Provider NewsBlast

Amerigroup
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August 2018

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TN-NB-0056-18-D

August 2018

updated August 31, 2018

Medicaid:

Important information about utilization management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, 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 free copy of our UM criteria 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. To access UM criteria online, go to https://providers.amerigroup.com/TN > Provider Resources & Documents > Quick Tools > Medical Policies.

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 by:

- Faxing to 1-800-964-3627.
- Calling us at 1-800-454-3730.
- Visiting the Availity Portal at https://www.availity.com.

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-0046-18

Member's 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 *Member's Rights and Responsibilities Statement*, which is located in your *Provider Manual under the Member Rights and Responsibilities section*.

TN-NB-0046-18

Electronic claim payment reconsideration

As currently outlined in your provider manual, providers can submit claim payment reconsiderations verbally, in writing or electronically. We are reaching out to notify you about some exciting new tools for electronic submission that will become available through the Availity Portal. In addition, you should soon see changes in the provider manual that will outline this new information regarding claim remediation tools through the Availity Portal.

Beginning September 1, 2018, providers will have the ability to submit claim reconsideration requests through the Availity Portal with more robust functionality. For you, this means an enhanced experience when:

- Filing a claim payment reconsideration.
- Sending supporting documentation.
- Checking the status of your claim payment reconsideration.
- Viewing your claim payment reconsideration history.

New Availity Portal functionality will include:

- Acknowledgement of submission at the time of submission.
- Email notification when a reconsideration has been finalized by Amerigroup Community Care.
- A worklist of open submissions to check a reconsideration status.

With the new electronic functionality, when a claim payment reconsideration is submitted through the Availity Portal, we will investigate the request and communicate an outcome through the Availity Portal. Once an outcome has been determined, the Availity Portal user who submitted the claims payment reconsideration will receive an email notification informing him/her that the reconsideration review has been completed. If you are not satisfied with the reconsideration outcome, continue to follow the existing process to file an appeal, as outlined in your provider manual.

Look for announcements on the Availity Portal for upcoming training opportunities. Providers who have questions as they begin to use the new functionality should contact Amerigroup at 1-800-454-3730.

TN-NB-0025-18

Electronic Data Interchange migration to Availity

Recently, Amerigroup Community Care partnered with Availity as our designated Electronic Data Interchange (EDI) gateway and E-Solutions Service Desk, and Amerigroup will not renew existing contracts with clearinghouse vendors. As a result, beginning January 1, 2019, Availity will manage all EDI trading partner relationships on behalf of Amerigroup. This new partnership will not interrupt your current services.

Transmitting 837 claims

If you currently transmit 837 claims using a clearinghouse, you should contact your clearinghouse as soon as possible to confirm your EDI submission path for Amerigroup

transactions has not changed. If your clearinghouse notifies you of changes regarding connectivity, workflow or the financial cost of EDI transactions, there is a no-cost option available to you – You can submit claims directly through Availity.

Direct submitters can also use Availity for their 837 transmissions.

Registering with Availity
If you choose to submit directly through Availity but are not yet a registered user, go to https://www.availity.com and select **REGISTER**. The registration wizard will lead you through the enrollment process. Once complete, you will receive an email with your login credentials and next steps for getting started. If you have any questions or concerns, please contact Availity at 1-800-AVAILITY (1-800-282-4548).

It is our priority to deliver a smooth transition to Availity for our EDI services. If you have questions, please contact your Provider Relations representative or Provider Services at 1-800-454-3730.

TNPEC-2424-18

Update: drug screen

Summary of update: Effective September 1, 2018, Amerigroup Community Care drug screening and benefit details will be updated to ensure alignment with state and plan requirements. The codes below will be configured to ensure benefit limitations are in place as listed. Please share this information with office staff and other providers in your practice.

Code	Description	Category	State requirement
80305	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (such as immunoassay) capable of being read by direct optical observation only (such as dipsticks, cups, cards or cartridges), includes sample validation when performed, per date of service	Presumptive	Budget reduction notice June 27, 2017; limit 12 per member per calendar year (any combination of 80305 and 80306 combined limit to total of 12 per year)
80306	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (such as immunoassay) read by instrument-assisted direct optical observation (such as dipsticks, cups, cards or cartridges), includes sample validation when performed, per date of service	Presumptive	Budget reduction notice June 27, 2017; limit of 12 per member per calendar year (any combination of 80305 and 80306 combined limit to total of 12 per year)

Code	Description	Category	State requirement
80307	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrument chemistry analyzers (such as utilizing immunoassay, e.g., IA, EIA, ELISA, EMIT, FPIA, KIMS, RIA) chromatography (i.e., GC, HPLC) and mass spectrometry either with or without chromatography (e.g., DART, DESI, GC-MS, GC-MS/MS, ML- MS/MS, LDTD, MALDI, TOF), including sample validation when performed, per date of service	Presumptive	Budget reduction notice June 27, 2017; limit of 4 per member per calendar year
80320	Alcohols	Definitive	Not covered
80321	Alcohol biomarkers; 1 or 2	Definitive	Not covered
80322	Alcohol biomarkers; 3 or more	Definitive	Not covered
80323	Alkaloids, not otherwise specified	Definitive	Not covered
80324	Amphetamines; 1 or 2	Definitive	Not covered
80325	Amphetamines; 3 or 4	Definitive	Not covered
80326	Amphetamines; 5 or more	Definitive	Not covered
80327	Anabolic steroids; 1 or 2	Definitive	Not covered
80329	Analgesics, nonopioid; 1 or 2	Definitive	Not covered
80330	Analgesics, nonopioid; 3-5	Definitive	Not covered
80331	Analgesics, nonopioid; 6 or more	Definitive	Not covered
80332	Antidepressants, serotonergic class; 1 or 2	Definitive	Not covered
80333	Antidepressants, serotonergic class; 3-5	Definitive	Not covered
80334	Antidepressants, serotonergic class; 6 or more	Definitive	Not covered
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2	Definitive	Not covered
80336	Antidepressants, tricyclic and other cyclicals; 3-5	Definitive	Not covered
80337	Antidepressants, tricyclic and other cyclicals; 6 or more	Definitive	Not covered
80338	Antidepressants, not otherwise specified	Definitive	Not covered
80339	Antiepileptics, not otherwise specified; 1-3	Definitive	Not covered
80340	Antiepileptics, not otherwise specified; 4-6	Definitive	Not covered
80341	Antiepileptics, not otherwise specified; 7 or more	Definitive	Not covered
80342	Antipsychotics, not otherwise specified; 1-3	Definitive	Not covered
80343	Antipsychotics, not otherwise specified; 4-6	Definitive	Not covered
80344	Antipsychotics, not otherwise specified; 7 or more	Definitive	Not covered
80345	Barbiturates	Definitive	Not covered
80346	Benzodiazepines; 1-12	Definitive	Not covered
80347	Benzodiazepines; 13 or more	Definitive	Not covered
80348	Buprenorphine	Definitive	Not covered
80349	Cannabinoids, natural	Definitive	Not covered
80350	Cannabinoids, synthetic; 1-3	Definitive	Not covered

