Provider Newsblast

https://providers.amerigroup.com/TN

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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.)
- **You 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

UPDATE: Ordering, prescribing or referring NPI requirement change

The Affordable Care Act (ACA) requires physicians or other eligible practitioners who submit all or part of a Medicaid claim as a secondary to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid beneficiaries. The enrollment requirement is applicable to physicians or other eligible practitioners even if they do not traditionally submit claims to Medicaid.

What this means to you:

Effective June 1, 2017, Medicaid institutional and professional claims must include the NPI of the ordering, prescribing, referring or rendering (OPRR) provider if applicable.

Why is this change necessary?

In order to comply with the ACA mandate, Amerigroup Community Care institutes the requirement that all OPRR providers must have an active and valid Medicaid provider ID number associated with an individual NPI.

What is the impact of this change?

Effective June 1, 2017, claims received from rendering providers and facilities for services that are ordered, prescribed or referred must contain the NPI of the Medicaid-enrolled ordering, prescribing or referring practitioner. Failure to report appropriately may result in a claim rejection.

OPRR providers who do not have a Medicaid provider ID number must enroll to meet the ACA program integrity requirement. Enrollment does not include a requirement to see Medicaid patients or to be listed as a Medicaid provider for patient assignments. Enrollment is designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from participation in Medicare or Medicaid. OPRR providers may apply for a Medicaid provider ID online at http://tn.gov/tenncare/topic/provider-registration.

If submitting via electronic data interchange (EDI), contact your clearinghouse for appropriate loops for the above details or call Amerigroup EDI at 1-800-590-5745.

What if I need assistance?

More information can be found on our website at https://providers.amerigroup.com/TN. If you have questions about this communication, received this message in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at the toll-free phone numbers listed below:

- Medicaid providers call 1-800-454-3730.
- Long-term services and supports (HCBS) call 1-866-840-4991.

TNPEC-1181-15

Reminder: precertification requirements for laparoscopy, gynecological services and hernia procedures

Amerigroup Community Care does not require precertification for certain laparoscopy procedures, hernia procedures and gynecological services for TennCare members when they are performed at an ambulatory surgical center (ASC).

What this means:

When any of the procedures listed below are performed in an ASC, precertification is not required. However, providers are required to obtain precertification for all services on the list when they are performed in a hospital facility regardless of whether care is provided on an inpatient or outpatient basis.

Does precertification apply to all providers?

Precertification applies to participating and nonparticipating Amerigroup providers. As a reminder, precertification is required for all inpatient services and all services performed by nonparticipating providers for TennCare members.

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.

Group	Code	Procedure
Gynecological services	58558	Hysteroscopy surgical — with bx endomet and polypect with/without D&C
	58563	Hysteroscopy surgical — with endometrial ablation
	57522	Conization cervix — with/without D&C with/without Repr; Loop Elec Exc
	58565	Hysteroscopy surgical — with bilateral fallopian tube cannulation to in
	57461	Colposcopy cervix with up vag — with loop elec conizat cerv
	57460	Colposcopy cervix with up/adj vag — with loop elec bx cerv
	57520	Conization cervix with/without D&C with/without Repr — knife/laser
	57410	Pelvic examination under anesthesia
	58353	Endometrial ablat thermal with/without hysteroscopic guid
	57155	Insrt utern tandems and/or vag ovoids clin brachytx
	56620	Vulvectomy simple — partial
	57452	Colposcopy cervix including upper/adj vagina
	56501	Destruction of lesion vulva — simple
	58562	Hysteroscopy surgical — with removal impacted fb
	57135	Excision of vaginal cyst or tumor
	56440	Marsupialization of bartholins gland cyst
	57061	Destruction of vaginal lesion — simple
	57300	Clos rectovaginal fistula — vag/trnsanal apprch
	57500	Bx single/mx/local excision lesion with/without fulg
	58555	Hysteroscopy diagnostic
	56515	Destruction of lesion vulva — extensive

Reminder: precertification requirements for laparoscopy, gynecological services and hernia procedures (cont.)

