Provider Newsblast

https://providers.amerigroup.com/TN

Amerigroup RealSolutions in healthcare

March 2017

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Interactive Care Reviewer tool: Register and start using today!

Beginning February 18, 2017, your practice can initiate online preauthorization requests for TennCare members more efficiently and conveniently with our Interactive Care Reviewer (ICR) tool available through the Availity Web Portal. The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Web Portal. There are no changes to the preauthorization capabilities on the provider website (https://providers.amerigroup.com/TN).

How do I gain access to the ICR?

You can access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select **Register** in the upper right-hand corner of the page. If your organization already has access to Availity, your Availity administrator can grant you access to "authorization and referral request" for submission capability and "authorization and referral inquiry" for inquiry capability. You can then find our tool under Patient Registration > Authorizations & Referrals. From this area, you can select the authorizations or authorization/referral inquiry option as appropriate.

Who can I contact with questions?

For questions regarding our ICR tool, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY. Availity Client Services is available Monday-Friday from 8 a.m.-7 p.m. ET (excluding holidays) to answer your registration questions.

What benefits/efficiencies does the ICR provide?

- **You are automatically routed to our ICR.** Once the ICR is available, when you go to Authorizations in the Availity Web Portal, you are automatically routed to the ICR in order to begin your prior authorization request.
- **You can determine if prior authorization is needed**. For most requests, when you enter patient, service and provider details, you will receive a message indicating whether or not review is required.
- You will have inquiry capability. Ordering and servicing physicians and facilities can locate information on preauthorization requests for those they are affiliated with; this includes requests previously submitted via phone, fax, ICR or another online tool (e.g., AIM Specialty Health®, OrthoNet LLC, eReview).
- **The ICR is easy to use.** You can submit outpatient and inpatient requests for services online using the same, easy-to-use functionality.
- **The ICR reduces the need to fax.** The ICR allows text detail as well as images to be submitted along with the request. Therefore, you can submit requests online and reduce the need to fax medical records.
- **There is no additional cost to you.** The ICR is a no-cost solution that's easy to learn and even easier to use.
- **You can access the ICR tool almost anywhere.** You can submit your requests from any computer with internet access. (Note: We recommend you use Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.)
- Y**ou receive a comprehensive view of all your preauthorization requests.** You have a complete view of all the utilization management requests you submitted online, including the status of your requests and specific views that provide case updates and a copy of associated letters.

TN-NL-0053-16

Continuous interstitial glucose monitoring to require prior authorization

For dates of service on or after April 15, 2017, prior authorization (PA) will be required for continuous interstitial glucose monitoring 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:

- A9276: sensor — invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system (one unit = one-day supply)
- A9277: transmitter — external, for use with interstitial continuous glucose monitoring system
- A9278: receiver (monitor) — external, for use with interstitial continuous glucose monitoring system
- 95250: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording
- 95251: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — interpretation and report

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-0038-16

Abortion, sterilization and hysterectomy services

When submitting claims for abortion, sterilization or hysterectomy (ASH) services, providers should use the most current ASH form and review the instructions. The forms and their applicable instructions can be found online at http://www.tn.gov/tenncare/topic/miscellaneous-provider-forms.

Only forms approved by TennCare will be reimbursed for ASH services. Forms must be filled out correctly and in their entirety. Use of unapproved forms will result in a claim denial. Please remind your claims or billing staff of this requirement.

TN-NL-0055-17

Appointment availability and after-hours access requirements

To ensure members receive care in a timely manner, PCPs, specialty providers and behavioral health providers must maintain the following appointment availability standards:

Requirements for PCPs and specialists		
	Appointment type	Appointment standard
	Emergency visits — all provider types	Immediately
	Urgent visits — all provider types	Within 48 hours
	Routine or preventive visits — PCPs	Within three weeks
	Routine visits — specialists	Within 30 days of referral
	Optometry visits, regular visits	Within three weeks
	Wait time	Should not exceed 45 minutes for scheduled appointment
Requirements for behavioral health providers		
	Outpatient (non-MD services)	Within 10 business days; urgent within 48 hours
	Intensive outpatient services	Within 10 business days; urgent within 48 hours
	Substance abuse, outpatient services	Within 10 business days; for detoxification: within 24 hours
	Mental health case management	Within seven calendar days
	Crisis services (mobile)	Face-to-face contact within one hour for emergencies; within four hours for urgent
	Crisis stabilization	Within four hours of referral

After-hours access requirements for PCPs:

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to make contact after normal business hours:

- Have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 60 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP to direct the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Amerigroup network medical practitioner who can return the call within 60 minutes.

