Provider Newsblast

https://providers.amerigroup.com/TN

Amerigroup RealSolutions® in healthcare

December 2016

Table of Contents

Intracardiac electrophysiological studies and catheter ablation to require prior authorization

Effective April 1, 2017, intracardiac electrophysiological studies and catheter ablation will require prior authorization (PA). All requests with dates of service beginning on or after April 1, 2017, must be submitted for PA.

Please refer to the provider self-service tool for detailed authorization requirements. To locate the provider self-service tool:

- Go to https://providers.amerigroup.com/TN
- Under Provider Resources & Documents, select Quick Tools and then select Precertification Lookup Tool.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

Please use one of the following methods to request PA:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: https://providers.amerigroup.com

Federal and state law, state contract language, CMS guidelines and definitions, as well as specific contract provisions and exclusions take precedence over these PA rules and must be considered first when determining coverage.

Update to the ClaimsCheck® upgrade to ClaimsXten™

Earlier this year, Amerigroup announced plans for an upgrade from ClaimsCheck to McKesson's next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

With the new software functionality, edits will be applied with greater accuracy. The new software functionality will also allow for greater flexibility with rule development and configuration.

For additional details regarding this software update, please refer to the original communication posted at https://providers.amerigroup.com/TN > Provider Resources & Documents > Newsletters > Provider Newsblast – July 2016.

Reminder: level 2 mental health case management services

As a reminder, Amerigroup Community Care will not reimburse for level 2 mental health case management services rendered after November 30, 2016. Beginning December 1, 2016, your patients who receive level 2 mental health case management services will transition to an approved Tennessee Health Link provider for care coordination activities. Patients will then receive care coordination services from this Tennessee Health Link provider. For more information about Tennessee Health Link, please visit https://www.tn.gov/hcfa/article/tennessee-health-link.

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On August 4, 2016, the Amerigroup Community Care Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies*. 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 the Amerigroup provider website on the effective date listed below. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies. **Existing precertification requirements have not changed.**

The Medical Operations Committee also adopted the Interqual Coronary Bypass Procedures Criteria for use in review of the 1-2 vessel coronary artery bypass grafting (CABG) procedures on September 11, 2016.

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
10/4/2016	DME.00039	Prefabricated Oral Appliances for the Treatment of Obstructive Sleep Apnea	New
10/6/2016	DRUG.00081	Eteplirsen (Exondys 51™)	New
8/18/2016	DRUG.00087	Asfotase Alfa (Strensiq™)	New
8/1/2016	DRUG.00088	Atezolizumab (Tecentriq™)	New
8/18/2016	DRUG.00089	Daclizumab (Zinbryta™)	New
8/18/2016	DRUG.00091	Naltrexone Implantable Pellets	New
8/18/2016	DRUG.00092	Probuphine® (buprenorphine implant)	New
8/18/2016	DRUG.00093	Sebelipase alfa (KANUMA™)	New
10/4/2016	GENE.00046	Prothrombin G20210A (Factor II) Mutation Testing	New
10/4/2016	GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing	New
8/18/2016	LAB.00032	Zika Virus Testing	New
8/1/2016	RAD.00066	Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy	New
10/4/2016	SURG.00144	Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia	New
8/18/2016	BEH.00002	Transcranial Magnetic Stimulation	Revised
10/4/2016	DRUG.00002	Tumor Necrosis Factor Antagonists	Revised
8/18/2016	DRUG.00024	Omalizumab (Xolair®)	Revised
8/18/2016	DRUG.00058	Pharmacotherapy for Hereditary Angioedema (HAE)	Revised
8/1/2016	GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	Revised
10/4/2016	GENE.00026	Cell-Free Fetal DNA-Based Prenatal Testing	Revised
10/4/2016	MED.00051	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Revised

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
8/18/2016	RAD.00042	SPECT/CT Fusion Imaging	Revised
8/18/2016	SURG.00014	Cochlear Implants and Auditory Brainstem Implants	Revised
8/18/2016	SURG.00020	Bone-Anchored and Bone Conduction Hearing Aids	Revised
10/1/2016	SURG.00028	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions	Revised
8/18/2016	SURG.00055	Cervical Total Disc Arthroplasty	Revised
8/18/2016	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Revised
8/18/2016	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical Utilization Management Guidelines update

Summary: On August 4, 2016, 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 below listing. This list represents the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on September 1, 2016.