Gynecological services	57505	Endocervical curettage
	57513	Cautery of cervix — laser ablation
	56405	I&D of vulva or perineal abscess
	56740	Excision of bartholins gland or cyst
	58561	Hysteroscopy surgical — with removal of leiomyomata
	45337	Sigmoidscpy flexible — with decomprs volvulus meth
	51700	Bladd irrigation simple lavage and instillation
	52342	Cysturethrscpy; with tx ureteropelv junc stricture
	53240	Marsupialization urethral divertic male/female
	56420	I&D of bartholins gland abscess
	56605	Biopsy of vulva or perineum — one lesion
	56700	Partial hymenectomy or revision of hymenal ring
	56820	Colposcopy of the vulva
	57454	Colpscopy cerv up/adj vag — bx cerv and endocerv curet
	57510	Cautery of cervix — electro or thermal
	57720	Trachelorrhaphy plstc repr utern cerv vag apprch
	58110	Bx done with colposcopy add-on
	59871	Removal of cerclage suture under anesthesia
Hernia	49505	Repair init ing hernia age 5 yr/over — reducible
	49560	Repair initial inci/ventral hernia — reducible
	49587	Repr umb hern age 5 yr> — incarcerat/strangulat
	49585	Repair umbilical hernia, age 5 years or older — reducible
	49650	Laparoscopy surgical — repair initial ing hernia
	49651	Laparoscopy surgical — repair recurrent ing hernia
	49329	Unlisted lap procedure abd peritoneum and omentum-sp
Laparoscopy procedures	58662	Lap surg; with fulg/excis les-ovary/peritoneum
	58670	Laparoscopy surgical — with fulguration of oviducts
	58671	Laparoscopy surg — with occlusion oviducts-device
	49320	Lap abd perit and omentm dx with/without collect brsh/wsh-sp
	58661	Laparoscopy surg — with removal adnexal structures
	44180	Lap, enterolysis
	49322	Laparoscopy surgical — with aspiration cavity/cyst
	49321	Laparoscopy surgical — with biopsy
	58545	Lap myomect — 1-4 myom tot 250 gms/<&/surfce myom
	49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia — reducible
	58679	Unlisted laparoscopy procedure oviduct ovary
	38571	Laparoscopy surgical — with bil total pelvic lymphect
	49655	Laparoscopy, surgical, repair, incisional hernia — incarcerated or strangulated

Change to prior authorization requests for Makena

Effective immediately, prior authorization requests for Makena are processed under a member's medical benefit and not their pharmacy benefit. This bulletin outlines the new process.

Why is this change necessary?

To provide better access and cost savings, Amerigroup Community Care has contracted with CVS/Caremark to fulfill Makena requests.

What is the impact of this change?

The following outlines the new ordering process for Makena:

- Obtain the required prior authorization using our *Makena Prior Authorization Form*. You can access this form at https://providers.amerigroup.com/TN > Provider Resources & Documents > Pharmacy > Makena Prior Authorization.
- Fill out the *Makena Prior Authorization Form* completely.
- Once approval is received, fax a complete order **plus** a copy of the prior authorization approval to Caremark Medical Specialty at 1-866-336-8479 or call 1-877-254-0015
- Monday-Friday, 8 a.m.-8 p.m. Eastern time or Saturday from 9 a.m.-1 p.m. Eastern time).
- After verifying benefits and authorization approval, Caremark Medical Specialty will ship the requested drug to the member's home or prescriber's office with the patient's name affixed to the container.
- Caremark Medical Specialty will bill Amerigroup directly for the medication.

TNPEC-1813-17

Extended wait times in provider offices cause emergency medical services vendor concerns

Patients transported on stretchers to provider offices frequently wait for hours on the stretcher in waiting rooms. The provider often then sees the patient on the stretcher. This process requires paramedics to sit at the location for the duration of the appointment, unable to respond to any other calls because their stretcher is in use. As these emergency medical services (EMS) vendors are the same ones who respond to 911 calls, freeing up their time is critical to us all.

When EMS is present, please ensure patients receive an expedited visit or are transferred to an exam table immediately. This will allow the EMS vendor to continue services in a timely manner rather than waiting for the patient to be seen by the provider. In the past, patients have been kept waiting on a stretcher for extended periods of time, rendering valuable EMS resources unavailable to respond to other nonemergent and emergency situations.

Thank you for your participation and support in this effort to reduce wait times for our EMS partners.

TN-NL-0076-17

Emergency Department Diversion Case Management Program

Are you concerned that your patients may:

- Use the emergency room for primary care?
- Need assistance accessing needed resources?
- Need additional information about their benefits?
- Need advocacy and assistance in finding specialists?
- Be chronically ill and need complex case management?