The following telephone answering procedures are **not** acceptable:

- Office telephone is only answered during office hours.
- Office telephone is answered after hours by a recording that tells members to leave a message.
- Office telephone is answered after hours by a recording that directs members to go to an emergency room for any services needed.
- After-hours calls are answered outside of 60 minutes.

Billing changes for fluoride varnish

Effective May 1, 2017, Amerigroup Community Care will no longer reimburse for the application of topical fluoride varnish by a physician or other qualified health care professional. Fluoride varnish is typically applied as part of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) well-child visit.

What this means:

Fluoride varnish may be provided by physicians, nurse practitioners and physician assistants who have received training for this service. However, the application of fluoride varnish by a PCP does not constitute a dental visit. The PCP Fluoride Varnish program requires referral to a dentist for a complete oral evaluation including appropriate diagnostic and preventive services. In order to count toward EPSDT dental requirements, an actual dental visit must occur.

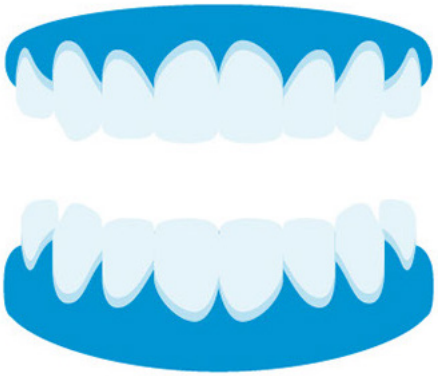
Why should I provide fluoride varnish?

Fluoride varnish acts to impede, arrest and reverse the decay process. The teeth absorb the fluoride varnish, which strengthens the enamel and helps prevent cavities. It is not a substitute for fluoridated water or toothpaste.

How is fluoride varnish reimbursed?

Qualified health care professionals should contact DentaQuest at 1-855-418-1623 or visit www.dentaquest.com > Dentists > Tennessee > TennCare Dentist Page > TennCare Non-Traditional Fluoride Varnish Program for more information.

TNPEC-1748-17



Notification process reminder

Effective April 24, 2017, failure to obtain precertification for TennCare members and failure to notify Amerigroup Community Care of a member's admission or transfer within established time frames (as outlined below) will result in your claims being administratively denied, and you will not receive payment for the service(s). For participating providers, this is a contractual obligation and has been in effect since the execution of your contract. As a reminder, providers cannot balance bill members for services that are administratively denied. Members who are retroactively enrolled into the plan by the state are deemed out of scope.

If your claim is administratively denied, you may file a payment dispute in accordance with rules and regulations. As part of the payment dispute, you must demonstrate that you notified or attempted to notify Amerigroup within the contractually established time frame and that the service(s) are medically necessary.

What is the impact of this change?

Notification requirements:

Amerigroup must be notified of all member admissions or transfers within one business day of admission or transfer. Ideally, notification should occur the day of admission or transfer; however, you have one business day to notify Amerigroup without penalty. A business day is considered Monday-Friday and does not include weekends or weekdays that fall on federal holidays.

Notification process reminder (cont.)

Notification requirements (cont.):

Notification for all post-stabilization admissions including transfers should occur within one business day of admission. The following clinical scenarios are excluded:

- Admission to a Neonatal Intensive Care Unit (NICU) level III
- Admission to an Intensive Care Unit (ICU)
- Direct admission to an operating room (OR)/recovery room
- Direct admission to a telemetry floor
- Involuntary behavioral health admission

Note, admission to a general ward is considered in scope for our notification requirements. Failure to notify us within one business day of admission to the general ward or NICU level I or II is considered failure to notify, and administrative denial applies. Once the member has been downgraded to a general ward from the NICU level III, ICU, OR/recovery or telemetry, the requirement for notification within one business day applies.

Notification of OB antepartum/postpartum admissions that do not result in a delivery should occur within one business day.

Precertification requirements:

Precertification is required for the following:

- Nonemergent inpatient transfers between acute facilities
- Elective inpatient admissions
- Rehabilitation facility admissions
- Long-term acute care admissions
- Skilled nursing facility admissions
- Behavioral health levels of care (as outlined in the provider handbook and precertification documents)
- Out-of-area/out-of-network services
- Outpatient services (as outlined within the Precertification Lookup Tool on the website)
- Outpatient durable medical equipment purchases and rentals (as outlined within the Precertification Lookup Tool on the website)

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

To obtain precertification or to verify member eligibility, benefits or account information, follow instructions outlined on the provider website or in the *Quick Reference Guide*, provider manual, interactive voice response system or Availity Web Portal where applicable.

