Provider NewsBlast

Amerigroup
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https://providers.amerigroup.com/TN

September 2019

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Medicaid:

Hospice reminder

Hospice room and board
As of July 1, 2018, the billing hospice provider is required to obtain the NPI of the facility where the patient is receiving care and report the facility's name, address and NPI in box 80 of the *UB-04* claim form. If any of the three items are missing in box 80, the claim will be denied as a billing error. Box 80 contains four lines with a 19-character limit for line 1 and a 24-character limit each for lines 2-4.

For claims billed on dates of service prior to and including June 30, 2018, the nursing facility name and facility level ID must be included in box 80. If any of the two items are missing in box 80, the claim will be denied as a billing error.

Patient liability information should be in box 39, 40 or 41, along with value code 23 and the patient liability amount. If there is no patient liability, please enter $0. If patient liability is left blank, the claim will be denied as a billing error.

Hospice room and board claims billed with revenue code 0658 and procedure codes Q5003 (level one) or Q5004 (level two) should be used. The use of T codes will cause the claim to be denied as a billing error.

Routine care and service intensity add-on (SIA) payments
Routine care (revenue code 0651 with applicable HCPCS Q codes) will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the market index for the county of the hospice facility, not the location of the member. Hospice rates are established annually by CMS.

SIA payment for hospice services will include revenue code 0551 with HCPCS code G0299 (RN) or revenue code 0561 with HCPCS code G0155. Reimbursement will have a maximum of four hours (in 15-minute intervals) or 16 units per day combined for both disciplines. These services will occur during the last seven days of life. Per CMS, the state period cannot span accounting years. The patient status must be either 40 (expired at home), 41 (expired at medical facility), or 42 (expired – place unknown).

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll within 60 days will continue with the current date/payment calculations.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll outside of 60 days will restart routine care eligibility and day one for pricing.

For more information, view our *Hospice Tips* on the provider website.

TN-NB-0194-19

MCG Care Guidelines update and customizations

The upgrade to the 23rd edition of the MCG Care Guidelines for Amerigroup Community Care has changed from May 24, 2019, to October 5, 2019. In addition, Amerigroup has customized some of the MCG criteria.

Customizations to the 23rd Edition of the MCG Care Guidelines
Effective October 5, 2019, the following customizations will be implemented:

- **Left Atrial Appendage Closure, Percutaneous (W0157)** — customized to refer to SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- **Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)** — customized to refer to Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:

- Clinical indications for admission; examples will also be added for:
    - Aggressive hydration needs that cannot be managed in an infusion center.
    - Prolonged marrow suppression.
- Regimens that cannot be managed outpatient; examples will also be added.

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations online by selecting **Customizations to MCG Care Guidelines 23rd Edition (Publish date November 1, 2019)**.

TN-NB-0197-19

CPT Category II payment opportunity

As a reminder, Amerigroup Community Care pays participating providers a $10 administrative fee per code, per eligible member when they report select CPT Category II codes on claims once per calendar year. Eligible members include those receiving benefits from Amerigroup Amerivantage (Medicare Advantage) and TennCare.

The qualifying Category II codes must be billed with a charge of at least $0.01. Any required outpatient visits or global codes (outlined on the following pages) must also be billed on the same claim as the Category II code.

Body mass index (BMI):
Effective immediately, for HEDIS® reporting purposes, please include one of the ICD-10-CM codes listed.

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

Category II code
• 3008F: BMI assessed/documented[1]
CPT codes (Bill CPT Category II with one of these outpatient visit codes). 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456
ICD-10 code (Bill CPT Category II with one of these ICD-10-CM codes.) • Z68.1: BMI 19.9 or less, adult • Z68.20-Z68.29: BMI 20.0-29.9, adult • Z68.30-Z68.39: BMI 30.0-39.9, adult • Z68.41: BMI 40.0-44.9, adult • Z68.42: BMI 45.0-49.9, adult • Z68.43: BMI 50-59.9, adult • Z68.45: BMI 70 or greater, adult • Z68.51: BMI pediatric, less than 5th percentile for age • Z68.52: BMI pediatric, 5th percentile to less than 85th percentile for age • Z68.53: BMI pediatric, 85th percentile to less than 95th percentile for age • Z68.54: BMI pediatric, greater than or equal to 95th percentile for age

