Provider Newsblast

Amerigroup Community Care
providers.amerigroup.com/TN
Medicaid providers: 1-800-454-3730
Medicare providers: 1-866-805-4589

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In this issue

p. 1 Enhanced Availity eligibility and benefits inquiry
p. 2 Marshall Medical Center and Wayne Medical Center will no longer participate in the Amerigroup network
p. 2 Sanctioned or debarred provider affecting claims payments
p. 3 Prior authorization requirements for tumor treatment field
p. 3 DME PA requirements for enteral formula and related codes
p. 3 Access to Lupron Depot® and RhoGAM® Injectables
p. 4 Level II case management guidelines new adult and child/adolescent guidelines
p. 9 Reimbursement policy updates

Enhanced Availity eligibility and benefits inquiry

Summary of update: Beginning in Q2 2016, users will have the added benefit to query for multiple members at one time through the Availity eligibility and benefits inquiry.

What this means to you: You can check up to 50 members' eligibility and benefits during one system transaction. You no longer have to request eligibility information one member at a time, and you can download the results of all your eligibility and benefits inquiries across multiple payers.

My organization is not using Availity. What do I need to do?
To initiate the registration process, have your primary controlling authority (PCA), a person who is authorized to sign on behalf of your organization, register. Go to availity.com, select Get Started under the Register Now button and complete the online registration wizard.
After your PCA completes registration for the organization, your designated primary access administrator (PAA) will receive an email from Availity with a temporary password and next steps. Once logged in, the PAA can add users, providers and additional enrollments, if applicable.
Please make sure every user has their own login and password. Logins and passwords should not be shared.

How can I get additional training on Availity?
Once you complete registration, you can view the current training resources by selecting **Help**, then **Get Trained**, at the top of any page in the Availity Web Portal to view Availity workshops and webinars that are available.

What if I need assistance?
For questions or additional registration assistance, contact Availity Client Services at 1-800-282-4548, Monday through Friday from 5 a.m. to 4 p.m. Pacific time.

If you have questions about the tools and resources available on the Amerigroup or Availity websites, please visit providers.amerigroup.com.

Marshall Medical Center and Wayne Medical Center will no longer participate in the Amerigroup network

Summary: Effective May 14, 2016, the Maury Health System hospitals listed below will no longer be participating providers in the Amerigroup provider network. We will continue to offer our members a full range of quality health care services at 44 hospitals and other health care providers in our middle Tennessee network. We are notifying our members of this development and are assisting them with any transitions they might make.

Maury Health System hospitals	County
Marshall Medical Center	Marshall
Wayne Medical Center	Wayne

If you only have admitting privileges at these facilities, you may be required to obtain admitting privileges at one or more network hospitals. The following options are available:

- If you have admitting privileges to other network hospitals, please admit Amerigroup members to such network hospitals.
- If you do not have admitting privileges at other network hospitals, but have a covering physician who has privileges at other network hospitals and will admit members for you or has an arrangement with the covering hospitalist group at the other network hospitals, no action is required unless you are a surgeon or OB/GYN specialist. (Surgeons and OB/GYN specialists may not use a covering physician.)
- If you are a radiologist, dermatologist or other specialist who does not normally admit members, no action is required and you do not need admitting privileges.
- If you do not have admitting privileges at other network hospitals or a covering physician as described above, and do not have immediate plans to obtain privileges at other network hospitals, you may terminate with Amerigroup in accordance to your agreement.

We will continue to work with both hospitals for our members who have special needs and/or who are preauthorized for care, as appropriate. We will continue medically necessary coverage services that are approved at these hospitals through up to 90 calendar days or through the current period of active treatment, whichever is less.

We are committed to offering our members the quality health care they deserve and to working with our partners at the Bureau of TennCare to operate as efficiently and effectively as possible.

We appreciate your continued commitment to providing quality care to our members. Please direct any member or provider questions to the contact numbers below.

Important Amerigroup phone numbers:
Member Services: 1-800-600-4441 (TTY 711)
Provider Services: 1-800-454-3730
Provider Relations: 615-316-2400, ext. 22160

Sanctioned or debarred provider affecting claims payments

Summary: Effective June 1, 2016, Amerigroup will no longer process for payment, claims submitted with an attending, referring or ordering provider NPI that is currently sanctioned or debarred.

