Provider Newsblast

https://providers.amerigroup.com/TN

Amerigroup RealSolutions® in healthcare

April 2017

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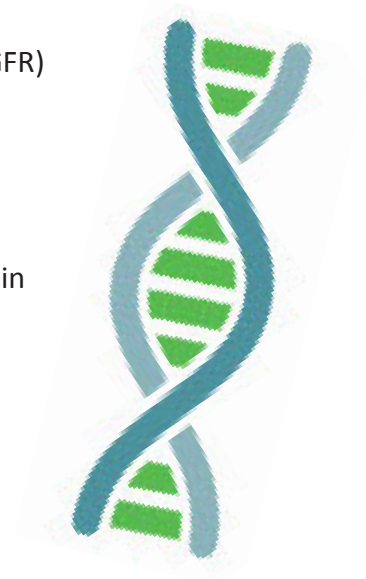
TN-NL-0074-17-D

April 2017

Revised April 18, 2017

Genetic testing services to require prior authorization



Effective June 1, 2017, genetic testing services for epidermal growth factor receptor (EGFR) testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing require prior authorization (PA).

What is the impact of this change?

For dates of service on or after June 1, 2017, PA is required for EGFR testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing covered by Amerigroup Community Care for TennCare 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 codes:

- 81235
- 81291
- 81420
- 81507
- 0009M

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/TN > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

TN-NL-0052-16

Prescriptions with no office visit education

TennCare has identified Medicaid registered providers who are writing a significant number of prescriptions for our enrollees with no corresponding professional claim. This notice is meant as a reminder that any provider registered with TennCare cannot accept any cash payment from a TennCare enrollee beyond authorized co-pays. We will be sending out notices to providers with a high volume of filled prescriptions with no professional claim but also want to remind all TennCare registered providers that accepting unauthorized cash payments from a TennCare enrollee can result in the provider losing their right to participate in the TennCare program in addition to other possible actions.

TNPEC-1782-17

Member appeals

Expedited appeals

Effective January 1, 2017, TennCare made some changes to the Member appeal process. If a member (or a provider on behalf of a member) requests an expedited appeal, TennCare Solutions has delegated authority to Amerigroup Community Care to downgrade the request if there is no immediate danger to the enrollee's life; physical health; mental health; or their ability to attain, regain or maintain full function. If Amerigroup deems an appeal to be truly expedited, Amerigroup does not complete the reconsideration process. Amerigroup must respond to TennCare Solutions within one business day and provide all information (records, denial letter, etc.) on which the initial decision was based.

Expedited appeals should only be requested if the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee's life; physical health; mental health; or their ability to attain, regain or maintain full function.

Accelerated appeals

An accelerated appeal is defined as a request for an expedited appeal that Amerigroup has reviewed and deems does not seriously jeopardize the enrollee's life; physical health; mental health; or their ability to attain, regain or maintain full function. The time frame in which Amerigroup reconsideration of an accelerated appeal must be completed is based on the medical or behavioral immediacy of the condition, procedure or treatment but may not exceed five calendar days from the date the reconsideration request is received from TennCare Solutions. However, Amerigroup may request a nine-day extension if additional time is required to obtain member records.

Provider's Expedited Appeal Certification can be found at http://tn.gov/tenncare > Providers > Miscellaneous Provider Forms > Provider's Expedited Appeal Certificate.

The updated member appeal form can be found at http://tn.gov/tenncare/topic/how-to-file-a-medical-appeal.

TN-NL-0064-17

Procedure for processing overpayments

The Amerigroup Community Care procedure for processing overpayments has been updated to include retro rate reconciliation language. Please read the updated language below.

What is the procedure for processing overpayments?

Refund notifications may be identified by two entities: the Amerigroup Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment, requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Amerigroup, the CCU will notify the provider of the overpayment. The provider will have the option submit a *Refund Notification Form* along with the refund check or have the overpayment offset from future claim payments. If a provider identifies the overpayment and returns the Amerigroup check, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at https://providers.amerigroup.com/TN. The submission of the *Refund Notification Form* will allow the CCU to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at 1-800-454-3730 and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act, commonly known as the Healthcare Reform Act.

TNPEC-1773-17

Behavioral health provider survey

We are committed to finding the best way possible to support our members and providers, and you can help! We are looking to identify areas of expertise or services for which you are licensed and have at least two years of clinical experience. We have created a short online survey to make it easy for you to supply us with this information. All you need to do is follow the link and instructions below. The information you provide will be used to locate services for members more efficiently.