Controlling High Blood Pressure (CBP) *(*effective immediately*)*

Category II codes[1]
• 3079F: Diastolic of 80-89 • 3080F: Diastolic of 90 or greater • 3078F: Diastolic of less than 80 • 3077F: Systolic of 140 or greater • 3074F or 3075F: Systolic of less than 140
Bill CPT category II code with one of these outpatient visit codes: 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456

Comprehensive Diabetes Care (CDC)

Category II codes[1]
• 3044F: Most recent hemoglobin A1c (HbA1c) level less than 7% • 3045F: Most recent HbA1c level of 7-9% • 3046F: Most recent HbA1c level greater than 9% • 3060F: Positive microalbumin • 3061F: Negative microalbumin • 3062F: Positive macroalbumin • 2022F: Dilated retinal eye exam with interpretation by ophthalmologist or optometrist. • 2024F: Seven standard field stereoscopic photos with interpretation by ophthalmologist or optometrist • 2026F: Eye imaging validated to match diagnosis from photos. • 3072F: Low risk for retinopathy (no evidence of retinopathy in the previous year).
Bill CPT category II with one of these outpatient visit codes: 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456

Prenatal and Postpartum Care (PC): TennCare population only

This benefit is eligible once per pregnancy. Maximum incentive payment is $20 per pregnancy and only applies if both prenatal **and** postpartum codes are submitted.

Category II codes:	
• 0500F:	Initial prenatal care visit (Report at first prenatal encounter with health care professional providing obstetrical care. In a separate field, report the date of the last menstrual period LMP.) Bill with the appropriate evaluation and management code within 30 days of the visit that confirmed the pregnancy (99201-99205, 99211-99215).
• 0501F:	Prenatal flow sheet documented in medical record by first prenatal visit (Documentation must include blood pressure, weight, urine protein, uterine size, fetal heart tones and estimated date of delivery. In a separate field, report date of the LMP. Note: If you are reporting 0501F prenatal flow sheet, you do not have to report 0500F initial prenatal care visit.)
• 0502F:	Subsequent prenatal care visit (excludes patients seen for a condition unrelated to pregnancy or prenatal care). **Bill CPT II with one of the following global codes**: 59400, 59510, 59610, 59618
• 0503F:	Postpartum visit (to be completed between 21-56 days after delivery) Bill with CPT code 59430.

Care for older adults – advance directives[2]

Category II codes[2]
• 1157F: Advance care plan in chart
• 1158F: Advance care planning discussion documented in medical record
• 1125F: Pain severity quantified and pain present
• 1126F: No pain present
• 1170F: Functional status assessed
• 1159F: Medication list documented in medical record
• 1160F: Review of all medications by prescribing practitioner or clinical pharmacist
Bill CPT II with one of these outpatient visit codes: 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456

Medication Reconciliation Post-Discharge (MRP)

Category II code (Eligible for an incentive once per post-inpatient hospital stay, per year.)
• 1111F: Medication reconciliation[2]
Bill CPT category II with one of these outpatient visit codes: 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456

1 Category II codes for members enrolled in TennCare and dual enrollees (those enrolled in both TennCare and Amerigroup Amerivantage).

2 Category II codes for dual enrollees only (those enrolled in both TennCare and Amerigroup Amerivantage).

TNPEC-2846-19

Providers CARE Survey

C= Community Resources
A= Acting for Better Health
R=Reducing Stigma
E= Empowerment

Good health outcomes start in the communities where your patients live. Starting September 20, we invite you to Connect with Us by taking the Providers CARE Survey.

By taking the survey, you'll give us information about challenges your patients are facing in their communities. Our goal is to help you improve your patients' health by:

C= Connecting them with community resources (like food pantries and housing help);
A= Acting for better health by teaching them about their care needs;
R=Reducing stigma by showing compassion to others and taking time to think about your actions and thoughts about yourself and others; and
E= Empowering yourself and others. Take the time to listen to your patients. Treating them with kindness and support can help them take the steps they need for better health and supporting them on their journeys to better health

We are here to help you Connect your patients to CARE. The CARE survey will ask you about the needs of your patients and learning opportunities that can assist your practice team. To fill out the survey, please visit https://www.tn.gov/tenncare/providers/social-and-health-needs.html on September 20.

