NewsBlast

TENNESSEE – December 2014 TNPEC-0909-14

The following entries apply to all Tennessee Amerigroup Community Care Providers.

Annual CAHPS Results

Our members have a voice!

We always want feedback from you and our members, so we conduct satisfaction surveys each year. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) asks our members to rate their experiences with their doctors and/or specialists and with our health plan over a six-month period. We rate our CAHPS performance against benchmarks set by the National Committee for Quality Assurance (NCQA). Our goal is to reach the 90th percentile benchmark set by the NCQA, as we are dedicated to continuous improvement of health care quality.

2013 vs. 2014 Member experience performance against NCQA benchmark

Adult Member Experience	2013	2014	Benchmark achieved
Getting care quickly	83	84	90th
How well doctors communicate	90	88	75th
Getting needed care	84	84	90th
Overall satisfaction with your personal doctor	78	74	25th
Overall satisfaction with your specialist	75	82	75th
Overall satisfaction with health care	70	74	25th
Child Member Experience			
Getting care quickly	92	90	90th
How well doctors communicate	93	93	90th
Getting needed care	90	87	75th
Overall satisfaction with your personal doctor	88	91	90th
Overall satisfaction with your specialist	85	95	90th
Overall satisfaction with health care	88	90	90th

How we did

Overall, our members with children are happier with our services and the services provided by our network of providers. Together we achieved the 75th percentile or higher in 10 of the 12 measures, including 90th percentile for Satisfaction with your Personal Doctor and Satisfaction with your Specialist for members with children. In fact, Satisfaction with your Specialist for members with children improved 10 percentage points over the 2013 rate. That is a big achievement! We also made improvements in six of the 12 measures; that's a 50 percent improvement over our 2013 rating.

How we'll do better

Our areas of focus for 2014:

- Continue to work on "How well doctors communicate"
  - Provide more information to members and providers on covered benefits
  - Continue to encourage members to use the pre-visit tool prior to physician office visits to help improve member-physician communication and discussion of care needs
  - Continue to provide information to members about shared decision making tips

What our members are saying:

When asked if our providers explain things in ways they could understand,

73%

responded with ALWAYS.

- Continue to work on "Getting needed care"
  - Continue to provide members with more information on benefits to increase their overall knowledge of available benefits
  - Continue to educate and encourage members on the importance of seeing their assigned primary care provider
  - Educate member on the appropriate use of emergency care and the use of urgent care facilities when needed
  - Ensure that members and providers are aware of specialists within the network

What you can do to help

- Take our no-cost online cultural competency course to expand your knowledge of best communication techniques
- Attend our Town Hall meetings to receive updates and new information
- Continue to encourage members to use the pre-visit brochure; provide a blank copy when they leave their appointments so they'll have it ready for next time
- Make use of patient education materials provided by Amerigroup and federal/state entities — visit tn.gov, ahrq.gov or healthfinder.gov for more information

What our members are saying:

When asked if our providers spend enough time with them,

79%

responded with ALWAYS.

HEDIS – Help us help you

HEDIS is a set of standardized performance measures reported to NCQA by managed care plans nationally. HEDIS measures are used to compare how well a health plan performs in areas related to quality of care, access to care and member satisfaction. We use the HEDIS results to identify areas of strength and areas for improvement, measure results against our goals and measure the effectiveness of actions we implemented to improve our results. Some of the performance measures we focus on are related to health issues such as immunizations, blood lead screening, diabetes, asthma, well-child visits and adult access to care. Together we achieved improvement in our 2014 scores, but we still have work to do!

What our members are saying:

When asked if providers show respect for what they had to say,

80%

responded with ALWAYS.

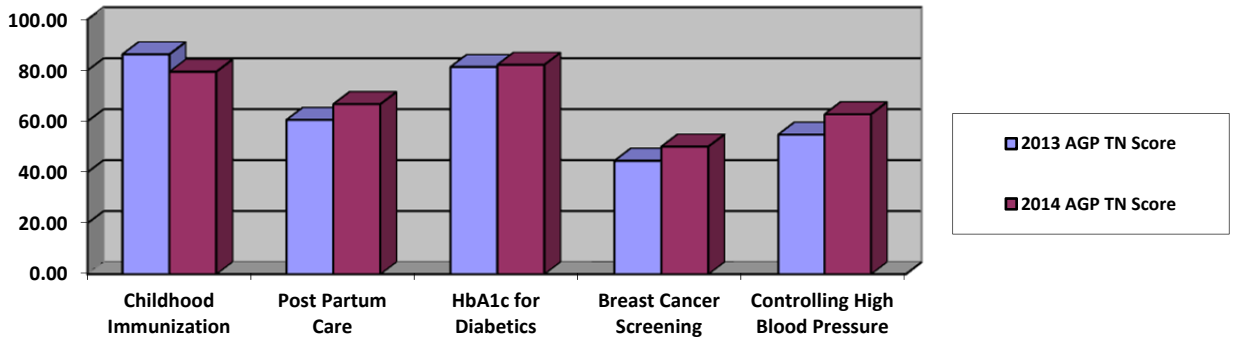
We are constantly seeking opportunities for improvement.