The *Behavioral Health Areas of Expertise Profile* is designed to capture informational data only. While not all services listed are covered benefits in your state, having complete information about what our providers offer will be valuable should changes occur. The information you provide will not affect your provider application, credentialing or contract. These will not be changed as a result of this profile. Any changes or amendments to a provider contract or credentialing must be requested through your Provider Relations department.

You can access the online survey below:

- Behavioral health facilities
- Behavioral health individual practitioners and medical groups

You can also access the survey link at https://providers.amerigroup.com/TN > Provider Resources & Documents > Behavioral Health > Behavioral Health Facility Survey or Behavioral Health Practitioner Survey. Please follow the instructions to complete the appropriate survey.

Behavioral health facility practitioners: If you have more than five locations, please complete one survey per location.

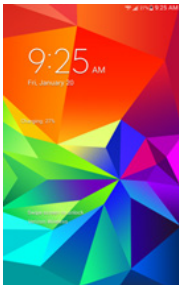
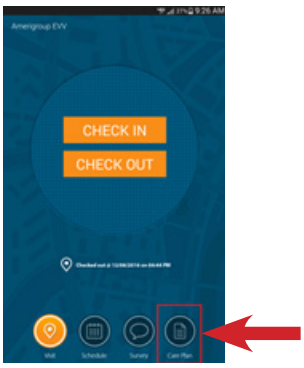
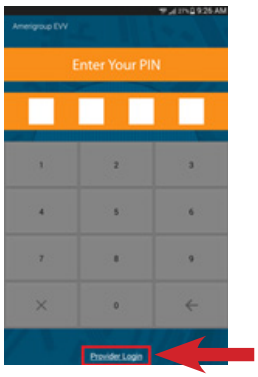
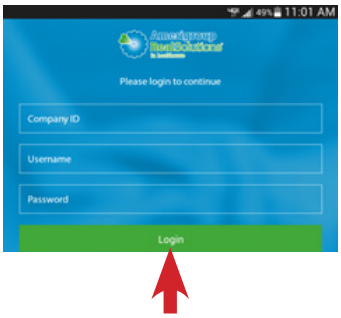
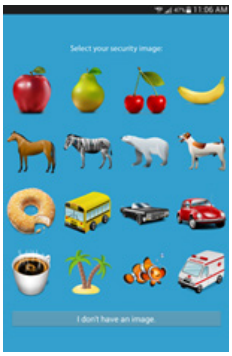
Behavioral health individual practitioners: Please complete one survey for every practitioner in your organization.

Your response is critical to helping us match your services to the needs of our members. If you have questions about completing the survey or would like a paper copy of a survey, please contact your local Provider Relations department.

TN-NL-0071-17

How to view a Care Plan on a tablet

TennCare members are now able to access a copy of their Care Plan on their Samsung tablets. This electronic version will not take the place of the paper copy kept in the member's home, but will allow members to view their Care Plan directly from the tablet if the copy left by the Care Coordinator is misplaced.

<table>
<tr><th colspan="4">To view a Care Plan:</th></tr>
<tr>
<td>1. Select the Home button at the bottom of the tablet.
  </td>
<td>2. To unlock the tablet, slide your finger from left to right or from right to left.
  </td>
<td>3. Select the Amerigroup EVV application icon.
  </td>
<td>4. Select Continue.
  </td>
</tr>
<tr>
<td>5. Select the Care Plan icon at the bottom of the screen.
  </td>
<td>6. Select Provider Login at the bottom of the Enter Your PIN screen.
  </td>
<td>7. Complete the Company ID, Username and Password sections. Select Login.
  </td>
<td>8. Select a security image. This will complete the login process.
  </td>
</tr>
<tr>
<td>9. Once login is complete, you will be taken to the member's Care Plan. The Care Plan will appear in the orange space shown below.
  </td>
<td colspan="3">Members should not share their PIN with caregivers or providers. To change a PIN, or for any additional questions or concerns, please contact Amerigroup Community Care at 1-866-840-4991.</td>
</tr>
</table>

TN-NL-0063-17

2017 medical record documentation audit standards for behavioral health providers

We may contact your office to schedule an appointment for an audit in the coming weeks. Please take the time to review your medical records documentation to ensure your compliance.

By what standard will my office be assessed in this audit?

