guidance on medical record documentation and coding
- **Credits**: This live activity is offered from December 5, 2018-November 6, 2019. It has been reviewed by the American Academy of Family Physicians and is acceptable for up to 1.00 prescribed credit.

For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions.

Medicare Risk Adjustment, Documentation and Coding Guidance (Condition Specific) training

- **Series**: Offered bimonthly on the fourth Wednesday from noon-1 p.m. ET
- **Learning objective:** Collaborative learning event with enhanced personal health care to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding HCCs, with guidance on documentation and coding
- **Credits**: This live activity series is offered from January 23, 2019-November 27, 2019. It has been reviewed by the American Academy of Family Physicians and is acceptable for credit.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates to register for below:

1. Documentation and Coding Guidance: Red Flag HCCs, Part 1 (*Recording*): Training covers HCCs most commonly reported in error as identified by CMS: chronic kidney disease (stage 5), ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, and end-stage liver disease.
2. Documentation and Coding Guidance: Red Flag HCCs, Part 2 (*Recording*): Training covers HCCs most commonly reported in error as identified by CMS: atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, and diabetes with ophthalmologic or unspecified manifestation.
3. Opioids and more: Substance abuse and dependence (May 22, 2019)
4. Acute, chronic and status conditions (July 24, 2019)
5. Diabetes mellitus and other metabolic disorders (September 25, 2019)
6. Behavioral health (November 27, 2019)

AGPCARE-0042-19

Partial hospitalization services

Amerigroup Amerivantage (Medicare Advantage) follows original Medicare guidelines and billing requirements for partial hospitalization services. CMS regulations *(42 CFR 410.43(c)(1))* state that partial hospitalization programs (PHPs) are intended for members who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. All partial hospitalization services require prior authorization.

Highlights:

Bill types	**Hospitals:** • 131 — admit through discharge • 132 — interim (first) • 133 — interim (continuing) • 134 — interim (last) **Critical access hospital (CAH):** • 851 — admit through discharge • 852 — interim (first) • 853 — interim (continuing) • 854 — interim (last)
Condition code	Hospitals and CAHs report condition code 41 to indicate claim is for partial hospitalization services.
Community Mental Health Center (CMHC) revenue codes *CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 260.1.1C*	PHP services must be billed with below revenue codes and a CPT or HCPCS code descripting encounter • 0250 — drugs and biologicals • 043x — occupational therapy • 0900 — behavioral health treatment/services • 0904 — activity therapy • 0914 — individual therapy • 0915 — group therapy • 0916 — family therapy • 0918 — testing • 0942 — education training
CPT/HCPCS for PHP reimbursement *CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 260.1.1C*	Hospitals other than CAHs are also required to report these CPT/HCPCS codes: • G0129 — occupational therapy (partial hospitalization) • 90791 or 90792 — behavioral health treatment/services • G0716 — activity therapy (partial hospitalization) • Individual psychotherapy — 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90845, or 90880 • Group psychotherapy — G0410 or G0411 • Family psychotherapy — 90846 or 90847 • Psychiatric testing — 96101, 96102, 96103, 96116, 96118, 96119, or 96120 • Education training — G0177
Service units	Report number of times a service or procedure was performed as described by code descriptor.
Line Item Date of Service (LIDOS)	Report LIDOS per revenue code.
Interim Billing on PHP Claims *CMS Medicare Learning Network (MLN) Matters (MM)8048*	Effective January 1, 2013: • Submit claim in service date sequence as services are furnished. • Prior claim must be finalized or incoming claim with RTP.
Eligible professionals	• Physicians • Nurse practitioner (NP) • Physician assistant (PA) • Clinical nurse specialist (CNS) • Certified nurse midwife (CNM) • Clinical psychologist (CP) • Clinical social worker (CSW) • Independently practicing psychologists (IPP)

PHP services	A PHP is furnished by a hospital to outpatients that provide partial hospitalization services. Partial hospitalization services are a distinct and organized intensive ambulatory psychiatric treatment program that offer less than 24-hour daily care to patients meeting one of the following criteria: • The patient has been discharged from inpatient hospital treatment. • The patient would be at reasonable risk of requiring inpatient hospitalization in absence of partial hospitalization. • Active treatment is furnished that incorporates an individual plan of care with a coordination of services designed to needs of patient. • Treatment includes a multidisciplinary team approach to care under direction of a physician for a minimum of 20 hours per week. **Treatment goals:** • Patient requires comprehensive, highly structured and scheduled multimodal treatment that requires medical supervision and coordination under plan of care. • Patient is able to cognitively and emotionally participate in active treatment.
Non-PHP services	Items listed below are not PHP services and are paid according to Medicare provisions for each type of service: • Services to hospital inpatients • Meals • Self-administered medications • Transportation • Vocational training (career)
Payment for PHP *CMS Internet Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1*	APC payment rate for PHP • 5853 — partial hospitalization (3 or more services per day) for hospital-based PHPs
Frequency of billing	Monthly, claims in sequence date order

Sources:

- *CMS Medicare Learning Network Matters Number MM9880*
- *CMS Medicare Learning Network Matters Number MM11066*

AGPCRNL-0012-19

Special section:
Long-Term Services and Supports (LTSS)

Reminder: pest control services Page 16

Nursing facility patient liability reminder Page 16

Reminder: pest control services

Routine pest control services must be scheduled and performed by the provider as authorized. Providers should not wait for the member's request to initiate, schedule or perform authorized in-home services. We send an authorization form and a copy of the *Person-Centered Support Plan* (*PCSP*) on an annual basis. The authorization form and *PCSP* states the number of visits an individual is authorized to receive per calendar year. The *PCSP* must be signed and returned to the authorization team to acknowledge receipt and agreement to render services.

Pest control is only covered for TennCare CHOICES (CHOICES) members in groups two and three with a limit of nine treatment visits per member per calendar year.

Note: Pest control services are not covered for CHOICES members living in community-based residential alternative (CBRA) facilities or members receiving short-term nursing facility (NF) services.

Pest control services provided under the CHOICES program are defined as the one-time or intermittent use of sprays, poisons and traps, as appropriate, in the member's residence (excluding NFs or assisted care living facilities [ACLFs]) to regulate or eliminate the intrusion of roaches, wasps, mice, rats and other species of pests into the household environment, thereby, removing an environmental issue that could be detrimental to the health and well-being of a person who is frail, elderly or disabled.

TN-NB-0153-19

Nursing facility patient liability reminder

Patient liability is applied to a nursing facility (NF) claim based on the number of days the member is eligible for group one services. In other words, if the member is eligible for the full month, then the full month of patient liability will be applied to the claim. If the member is only eligible for 20 days, then the claims analyst will prorate the patient liability amount for 20 days.

For more information, access the *Guide to Patient Liability for Nursing Facility Services* from the Division of TennCare.

TN-NB-0153-19