Current Amerigroup interventions include:

- Providing members with educational resources related to a variety of health topics, including immunizations, diabetes, women's health, BMI at health fairs, community events and clinic day events at your offices.
- Improving provider and member outreach for those members due or past due for preventive services.
- Providing a variety of both member and provider incentives to motivate and promote collaboration and follow-through with care recommendations.
- Providing primary care providers with a monthly Quality Report card and member "gap in care" detail, if requested.

HEDIS results

The Annual HEDIS report is provided as a service and reference for you and the rest of our provider network. HEDIS 2014 measures are calculated based upon 2013 performance data. We produce this report to monitor the quality of care our membership receives and to identify where opportunities exist to improve care delivery. The graph below denotes the rate of our members who received services for the specific HEDIS measures listed.



Keys to effective patient communication

Communication between a patient and his or her provider is the single most effective predictor of patient compliance to prescribed treatment plans. However, there are major barriers to effective communication between providers and patients, including health literacy, language differences and how patients feel about health care and treatment within their own cultural context. We know it's worth the effort to overcome these barriers.

According to the Institute for Health Care Communication (formerly the Bayer institute), successful communication with patients involves four elements[1]:

1. **Engagement** is a connection between you and your patient that continues throughout the visit and establishes a partnership. Engage a patient by showing interest in him or her as a person, finding out what the patient hopes to get out of the visit up front and using the patient's language instead of medical terminology or jargon.
2. **Empathy** is the ability to imagine oneself in another's place and understand the other's feelings, desires, fears and actions. You can show empathy by making proper introductions while patients are fully clothed. This can be accomplished while the patient's vitals are being taken. Once inside the exam room, make eye contact, approach patients at eye level, acknowledge what patients are saying and speak in a friendly manner.
3. **Education** involves providing your patient increased knowledge and understanding while decreasing his or her uncertainty and anxiety. You can start this process by asking, "What do you think is going on?" You might be surprised by the valuable information this question elicits. Always be clear in describing or defining terms to avoid confusion.
4. **Enlistment** is your invitation to the patient to collaborate in the decision-making process. If patients feel involved in the process, they are more likely to comply with agreed-upon treatment plans. Try offering patients possible explanations and ask if your findings are in line with what they thought. Be sure to discuss any differences in the diagnosis. Lay out all the variables for patients in a simple format, including dosage requirements and the benefits of treatment. Solicit feedback from the patient to confirm true collaboration. At the end of the visit, summarize the mutually agreed-upon treatment plan and discuss next steps.

Get referrals and authorizations online!

Access them through the Quick Tools at the top of our provider self-service home page.

Need to make a referral?

Our online directory makes it easy to find network doctors and specialists. Click on Find a Doctor at the top of our provider self-service webpage. Search by name, specialty or area, or download a PDF of our latest printed directory.

Patients spend about two percent of their time with you and 98 percent of their time living with and managing their illnesses. With effective communication, you can help them become educated participants in their treatment and help them take ownership of their health.

Want more information about how to effectively engage with patients and communicate in a culturally competent way? Our provider self-service website offers no-cost cultural competency training for you and your staff.

It's HEDIS season all year long

HEDIS scoring is no longer an annual event with a season lasting from January to June, but rather a year-round effort. To get the most out of our continuous improvement initiatives, we need information from you that is both current and actionable. We get this information directly from reports produced using your claims coding and submissions. We track and monitor data on a rolling 12 months and month-to-date basis to identify and immediately address any opportunities for improvement. Monthly updates — including administrative, supplemental and chart-based data — make identifying trends possible for us and are important to obtaining accurate lists of members who are eligible for, but haven't yet received, key preventive services required by NCQA HEDIS guidelines.

[1] Mock, Kathleen. "Effective clinician-patient communication." *Physician's News Digest* (2001): 1-6.