Code	Description	Category	State requirement
80351	Cannabinoids, synthetic; 4-6	Definitive	Not covered
80352	Cannabinoids, synthetic; 7 or more	Definitive	Not covered
80353	Cocaine	Definitive	Not covered
80354	Fentanyl	Definitive	Not covered
80355	Gabapentin, nonblood	Definitive	Not covered
80356	Heroin metabolite	Definitive	Not covered
80357	Ketamine and norketamine	Definitive	Not covered
80358	Methadone	Definitive	Not covered
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	Definitive	Not covered
80360	Methylphenidate	Definitive	Not covered
80361	Opiates; 1 or more	Definitive	Not covered
80362	Opioids and opiate analogs; 1 or 2	Definitive	Not covered
80363	Opioids and opiate analogs; 3 or 4	Definitive	Not covered
80364	Opioids and opiate analogs; 5 or more	Definitive	Not covered
80365	Oxycodone	Definitive	Not covered
80366	Pregabalin	Definitive	Not covered
80367	Propoxyphene	Definitive	Not covered
80368	Sedative hypnotics (nonbenzodiazepines)	Definitive	Not covered
80369	Skeletal muscle relaxants; 1 or 2	Definitive	Not covered
80370	Skeletal muscle relaxants; 3 or more	Definitive	Not covered
80371	Stimulants, synthetic	Definitive	Not covered
80372	Tapentadol	Definitive	Not covered
80373	Tramadol	Definitive	Not covered
80374	Stereoisomer (enantiomer) analysis, single drug class	Definitive	Not covered
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	Definitive	Not covered
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	Definitive	Not covered
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	Definitive	Not covered
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Budget reduction notice June 27, 2017; limit of 2 per member per calendar year
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Budget reduction notice June 27, 2017; limit of 2 per member per calendar year
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify	Definitive	Budget reduction notice June 27, 2017; limit of 2

Code	Description	Category	State requirement
	individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)		per member per calendar year
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Budget reduction notice June 27, 2017; limit of 2 per member per calendar year
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes	Definitive	Not covered

What if I need assistance?
If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at 1-800-454-3730.

TN-NB-0042-18

Dialysis supplies update

Summary of change: Effective September 1, 2018, Amerigroup Community Care dialysis supplies and benefit details will be updated to ensure alignment with state and company requirements.

What this means to me: Effective September 1, 2018, the following codes will be configured to ensure benefit limitations are in place as listed. **Please share this information with office staff and other providers in your practice.**

Code	Description	Tennessee Medicaid
A4657	Syringe, with or without needle, for dialysis, each	No charge (NC) — Dialysis paid at all-inclusive rate that includes supplies
A4657AY	Syringe, with or without needle, for dialysis, each	
A4657GY	Syringe, with or without needle, for dialysis, each	
A4657KX	Syringe, with or without needle, for dialysis, each	
A4660	End-stage renal disease (ESRD) blood pressure device	
A4660GY	ESRD blood pressure device	
A4660NU	ESRD blood pressure device	
A4663	ESRD blood pressure cuff	
A4663NU	ESRD blood pressure cuff	
A4670	Auto blood pressure monitor	
A4670GY	Auto blood pressure monitor	
A4670GZ	Auto blood pressure monitor	
A4670KX	Auto blood pressure monitor	
A4670NU	Auto blood pressure monitor	
A4670RR	Auto blood pressure monitor	
A4670U9	Auto blood pressure monitor	
A4670UE	Auto blood pressure monitor	
A4690	Dialyzers	
A4750	Arterial or venous tubing	
A4760	Standard testing solution	
A4913	Miscellaneous dialysis supplies, not otherwise specified	
A4928	Surgical mask, for dialysis, per 20	
E1639NU	Scale, each	

What if I need assistance?
If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

TN-NB-0033-18

Amerigroup Community Care fights opioid addiction: Extension for Community Healthcare Outcomes and Quality Medication-Assisted Therapy

Extension for Community Healthcare Outcomes (ECHO)
People are dying of opioid addiction. With the ECHO opioid addiction treatment, you can help save lives! Join one of several video tele-consultative ECHO learning communities nationwide and participate with other clinicians learning about medication-assisted treatment for individuals with opioid disorders. For more information, visit the ECHO website.

Benefits of participating include:

- Addiction treatment training.
- Free continuing education credits.
- Opportunity to receive expert input on your (de-identified) patient cases.

- Access to a virtual learning community for treatment guidelines, tools and patient resources.
- Opportunity to ask questions and get a variety of support from specialists.

Quality Medication-Assisted Therapy (MAT)
To help ensure members have access to comprehensive evidence-based care, Amerigroup is committed to helping its providers double the number of members who receive behavioral health services as part of MAT for opioid addiction.

When treating patients with opioid use disorder, it is considered best practice to offer and arrange evidence-based treatment. This usually consists of MAT with buprenorphine or, in some plans, methadone maintenance treatment in combination with behavioral therapies. Behavioral therapies focused on medication adherence and relapse prevention can improve MAT outcomes and improve other social determinants of health, including development of an enhanced social support network in recovery.

For more information
For more information about what is considered best practice for medication-assisted treatment, please read the American Society of Addiction Medicine's *National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use*.

You can also contact Jennifer Tripp by email at jennifer.tripp@anthem.com for more information about the ECHO and MAT programs.

TN-NB-0035-18

Remittance Inquiry tool available September 1, 2018

Summary of change: We've made it easy for you to access remittance advices online for all Amerigroup Community Care members using the new Remittance Inquiry tool on the Availity Portal.

Here's how to access the remittance inquiry tool:
- Log in to the Availity Portal.
- From the Availity home page, select **Payer Spaces**.
- Select **Amerigroup** from the list of payer options.
- Select **Applications** and then **Remittance Inquiry**.

Here's how it works:
After selecting the organization, select the tax ID number from the drop-down menu. Then, select the provider under the *Express Entry* drop-down or enter the NPI (typically the group NPI). You have the option to sort your results by provider name, issue date, check/EFT number and check/EFT amount.

Do you need an imaged copy of the remittance for your files?
Select the **View Remittance** link associated with each remit and print or save.

Don't see this valuable tool when you log in to the Availity Portal?
Contact your administrator to request **claims status access**, which includes the Remittance Inquiry tool. If you do not know who the administrator for your organization is, log in to Availity, go to your account and select **My Administrators**.

If you have questions about the features on the Availity Portal or need additional registration assistance, contact Availity Client Services at 1-800-282-4548.

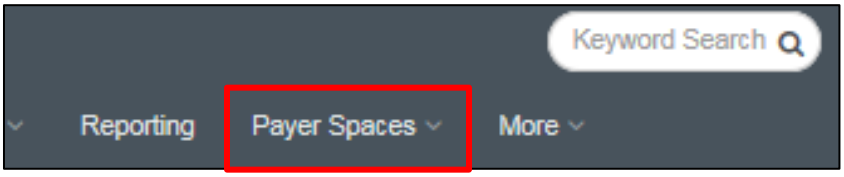
If you have questions about the tools and resources available within Payer Spaces or on the Amerigroup website, contact Provider Services at 1-800-454-3730 or your local Provider Relations representative.

TN-NB-0053-18

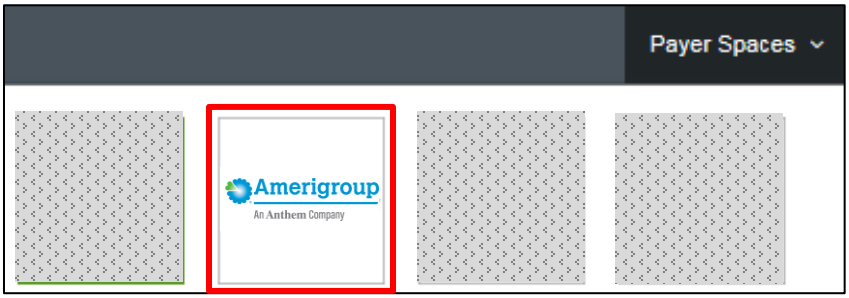
Accessing remittance inquiry beginning September 1, 2018

To access remittance inquiries, follow the steps below:

1. Log into the Availity Portal.
2. Access the Remittance Inquiry Tool via the **Payer Spaces** option from the top navigation.