What this means to you: Claims submitted with a sanctioned or debarred NPI number for an attending, referring, or ordering provider will be rejected and returned.

Why is this change necessary?
Amerigroup requires all claims, both paper and electronic, to be submitted with appropriate attending, referring and ordering provider NPI on the claim forms. For more information, see providers.amerigroup.com/TN.

Prior authorization requirements for tumor treatment field

Summary of change: Effective June 1, 2016, Amerigroup will require authorization for tumor treatment fields.

What this means to you: Effective June 1, 2016, Amerigroup will require prior authorization for the HCPCS codes related to tumor treatment field listed below.
Requests for authorizations may be obtained:

- Online: providers.amerigroup.com
- By phone: 1-800-434-3730
- By fax: 1-877-423-9958

What HCPCS codes are affected by this new prior authorization requirement?
E0766 Electrical stimulation device used for cancer treatment; includes all accessories, any type
A4555 Electrode/transducer for use with electrical stimulation device used for cancer treatment; replacement only

Durable medical equipment (DME) prior authorization (PA) requirements for enteral formula and related codes

Summary: Effective June 1, 2016, Amerigroup will require PA for enteral formula and other related HCPCS codes.

What this means to you: Below is a list of HCPCS codes related to enteral formula codes Amerigroup will require PA for effective June 1, 2016. Requests for authorizations may be obtained via:

- Online: providers.amerigroup.com/TN
- By phone: 1-800-434-3730
- By fax: 1-877-423-9958

What HCPCS codes are affected by this new PA requirement?

B4100	Food thickener, administered orally, per ounce
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit
B4104	Additive for enteral formula (e.g., fiber)
B4149 – B4162	Enteral formula (administered through an enteral feeding tube) [includes codes B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162]

Access to Lupron Depot® and RhoGAM®Injectables

Background: This article has important news about access to certain medical injectables.

While a majority of our prescribers buy these drug agents and bill these to Amerigroup directly, a few prescribers have had difficulty obtaining these drugs for our members. In order to ensure the members you treat have access to these needed medications, follow the appropriate process that follows:

<u>For Lupron Depot® Injection</u>

- Prescribers should continue to purchase **Lupron Depot®** and bill directly to Amerigroup if this is their current process. Prior authorization is still required through Amerigroup.
- For those prescribers who are unable to purchase **Lupron Depot®,** the following steps should be followed in order to obtain this drug for your patients:
    - Obtain the required prior authorization.You can use the fax form or our online prior authorization tool found at providers.amerigroup.com.
    - **<u>Once approval is granted, fax a complete order *PLUS* a copy of the prior authorization approval to Bradley's Extended Care at 1-615-383-7365</u>**.
    - Bradley's will ship the requested drug to the prescriber's office with the patient's name affixed to the container.
    - Bradley's will bill Amerigroup directly for the **Lupron Depot®.**

<u>For RhoGAM® Injection</u>

- Prescribers should continue to purchase RhoGAM® and bill directly to Amerigroup if this is their current process**.** ***<u>*No prior authorization is required.</u>***
- For those prescribers who are unable to purchase RhoGAM®, the following steps should be followed in order to obtain this drug for your patients:
    - **<u>Fax a complete order *PLUS* the member's Amerigroup Identification Card, the patient's diagnosis code, and the HCPCS code for the RhoGAM® to Bradley's Extended Care at 615-383-7365.</u>**
    - Bradley's will ship the requested drug to the prescriber's office with the patient's name affixed to the container.
    - Bradley's will bill Amerigroup directly for the RhoGAM®.

In order to ensure prompt and accurate delivery of these drug agents from Bradley's, all information must be supplied at the time the order is placed. Any deficiencies will delay order processing.

Should you have further questions, you may either contact our Provider Relations department at 615-316-2400 or Bradley's Extended Care at 615-383-7365.

<u>Level II case management guidelines new adult and child/adolescent guidelines</u>

Summary: Effective March 1, 2016, Amerigroup uses new state-issued clinical guidelines to review for medical necessity for Level II case management for the adult population. The Level II case management definition has changed as well. Effective April 1, 2016, we use new state-issued clinical guidelines to review for medical necessity for Level II case management for the child and adolescent population. The Level II case management definition is changing as well.