Through year-round analysis, we can provide you with lists of members who are missing important health screenings. Data collection throughout the year may also reduce your number of chart assessments during the annual HEDIS project performed in the first two quarters of a measurement year. It may even eliminate our need to visit your office at all during that span. If you would like to submit Amerigroup Electronic Data Record electronic data feeds, let your Provider Relations representative know!

Thank you for your continued partnership to ensure that together we can achieve year-round success in meeting the measures!

TNPEC-0910-14

Amerigroup pharmacy quick tips

This section is a resource guide from our Pharmacy department. You will find contact information, clinical guidelines, prior authorization and other helpful information.

Helpful contacts:
Magellan Health Services:
https://tenncare.magellanhealth.com
TennCare Pharmacy Program: www.tn.gov/tenncare

Magellan provides these toll-free phone numbers for prescribers 24 hours a day, 7 days a week, 365 days a year:

- 1-866-434-5524 Clinical Support Call Center for prior authorization (PA) requests
- 1-800-241-8726 Web Support Call Center
- 1-866-434-5523 Magellan fax number

Mandatory generic requirements

- TennCare is a mandatory generic program.
- Multisource brand products submitted with a DAW code of "1" require PA to bypass the MAC/FUL pricing.

Branded drugs classified as generics

- Exceptions to the mandatory generic policy exist where TennCare prefers a brand product over a generic.
- Enrollees are charged the generic copay of $1.50.
- These TennCare-mandated brands do not count toward the two-brand monthly limit.
- For a current detailed listing of these drugs, please see the *Branded Drugs Classified as Generics* list on the Magellan website at https://tenncare.magellanhealth.com.

Days' supply

The standard days' supply maximum is 31 days per prescription.

Rx/month

- TennCare Medicaid adults (defined as 21 or older) who are not in an institution or home- and community-based services (HCBS) waiver are subject to a monthly prescription limit (see Section 7.6.6.1 – *Prescription Limits*).
- The monthly prescription limit is five prescriptions per calendar month, of which no more than two can be brand-name drugs (see Section 7.6.6.2 – *Exceeding Prescriptions Limits* for approved exceptions).

Accumulation Edits

- Hydrocodone 1200 mg per rolling 30 days
- Oxycodone 1200 mg per rolling 30 days
- Acetaminophen 4 gm per day

Client Copays

The TennCare Pharmacy system determines the copay. Members cannot be denied services for failure to pay copay. Brand-name medications have a $3 copay per prescription. Generic name medications have a $1.50 copay per medication. A claim for multi-ingredient compounds receives the brand copay. TennCare Medicaid members 21 years or older who have a pharmacy benefit and who are not long-term care residents or HCBS waiver recipients are subject to copays. Exceptions from copay include:

- TennCare Medicaid members under the age of 21
- Pregnant women who self-declare at the pharmacy
- Members in hospice care who self-declare a the pharmacy
- Children at or above 100 percent of the federal poverty level
- Family planning drugs

Newborn Prescription Claims
Submit the claim under the mother's ID number, date of birth, last name and first name with the word "baby" at the end of the first name. If the mother is not covered, the newborn will not have coverage until added. If the claim rejects as being over the monthly prescription limit, contact Magellan Pharmacy Support Center Help with the phone number provided above.

Diagnosis Override PAs
PA requirements can be bypassed for certain medications when specific medical conditions exist. Those specific medications and diagnoses are available at https://tenncare.magellanhealth.com. Prescribers are encouraged to include the applicable diagnosis code on written prescriptions for inclusion on the electronic pharmacy claim.

Emergency Supply Override Process
- The claim is denied as nonpreferred or requiring PA.
- The pharmacist should determine if an immediate threat of severe adverse consequences exists if the patient does not receive an emergency supply.
- If the pharmacist does determine that an emergency supply is warranted, he or she must determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed.
- The enrollee is not charged a copay for the emergency supply.
- The emergency supply does count toward the monthly prescription limit.
- Only one emergency supply is provided per drug per member per year.
- Recipients are not permitted to receive, nor will TennCare pay for, the remainder of the original prescription at any pharmacy unless the prescriber has received a PA.
- If the prescriber obtains a PA or changes the drug to an alternative not requiring a PA in the same month, the remainder of the prescription and/or substitute prescription does not count toward the monthly limit. To exempt the remainder of the prescription from the prescription limit once a PA is obtained, or to exempt the replacement prescription from counting toward the prescription limit, the value of "5" must be submitted in the Submission Clarification Code (NCPDP Field # 42Ø-DK) on the incoming claim within 14 days of the initial prescription.