The standards developed for medical record documentation reflect a set of commonly accepted standards; *Clinical Practice Guidelines (CPG)*; and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits. The standards include demographic information, health history (including details of ongoing clinical issues), CPGs and preventive health care. Only records within a one-year period from the date of audit will be reviewed. Up to ten charts, with a minimum of eight, are assessed for compliance.

How do you determine who is selected for the audit?

Behavioral health providers identified as a top-10 provider and/or with 100 or more encounters will be audited against the standards. If your office meets these criteria, the Quality Management department will contact your office to schedule an appointment for the audit within the next two weeks.

How can I make sure my office is compliant?

To help you prepare for this important quality assurance activity, please review the standards listed above.

What if I need assistance?

If you have questions or concerns about the audit, feel free to call the Quality Management department at 615-316-2400, ext. 22409. If you received this communication in error or have questions on another topic, call your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Medical record documentation standards

Core standards		
	Standard	**Purpose**
1.	Policies and procedures are in place to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPPA regulations, the HITECH Act (A.R.R.A.Secs. 13001 *et seq.*), security as defined by HIPPA and member accessibility to the extent provided by TCA 33-3-101 *et seq.* for patients/members with behavioral health issues. *CRA 2.24.8.2.3.2, CRA 2.24.8.2.3.3* *CRA 2.24.8.2.3, CRA 2.24.8.2.4* *CRA 2.24.82.5*	To ensure the confidentiality, security and member accessibility of medical records
2.	Policies and procedures are in place for member, parent or legally appointed representative involvement with behavioral health situations. *CRA 2.18.10.1.1, CRA 2.18.10.1.2*	To ensure member, parent or legally appointed representative involvement with behavioral health and provide a description of the quality monitoring activities to be used to measure practitioner compliance with the requirement for member, parent or legally appointed representative involvement in behavioral health treatment planning

2017 medical record documentation audit standards for behavioral health providers (cont.)

	Standard	Purpose
3.	Policies and procedures are in place for cultural competency training of staff on an annual basis. *CRA 2.18.2.1*	To ensure effective delivery of health care services that meet the social, cultural and linguistic needs of patients
4.	Policies and procedures are in place that define training provided to relevant unlicensed employees in accordance with Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) TennCare 2010 specialized training requirements for behavioral health staff.	To ensure organizational network providers who deliver behavioral health services provide relevant unlicensed employees training in accordance with TDMHDD TennCare 2010 specialized training requirements for behavioral health staff
5.	Patient demographic data is present in chart, and name or ID is on each document. *42 CFR Part 456*	To provide biological and identifiable data pertinent to the patients care and treatment planning and to provide emergency information should an incident occur within the physician's office
6.	Medication allergies and adverse reactions are prominently noted and displayed on record. *42 CFR Part 456*	To prevent the prescribing of any medication that the patient is allergic to
7.	Advanced directives such as a living will for members 16 years or older have been discussed and documented with a date by physician. *CRA 2.7.7*	To ensure that the health care choices of the member are followed when the member is unable to make the decisions for themselves
8.	A current medication list is present in patient record and indicates dosage, initialization date and dates of refills. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure the practitioner can easily assess medications for possible drug interactions, overmedication, drug treatment history and management of potential habit-forming medications
9.	A current problem list that includes significant illnesses, medical conditions and psychological conditions is present. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure that a current problem list is maintained to enhance information from which a practitioner can effectively develop a treatment plan and to enhance the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time

2017 medical record documentation audit standards for behavioral health providers (cont.)

	Standard	Purpose
10.	Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. (For children ages 0-20, developmental/behavioral assessment should be included. Interval histories should be present as appropriate.) *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure that all patients have documentation of medical/social histories in their record base from which a planned course of treatment can be developed
11.	Behavioral health screenings and results (e.g., substance use, depression, etc.) are present on record.	To ensure appropriate assessment of presenting symptoms and problems
12.	For each visit, risk status is clearly documented and situations such as imminent risk of harm to self or others, homicidal ideation, suicidal ideation or elopement potential are prominently noted, documented and revised in the treatment record. Follow-up recommendations are also documented. All entries are signed by rendering practitioner with credentials and dated (may be a handwritten signature, unique electronic identifier, or initials and credentials). *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure the safety of member and involved parties and to ensure appropriate identification of treating practitioner
13.	Provides for members, parents or legally appointed representatives a meaningful opportunity to participate in the treatment planning process both at initial formulation and when changes or re-evaluations are done. *CRA A.2.18.10*	To empower individuals involved in treatment planning and make full use of the unique knowledge and perspectives of the individuals undergoing treatment and their family members or legal representatives as appropriate
14.	Evidence is present in medical record of coordination of care with member's primary care physician (PCP) and referring practitioner if referring practitioner is other than PCP.	To ensure continuity and coordination of care for members with both physical and behavioral health problems
15.	Provider has in place a policy or procedure for follow-up of missed appointments.	To ensure the resolution of health issue/ complaint when there is no access to care issues