What this means to you: The guidelines used in the review of Level II case management services for adults, children, and adolescents are changing. The attached guidelines will be effective March 1, 2016, for adults and April 1, 2016, for children/adolescents. All preauthorization requests for Level II case management services faxed on or after March 1, 2016, for adults and April 1, 2016, for children/adolescents will have these guidelines used in the review for medical necessity. The Level II case management definition for both populations is changing as well. The definition is for reference only; it is not used in review for medical necessity determinations.

What is the impact of this change? For additional reference, please see TennCare documents that follow.

Level 2 Adult Mental Health Case Management Definition

Level 2 Child and Adolescent (C&A) Mental Health Case Management is defined as services furnished to assist youth and their families in gaining access to areas of basic needs to include medical, social, educational, and other services, eligible under the Tennessee State Plan who reside in a community setting or are transferring to a community setting, in accordance with Code of Federal Regulations (CFR) §441.18.

Case management does not include, and FFP is not available in expenditures for, services defined in CFR §440.169 of this chapter when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred.

Case management provides a system of care philosophy for children and adolescents whose emotional or behavioral disturbances require multiple interventions or services. Through planning, linking and advocacy, case managers coordinate each child's care and treatment, resulting in a cohesive, systemized approach for better clinical outcomes. Services are provided in the office and in natural environments such as home, school or other community settings.

Level 2 children and adolescent mental health case management services include assessment, referral, treatment planning, linkage and coordination with community services, monitoring and advocacy. Case management enables parents to become informed about resources and to be able to effectively advocate for their child. Case managers work with families to develop individualized service plans to identify and meet needs in areas including therapy, psychiatry, behavioral services, educational advocacy and consultation, social/recreation, coordination of treatment teams and plans, accessing benefits, and support, coaching, and guidance.

C&A Case Management:
- Helps individuals gain access to needed community services and resources in the areas of basic needs, education, health care, financial, social and/or recreational;
- Helps individuals and families coordinate resources when they are involved with multiple agencies and/or programs;
- Helps individuals and families coordinate with the psychiatrist or nurse practitioner when they are receiving medication services for a mental health condition;
- Provides supportive services such as social skills coaching, parent education, development of coping skills, and crisis intervention.

Level 2 C&A mental health case management is person centered, strengths based, and focused on recovery and resiliency. C&A case management services are typically provided within the family home, in the office, and in other community settings. Frequency and intensity of contact depends on the needs of each individual and family and on medical necessity.

Level 2 C&A mental health case management services are comprehensive, linked and driven by the individual's treatment or service plan and include:
1. An assessment of the eligible individual which includes history-taking, a needs and strengths assessment, and information gathered from other current or former treatment providers and family members or other care givers. The assessment should address the individual's circumstances, strengths and needs that impairs their ability to achieve personal goals independently in the following areas:

- Medical / Psychiatric History
- Mental Health and Substance Abuse
- Activities of Daily Living
- Educational / Vocational
- Social / Family Supports
- Leisure / Recreation
- Legal Issues
- Community Resources (e.g., health care, educational, food assistance, religious and cultural, etc.)
- Financial Assistance
- Housing
- Transportation

2. Development of a specific treatment or service plan which addresses identified needs from the assessment elements outlined above in subsection one will match the consumer's strengths and needs and link to specific community resources.

3. Referral, linkage, and coordination to services, including: medical, psychiatric, educational, social and natural supports benefits for which they are eligible, housing, transportation, and community resources.

4. Follow-up and Monitoring in order to assess the effective implementation of the service plan as well as provide an on-going assessment of needs related to their physical and behavioral health and progress.

5. The ultimate goal of Level 2 C&A mental health case management is to empower youth and their families to navigate needed services and systems in the community successfully on their own, or with minimal support.

Level 2 Adult Mental Health Case Management
Medical Necessity Criteria
February 3, 2016

Program Description

Level 2 Case Management is a level of Child & Adolescent (C&A) MHCM-Tennessee services supplied through an individual approach. Services at this level are geared toward individuals under the age of 18 diagnosed with a serious emotional disturbance (SED) who have not successfully engaged in community-based mental health and/or medical services. (Transitional young adults, ages 18 to 21 may continue to access C&A case management services, depending on the systems needed by the individual and family.) Individuals and their families receiving this level of service typically require interventions or services across multiple systems, including mental health, education, Department of Children's Services (DCS), and medical services. These individuals and their families often fail to schedule or keep appointments consistently and have difficulty consistently accessing and utilizing community based services. Engagement of natural support systems is unpredictable at best and they may be high utilizers of crisis services.