On August 4, 2016, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific guidelines. **Existing precertification requirements have not changed.**

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Effective date	*Clinical UM Guideline* number	*Clinical UM Guideline title*	New or revised
8/18/2016	CG-ADMIN-01	Clinical Utilization Management (UM) Guideline for Pre-Payment Review Medical Necessity Determinations When No Other Clinical UM Guideline Exists	New
10/4/2016	CG-DRUG-59	Testosterone, Injectable	New
10/4/2016	CG-MED-55	Level of Care: Advanced Radiologic Imaging	New
10/4/2016	CG-SURG-57	Diagnostic Nasal Endoscopy	New
10/4/2016	CG-SURG-58	Radioactive Seed Localization of Nonpalpable Breast Lesions	New
10/4/2016	CG-DRUG-21	Naltrexone (Vivitrol®) Injections for the Treatment of Alcohol and Opioid Dependence	Revised
8/18/2016	CG-SURG-27	Sex Reassignment Surgery	Revised
10/4/2016	CG-SURG-55	Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation	Revised

Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) updates

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the DSM-5.

When transitioning from the DSM-IV-TR to the DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in DSM-5.

Although formatted differently, the same information is found within the DSM-5 diagnostic system. DSM-5 combines DSM-IV-TR axes I-III diagnoses into one list, as shown in Table 1.

Table 1: DSM-5 diagnosis

DSM-IV multiaxial system	DSM-5 nonaxial system
Axis I: clinical disorder (d/o) and other conditions that are focus of treatment **Axis II:** personality d/o and mental retardation Axis III: general medical conditions	Combined attention to clinical disorders, including personality disorders and intellectual disability, other conditions that are the focus of treatment, and medical conditions.
Axis IV: psychosocial and environmental stressors	Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.
Axis V: Global Assessment of Functioning (GAF)	Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis V GAF was removed from DSM-5. Alternatively, WHODAS 2.0 is included in section III of DSM-5.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

***Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®)* updates continued**

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at http://psychiatryonline.org. Select **View the DSM-5® Update (September 2016)**.

Table 2

Disorder	Codes effective October 1, 2016
Avoidant/Restrictive Food Intake Disorder	F50.89
Binge-Eating Disorder	F50.81
Disruptive Mood Dysregulation Disorder	F34.81
Excoriation (Skin-Picking) Disorder	F42.4
Gender Dysphoria in Adolescents and Adults	F64.0
Hoarding Disorder	F42.3
Obsessive-Compulsive Disorder	F42.2
Other Specified Depressive Disorder	F32.89
Other Specified Feeding or Eating Disorder	F50.89
Other Specified Obsessive-Compulsive and Related Disorder	F42.8
Pica, in adults	F50.89
Premenstrual Dysphoric Disorder	F32.81
Social (Pragmatic) Communication Disorder	F80.82
Unspecified Obsessive-Compulsive and Related Disorder	F42.9

Some resources that may best help you include:

- *American Medical Association, Professional Edition CPT* (current procedural terminology), 2016.
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA, American Psychiatric Association, 2013.
- *ICD-10-CM and ICD-10-PCS Coding Handbook 2016*.

Amerigroup Community Care *Provider Manual* updates

The latest update to the Amerigroup *Provider Manual* is now available online. To view the Provider Manual, visit our provider website (https://providers.amerigroup.com/TN > Provider Resources & Documents > Manuals & QRCs > Medicaid Provider Manual).