Clinical Practice Guidelines (CPG)		
	Standard	**Purpose**
16.	ADHD guidelines	
A.	Documentation to support diagnosis of ADHD is present in record.	To show evidence that CPGs are utilized to outline approaches for the management of ADHD
B.	Medication prescription and dosage for ADHD follows recommendations as outlined in clinical practice guideline.	To ensure adherence to clinical practice guideline accepted prescribing protocols and criteria
C.	If tricyclic antidepressants are used, a baseline ECG prior to use is present with a follow-up ECG after each significant dosage change. If a higher level tricyclic medication is documented, blood levels are present in the medical record.	To ensure therapeutic results of medication and prevention of overdose
D. HEDIS®* measure	**Initiation phase:** Documentation is present for patients who receive an initial prescription for ADHD medication of at least 1 follow-up visit with a prescriber within 30 days of initiation of medication and at least 2 additional visits between 4 weeks-9 months of the initiation of the medication.	To ensure effectiveness of medication prescribed and member compliance with medication treatment
E. HEDIS measure	**Continuation and maintenance phase:** After treatment for initiation phase, documentation is present of at least 2 follow-up visits between 30 days-10 months of the initiation of the medication.	To prevent relapse of symptoms and ensure member compliance with medication treatment
F.	**Follow-up visits include assessment for:** • Behavior assessment (school, peer, family). • Height and weight. • Abnormal movement (signs and symptoms). • Follow-up testing with Conners' scales or equivalent scales to track treatment response. • School informal plan or Section 504 Plan every 2 years.	

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

2017 medical record documentation audit standards for behavioral health providers (cont.)

	Standard	Purpose
17.	Major depression (acute and chronic) guidelines	
	The CPG outlines available approaches for the management of acute and chronic depression. All member care and related decisions are the sole responsibility of the practitioner. The *CPG* for major depression does not dictate or control the practitioner's clinical decisions regarding the appropriate care of members but should be used as a guide for best practice.	
A.	Documentation to support diagnosis of major depression is present in the clinical record.	To provide evidence that the CPG is utilized to outline approaches for the management of acute and chronic depression
B.	DSM-IV/ICD10 diagnosis is documented.	To ensure appropriate treatment planning and claims processing
C.	Medication prescription and dosage of antidepressant medications follows recommendations as outlined in clinical practice guideline.	To ensure adherence to clinical practice guideline accepted prescribing protocols and criteria
D. HEDIS measure	**Acute phase:** After initiation of medication for a new diagnosis of major depression, 3 follow-up contacts take place during the first 12 weeks of treatment, 1 of which must be with the prescribing practitioner.	To ensure effectiveness of medication prescribed and member compliance with medication treatment
E. HEDIS measure	**Continuation phase:** After treatment for acute phase, documentation is present that member is maintaining medications for at least 6 months following remission of symptoms.	To prevent relapse of symptoms and ensure member compliance with medication treatment
F.	**Maintenance phase:** After treatment for continuation phase, documentation of assessment for recurrence of depression symptoms, presence of comorbid conditions, suicidal thoughts and psychotic features is present.	To prevent relapse of symptoms and ensure member compliance with medication treatment
G. HEDIS measure	If a hospitalization occurred prior to or during the course of treatment, documentation is present of follow-up visits within 7 days of discharge and within 30 days of discharge.	To prevent relapse of symptoms and ensure member compliance with medication treatment

2017 medical record documentation audit standards for obstetrics and gynecology providers

We may contact your office to schedule an appointment for an audit in the coming weeks. Please take the time to review your medical records documentation to ensure your compliance.

By what standard will my office be assessed in this audit?

The standards developed for medical record documentation reflect a set of commonly accepted standards; *Clinical Practice Guidelines (CPG)*; and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits. The standards include demographic information, health history (including details of ongoing clinical issues), CPGs and preventive health care. Only records within a one-year period from the date of audit will be reviewed. Up to ten charts, with a minimum of eight, are assessed for compliance.

How do you determine who is selected for the audit?