For additional information and/or detailed precertification requirements, refer to the provider website (https://providers.amerigroup.com/TN > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On November 3, 2016, 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 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. Please share this notice with other members of your practice and office staff.

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
12/28/2016	DME.00040	Automated Insulin Delivery Devices	New
12/28/2016	DRUG.00090	Bezlotoxumab (ZINPLAVA™)	New
11/17/2016	DRUG.00097	Olaratumab (Lartruvo™)	New
12/28/2016	DRUG.00102	Cabazitaxel (Jevtana®)	New
12/28/2016	LAB.00033	Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer	New
11/17/2016	DME.00036	Ultraviolet Light Therapy Delivery Devices for Home Use	Revised
11/17/2016	DRUG.00038	Bevacizumab (Avastin®) for Non Ophthalmologic Indications	Revised
11/17/2016	DRUG.00041	Rituximab (Rituxan®) for Non-Oncologic Indications	Revised
11/17/2016	DRUG.00042	Ustekinumab (Stelara®) (HAE)	Revised
11/17/2016	DRUG.00048	Eribulin mesylate (Halaven®)	Revised
11/17/2016	DRUG.00057	Canakinumab (Ilaris®)	Revised
11/17/2016	DRUG.00068	Vedolizumab (Entyvio®)	Revised
12/28/2016	DRUG.00066	Antihemophilic Factors and Clotting Factors	Revised
11/17/2016	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
11/17/2016	DRUG.00075	Nivolumab (Opdivo®)	Revised
11/17/2016	DRUG.00082	Daratumumab (DARZALEX™)	Revised
11/17/2016	DRUG.00085	Ixabepilone (Ixempra®)	Revised
11/17/2016	DRUG.00088	Atezolizumab (Tecentriq™)	Revised
12/28/2016	GENE.00002	Preimplantation Genetic Diagnosis Testing	Revised
11/17/2016	GENE.00019	BRAF Mutation Analysis	Revised
11/17/2016	GENE.00035	Genetic Testing for TP53 Mutations	Revised
11/17/2016	MED.00064	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	Revised

***Medical Policies* and *Clinical Utilization Management Guidelines* update (cont.)**

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
11/17/2016	MED.00083	Melanoma Vaccines	Revised
11/17/2016	SURG.00055	Cervical Total Disc Arthroplasty	Revised
11/17/2016	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical Utilization Management Guidelines update

On November 3, 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 following listing. This list represents the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on December 6, 2016.

On November 3, 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 share this notice with other members of your practice and office staff.

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
11/17/2016	CG-DRUG-64	FDA-Approved Biosimilar Products	New
12/28/2016	CG-DRUG-54	Agalsidase beta (Fabrazyme®)	New
12/28/2016	CG-DRUG-55	Elosulfase alfa (Vimizim®)	New
12/28/2016	CG-DRUG-56	Galsulfase (Naglazyme®)	New
12/28/2016	CG-DRUG-57	Idurasufase (Elaprase®)	New
12/28/2016	CG-DRUG-58	Laronidase (Aldurazyme®)	New
12/28/2016	CG-DRUG-60	Gonadotropin Releasing Hormone Analogs for the Treatment of Oncologic Indications	New
12/28/2016	CG-DRUG-61	Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications	New
12/28/2016	CG-DRUG-62	Fulvestrant (FASLODEX®)	New
12/28/2016	CG-DRUG-63	Levoleucovorin Calcium (Fusilev®)	New
12/28/2016	CG-SURG-56	Diagnostic Fiberoptic Flexible Laryngoscopy	New
11/17/2016	CG-DRUG-38	Pemetrexed Disodium (Alimta®)	Revised
11/17/2016	CG-SURG-15	Endometrial Ablation	Revised
11/17/2016	CG-SURG-45	Bone Graft Substitutes	Revised
11/17/2016	CG-SURG-58	Radioactive Seed Localization of Nonpalpable Breast Lesions	Revised

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.