Covered Over-the-Counter (OTC) Products
TennCare has certain OTC items that are covered. These items must be dispensed pursuant to the order of a physician or legally authorized prescriber. Full lists are available at https://tenncare.magellanhealth.com.

Injectable Drugs
If an injectable product is not listed on the Covered Injectables list at https://TennCare.magellanhealth.com and not otherwise included, the injectable product will be denied and will need to be billed to the patient's respective managed care organization (MCO). MCO contact information can be found at www.tn.gov/tenncare/pro-mcos.shtml.

Exceeding Prescription Limits
There are three ways a TennCare enrollee can receive prescriptions over and above the monthly limit (i.e., more than five prescriptions or two brand names per month):
- **Auto-exemption list**
- **Dose titration override**
- **Prescriber attestation list:** a list of drugs an enrollee may receive if the prescriber attests the need for these drugs is urgent

1. Auto-Exemption List
- TennCare has developed a list of medications called the Auto-Exemption List that do not count towards the monthly prescription limit.
- The *Auto-Exemption List* is applicable only to persons who have pharmacy coverage. Persons without pharmacy coverage may not obtain drugs on this list.
- The pharmacy POS recognizes *Auto-Exemption List* drugs and ensures that they are not counted toward the limit.

Examples of Categories included in the Pharmacy Auto-Exemption List*	
Anti-neoplastics	Anti-parkinsonian Agent
Anti-tubercular Agents	Anti-Virals
Cardiovascular Disease - Oral Formulations (generics only)	Clotting Factors
Diabetes Agents – Insulins	Diabetes Agents – Oral Hypoglycemics (generics only)
Diabetic Supplies	Dialysis Medications
Flu Vaccine – Injectable formulations only	Hematopoietic Agents
Hepatitis C Agents	Immunosuppressives
Iron preparations	Long-acting Antipsychotics
Prenatal Vitamins	Respiratory Agents (generics only)
Total Parenteral Nutrition (TPN)	Transplant Agents
	Clotting Factors

2. Dose Titration List

This list contains select drugs and/or drug classes the pharmacy provider is allowed to process a second claim for within 21 days of the initial claim. To do this, pharmacy providers must place a **"2"** or **"6"** in the Submission Clarification Code field (NCPDP Field # 420-DK).

Dose Titration List for a submission clarification code of "2"*	
Anticoagulants	Warfarin, Jantoven, Coumadin
Low Molecular Weight Heparins	Arixtra, Fragmin, Lovenox and Innohep
Anticonvulsants	All Anticonvulsants
Xanthines	Theophylline
Selective Serotonin Reuptake Inhibitors	All agents
Selective Norepinephrine Reuptake Inhibitors	All agents
Atypical Antipsychotics	All agents
Thyroid Hormones	Levothyroxine
Immune Globulin	Hizentra™, Vivaglobin
Thrombopoietin Agonists	Promacta
Dose Titration List for a submission clarification code of "6"	
Atypical Antipsychotics	Clozapine, Fazaclo Odt and Clozaril
Miscellaneous Agents	Subutex, Buprenorphine, Suboxone

3. Prescriber Attestation List

The Prescriber Attestation List (also known as soft limits) is a process in which the prescriber may ask TennCare for an exception to limited medications.

How does the prescriber attestation process work?

- The prescriber determines an additional prescription is needed to prevent serious health consequences.
- The drug in question is not on the Auto-Exemption List or the Dose Titration List but is on the Prescriber Attestation List.
- The prescriber or prescriber's agent must initiate a telephone call to the Magellan Pharmacy Support Center.
- For a drug that may be needed for longer than a one-month period, the prescriber or prescriber's agent must review the patient's full medication profile with a clinical pharmacist at Magellan, and he or she must attest that no viable option exists to substitute one of the drugs the patient receives under the prescription limit for the drug for which the special exemption is sought.
- An individualized attestation form is faxed to the prescriber for signature immediately following the telephone call. The form must then be signed by the prescriber and faxed back to Magellan via the number provided on the form within three days or else the form will be denied and the prescriber or prescriber's agent must initiate the entire process again.
- Upon receipt of an attestation form signed by the requesting prescriber, an override is entered, and the enrollee receives the prescription that helps avert an immediate threat of severe consequences.