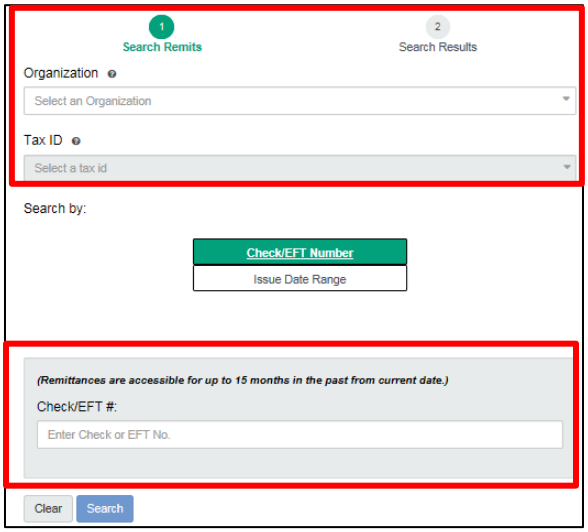


3. Choose **Amerigroup Community Care** from the *Payer Spaces* drop-down box.

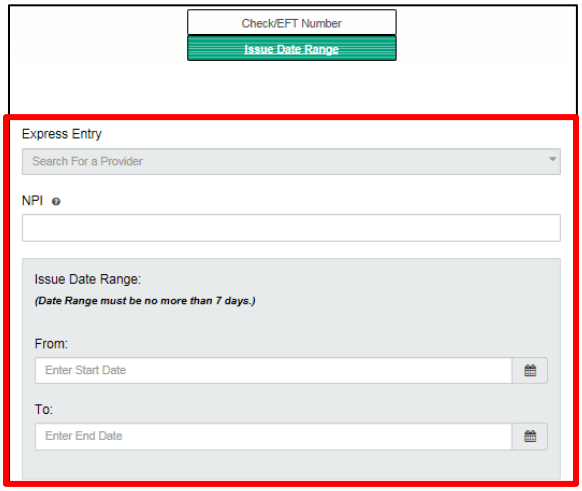


4. Select **Applications**, then select the **Remittance Inquiry** tile.

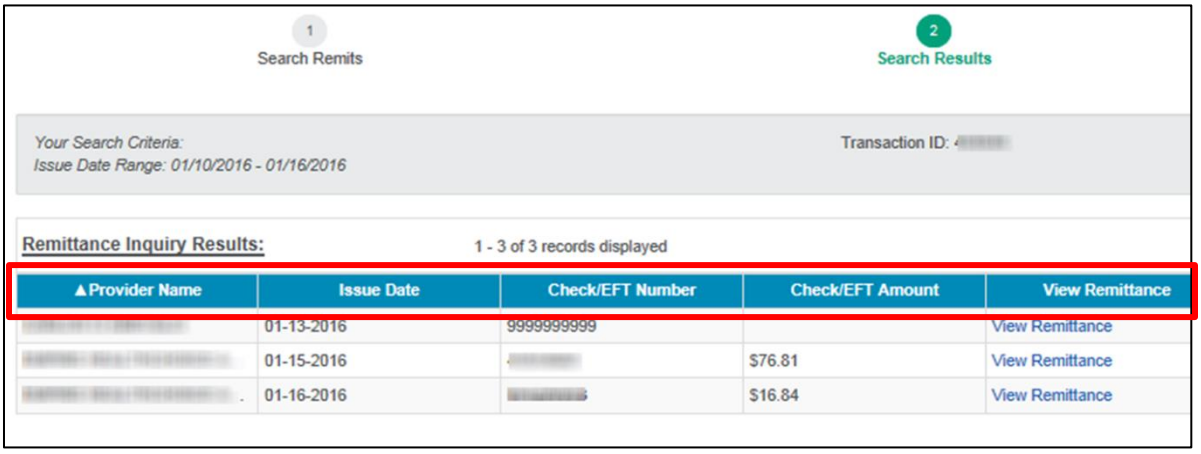
5. Choose your organization and tax ID from the drop-down box, and search by Check/EFT Number or Issue Date Range. After entering the appropriate information, select **Search**. (Note, this image is by Check/EFT Number.)



6. To search by Issue Date Range: Either select the provider from the Express Entry drop-down or enter the NPI, indicate the date range, and then select **Search**.



7. From the *Remittance Inquiry Results* page, the results can be sorted by provider name, issue date, check/electronic funds transfer (EFT) number or check/EFT amount.



Additional information:

- Remit images are available for all Amerigroup members.
- Remits of over 50 pages will return the first 50 pages for viewing.
    - To view all pages, download or print the remit.
- Search in span of seven days and up to 15 months back.
- To conduct a remittance inquiry, access to "View Claims Status Inquiry" is needed.

TN-NB-0054-18

Outpatient Code Editor

Effective August 1, 2018, Amerigroup Community Care will turn on all CMS Outpatient Code Editor (OCE) edits to avoid incorrect and inappropriate coding of claims. The OCE is an editing system created and maintained by CMS to process outpatient facility claims.

If you have questions or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

TN-NB-0044-18

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On January 25, 2018, the medical policy and technology assessment committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The *Medical Policies* were made publicly available on our provider website on the effective date listed. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.

Please note:

- Starting July 1, 2018, AIM Specialty Health® *Cardiology and Radiation Oncology Guidelines* are utilized for clinical reviews.
- For markets with carved-out pharmacy services, the applicable listings below are informational only.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
2/28/2018	DRUG.00116	Vestronidase alfa (Mepsevii™)	New
2/28/2018	DRUG.00046	Ipilimumab (Yervoy®)	Revised
2/28/2018	DRUG.00075	Nivolumab (Opdivo®)	Revised
2/28/2018	DRUG.00077	Monoclonal Antibodies to Interleukin-17A	Revised

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
2/1/2018	DRUG.00080	Monoclonal Antibodies for the Treatment of Eosinophilic Conditions	Revised
2/28/2018	DRUG.00082	Daratumumab (DARZALEX™)	Revised
2/28/2018	DRUG.00099	Cerliponase Alfa (Brineura™)	Revised
2/28/2018	GENE.00028	Genetic Testing for Colorectal Cancer Susceptibility	Revised
2/1/2018	GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	Revised
2/28/2018	GENE.00035	Genetic Testing for TP53 Mutations	Revised
2/28/2018	MED.00100	Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems	Revised
2/1/2018	SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
2/1/2018	SURG.00098	Mechanical Embolectomy for Treatment of Acute Stroke	Revised
2/28/2018	SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)	Revised

***Clinical Utilization Management Guidelines* update**

On January 25, 2018, the MPTAC approved the following *Clinical Utilization Management (UM) Guidelines* applicable to Amerigroup. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the *Clinical UM Guidelines* adopted by the medical operations committee for the Government Business Division on March 2, 2018.

The clinical guidelines were made publicly available on our provider website on the effective date listed. Visit https://medicalpolicies.amerigroup.com/search to search for specific guidelines.