Your answers will not have your name on them and will be combined with information from other providers.

Thank you for caring about the health of your community.

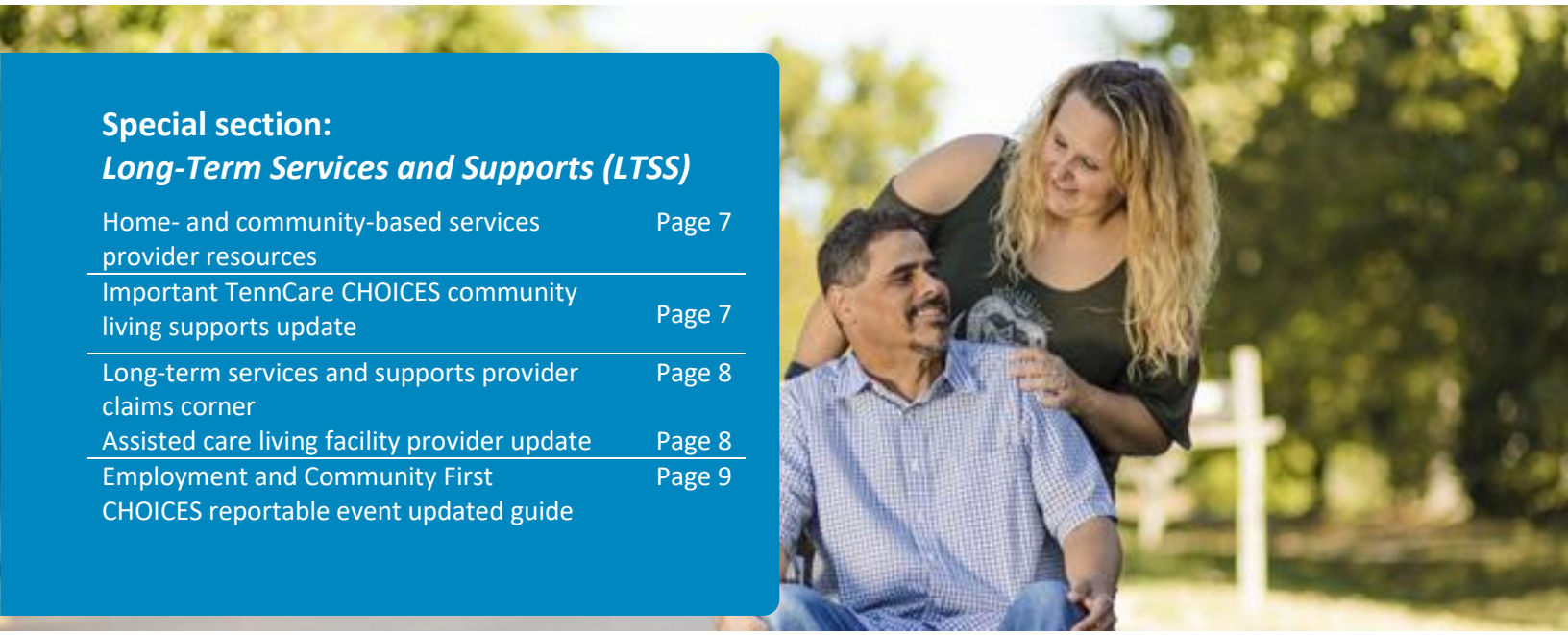
If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

TN-NB-0058-18

Medicare Advantage:

MCG Care Guidelines update and customizations

View the full article in the Medicaid section.



Special section:
Long-Term Services and Supports (LTSS)

Home- and community-based services provider resources

Below are links to transportation grants available to home- and community-based services providers. The information on these sites can assist providers in getting supported members out into their communities.