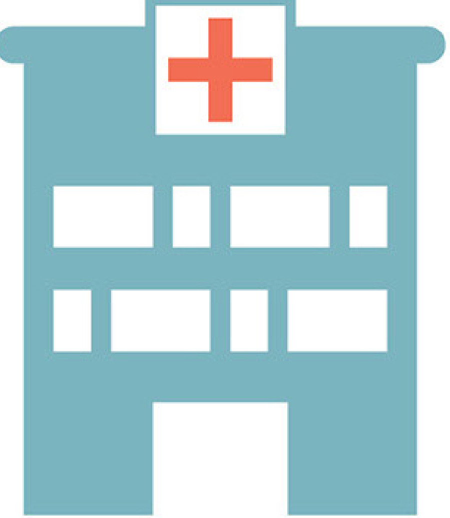
The Emergency Department (ED) Diversion Case Management Program works to ensure your Amerigroup Community Care patients receive the care they need in the most appropriate setting. This is accomplished through a team of Amerigroup ED nurse case managers who work collaboratively with facility ED case management teams.

We would like to help educate your patients on appropriate use of the ED, including TennCare requirements.

Better health outcomes for Amerigroup members happen through education, advocacy, evaluation and care coordination. Our mission is to help you help our members. Therefore, we provide:

- Easy access to a dedicated contact with a direct number.
- Access to your dedicated contact via email after hours, on weekends and on holidays.
- Case managers who are available to discuss patient needs.
- A nurse line 24 hours a day, 7 days a week.
- Assistance in referring patients to complex case management when necessary. (This includes high-risk obstetrics, pediatrics, physical health and behavioral health.)
- Advocacy to ensure your Amerigroup patients are getting the best possible care in the most appropriate setting.
- Feedback on member status and disposition when requested.

The ED Diversion Case Management Program is part of the Reconnection and Advocacy Program (RAP) offered by Amerigroup. For additional information about the program or to become part of our collaborative team, please contact one of the following individuals:



- Cory Dransfield, BSN, RN, CCM
  Emergency department program manager
  615-316-2400, ext. 22561
  corinna.dransfield@amerigroup.com
- Barbara Hellman, BSN, RN
  Emergency department team lead
  615-316-2400, ext. 22604
  barbara.hellman@amerigroup.com

Amerigroup has dedicated ED case managers located in East, Middle and West Tennessee.

TN-NL-0073-17

2017 medical record documentation audit standards for PCPs

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

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

The standards developed for medical record documentation reflect a set of commonly accepted standards; *Clinical Practice Guidelines (CPG)*; and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits. The standards include demographic information, health history (including details of ongoing clinical issues), *CPGs* and preventive health care. Only records within a one-year period from the date of audit will be reviewed. Up to 10 charts with a minimum of eight are assessed for compliance.

New standards added for Amerigroup Community Care 2017 EPSDT:

Standard	Purpose
Provider is utilizing appropriate CPT and ICD-10 codes for EPSDT well-child exams with claims submission	To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives toward closing gaps
Provider has assessed if child has a dental home; if no dental home is identified, provider has performed risk assessment at appropriate stages of development based on age	To ensure access and availability of dental services and prevention of dental caries
If provider has not performed a well-child exam during the previous 12 months, provider has recommended the exam or performed various components of the exam during a sick visit or medication management visit	To ensure access and availability of prevention services and close gaps in care

How do you determine who is selected for the audit?

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

How can I make sure my office is compliant?

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

What if I need assistance?

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

Medical record documentation standards:

Core standards		
	Standard	**Rationale**
1.	Provider has in place policy and procedures to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPPA regulations, security as defined by HIPPA, and member accessibility to the extent provided by TCA 63-2-101/ 63-2-102/33-3-104 et seq of medical records *CRA A.2.24.8.2.3.2, CRA A.2.24.8.2.3.3, CRA A.2.24.8.2.3, CRA A.2.24.8.2.4 and CRA A.2.24.8.2.5*	To ensure the confidentiality, security, and member accessibility of medical records
2.	A policy and procedure is in place for Cultural Competency training of staff on an annual basis *CRA A.2.18.2.1*	To ensure effective delivery of health care services that meet the social, cultural and linguistic needs of patients
3.	Patient demographic data is present in chart and name or ID # is on each document. *42 CFR Part 456*	To provide biological and identifiable data pertinent to the patients care and treatment planning; to provide emergency information should an incident occur within the physician's office; many names are not gender specific; recording the sex of a patient helps differentiate males from females
4.	Medication allergies and adverse reactions are prominently noted/displayed in the record. If the member does not have allergies, this should also be noted. *42 CFR Part 456*	To prevent the prescribing of any medication that the patient is allergic to
5.	Advanced directives such as living will for members 18 years and over has been discussed and documented with a date. If the member has a behavioral health diagnosis, advance directive discussion should be documented for members 16 years and over. *CRA A.2.7.7*	To ensure that the health care choices of the member are followed when the member is unable to make the decisions for his or her self

2017 medical record documentation audit standards for primary care providers (cont.)