Please note:

- Starting July 1, 2018, AIM Specialty Health® *Cardiology and Radiation Oncology Guidelines* are utilized for clinical reviews.
- For markets with carved-out pharmacy services, the applicable listings below are informational only.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
5/1/2018	CG-DME-42	Nonimplantable Insulin Infusion and Blood Glucose Monitoring Devices	New
5/1/2018	CG-DME-43	High-Frequency Chest Compression Devices for Airway Clearance	New

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
5/1/2018	CG-DRUG-82	Prostacyclin Infusion Therapy and Inhalation Therapy for Treatment of Pulmonary Arterial Hypertension	New
5/1/2018	CG-DRUG-83	Growth Hormone	New
5/1/2018	CG-DRUG-84	Belimumab (Benlysta®)	New
5/1/2018	CG-DRUG-85	Tesamorelin (Egrifta®)	New
5/1/2018	CG-DRUG-86	Ocriplasmin (Jetrea®) Intravitreal Injection Treatment	New
5/1/2018	CG-DRUG-87	Vedolizumab (Entyvio®)	New
5/1/2018	CG-DRUG-88	Dupilumab (Dupixent®)	New
5/1/2018	CG-SURG-70	Gastric Electrical Stimulation	New
5/1/2018	CG-SURG-71	Reduction Mammaplasty	New
5/1/2018	CG-SURG-72	Endothelial Keratoplasty	New
7/1/2018	CG-THER-RAD-03	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy	New
7/1/2018	CG-THER-RAD-04	Selective Internal Radiation Therapy of Primary or Metastatic Liver Tumors	New
5/1/2018	CG-DRUG-29	Hyaluronan Injections	Revised
2/28/2018	CG-DRUG-50	Paclitaxel, protein bound (Abraxane®)	Revised
2/28/2018	CG-DRUG-59	Testosterone Injectable	Revised
2/28/2018	CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	Revised
2/28/2018	CG-DRUG-78	Antihemophilic Factors and Clotting Factors	Revised
2/28/2018	CG-MED-39	Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry	Revised
2/28/2018	CG-MED-53	Cervical Cancer Screening Using Cytology and Human Papillomavirus Testing	Revised
2/28/2018	CG-SURG-33	Lumbar Fusion and Lumbar Total Disc Arthroplasty	Revised

TNPEC-2292-18

Medical Policies and *Clinical Utilization Management Guidelines* update

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

Please share this notice with other members of your practice and office staff.
To search for specific policies or guidelines, visit
https://medicalpolicies.amerigroup.com/search.

Medical Policies

On March 22, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Community Care.

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
3/29/2018	MED.00120	Voretigene neparvovec-rzyl (Luxturna™)	New
4/25/2018	SURG.00151	Balloon Dilation of Eustachian Tube	New
4/25/2018	DME.00009	Vacuum-Assisted Wound Therapy in the Outpatient Setting	Revised
3/29/2018	GENE.00028	Genetic Testing for Colorectal Cancer Susceptibility	Revised
4/25/2018	RAD.00029	CT Colonography (Virtual Colonoscopy) for Colorectal Cancer	Revised
4/25/2018	SURG.00033	Cardioverter Defibrillators	Revised
4/25/2018	SURG.00098	Mechanical Embolectomy for Treatment of Acute Stroke	Revised
4/25/2018	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical UM Guidelines

On March 22, 2018, the MPTAC approved the following *Clinical UM Guidelines* applicable to Amerigroup. This list represents the guidelines adopted by the medical operations committee for the Government Business Division on April 19, 2018.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
6/28/2018	CG-BEH-15	Activity Therapy for Autism Spectrum Disorders and Rett Syndrome	New
6/22/2018	CG-DRUG-89	Implantable and Extended-Release Buprenorphine-Containing Products	New
6/28/2018	CG-DRUG-90	Intravitreal Treatment for Retinal Vascular Conditions	New
6/28/2018	CG-DRUG-91	Intravitreal Corticosteroid Implants	New
6/28/2018	CG-DRUG-92	Alpha-1 Proteinase Inhibitor Therapy	New
6/28/2018	CG-DRUG-93	Sarilumab (Kevzara®)	New
6/28/2018	CG-LAB-13	Skin Nerve Fiber Density Testing	New
6/28/2018	CG-MED-69	Inhaled Nitric Oxide	New
6/28/2018	CG-MED-70	Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule	New
6/28/2018	CG-SURG-73	Balloon Sinus Ostial Dilation	New
6/28/2018	CG-SURG-74	Total Ankle Replacement	New
6/28/2018	CG-SURG-75	Transanal Endoscopic Microsurgical Excision of Rectal Lesions	New
6/28/2018	CG-THER-RAD-07	Intravascular Brachytherapy (Coronary and Noncoronary)	New
4/25/2018	CG-SURG-31	Treatment of Keloids and Scar Revision	Revised
4/25/2018	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	Revised

Coding Spotlight — Obesity

The obesity epidemic is a serious issue in the United States. The obesity rate is rising. Obesity has significant health consequences, contributing to increased rates in several diseases, including metabolic syndrome, high blood pressure, diabetes, heart disease, high blood cholesterol, sleep disorders and cancers.[1]

Facts:

- According to the 14th annual *State of Obesity: Better Policies for a Healthier America* report from the Trust for America's Health and the Robert Wood Johnson Foundation, in 2017, adult obesity rates exceeded 35 percent in five states, 30 percent in 25 states and 25 percent in 46 states. As of 2000, no state had an obesity rate above 25 percent.[2]
- Obesity rates are around 30 percent higher among adults without a college education and with incomes below $15,000 compared with other adults.[2]
- The prevalence of obesity has remained at about 17 percent and affects about 12.7 million children and adolescents.[3]

Body mass index (BMI) — adults:

- Body fat is measured through BMI.
- The equation to calculate BMI is body weight in kilograms/height in meters squared.
- Overweight BMI is between 25-29.9 kg/m^2.
- Morbid (severe) obesity BMI is 40 or more kg/m^2.[4]
- The CDC's Adult BMI Calculator can be found at https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html.

BMI — pediatric:

- Pediatric BMI is used for individuals ages 2-20 years and is based on percentiles that allow a child's BMI to be categorized based on age group:
    - Underweight is a BMI less than the fifth percentile.
    - Normal weight is a BMI from the fifth percentile to below the 85th percentile.
    - Overweight is a BMI above the 85th percentile to below the 95th percentile.
    - Obese is a BMI greater than or equal to the 95th percentile.[4]
- The CDC's BMI Percentile Calculator for Child and Teen can be found at https://nccd.cdc.gov/dnpabmi/Calculator.aspx.

Risk factors:

- Sedentary lifestyle
- High amounts of stress
- Less than seven hours of sleep
- Family history and genetics
- More common in African American and Hispanic populations in the United States
- Low socioeconomic status or unsafe environment in the neighborhood[1]

Treatment
Treatment for overweight and obesity depends on the condition's cause and severity. Possible treatments include healthy lifestyle changes, behavioral weight-loss treatment programs, medicines and weight-loss surgery:[1]

- Healthy eating:
    - Low-calorie meals
    - Consuming vegetables, fruits, whole grains, nuts, etc.
    - Eliminating beverages filled with sugar
    - Eating small meals about 5-6 times daily
- Physical activity:
    - 60 minutes of physical activity daily for children ages 6-17
    - 30 minutes of physical activity daily for adults ages 18-64 (gym membership)[5]
- Patients with certain obesity-related complications:
    - May be eligible for the surgical intervention, such as gastric bypass surgery, gastrectomy and gastric banding
- Weight-loss medications to include with lifestyle changes[1]

HEDIS® quality measures for BMI
Adult BMI Assessment (ABA) is a measure that focuses on individuals ages 18-74 years old who had an outpatient visit with documented weight and BMI value during the current year or prior year.