- https://www.transit.dot.gov/grants
- https://www.grantwatch.com/cat/37/transportation-grants.html
- https://www.transportation.gov/grants
- https://uzurv.com

TN-NB-0208-19

Important TennCare CHOICES (CHOICES) community living supports update

The Division of TennCare recently implemented an update in the CHOICES definition of community living supports (CLS) 3 and CLS-Family Modal (FM) 3. Traditionally, level 3 was for individuals who required care from staff 24 hours a day, 7 days a week. **The new definition allows for the care coordinator and the supported person to discuss whether or not to have staff in the home 24 hours a day, if appropriate.** This allowance is for individuals who require skilled assistance rather than hands-on care. Prior to any changes to CLS 3 or CLS-FM 3 care, a conversation and planning are required.

The person-centered support plan (PCSP) must reflect the number of hours an individual will need hands-on care. There will be many individuals who need 24-hour staff available to them;

the PCSP will identify this, and it will be discussed during the discharge/care plan meeting or during ongoing care coordination visitations with you, the provider.

If you have questions, please reach out to your Provider Relations representative or one of the CHOICES CLS team members listed below:

- Anita McClard, RN, statewide CLS manager
  Phone: 615-476-1201
  Email: Anita.Mcclard@amerigroup.com
- Jo Massey, RN, west region CLS coordinator
  Phone: 731-504-2635
  Email: Jo.Massey@amerigroup.com
- Jamie Newman, RN, middle region CLS coordinator
  Phone: 615-917-8881
  Email: Jamie.Newman@amerigroup.com
- Bill Chandler, RN, east region CLS interim coordinator
  Phone: 423-280-4023
  Email: Billy.Chandler@amerigroup.com

TN-NB-0208-19

Long-term services and supports provider claims corner

Review the following best practices to avoid a long-term services and supports claim denial. The most common claim denial we see is *deny preauth not obtained*. As a best practice, providers should have access to the authorization at the time of billing. Reviewing the authorization to ensure information is correct and the date span is still covered for the dates being billed can decrease the potential of a claim being denied for this reason. As a reminder, if you need an authorization or need a correction to an authorization, please email Amerigroup Community Care at ltcprovreq@amerigroup.com.

Another common claim denial we see is *inappropriate billing for this contract*. When using Availity to bill long-term services and supports claims for TennCare CHOICES and Employment and Community First CHOICES, always bill a facility claim. Another best practice is to reference the appropriate rate sheet and ensure the procedure code is listed first and any modifiers are listed in order as laid out in Availity. These two tips will help decrease the potential for receiving this denial code. If you need a copy of a rate sheet, please reach out to your assigned Provider Relations representative.

TN-NB-0208-19

Assisted care living facility provider update

As a reminder, when the daily code is needed for an assisted living facility, please submit a *Provider Authorization Request Form* and select the appropriate code, T2031. The daily code needs to be requested when an individual is not in the assisted living facility for the entire month. If the care coordinator is aware of an inpatient stay, they assist with ensuring the

appropriate code is authorized for billing. Once an authorization is entered for the daily code, you will receive notification from the authorization team via DocuSign. The daily code authorization code needs to be used for billing. Please send the completed authorization request form to the long-term care provider request mailbox at ltcprovreq@amerigroup.com or fax it to 1-888-762-3203.

The *Provider Authorization Request Form* is available here:

Provider Authorization Request

TN-NB-0208-19

Employment and Community First CHOICES reportable event updated guide

The following attachment includes minor changes to Tier 1, 2 and 3 classifications and language.

TNPEC-2639-19 ECF CHOICES Report Even

TN-NB-0208-19

Reimbursement Policy:

New Policy

Emergency Department: Level of Evaluation and Management Services

(*Policy 19-002, effective 09/01/19)*

Effective September 1, 2019, Amerigroup Community Care classifies the intensity/complexity of facility emergency department (ED) interventions used for services rendered with an evaluation and management (E&M) code level. E&M services will be reimbursed based on this classification at the highest E&M level supported on the claim. Facilities must utilize appropriate CPT/HCPCS and revenue codes for all services rendered during the ED encounter.

Please refer to the Emergency Department: Level of Evaluation and Management Services reimbursement policy for additional details at https://providers.amerigroup.com/TN.

Providers who feel that the level of reimbursement should be reconsidered can file a claims dispute in accordance with the terms of their contract. Claims disputes require a statement as to why the intensity/complexity would require a different level of reimbursement as well as the

medical records, which should clearly document the facility interventions performed and referenced in that statement.

TN-NB-0181-19