Physicians: enrollment deadline for PIPP — updated

Physicians, Nurse Midwives, Nurse Practitioners, & Physician Assistants

Program Year 2016 Provider Incentive Payment Program (PIPP) attestations are due March 31, 2017, at 11:59 PM CT. This means that if you have never registered before to participate, you must register at CMS, and then get that first attestation to TennCare by March 31, 2017.

Need more information about PIPP, please go to the TennCare EHR Incentive web site: http://www.tn.gov/tenncare/section/electronic-health-record. You can email TennCare at TennCare.EHRIncentive@tn.gov for assistance. Got a question about Meaningful Use? Send an email to EHRMeaningfuluse.TennCare@tn.gov.

Note: Physician Assistants: In order to participate, you must be working in a PA-led FQHC or an RHC so led by a PA to receive the EHR Provider Incentive Payment. See our web site for more information.

Physicians: update to MU requirements for PIPP

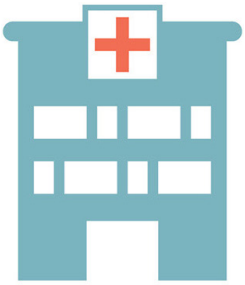
Physicians, Nurse Midwives, Nurse Practitioners, & Physician Assistants

The records of the TennCare Medicaid EHR Provider Incentive Payment Program (PIPP) indicate that a number of providers have begun the attestation process, but have not gone beyond one or two EHR incentive payments. Does that describe you? We know some providers may have stopped attesting because they did not meet the 30% patient volume (PV) requirement. Have you checked your mix of patients lately? You may not realize that your patient load has changed and you again meet the PV requirement.

Some providers stopped attesting because they felt meeting Meaningful Use (MU) was too complex or difficult. Did you know CMS heard you? MU requirements have changed – some have been eliminated; the targets for some measures have been lowered or otherwise changed. Whatever the reason which caused you to stop attesting, we would like to hear from and try to help you get back on track. Send an email to TennCare.EHRIncentive@tn.gov, let us know what's going on and we'll do our best to help you complete the EHR Incentive Program.

Hospitals: enrollment deadline for PIPP — updated

Acute Care Hospitals, Critical Access Hospitals, & Children's Hospitals



Program Year 2016 Provider Incentive Payment Program (PIPP) attestations are due March 31, 2017, at 11:59 PM CT. This means that if you have never registered before to participate, or haven't submitted your first EHR attestation, you must register at CMS, and then get that first attestation to TennCare by March 31, 2017.

Need more information about PIPP, please go to the TennCare EHR Incentive web site: http://www.tn.gov/tenncare/section/electronic-health-record. You can email TennCare at TennCare.EHRIncentive@tn.gov for assistance. Got a question about Meaningful Use? Send an email to EHRMeaningfuluse.TennCare@tn.gov.

Hospitals: update to MU requirements for PIPP

Acute Care Hospitals, Critical Access Hospitals, & Children's Hospitals

The records of the TennCare Medicaid EHR Provider Incentive Payment Program (PIPP) indicate that a number of providers have begun the attestation process, but have not gone beyond one or two EHR incentive payments. Does that describe you? We know some providers may have stopped attesting because they did not meet the 10% patient volume (PV) requirement (Children's hospital do not have a minimum patient volume requirement). Have you checked your mix of patients lately? You may not realize that your patient load has changed and you again meet the PV requirement.

Some providers stopped attesting because they felt meeting Meaningful Use (MU) was too complex or difficult. Did you know CMS heard you? MU requirements have changed – some have been eliminated; the targets for some measures have been lowered or otherwise changed. Whatever the reason which caused you to stop attesting, we would like to hear from and try to help you get back on track. Send an email to TennCare.EHRIncentive@tn.gov, let us know what's going on and we'll do our best to help you complete the EHR Incentive Program.

HCPCS codes required for rural health clinic claims

All claims for Amerigroup Amerivantage (Medicare Advantage) members from rural health clinics with dates of service on or after April 1, 2016, must contain an appropriate HCPCS code for each service line along with a revenue code. This pertains to contracted and noncontracted providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including dual special needs plans and Medicare-Medicaid plans.