Documentation should reflect all of the following:

- The outpatient visit date
- The weight and BMI values for patients ages 20-74 years old
- Height, weight, BMI percentile documented as a value and BMI percentile plotted on an age-growth BMI chart for patients younger than 20[6]

Tips for providers:

- Discuss with all patients why ideal weight, nutrition and exercise are important.
- Document all discussions about BMI, including documentation about any patient nutritional counseling sessions.
- Discuss BMI assessment during annual well visits.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) is a measure that focuses on patients ages 3-17 years old who had one or more outpatient visits with a PCP or OB/GYN during the measurement year and documented evidence of weight assessment, physical activity and nutritional counseling.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
This measure focuses on reporting the following rates:

- Height, weight and BMI percentile (not BMI value)
- Counseling for nutrition
- Counseling for physical activity with recommendations and not solely topics on sports or safety[6]

Documentation should reflect the following:

- Measures for height and weight at least annually and documentation of the BMI percentile
- Incorporate appropriate nutritional and weight management questioning and counseling into the routine of the clinical practice
- Document any advice that was given to the patient
- Document face-to-face discussion about current nutritional behavior, any counseling or referral to nutrition education, any nutritional educational materials that were provided, anticipatory guidance for nutrition, eating disorders, nutritional deficiencies, underweight, and obesity or overweight discussion
- Document face-to-face discussion about current physical activity behaviors, referral to physical activity, educational materials that were provided, anticipatory guidance on physical activity, and obesity or overweight discussion[6]

ICD-10-CM: general coding and documentation:

- Obesity codes are located in Chapter 4, *(E00-E89) Endocrine, Nutritional and Metabolic Diseases*.
- The ICD-10-CM coding guidelines note that BMI code assignment may be based on medical record documentation from clinicians who are not the patient's provider (e.g., dietician or nurse often document the BMI).[7]
- Documentation to support any clinical condition, including morbid obesity, obesity and overweight diagnosis and should be supplied by the provider.
- BMI needs to be measured annually.
- Any associated conditions related to an abnormal BMI should be documented.
- Plan and follow-up should be documented.

Commonly reported obesity codes:

- E66.01 — morbid (severe) obesity due to excess calories
- E66.09 — other obesity due to excess calories
- E66.1 — drug-induced obesity; requires an additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
- E66.2* — morbid (severe) obesity with alveolar hypoventilation
- E66.3 — overweight
- E66.8 — other obesity
- E66.9 — obesity, unspecified[7]

* Code E66.2 — morbid (severe) obesity with alveolar hypoventilation, also known as Pickwickian syndrome, involves sleep-disordered breathing that causes a person to stop breathing for short periods of time while sleeping. It may be related to both obesity and neurological conditions.[8]

If the BMI is known, category E66 — overweight and obesity **requires** the assignment of an additional code (Z68.-):

- BMI codes are located in Chapter 21, *Factors Influencing Health Status and Contact with Health Services (Z00-99) of ICD-10-CM*.
- Adult BMI codes range from Z68.1-Z68.45.

- The pediatric BMI code is Z68.5. (An individual character is required to identify the percentile for the patient's age.)
- Screening for obesity: obesity screening can be reported with Z13.89 (encounter for screening for other disorder).[7]

References

1 Overweight and Obesity. Retrieved from https://www.nhlbi.nih.gov/health-topics/overweight-and-obesity

2 The State of Obesity 2017 Report. Retrieved from http://healthyamericans.org/reports/stateofobesity2017.

3 Prevalence of Childhood Obesity in the United States, 2011-2014. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db219.htm.

4 Calculate Body Mass Index. Retrieved from https://www.nhlbi.nih.gov/health/educational/wecan/healthy-weight-basics/body-mass-index.htm.

5 Department of Health and Human Services. (2008). Physical Activity Guidelines for Americans.

6 HEDIS Benchmarks and Coding Guidelines for Quality Care. Amerigroup Community Care. Retrieved from https://providers.amerigroup.com/TN.

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

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

axial healthcare®

axialPRACTICE

Risk Informed Surgical Evaluation (RISE)

As part of axialPRACTICE's clinical decision support, the Risk Informed Surgical Evaluation (RISE) assesses member risk for poor outcomes after elective surgery. Risk is evaluated based on three domains: behavioral health, opioid usage, and care coordination. The patient's overall RISE score as well as the risk associated with each individual domain are displayed for provider review. Providers may review RISE information prior to the patient undergoing elective surgery. The RISE model does not evaluate medical necessity.

RISE Criteria and Scoring

The RISE report gives patient-level information for consideration and risk management prior to a patient's elective surgery. A patient's RISE score is based on the following criteria proven to contribute to a patient's risk for poor outcomes following elective surgery:

- Substance Use Disorder
- Tobacco Use

- Behavioral Health Conditions
- Opioid Dose
- Opioid Duration
- Multi-Pharmacy
- Multi-Prescriber
- Polydrug Prescribing

A patient's RISE Score is a weighted summary of these criteria. RISE score is based on a scale of 0-100, with a higher score indicating greater patient risk.

Opioid Use and Elective Surgical Outcomes
Preoperative opioid use is associated with longer hospital stays, discharge to rehabilitation facilities, higher readmission rates, increased healthcare expenditure, and persistent postoperative opioid use[1,2,3].

RISE assesses known patient risk factors of poor post-surgical outcomes and is supported by a growing body of evidence that recommends opioid tapering prior to elective surgery in cases of increased risk. RISE does not evaluate for medical necessity, and RISE interventions have not been validated.

References:

1. Waljee JF, Cron DC, Steiger RM, Zhong L, Englesbe MJ, Brummett CM. Effect of Preoperative Opioid Exposure on Healthcare Utilization and Expenditures Following Elective Abdominal Surgery. Annals of Surgery. 2017;265(4):715–21.
2. Zarling BJ, Sikora-Klak J, Bergum C, Markel DC. How do Preoperative Medications Influence Outcomes after Total Joint Arthroplasty? The Journal of Arthroplasty Internet. 2017 Apr cited 2017 May 5;
3. Kim SC, Choudhry N, Franklin JM, Bykov K, Eikermann M, Lii J, et al. Patterns and predictors of persistent opioid use following hip or knee arthroplasty. Osteoarthr Cartil. 2017 Apr 19

Amerivantage:

The Interactive Care Reviewer tool is available — Start using today!

The Interactive Care Reviewer (ICR) tool offers a streamlined process to request authorization of inpatient and outpatient procedures as well as locate information on previously submitted requests for Amerigroup members via the Availity Portal.

What benefits does the ICR tool provide?
- Free and easy to use
- Access almost anywhere
- Preauthorization determinations
- Inquiry capability
- Fax reduction

- Ability to view decision letter
- Ability to save favorites
- Comprehensive view of all your preauthorization requests

How do I gain access to the ICR tool?
You can access the ICR tool through Availity. (Select **Authorizations & Referrals** from the *Patient Registration* drop-down menu in the upper left of the page.)

If you have not yet registered for Availity, go to https://www.availity.com and select **Register** at the top of the page. Select your **Organization Type** from the available options at the bottom of the page and follow the registration wizard.

How can I learn more about ICR?
Learn more about ICR by attending one of the monthly webinars.

Who can I contact with questions?
For questions regarding our ICR tool, please contact your local Provider Network Relations representative or contact Provider Services at 1-866-805-4589.

For questions on accessing our tool via Availity, call Availity Client Services at 1-800-282-4548. Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your questions.

Note: ICR is not currently available for requests involving transplant services or services administered by AIM Specialty Health® or OrthoNet LLC. For these requests, follow the same preauthorization process you use today.

SSO-NL-0046-18

Electronic claim payment reconsideration

Please view the full article included in the Medicaid section.

Providers who have questions as they begin to use the new functionality should contact Amerigroup at 1-866-805-4589.

SSO-NL-0045-18

Electronic Data Interchange migration to Availity

Please view the full article included in the Medicaid section.

It is our priority to deliver a smooth transition to Availity for our EDI services. If you have questions please contact your Provider Relations representative or Provider Services at 1-866-805-4589.

SSO-PEC-1080-18

Reimbursement Policies:

Policy Update

Medical Recalls

(Policy 06-111 — effective 11/01/2018)

In applicable circumstances, the appropriate modifier, condition code or value code (identified below) should be used to identify a medically recalled item. This will assist Amerigroup Community Care in identifying medically recalled items and support correct coding guidelines.

Applicable condition codes are 49 and 50. Condition code 49 signifies products replaced within the product lifecycle due to the product not functioning properly, and condition code 50 is used for product replacement for known recall of a product.