Examples of Categories Included on the Prescriber Attestation Drug List*		
Antibiotics	Antipsychotics	Nitroglycerin preparations
Antifungals	Anticonvulsants	Antiplatelet agents
Antivirals	Antidepressants	Anticoagulant agents
Ophthalmic preparations	Rheumatoid arthritis agents	Oral Steroids
Respiratory agents	Antiarrythmics	Thyroid hormones
Diabetes	Hypotensives	Multiple Sclerosis Agents
Parkinson's Agents	Otics	Pancreatic Enzymes

*The above lists may not be all-inclusive and are subject to change. Full lists are available at https://tenncare.magellanhealth.com.

TNPEC-0777-14

Reminder – Diabetic supplies are covered through the TennCare pharmacy benefit

Your patients with diabetes will need a prescription to obtain their needed supplies to properly manage their blood glucose levels. These items do not count against the member's prescription limits. For a more complete list of covered diabetic supplies, please see the TennCare auto-exempt list at www.tn.gov/tenncare/mem-pharmacy.shtml > Automatic Exemption List (Exempt).

TNPEC-0864-14

Diabetic eye exams

Summary: Many Amerigroup members do not receive annual diabetic eye exams because they do not think it is a covered benefit. The TennCare managed care organizations recently launched a collaborative initiative to increase the number of diabetic members who receive these exams.

✦ **What this means to you:** We encourage our PCPs to refer patients covered by Amerigroup, UnitedHealthcare, BlueCare or TennCare *Select* for an annual diabetic eye exam by a qualified ophthalmologist or optometrist. As a network provider, you may see an increase in referrals for diabetic eye exams.

What action should I take?

The information below is provided as a quick reference to assist you in proper coding.

Codes to identify diabetes	
Description	**ICD-9-CM diagnoses**
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Codes to identify eye exams		
CPT	**CPT category II**	**HCPCS**
67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 920.12, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S300

TNPEC-0851-14

Medical record documentation audit changes for obstetrics-gynecology providers

Summary: The Quality Management (QM) staff of Amerigroup Community Care will conduct medical record documentation onsite audits to assess compliance to our medical record standards and Clinical Practice Guidelines (CPGs). Records kept in accordance with these standards facilitate effective medical care and continuity of care among practitioners.

✦ **What this means to you:** 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.

Changes in standards

We added the following standards:

- Providers have in place policy or procedures for the follow-up of missed appointments.
- If member has a postpartum depression diagnosis and a referral to a behavioral health (BH) provider was completed, documentation from the BH provider is present if member approved coordination of care between obstetrics and the BH provider.

We removed the following standards:

- Advance directives

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 and CPGs. These standards include demographic information, health history, 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. Ten charts with a minimum of eight are assessed for compliance.

How do you determine who is selected for the audit?

Obstetrics-gynecology providers with 500 or more encounters are audited against the standards. If your office meets these criteria, the QM department will contact your office to schedule an appointment for the audit.

How can I make sure my office is compliant?

To help you prepare for this important quality assurance activity, the standards are attached for your review and reference. You can also find these standards detailed in Section 17 of your Amerigroup provider manual.

What if I need assistance?

If you have questions or concerns about the audit, call our QM department at 615-316-2400, ext. 22409.

Medical record documentation standards

	Core standard
1.	Provider has in place policy and procedures to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPAA regulations, security as defined by HIPAA, and member accessibility to the extent provided by TCA 63-2-101/63-2-102/33-3-104 et seq of medical records.
2.	Patient demographic data is present in chart and name or ID is on each document.
3.	Medication allergies and adverse reactions are prominently noted/displayed in the record. If the member does not have allergies, this should also be noted.
4.	A current medication list is present in the patient record. (For best practice: dosage, date medication was initiated and dates of refills are present.)
5.	A current problem list that includes significant illnesses, medical conditions and psychological conditions is present.
6.	Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses.
7.	A history of immunizations is present in the medical record for adults.

8.	Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan and follow-up recommendations. The treatment plan is appropriate to findings and the patient is not at risk by diagnostic or therapeutic problems. All entries are signed and dated (may be a handwritten signature, unique electronic identifier or initials).
9.	Provider has in place a policy and procedure for follow-up of missed appointments.
10.	If member has a postpartum depression diagnosis and a referral to a BH provider was completed, documentation from the BH provider is present if member approved coordination of care between obstetrics and the BH provider.
11. Antepartum and postpartum guidelines	
11a.	Prenatal visit as an Amerigroup member in the first trimester or within 42 days of enrollment with Amerigroup.
11b.	Prenatal visits every four weeks until 28 weeks of pregnancy, then every two to three weeks until 36 weeks, then weekly until delivery.
11c.	At 28 weeks, glucose screening for gestational diabetes and assays for hemoglobin and hematocrit. If patient is Rh-negative and unsensitized, give RH immunoglobin.
11d.	At 35-37 weeks, vaginal and rectal cultures are obtained for group B Streptococcus.
11e.	If previous C-section, vaginal birth after cesarean counseling.
11f.	Postpartum visit on or between 21 and 56 days after delivery.