A single case manager provides individual Level 2 C&A MHCM-Tennessee services, in contrast to the team-approach of Level l. The case manager's sole responsibility is to provide case management services for the individuals and their family using system of care principles which involves contact with the individuals and their caregivers, and other systems impacting the family, monitoring and coordination of necessary services that assist the family in moving toward independence. The case manager does not and will not provide direct clinical services or services for the consumer outside of those activities approved as case management services in accordance with the TennCare Contractor Risk Agreement.

Admission Criteria

Admission to Level 2 C&A MHCM-Tennessee will be based on medical necessity and must meet medical necessity criteria per TennCare Rule 1200-13-16-.05 including the recommendation of a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member, to include the member's treatment team that are located at the provider site. In addition, admission criteria should include the following key components:

The individual currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD-10 or DSM V (and subsequent revisions) of the American Psychiatric Association with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

1. In addition, the diagnosable disorder identified above, one of the following criteria are met:
   a) The individual has a functional impairment that substantially interferes with or limits the individual's role or functioning family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the individual in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.
   b) Would have met functional impairment criteria during the reference year without the benefit of treatment or other support services are included in this definition.
   c) Is actively participating in treatment at an outpatient setting or is reasonably expected to participate in outpatient treatment as a result of referral and/or education. The families of these individuals may exhibit behaviors to suggest that they are not able to coordinate services resulting in failure to access or follow through with needed services. These families and individuals may require education in the areas of mental health/physical health to engage in treatment and adhere to appointments; AND need assistance utilizing or accessing behavioral health, medical, and/or community-based services to function successfully in the community.
   d) Have had at least one psychiatric hospitalization, residential treatment stay, or involvement with Mobile Crisis or CSU within the last six (6) months

OR

Due to his or her emotional or behavioral condition, the individual and/or family meets any two of the following with service goal being to impact quality of life in areas of resiliency and recovery:

   a) Demonstrates a pattern of inconsistency or failure in scheduling or keeping appointments at an outpatient facility in order to meet the needs related to the mental/physical health symptoms of his/her mental and/or physical illness within the last six (6) months.
   b) Demonstrates a pattern of inconsistency in his/her adherence to prescribed behavioral health or medical treatment within the last six (6) months.
   c) Has received a medication adjustment in the previous six months due to instability of symptoms and has developed additional conditions which require assessment, planning, linkage and referral monitoring and follow up.
   d) Have had at least two psychiatrically driven presentations at an ER within the last six (6) months.
   e) Demonstrates a pattern of inconsistency or failure to identify or access needed medical, educational, social, or other services within the last six (6) months.
   f) Involvement with law enforcement or the juvenile justice system within the last six (6) months.

g) Involvement with the Department of Children's Services within the last six (6) months.
h) Involvement with disciplinary action with the local educational system.

Exclusion Criteria

Any of the following criteria are sufficient for exclusion from this level of care:

- Member is receiving non-team based case management or Level I case management (i.e., CTT, CCFT) services from another provider at the time of the request, unless the service in question is being used in a transitional manner; or
- Severity of psychosocial impairment due to a behavioral health condition requires higher intensity of intervention than can be provided through Level 2 mental health case management services; or
- The person with the authority to consent to treatment for the individual refuses case management services.
- The individual is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other resident treatment setting at the time of referral and is unable to return to a family home environment or community setting with community based supports within the next 90 days.

Continuation Criteria

Components of continued stay for the service recipient in Level 2 Mental Health Case Management would include the following:

- The individual continues to meet admission criteria

OR

- The individual has made measureable progress on service plan goals, but continues to demonstrate a need for support, advocacy and monitoring in order to access resources as documented in the record (i.e., service notes, assessment tools, other outcomes based measurement tools)
- Progress has not been made, and the case manager has identified and implemented changes and revisions to the service plan to support the goals of the individual and family.
- There is demonstrated meaningful benefit for the continuation of Case Management. For the continuation to be meaningful there must be evidence that Case Management has a positive impact on moving towards recovery and demonstrates gains as evidenced in treatment plan. Benefit of case management can be generalized at the conclusion of the service.