When a credit or cost reduction is received by the provider for the replacement device, applicable modifiers are FB and FC. Modifier FB is used when items are provided without cost to the provider, supplier or practitioner, and modifier FC is used when a partial credit is received by the provider, supplier or practitioner for the replacement device.

Note: In circumstances where we have reimbursed the provider for repair or replacement of items or procedures related to items due to a medical recall, we are entitled to recoup or recover fees from the manufacturer and/or distributor as applicable. In circumstances where we have reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, we are entitled to recoup or recover fees from the provider.

Please refer to CMS and/or your state's guidelines, and the Medical Recalls reimbursement policy for additional details at https://providers.amerigroup.com/TN > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

TN-NB-0010-18

Normal newborn diagnosis-related group claims processing update

Summary of change: Effective November 1, 2018, Amerigroup Community Care will update the claims processing system to ensure accurate payment of newborn claims in accordance with Tennessee normal newborn diagnosis-related group (DRG) requirements and our inpatient authorization requirements.

All newborn inpatient stays must have sufficient documentation provided to support an admission to an area beyond the newborn nursery, such as a neonatal intensive care unit (NICU) or for the higher level of care associated with the more complex newborn DRG. Documentation to support the higher level admission includes authorization or medical records.

Failure to provide the appropriate documentation will result in the claim being processed based on the normal newborn rate. Please note that current authorization guidelines for normal newborn and higher level of care baby inpatient stays will be applied.

What is the impact of this change?

- Newborn claims billed with higher level of care newborn DRG codes (see Table A) must have the required documentation on file. If the required documentation is not on file, the claim will be processed based on the normal well-newborn DRG rate.
- Documentation is required for reimbursement of non-normal newborn care or an inpatient stay beyond the normal well-newborn period or admission to an NICU.
- When newborn claims are submitted with only newborn care revenue codes (170 and 171) and there is no authorization for services provided for a higher level of care to support the higher level of care DRG, the claims will automatically be paid down to the normal newborn rate.

***Explanation of Payment* code**

Based on the above, we have implemented a new explanation (EX) code A 59 (DRG billed does not match the revenue code submitted). This code will appear on your *Explanation of Payment* when a claim is billed with a higher level of care newborn DRG code and the required authorization for the higher level of care is not on file.

You may appeal your request for payment of the higher acuity DRG by submitting the appropriate supporting clinical documentation. Please follow the normal appeal process detailed in our provider manual, which is available online at https://providers.amerigroup.com/TN.

What if I need assistance?

For precertification requests, please call Provider Services at 1-800-454-3730.

Table A: Medicare Severity (MS)-DRG codes

MS-DRG	Description
790	Extreme immaturity or respiratory distress syndrome, neonate
791	Prematurity with major problems
792	Prematurity without major problems
793	Full term neonate with major problems
794	Neonate with other significant problems
795	Normal newborn

TN-NB-0013-18

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

Employment and Community First CHOICES streamlined referral process

In an effort to reduce delays with service initiation for Employment and Community First CHOICES (ECF CHOICES) enrollees, Amerigroup Community Care has initiated a process improvement to aid in improving referral acceptance rates. Provider agency referral acceptance/rejection rates are now being tracked through TennCare and reported by administering MCOs on a monthly basis to network gaps or areas of opportunity.

The goal of the process improvement is to achieve sustained reduction in service initiation delays through administrative simplification, and aggressive management and follow up of open referrals. This includes understanding, elevating and clearing the barriers identified by providers to be inhibiting their ability to consistently accept and staff needed referrals.

To aid in this process, Amerigroup has put together the following details outlining the streamlined
ECF CHOICES referral process:

- Previously, provider agencies received referrals directly from support coordination, either through email or via phone call. This process has changed. Provider agencies will now receive all ECF CHOICES service referrals from the email box

tnecfreferrals@anthem.com in a secure format (that requires providers to log in to view) with the individual's support coordinator copied on the email.

- Secure referrals sent to provider agency intake teams also include a PDF version of the referral to include the following details:
    - Demographic info (name, age, gender, city, county, region)
    - Short story: summary of person pulled from the most recent person-centered support plan (PCSP)
    - Service needs including any specific ratios (i.e., CISS 1:1, 1:2); goal service is targeted to assist in reaching, preferred days/times of service, amount of service needed, and flexibility/preferred start date
    - Meet-and-greet details including contact info
    - Diagnosis information
    - Additional info including PCSP risks, staffing preferences, social/behavioral info, communication needs and conservatorship
- Provider agencies are then required to reply back to the referral email at tnecfreferrals@anthem.com with either their acceptance/rejection of the referrals within **48 hours of receipt**.
    - If a provider agency accepts the referral, Amerigroup requires the provider to notify us that either:
        - Staff are trained and ready to perform the service(s).
        - Staff are in the process of training and nearing completion to provide service(s).
        - No trained staff are available and agency would need to hire staff to provide service(s).
    - If a provider agency rejects the referral, the reason for rejection is required (i.e., no staffing, no training, no reach for service area, etc.)
    - Multiple service needs may be included on the referral form. However, providers are only expected to give their acceptance/rejection for the services that they are contracted to provide.
- Provider agencies will contact the individual's support coordinator to communicate details surrounding the meet and greet such as scheduling and results.
    - Accepting a referral to schedule a meet and greet does not lock the provider agency into having to provide the services. The meet and greet is an in-person meeting that allows both the member and the potential provider agency to discuss service needs. Only if there is a mutual agreement to partner for the provision of services would the provider agency be expected to complete the delivery of service(s) to the person.
- Amerigroup recommends as a best practice that each provider agency have one referral email address (or possibly two if dedicating an address specifically for employment referrals) to streamline the referral transmission process.
    - Amerigroup would prefer that these email addresses are not tied to an individual's email to avoid any potential referral gaps due to turnover.
    - Amerigroup requests that provider agencies update us immediately with any email or contact changes, including the adoption of a dedicated email box for referrals. Please send these updates directly to mailto:mltcprovreq@amerigroup.com.

- Amerigroup will initiate a representative outreach by phone to discuss any referrals that do not have a response within the requested timeframe of 48 hours.
- Amerigroup will continue to send out open referrals for individuals that your agency has declined previously in hopes that staffing and agency situations have changed to allow acceptance; the expectation will be that your agency responds to these rereferrals in the same time frame mentioned above.
    - Per reporting guidelines from TennCare, any rereferrals are counted as a separate and independent referral to the provider each time it is sent, which means providers are expected to provide a response each time, even if the previous response is still valid.
    - Rereferrals will be sent out (at minimum) a week after the initial referral was sent.
- Please notify your Provider Services representative immediately with any desire to expand your service reach (contracted counties) or service portfolio (expansion of contracted services).

TN-NB-0039-18

Joint MCO Credentialing and Re-Credentialing Site Visit Pilot

In collaboration with TennCare and the other MCOs, Amerigroup Community Care is pleased to inform the TennCare CHOICES and the Employment and Community First CHOICES provider network that we have completed the process development and consolidation for credentialing and recredentialing LTSS providers. This consolidated process seeks to minimize duplicative reviews when a provider is contracted with more than one MCO. In an effort to streamline the credentialing and recredentialing site visit process, the MCOs have worked together to create a uniform, electronic version of the onsite assessment tool.

Prior to implementing this change, we previewed both the universal tool as well as the combined joint MCO onsite processes with a few select providers to solicit feedback during the month of June.

Following completion of this pilot, we will conduct widespread notification and educational opportunities to introduce this exciting change to the LTSS network at large.

TN-NB-0039-18

Provider feedback requested — joint MCO *Critical Incident Reporting Form*

The new *Critical Incident Reporting and Investigation Form* was formally implemented on September 1, 2017. We are asking all home- and community-based service providers and the fiscal employer agent to provide us with any feedback that may help us improve the form in the future.