	Standard	Rationale
6.	A current medication list is present in patient record (For best practice: dosage, date medication was initiated and dates of refills are present) *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	A centrally located listing of a member's maintenance medications assists the provider and support staff with an overview of prescribed medications. The provider can easily assess medications for possible drug interactions, over medication, drug treatment history and management of potential habit forming medications. Medications, when clearly identified, prevent duplication of prescriptions.
7.	A current problem list that includes significant illnesses, medical conditions and psychological conditions is present. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	Maintaining a current problem list enhances information from which a provider can effectively develop a treatment plan, the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
8.	Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. For children ages birth through age 20, developmental/behavioral assessment is included. Interval histories should be present as appropriate. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	All patients need to have documentation of medical/social histories in their record base from which a planned course of treatment can be developed. Substance abuse is an important factor when planning a course of treatment and attempting to diagnose a particular problem. Behavioral along with physical assessment for children gauges how well a child's development is progressing based on age.
9.	A history of immunizations is present in the medical record for adults. *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	Adult immunizations are important preventive medical procedures. Documenting tetanus boosters prevents duplication of vaccination at times when urgent care treatment required. If the status is unknown and not easily obtained from a previous physician, the CDC recommends that the tetanus booster be given. Yearly flu vaccines help reduce large epidemics in communities and serious complications when a patient's immune system is compensated.
10.	Provider has access established to the TennCare Immunization Information System (TennIIS).	To ensure provider has access to member immunization data as required by state and school regulations

2017 medical record documentation audit standards for primary care providers (cont.)

	Standard	Rationale
11.	Provider participates in the State's Vaccines for Children (VFC) Program and reports to the TennIIS registry.	To ensure member access to vaccinations and receipt of recommended immunization and to promote and support state efforts in data sharing to improve continuity and coordination of care
12.	Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan and follow-up recommendations. The treatment plan is appropriate to findings and patient is not at risk by diagnostic or therapeutic problem. All entries are signed by rendering practitioner with credentials and dated (may be a handwritten signature, unique electronic identifier or initials and credentials). *NCQA 2007-02-08-105600-000 Guidelines for Medical Record Documentation*	To ensure appropriate review of all systems that relate to the problem currently being assessed for treatment, accurate and appropriate assessment of a patient's problem and appropriate treatment planning; to prevent injury and unnecessary treatment that may jeopardize the patient's health; and to ensure appropriate identification of treating physician
13.	Is there evidence in the chart to indicate that PCPs are making referrals to other levels of care?	To ensure appropriate level of care is provided to members and there is no access to care issues
14.	Is there a policy or procedure for follow-up of missed appointments?	To ensure the resolution of health issue/complaint and there is no access to care issues
15.	If member has a behavioral health diagnosis and a referral to a behavioral health provider was completed, documentation from the behavioral health (BH) provider is present if member approved coordination of care between PCP and BH provider.	To ensure continuity and coordination of care for members with both physical and behavioral health problems