Based on the criteria selected, the member shows functional deficits, which can be impacted by Case Management services, in one or more of the following applicable domains:

- Medical/psychiatric
- Mental Health/substance abuse
- Activities of daily living
- Vocational/educational
- Social/family supports
- Leisure/recreation
- Legal issues
- Community resources
- Financial assistance
- Housing
- Transportation

OR

- Individual may have demonstrated relative stability in their functioning in the previous six months where there have been documented attempts to lessen mental health supports, but has a documented history of relapse and deterioration in the absence of mental health supports, as evidenced by:
  - Individual and family continues to obtain services from multiple providers/agencies, which may include medical, psychiatric, social, educational, or vocational; and their condition is such that coordination of care and active involvement of mental health case management is essential for a positive treatment outcome.
  - Individual has multiple complicating factors, (i.e., medical, social, vocational, financial) which require on-going assistance in order to avoid deterioration and assist the individual in maintaining community tenure.

- Individual continues to be in need of additional services, but has struggled to access or maintain those services
- Monitoring activities provided by mental health case management are necessary to ensure that the on-going needs of the consumer are met in accordance with the established care plan.

As part of the continuation criteria, individualized discharge planning for Level 2 Adult Mental Health Case Management should be addressed.

Discharge Criteria

Discharge decisions will be based on a review of the client's progress in the domains referenced in the admission/continuation criteria.

Discharge for Level 2 service recipients would consider the following criteria:

- The individual no longer meets the criteria for SED
- Consent for treatment is withdrawn
- Demonstration of little to no progress in meeting targeted goals for 6 months, despite documented attempts to engage the individual and family in services.
- Refusal to participate in coordination of services for 3 consecutive months.
- Movement out of the state.
- The individual is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, foster care setting that provides case management or other residential treatment setting and is unable to return to a family home environment or community setting with community based supports.
- Met case management goals as identified in the service plan *with no additional needs identified that could be impacted by case management.*
- Individual turns 18 (C&A mental health case management shall provide a transition to adult case management as appropriate– The decision to serve an 18-year old youth via the C&A mental health case management system versus the adult system shall be a clinical one made by the provider. Transition from children's services, including mental health case management, shall be incorporated in the child's treatment plan.)

Reimbursement policy updates

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

Modifier 62: Co-Surgeons *(Policy 06-005, 6/1/2016)*

Amerigroup in Tennessee allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62.

Reimbursement to each surgeon is based on 62.5 percent of the applicable fee schedule or contracted/ negotiated rate. Amerigroup in Tennessee requires co-surgeons to be from different specialties in order to receive reimbursement for Modifier 62. Co-surgery is always performed during the same operative session.

Each surgeon must bill the same procedure code(s) with Modifier 62. If one or both surgeons fail to use the modifier appropriately, it is possible that one surgeon may receive 100 percent of the applicable fee schedule or negotiated/contracted rate, and the other surgeon's claim may be denied or pended due to a duplicate or suspected duplicate service, respectively.

Refer to the Modifier 62: Co-Surgeons reimbursement policy for more information at providers.amerigroup.com/TN.

Locum Tenens *(Policy 06-063, originally effective 08/23/2006)*
Amerigroup allows reimbursement of locum tenens physicians in accordance with the Centers for Medicare and Medicaid Services (CMS) guidelines. Amerigroup will reimburse the member's regular physician or medical group for all covered services provided by a locum tenens physician during the absence of the regular physician in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis.

Please note that, Amerigroup requires the regular physician or medical group to identify the locum tenens physician by entering their Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

For market-specific information, refer to the Locum Tenens reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Professional Providers *(Policy 06-029, originally effective 06/16/2006)*
Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original Centers for Medicare and Medicaid Services (CMS)-1500 Health Insurance Claim Form to us for payment of health care services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include specific information outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Professional Providers reimbursement policy at providers.amerigroup.com.

Claims Submission – Required Information for Facilities *(Policy 06-030, originally effective 06/16/2006)*
Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original Centers for Medicare and Medicaid Services UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to us for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and Amerigroup can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Facilities reimbursement policy at providers.amerigroup.com.

Documentation Standards for Episodes of Care *(Policy 11-004, originally effective 12/07/2011)*

Amerigroup requires that documentation for all episodes of care must meet the following criteria:

- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated and timed.
- Documentation must reflect all aspects of care.
- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

For a complete list of minimum documentation requirements, refer to the Documentation Standards of Episodes of Care reimbursement policy at providers.amerigroup.com.

Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative. Medicaid providers can call Provider Services at 1-800-454-3730.