Your feedback is greatly appreciated!
Please direct your feedback to your MCO (Amerigroup Community Care, BlueCare or UnitedHealthcare Community Plan) provider advocate. You need only to respond to one MCO if

you are contracted with multiple TennCare health plans. Please Include Theresa Miller on your responses: theresa.miller@amerigroup.com.

TN-NB-0039-18

Electronic visit verification provider compliance update

The purpose of this notification is to ensure that all TennCare CHOICES and Employment and Community First CHOICES providers who utilize the electronic visit verification (EVV) system for the provision of home- and community-based services (HCBS) are aware of the updates to the tablet compliance requirements.

The policy changes are required to maintain compliance with TennCare requirements. Appropriate usage of the EVV system will also ensure providers receive less frequent outreach from the EVV team and that more appointments will be listed in an exportable status sooner when the check-in/out methods are utilized as intended.

Below, please find the detailed compliance requirements for EVV providers utilizing HealthStar. Please ensure all staff are aware of the changes related to the new compliance requirements as it relates to caregivers using either the tablet or the Bring Your Own Device (Android/iOS) application when both checking into and out of scheduled services.

Please take a moment to review this information, and should you have any questions please reach out to our EVV team box at: TN1LTCEVVCS@amerigroup.com.

Providers are responsible for complying with the following EVV system processes:

- Logging the arrival and departure of the provider/staff worker
- Verifying that services are being delivered at the correct location (i.e., the individual's home) and at the appropriate time
- Verifying the identity of the provider/staff worker providing the service to the individual
- Matching the services provided to an individual with the services authorized in the person-centered support plan
- Ensuring adherence to the established schedule of services
- Ensuring the provider/staff worker delivering the service is authorized to deliver such services
- Establishing a schedule of services for each individual that identifies the time each service is needed including the amount, frequency, duration and scope of each service
- Providing notification to the EVV team so contact can be made with the appropriate provider if a worker does not arrive as scheduled or otherwise deviates from the authorized schedule; this ensures service gaps and the reason service was not provided as scheduled are identified and addressed immediately and that backup plans are implemented as appropriate
- Logging the delivery of home-delivered meals including the individual's name, time delivered and, if applicable, the reason a meal was not delivered
- Generating claims for submission to Amerigroup Community Care
- Capturing worker/individual surveys
- Managing all tablets assigned to individuals under their care

Amerigroup requires all contracted providers to utilize the EVV system for applicable services. Contracted providers must also have at least two staff persons fully trained on the EVV system that can train caregivers on using the device in the individual's home. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitoring caregiver activity to ensure caregivers are in the individual's home providing services at the scheduled time agreed upon when the referral was accepted.

It is imperative providers comply with these standards to ensure individuals are receiving services in a timely manner. Failure to comply will result in corrective action, up to and including termination from the Amerigroup network.

Performance metrics for provider compliance

Staffed appointments
Provider compliance is calculated by taking the number of on-time appointments staffed by the provider and dividing by the total number of appointments for an individual over the calendar month.

Example:
Total appointments:..... 100
Missed visits:..... 5
Late visits:..... 5
On-time visits:..... 90
Compliance score (percent):..90/100=90

Provider compliance with appointment staffing will be monitored on an ongoing basis. The following minimum compliance scores are expected:

- Q2 2018: 85 percent
- Q3 2018: 90 percent
- Q4 2018 forward: 90 percent or higher

Providers that have not met the minimum performance requirements are subject to corrective actions, individual moratoriums, possible liquidated damages or termination from the Amerigroup provider network. Possible liquidated damages will not be applied to Q2 2018.

Manually confirmed visits
Manually confirmed visits are appointments for which the provider had to request and submit manual confirmations to Amerigroup for approval. Manual confirmations are instances in which the provider submits scanned time sheets requesting approval of time submitted.

Time sheets are required to contain the below items when submitted with a manual confirmation:

- Name of the individual receiving services
- Signature of the individual or an authorized representative
- Time services were rendered/duration of care — a.m./p.m. designation should be included
- Date services were rendered

- Tasks performed
- Name of caregiver performing services
- Name and/or logo of provider submitting time sheet

Any visit confirmed without any use of EVV for clocking in or clocking out is considered noncompliant and manually confirmed. Amerigroup will measure manual confirmation compliance by dividing the total number of manually confirmed visits by the total number of visits over the calendar month.

Example:
Total appointments:..... 100
Manually confirmed visits:..... 5
GPS/telephony confirmed visits: 95
Compliance score (percent):..95/100=95

Provider compliance with manually confirmed visits will be monitored on an ongoing basis. The following minimum compliance scores are expected:

- Q2 2018: 85 percent
- Q3 2018: 90 percent
- Q4 2018 forward: 90 percent or higher

Providers that have not met the minimum performance requirements are subject to corrective actions, individual moratoriums, possible liquidated damages or termination from the Amerigroup provider network. Possible liquidated damages will not be applied to Q2 2018.

Missed visit reason code/resolution status

It is the provider's responsibility to maintain the appropriate selection of reason codes/resolution statuses for all missed visits via the EVV system dashboard. This will be monitored through results from missed visits without reason codes/resolution statuses populated in an appropriate or timely manner. Providers have access to enter reason codes/resolution statuses up to seven days after the appointment date. Failure to submit a reason code/resolution status will result in an automated blank submission and will be added to the numerator in the missed visit calculation. Scores will be calculated as the total missed visits with reason codes/resolution statuses divided by the total number missed visits as applicable.

Example:
Total missed visits:..... 100
Missed visits with blank reason code/resolution status:5
Missed visits with reason code/resolution status: 95
Compliance score (percent):.....95/100=95

Provider compliance with missed visit reason code/resolution status entry will be monitored on an ongoing basis. The following minimum compliance scores are expected:

- Q2 2018: 85 percent
- Q3 2018: 90 percent
- Q4 2018 forward: 90 percent or higher

Providers that have not met the minimum performance requirements are subject to corrective actions, individual moratoriums, possible liquidated damages, or termination from the Amerigroup provider network. Possible liquidated damages will not be applied to Q2 2018.

TN-NB-0039-18

Spotlight on claims

In an effort to support the LTSS (TennCare CHOICES, Employment and Community First CHOICES) provider network with denial monitoring and management, Amerigroup Community Care is sharing the below trending data to assist you and your staff with:

- Identifying recurring and/or high-volume denial types.
- Helping you understand why this may be occurring.
- Correcting these types of errors.

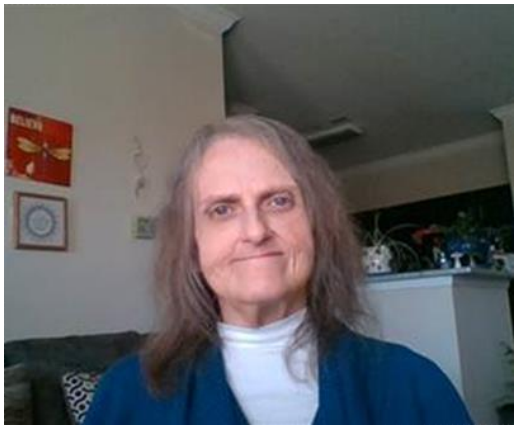
Top denial reasons	Why is this denial occurring?	How can providers correct this error?
Incorrect billing form/provider	Claim was billed using the *CMS-1500* claim form	• Resubmit a corrected claim using the required *UB-04* form format.
Definite duplicate claim	Claim or claim line exactly matches another claim or claim line: • Provider number • From date of service • Through date of service • Type of service • Procedure code • Place of service • Billed amount	• Check EOP for previously posted claim. • Verify reason initial claim was denied. • Do not resubmit to correct denial; this requires either a corrected claim or an appeal to resolve. • Use HeathStar or Availity Portal to check claim status.
Not a covered benefit/service	Service billed is either not a covered benefit or not a contracted service	• Verify covered benefit(s) outlined in the TennCare provider manual(s). • Verify provider contract to validate that you are contracted for the specified service billed. • Contact your provider relations representative for assistance.
Prior authorization (PA) not obtained	Authorization span, available units do not match to the service billed and/or are not included on the claim	• Verify what was billed against the authorization provided by Amerigroup. • Resubmit a corrected claim if necessary to correct available units and/or to add the PA info to the claim. • Contact the LTC authorization email: ltcprovreq@amerigroup.com
Resubmit with valid proc/rev code	Required coding defined by TennCare and/or MCO contract not utilized	• Verify the required coding to report the given service. • Resubmit a corrected claim using the appropriate coding.