TNPEC-1630-16

Physicians: update to MU requirements for PIPP

Physicians, Nurse Midwives, Nurse Practitioners, & Physician Assistants

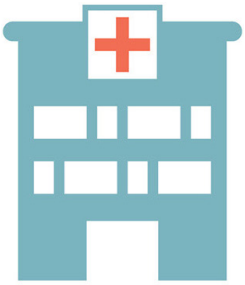
The records of the TennCare Medicaid EHR Provider Incentive Payment Program (PIPP) indicate that a number of providers have begun the attestation process, but have not gone beyond one or two EHR incentive payments. Does that describe you? We know some providers may have stopped attesting because they 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 Stage 2 requirements have been modified — some have been eliminated. 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.

TNPEC-1632-16

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.

TNPEC-1631-16

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 Stage 2 requirements have been modified — 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.

TNPEC-1633-16

Launch of the Retrospective Medical Record Review Program

Risk adjustment is the method used by CMS to adjust the capitated payment made to Amerigroup Community Care based on demographic characteristics and health status (represented by diagnosis data and disease interactions) of each Amerigroup Amerivantage (Medicare Advantage) member. Risk adjustment relies on the timely and accurate collection and submission of member diagnosis data each year. All diagnosis data must be supported by the member's medical record documentation. Federal regulations require Amerigroup to review and validate medical records to avoid underpayments and overpayments.

Program details:

Our retrospective medical record review initiative is a risk adjustment program intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations.

Amerigroup contracts with Verscend Health (formerly Verisk) to conduct outreach to providers as well as collect, review and code medical records with dates of service for the 2017 target year through present day.

What if I need assistance?

The Retrospective Risk Program Lead, Jaime Marcotte, is managing this initiative. For more information on this program, please contact Jaime at 314-925-6094.

FAQ — Retrospective Medical Record Review Program
Q. What is the Retrospective Medical Record Review Program? A. The program is intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations. We exclusively contract with Verscend Health (formerly Verisk) for this initiative.
Q. What services is Verscend performing on behalf of Amerigroup? A. Verscend is contracted to retrieve the medical records of targeted members as well as review these records and code them based on ICD-10-CM coding guidelines and requirements. Additionally, Verscend sends a data extract including the coded conditions to us.
Q. Is the retrospective medical record review an audit? A. This is not a retrospective claims validation audit.
Q. What dates of service are included for the 2017 initiative? A. The scope for this initiative includes 2016 dates of service through present day.
Q. Are all Amerigroup Amerivantage (Medicare Advantage) members targeted? A. No, Amerigroup conducts a complex effort synthesizing claims and pharmacy data with enrollment data. Due to the high probability of identifying undocumented data and/or new diagnosis information, persistent members are targeted for this initiative.

Launch of the Retrospective Medical Record Review Program (cont.)

Q. What is the provider notification process?

A. Beginning in early May, Verscend will initiate the record retrieval process. The process begins with phone/fax outreach to the provider that is followed by a written request. The written request includes:

- Role of Verscend
- Purpose of the medical record retrieval request
- Action being requested (e.g., submission of the entire medical record)
- Name of the member
- Date(s) of service being requested

Q. When do I need to submit the requested medical records?

A. You should supply the medical records within two weeks of receipt of the request. If the volume is large, Verscend will work with you throughout 2017 to obtain the requested records.

Q. What should I do if I did not actually see the member during the requested date(s) of service?

A. You should return the request to Verscend and include an explanation stating you do not have information relative to the request in the patient's medical record.

Q. How do I submit a medical record? Are there different submission options?

A. Medical records should be returned to Verscend using one of the following methods:

- Mail with prepaid postage
- Electronic medical record (EMR) integration (Verscend requires remote access to the provider's EMR system.)
- Secure file transfer protocol
- Secure Provider Upload Portal (Contact Jaime Marcotte for details regarding this option.)
- On-site scanning (reserved for providers with large record requests)

Q. I received a request for a large number of medical records; can special arrangements be made?

A. Verscend offers on-site scanning services for providers who receive a request for a large number of medical records.

Q. Am I required to comply with the request for medical records?

A. In accordance with the language in the Terms and Conditions of Payment section of your *Provider Agreement*, you are required to comply with requests from Amerigroup for medical records.

Q. Do I need HIPAA authorization or a release from the patient in order to supply their medical records?

A. No, the collection of risk adjustment data as well as the request for medical records to validate payment made to Medicare Advantage organizations is considered a health care operation and, as such, does not violate the privacy provisions of HIPAA (*CFR 164.502*).

Q. Whom can I contact if I have questions?

A. Verscend Retrospective Program Manager, Jaime Marcotte, is managing this initiative. She can be reached by phone at 314-925-6094.