Clinical Practice Guidelines		
	Standard	**Rationale**
16.	Obesity and obesity prevention guidelines	
A. HEDIS®-like measure	Provider is utilizing Category II code BMI assessments with claims submission to report closure of gaps in care for preventive screenings.	To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps
B. HEDIS-like measure	BMI calculated within past two years for adults, calculated and plotted for percentile for children age 3 and older are completed with each visit. For adults with obesity diagnosis, BMI is calculated periodically.	To improve the quality of life and help prevent short- and long-term complications of obesity
C. HEDIS-like measure	Documentation of counseling for nutrition or referral for nutrition education within the past year	To improve the quality of life and help prevent short- and long-term complications of obesity
D. HEDIS-like measure	Documentation of counseling for physical activity or referral for physical activity within the past year	To improve the quality of life and help prevent short- and long-term complications of obesity
17.	Diabetes guidelines	
A.	Provider is utilizing the Category II codes for diabetes with claims submission to report closure of gaps in care for preventive screenings.	To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps
B.	Annual history and physical exam completed with depression screening.	To assess the overall physical and mental health of the diabetic patient to establish stability of disease state
C. HEDIS-like measure	Annual comprehensive dilated eye exam for adults and children 10 years and older where retinopathy has been previously identified otherwise, if no evidence of retinopathy exams every two years.	To assess eye health and for prevention of blindness due to retinopathy
D.	Annual foot exam, visual with each visit	To assess for neuropathy and prevention of complications due to poor circulation
E. HEDIS-like measure	Annual medical attention for nephropathy	To evaluate urine for the presence of a protein for the prevention of kidney damage
F.	Annual lipid profile with LDL < 100mg for adults and children age 2 and older	To monitor patient's effectiveness of pharmacotherapy and severity of illness; for prevention and management of CVD

2017 medical record documentation audit standards for primary care providers (cont.)

	Standard	Rationale
G.	Annual influenza vaccine	To ensure appropriate services for the prevention of communicable disease is accessible to the member and offered and to prevent risk of complications that could arise from exposure and contraction of a communicable disease
H.	Pneumococcal vaccination for all members over 2 years old (Member to have completed series of pneumococcal vaccinations recommended at 2 months, 4 months, 6 months and between 12-15 months.)	To ensure appropriate services for the prevention of communicable disease is accessible to the member and offered and to prevent risk of complications that could arise from exposure and contraction of a communicable disease
I. HEDIS-like measure	Documented HgbA1c twice yearly if meeting treatment goals and quarterly if not (all ages)	To monitor patient's effectiveness of pharmacotherapy and severity of illness
J.	Advise to quit smoking	Tobacco abuse is an important factor when planning a course of treatment. A patient who has a history of tobacco abuse would need to avoid whenever possible any potential environments where encounters with tobacco smoke would affect him/her during a course of treatment.
K.	Education or counseling for physical activity, nutrition, self-monitored blood glucose, weight loss, psychosocial counseling and preconception/pregnancy counseling.	To ensure comprehension of treatment goals and plan and the importance of compliance
L. HEDIS-like measure	Blood pressure treatment to attain/maintain a blood pressure of less than 130/80.	For prevention and control of hypertension, blood pressure should be measured at every routine diabetes visit.

	Standard	Rationale
18.	EPSDT visit guideline — ages 0-20 years (42 CFR part 438.364[a][2])	
A.	Nutrition assessment	State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care of the Medicaid population State requirement to monitor and assess provider compliance to provision of screenings important to the quality of health care and education of the Medicaid population To close gaps in care and improve quality of service
B. HEDIS-like measure	Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. For children ages birth through age 20, developmental/behavioral assessment is included.	
C. HEDIS-like measure	A history of immunizations is present in the medical record or offered for children age 0-20. If parents refused vaccines, a signed waiver by parents and reason are documented.	
D.	Cholesterol risk assessment as appropriate for age	
E.	Lead risk assessment as appropriate for age	
F. HEDIS-like measure	Comprehensive unclothed physical completed	
G.	Appropriate laboratory test were performed or ordered for age.	
H. HEDIS-like measure	Health education was given as appropriate for age.	
I.	Vision screening was performed (or referral provided) as appropriate for age.	
J.	Hearing screening was performed (or referral provided) as appropriate for age.	
K.	If screening(s) is not completed in a single visit, is there documentation in the chart that a return visit is scheduled?	
L.	Is there documentation of any concerns or questions from the member or member's parent or guardian after the screening process?	
M.	Is there documentation in the chart to indicate that EPSDT services have been refused or declined by a parent, guardian, or member? (Document reason declined in comments.)	
N.	Is there evidence in the chart to indicate that PCPs are making referrals to other levels of care?	

2017 medical record documentation audit standards for primary care providers (cont.)