Tips and Reminders

- Do not:
  - Resubmit claims while an identical claim is pending.
  - Split claims for resubmission; do not resubmit the entire claim when a partial payment has been made.
- Do:
  - Check previously processed claims.
  - Verify the reason an initial claim did not allow payment:
    - Resubmission will cause unnecessary duplicate denials when the initial claim is processed.
    - Submit an appeal request as applicable.
    - Submit a corrected claim as applicable.
    - Contact the Dedicated Service Unit (DSU) at 866-840-4991 for additional assistance.
  - Verify documentation of the following:
    - Service is appropriate to bill (covered benefit, contracted service).
    - Coding is correct (revenue code, CPT code and/or modifiers).
    - Active/valid authorization is in place for the service billed and was included on the claim.

TN-NB-0039-18

TennCare CHOICES success story



Mrs. C is an inspiration to her care coordinator and many others at Amerigroup Community Care. When first introduced to Mrs. C three years ago, she weighed over 500 pounds, had several near death experiences related to chronic diagnoses and she felt that she was admitted to the nursing facility "to die."

During her stay at the nursing facility, Mrs. C and the care coordinator utilized a person-centered focus to establish long-term and short-term goals, which empowered her to take control of her health. Mrs. C lost over 200 pounds and reported she started to gain dignity back. Mrs. C. transitioned from the nursing facility back home with her spouse and children and she has continued to flourish.

Mrs. C reports she has re-established herself as wife and mother in her home. As Mrs. C's life has evolved, so have her goals. After returning to her home, Mrs. C. wanted to give back and serve her community. She and the care coordinator explored volunteer opportunities, and she now volunteers at an inpatient hospice center in her town. Being independent is also a very important goal to Mrs. C. She has made great strides in accomplishing this goal as she is preparing for the driving test and is planning to go to Gatlinburg this summer for her first vacation in over ten years.

Mrs. C recently made the decision to voluntarily disenroll from the TennCare CHOICES program because she no longer needs us!

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Project SEARCH — 2018 graduation

Nine months ago, Amerigroup Community Care embarked on a journey to include people with disabilities in their workforce and became the first health plan in Tennessee to develop a Project SEARCH internship site. Project SEARCH is an internship program for people with disabilities to learn valuable, marketable skills in a real work setting. During the past nine months, the interns have learned skills such as organization and time management, complex computer skills, how to operate office equipment utilizing technology, and business and meeting etiquette, just to name a few.

Amerigroup has seen significant positive changes in our workplace culture because of this experience, and we are grateful for the opportunity. Our associates now relate to their customers better, report higher job satisfaction and have raised their expectations around people with disabilities in the workplace.

On June 1, 2018, three interns successfully graduated from the program, surrounded by their friends, family and coworkers. They are now ready for the world of work and are prepared to find a career that they love.

Amerigroup would like to thank our partners in this program, Progress Inc., Vocational Rehabilitation and Project SEARCH Cincinnati Children's Hospital. These partnerships are vital to the success of this program, and we appreciate your efforts. We are currently recruiting interns for the next Project SEARCH class, which will begin in September. If you would like to find out more about the program or know someone who might be interested, please reach out to Pam Hollingsworth at mailto:p.hollingsworth@progress-inc.org.

Terrell, Danny and Lauren, we are so proud of you and can't wait to see you achieve your dreams!

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TennCare CHOICES and Employment and Community First CHOICES LTSS Provider Relations contact and territory list

Amerigroup Community Care has an LTSS Provider Relations staff dedicated to providing education to assist with your day-to-day interactions with our health plan. You may contact your Provider Relations representative to schedule training either onsite in your office, or offsite at one of our regional office locations.

Your Provider Relations representative is your liaison to our health plan, bringing your needs, suggestions and concerns to the attention of our medical directors, policy makers and communications staff.

LTSS Provider Relations staff are assigned to each of the three regions as follows:

LTSS Provider Relations territory listing — Middle Grand Region	
Matthew Ortiz *Provider Relations Manager* Cell: 615-906-0635 Email: Matthew.Ortiz@amerigroup.com	Manager, Provider Relations (Middle)
Roosevelt Fayne *Network Senior Consultant* Cell: 615-626-8263 Email: Roosevelt.Fayne@amerigroup.com	**Counties serviced:** Cheatham, Davidson (split ECF only), Dickson, Houston, Montgomery, Robertson, Stewart, Trousdale
Sharita McCoy *Network Senior Consultant* Cell: 615-218-9985 Email: Sharita.Mccoy@amerigroup.com	**Counties serviced:** Bedford, Cannon, Coffee, Davidson (split ECF only), Dekalb, Giles, Hickman, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Rutherford (split), Wayne, Williamson
Chiana Adair *Network Senior Consultant* Cell: (615) 686-7152 Email: Chiana.Adair@amerigroup.com	**Counties serviced:** Clay, Cumberland, Davidson (split ECF only), Fentress, Jackson, Macon, Overton, Pickett, Putnam, Rutherford (split), Smith, Sumner, Warren, White, Wilson, Van Buren
LTSS Provider Relations territory listing — East Grand Region	
Taylor Burnette *Provider Relations Manager* Cell: 615-761-4853 Email: Taylor.Burnette@amerigroup.com	Manager, Provider Relations (East)
Katie Adcock *Network Senior Consultant* Cell: 865-440-9422 Email: Katie.Adcock@amerigroup.com	**Counties serviced:** Anderson, Blount, Campbell, Knox, Louden, Morgan, Roane, Scott, Sevier, Union
Lee-Ann Hartlett *Network Senior Consultant* Cell: 865-567-2551 Email: Lee-Ann.Hartlett@amerigroup.com	**Counties serviced:** Carter, Claiborne, Cocke, Grainger, Greene, Hamblen, Hancock, Hawkins, Jefferson, Johnson, Sullivan, Unicoi, Washington
Emily Goolsby *Network Senior Consultant* Cell: 423-486-8716 Email: Emily.Goolsby@amerigroup.com	**Counties serviced:** Bledsoe, Bradley, Franklin, Grundy, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea, Sequatchie

LTSS Provider Relations territory listing — West Grand Region	
Maria Robinson *Provider Relations Manager* Cell: 901-569-7350 Email: Maria.Robinson@amerigroup.com	Manager, Provider Relations (West)
Sheldon House *Network Senior Consultant* Cell: 615-440-9608 Email: Sheldon.House@amerigroup.com	**Counties serviced:** Dyer, Fayette, Haywood, Lauderdale, Shelby (N-Z), Tipton
Karen Hughes *Network Senior Consultant* Cell: 615-571-0687 Email: Karen.Hughes@amerigroup.com	**Counties serviced:** Benton, Carroll, Decatur, Gibson, Henderson, Henry, Lake, Madison, Obion, Weakley
Christopher Kea *Network Senior Consultant* Cell: 901-422-0626 Email: Christopher.Kea@amerigroup.com	**Counties serviced:** Chester, Crockett, Hardeman, Hardin, McNairy, Shelby (A-M)