Obstetrics and gynecology providers identified as a top-10 provider and/or with 100 or more encounters will be audited against the standards. If your office meets these criteria, the Quality Management department will contact your office to schedule an appointment for the audit within the next two weeks.

How can I make sure my office is compliant?

To help you prepare for this important quality assurance activity, please review the standards listed above.

What if I need assistance?

If you have questions or concerns about the audit, feel free to call the Quality Management department at 615-316-2400, ext. 22409. If you received this communication in error or have questions on another topic, call your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Medical record documentation standards

Core standards		
	Standard	**Rationale**
1	Provider has in place policy and procedures to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPPA regulations, security as defined by HIPPA, and member accessibility to the extent provided by TCA 63-2-101/63-2-102/33-3-104 *et seq.* of medical records. *CRA 2.24.8.2.3.2, CRA 2.24.8.2.3.3, CRA 2.24.8.2.3, CRA 2.24.8.2.4 and CRA 2.24.8.2.5*	To ensure the confidentiality, security and member accessibility of medical records
2.	Patient demographic data is present in chart and name or ID is on each document. *42 CFR Part 456*	To provide biological and identifiable data pertinent to the patients care and treatment planning and to provide emergency information should an incident occur within the physician's office
3.	Policies and procedures are in place for cultural competency training of staff on an annual basis. *CRA 2.18.2.1*	To ensure effective delivery of health care services that meet the social, cultural and linguistic needs of patients

2017 medical record documentation audit standards for obstetrics and gynecology providers (cont.)

	Standard	Rationale
4.	Medication allergies and adverse reactions are prominently noted and displayed on record. *42 CFR Part 456*	To prevent the prescribing of any medication that the patient is allergic to
5.	A current medication list is present in patient record and indicates dosage, initialization date and dates of refills. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure the practitioner can easily assess medications for possible drug interactions, overmedication, drug treatment history and management of potential habit-forming medications
6.	A current problem list that includes significant illnesses, medical conditions and psychological conditions is present. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure that a current problem list is maintained to enhance information from which a practitioner can effectively develop a treatment plan and to enhance the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time
7.	Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. (For children ages 0-20, developmental/behavioral assessment should be included. Interval histories should be present as appropriate.) *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure that all patients have documentation of medical/social histories in their record base from which a planned course of treatment can be developed
8.	A history of immunizations is present in the medical record for adults. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure adult immunizations are administered. Documenting Tetanus boosters prevents duplication of vaccination at times when urgent care treatment required. If the status is unknown and not easily obtained from a previous physician, the Centers for Disease Control recommends that the tetanus booster be given. Yearly flu vaccines help reduce large epidemics in communities and serious complications when a patient's immune system is compensated.

2017 medical record documentation audit standards for obstetrics and gynecology providers (cont.)

	Standard	Rationale
9.	Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan and follow-up recommendations. The treatment plan is appropriate to findings, and patient is not at risk by diagnostic or therapeutic problem. All entries are signed by rendering practitioner with credentials and dated (may be a handwritten signature, unique electronic identifier or initials and credentials). *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure appropriate review of all systems that relate to the problem currently being assessed for treatment, accurate and appropriate assessment of a patient's problem with appropriate treatment planning, prevention of injury/unnecessary treatment that may jeopardize the patient's health, and appropriate identification of treating physician
10.	Provider has in place a policy or procedure for follow-up of missed appointments. *Amerigroup Quality Improvement Activity*	To ensure the resolution of health issue/ complaint when there is no access to care issues
11.	If member has a postpartum depression diagnosis and a referral to a behavioral health provider was completed, documentation from the behavioral health (BH) provider is present if member approved coordination of care between obstetrics and BH provider. *Amerigroup Quality Improvement Activity*	To ensure continuity and coordination of care for members with both physical and behavioral health problems
12.	Antepartum and postpartum guidelines	
A.	Provider is utilizing the Category II codes for prenatal and postpartum visits with claims submission to report closure of gaps in care for preventive screenings.	To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps
B. HEDIS measure	Prenatal visit as an Amerigroup Community Care member in the first trimester or within 42 days of enrollment.	To ensure early and timely prenatal care as per HEDIS measures
C. HEDIS measure	Prenatal visits every 4 weeks until 28 weeks of pregnancy, then every 2-3 weeks until 36 weeks, then weekly until delivery.	To assess maternal and fetal well-being
D.	At 28 weeks, there will be glucose screening for gestational diabetes, assays for hemoglobin and hematocrit. If Rhesus factor RH negative and unsensitized, RH immunoglobin will be provided.	To assess maternal and fetal well-being
E.	At 35-37 weeks, vaginal and rectal culture is obtained for group B Streptococcus.	To assess maternal and fetal well-being

2017 medical record documentation audit standards for obstetrics and gynecology providers (cont.)