	Standard	Rationale
O.	Provider is utilizing the appropriate CPT and ICD-10 codes for EPSDT well-child exams with claims submission. *Plan Quality Improvement Activity*	To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps
P.	Documentation is present the provider has assessed if the child has a dental home. If no dental home is identified, provider has performed a risk assessment at appropriate stages of development based on age. *State Required Standard*	To ensure access and availability of dental services and prevention of dental caries
Q.	If provider has not performed a well child exam during the previous 12 months, did provider recommend the exam or performed various components of the well child exam during a sick visit or medication management visit? *Plan Quality Improvement Activity*	To ensure access and availability of prevention services and close gaps in care
19.	Hypertension guidelines	
A.	Provider is utilizing the Category II codes for hypertension with claims submission to report closure of gaps in care for preventive screen-ings.	To improve reporting of gaps in care that will help identify and facilitate quality improvement initiatives towards closing gaps
B.	Provider conducts history and physical examination on an annual basis and assesses for comorbidities.	To assess provider compliance to provision of appropriate hypertension treatment
C.	Provider obtains as indicated laboratory and diagnostic tests to monitor disease progression, development of comorbid conditions and therapeutic levels of medications.	To ensure adequate monitoring of member’s disease state and reaction to drug therapy
D.	Review of member’s current lifestyle and recommendations for lifestyle modifications is documented with each visit.	To ensure quality of life assessment and self management of disease state
E. HEDIS-like measure	Blood pressure is taken and recorded with each visit, minimally monitored biannually and more frequently if blood pressure is uncontrolled.	To ensure adequate monitoring of member’s disease state and reaction to drug therapy
F.	Provider reviews medication and adherence to drug therapy with each visit, adjusting medications as indicated.	To assess provider compliance to provision of appropriate hypertension treatment
G.	Weight is taken and recorded with each visit.	To ensure adequate monitoring of member’s disease state and reaction to drug therapy

2017 medical record documentation audit standards for primary care providers (cont.)

	Standard	Rationale
20.	ADHD guidelines	
A.	Documentation to support diagnosis of ADHD should be present in record.	Evidence that *Clinical Practice Guideline* is utilized to outline approaches for the management of ADHD
B.	Medication prescribed and dosage for ADHD follows recommendations as outlined in *Clinical Practice Guideline*.	To ensure adherence to clinical practice guideline accepted prescribing protocols and criteria
C.	If tricyclic antidepressants are used, a baseline ECG prior to use is present with a follow up ECG after each significant dosage change. If a higher level tricyclic medication is documented, blood levels are present in the medical record.	To ensure therapeutic results of medication and prevention of overdose
D. HEDIS-like measure	**Initiation phase:** Documentation is present for patients who receive an initial prescription for ADHD medication of at least one follow-up visit with a prescriber within 30 days of initiation of medication and at least two additional visits between four weeks and nine months of the initiation of the medication.	To ensure effectiveness of medication and dosages prescribed; to ensure member compliance with medication treatment
E. HEDIS-like measure	**Continuation and maintenance phase:** After treatment for initiation phase, documentation is present of at least two follow-up visits between 30 days and ten months (300 days) of the initiation of the medication.	To prevent relapse of symptoms and ensure member compliance with medication treatment
F.	Follow-up visits include assessment for: • Behavioral assessment (school/peer/family) • Height • Weight • Abnormal movement, signs and symptoms • Follow-up testing with Conners' scales or equivalent scales to track treatment response • School informal plan or Section 504 Plan every two years	To ensure appropriate assessment after initiation phase and stability of member's mental health status

2017 medical record documentation audit standards for primary care providers (cont.)

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

TNPEC-1747-17

Additional information on ClaimCheck® upgrade to ClaimsXten™

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

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

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

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

If you have questions regarding ClaimsXten edits you receive on your EOP, please call Provider Services at 1-800-454-3730.

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

TN-NL-0061-17

CMS emergency preparedness rule — Medicaid and Amerivantage

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, which includes providers with Amerigroup Community Care seeing Amerigroup Amerivantage (Medicare Advantage) and TennCare members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicare and Medicaid participating providers and suppliers to meet the following best practice standards:

	1. Emergency plan	Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
	2. Policies and procedures	Develop and implement policies and procedures based on the plan and risk assessment.
	3. Communication plan	Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
	4. Training and testing program	Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

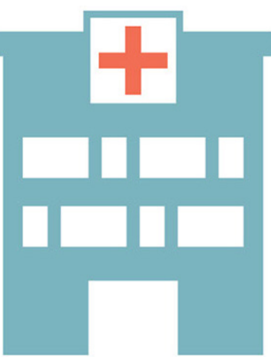
Important dates:
The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

CMS emergency preparedness rule (cont.)

Impacted providers:

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers



Note, while all 17 providers/suppliers are impacted, requirements may differ between types.

Additional information:

Amerigroup does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

TN-NL-0069-17