	Standard	Rationale
F.	If a Cesarean section (C-section) had previously taken place, vaginal birth after Cesarean counseling is provided.	To ensure understanding of risks of both a VBAC delivery and multiple C-sections
G. HEDIS measure	Postpartum visit on or between 21-56 days after delivery.	To ensure timely follow-up to assess physical status postdelivery and assess for postpartum depression

TNPEC-1755-17

Amerigroup Community Care partners with axialHealthcare

Amerigroup is partnering with axialHealthcare®, a national advanced analytics and pain care solutions company, to provide insight and guidance on opioid prescription and pain management practices of providers in the Amerigroup network.

Opioids are prescribed more often and at higher doses despite current evidence associating opioids with decreased patient well-being and poor outcomes. Overprescribing has led to a steady increase in opioid misuse, abuse and overdose, culminating in a public health crisis. Since 1999, overdose deaths due to prescription opioids have quadrupled.

Overprescribing of opioids has led to a steady increase in misuse, abuse and overdose, culminating in a public health crisis.

The Pain Medication and Care Improvement Program (PMCIP) is a joint initiative between axialHealthcare and Amerigroup to impact the pain problem using analytics and evidence-based standards. PMCIP will be implemented over the next several months with the goals of encouraging best practices for pain management and prescribing, improving quality of care for patients in pain, and mitigating opioid misuse. We appreciate your support as we tackle this important health and safety issue for our members.

If you have any questions, please email providersupport@axialhealthcare.com.

TN-NL-0072-17

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Community Care previously announced plans to upgrade from ClaimCheck® to the ClaimsXten auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-866-805-4589 and select the appropriate prompt.

ClaimCheck and ClaimsXten are registered trademarks of McKesson Technologies Inc. and McKesson Health Solutions LLC, respectively.

SSO-NL-0013-17

New Policy

Modifier 26 and TC: Professional and Technical Component

(Policy 15-004, effective 07/01/17)

Amerigroup Community Care allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC when appropriate.

Professional Component (Modifier 26)
The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

Technical Component (Modifier TC)
The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable X-ray suppliers should bill **only** for the technical component by appending Modifier TC.

Global Procedure
In the absence of Modifier TC and Modifier 26, the physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Amerigroup does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only, or global test only of a selected diagnostic test

Amerigroup reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

For additional information and to view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0025-16

Policy Update

Modifier Usage

(Policy 06-006, effective 08/01/16)

Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0019-16

Policy Update

Modifier 91: Repeat Clinical Diagnostic Laboratory Test

(Policy 06-020, effective 07/01/17)

Amerigroup Community Care allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100 percent of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0020-16

Policy Update

Reimbursement for Reduced and Discontinued Services

(Policy 10-003, effective 04/27/2015)

Amerigroup Community Care allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Modifiers 52, 53, 73 and 74 can be appended for reduced and discontinued services, if applicable.

Modifier 52 indicates procedures for which services performed are significantly less than usually required. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Do not report Modifier 52 on Evaluation & Management (E&M) and consultation codes.

Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes.

Modifier 73 indicates the physician canceled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

Modifier 74 indicates a procedure was stopped after the administration of anesthesia or after the procedure was started. Reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0015-16

Policy Reminder — Medicaid

Claims Timely Filing

(Policy 06-050, originally effective 07/01/2013)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 120 days from the date of service for participating and nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0018-16

Policy Update — Amerivantage

Claims Timely Filing

(Policy 06-050, originally effective 07/01/2013)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 12 months for participating and nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Reimbursement Policy Disclaimer

These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. To view the Reimbursement Policy Disclaimer, please visit https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Policy Disclaimer.

SSO-PEC-0006-16

Policy Reminder — Medicaid
Split-Care Surgical Modifiers
(Policy 11-005, effective 08/01/16)

Reimbursement of **surgical codes** appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 70 percent
- Modifier 55 (postoperative management only): 20 percent
- Modifier 56 (preoperative management only): 10 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NL-0026-16

Policy Reminder — Amerivantage
Split-Care Surgical Modifiers
(Policy 11-005, effective 08/01/16)

Reimbursement of **surgical codes** appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 20 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-PEC-0722-16