TNPEC-0822-14

The following reminder applies to Primary Care Providers.

PCP rate increase update

Background: In compliance with the Patient Protection and Affordable Care Act (PPACA), as amended by Section 1202 of the Health Care and Education Reconciliation Act, Amerigroup is required to reimburse Medicaid PCPs at parity with Medicare rates for qualified providers and qualified services in calendar years 2013 and 2014. Effective for dates of service on or after January 1, 2015, Amerigroup will no longer provide increased reimbursement to Medicare levels for primary care services. Amerigroup will continue to reimburse qualified providers and qualified services provided in 2013 and 2014 in accordance with the requirements of the PPACA.

✦**What this means to you:** This is an amendment to your existing provider manual. Please review the information and file it with your Amerigroup Participating Provider Agreement. You do not need to sign or return anything to Amerigroup.

What is the impact of this change?

Effective for dates of service on or after January 1, 2015, Amerigroup will no longer provide increased reimbursement to Medicare levels for primary care services. Reimbursement for primary care services will be in accordance with the rates specified in the Participating Provider Agreement.

For services provided in 2013 and 2014, Amerigroup will continue to reimburse qualified providers and qualified services in accordance with the requirements of the PPACA and Amerigroup Claims Submission and Adjudication Procedures.

TNPEC-0882-14

My PCP Connection frequently asked questions

Am I seeing my assigned members?

As an Amerigroup Community Care PCP, it is your responsibility to verify any member you see is assigned to the member panel for you or another participating PCP in your group (i.e., same tax ID number [TIN]). Check our website to confirm assignment or call National Customer Care at 1-800-454-3730. Only provide services to members who are on your assigned member panel or the panel of another participating PCP in your group. Download the complete provider frequently asked questions for more information you can share with your staff.

I am a participating provider with Amerigroup. How does My PCP Connection affect me?

If you are a specialist, My PCP Connection has no impact on you**.** If you are a PCP, it is your responsibility to verify any member you see is assigned to your member list or to a participating provider's member list within your group/TIN. Only provide services to members who are on your assigned member list or the list of another participating provider within your group. Effective July 15, 2012, for Middle Tennessee providers and effective August 1, 2015, for providers in the East TN and West TN expansion counties, you will not be reimbursed for any services you provide to a member who is not assigned to you or to your group/TIN. Please remember, group refers only to those providers operating under the same TIN.

I am an Amerigroup provider. What happens if my member is in the hospital after My PCP Connection is implemented (July 15, 2012, for Middle Tennessee providers and August 1, 2015, for providers in the East TN and West TN expansion counties)?

As a PCP, if you visit a member in a hospital or nursing facility setting, you will be reimbursed for the visit whether or not the member is assigned to you or your group/TIN.

What should I do if a member presents in my office and the member is not assigned to me or another participating provider in my group/TIN?

Please ask the member to change his or her PCP. We recommend you facilitate this from your office. The change can be made by calling 1-800-454-3730 or faxing the PCP Reassignment Request Form to 1-866-840-4993; changes are effective the same day. Note that PCP changes made by members using the member website are effective the next day.

I am a solo practitioner. Will the physician covering for me be paid for the services provided while covering for me?

As a solo practitioner, you are required to provide us with the name and the TIN of your covering physician. If someone other than the identified covering physician provides services for members on your assigned panel or the covering physician is nonparticipating, you are responsible for reimbursing that provider per the provider manual.

Will I be reimbursed if I see a newborn?

All participating PCP claims for newborns under 91 days of age will be reimbursed.

TNPEC-0835-14

The following reminder applies to long-term care providers.

Critical incidents update

Summary: The Bureau of TennCare updated section 2.15.7.1.4.3 as part of Amendment 16 to the TennCare MCO Contractor Risk Agreement (CRA).

✦ **What this means to you:** Ensure you and your staff have policies and procedures in place to comply with these requirements.

What is the new requirement for Amendment 16?

The CRA states that a contractor shall require its staff and contract CHOICES home- and community-based services (HCBS) providers to report, respond to and document critical incidents. This shall include, but not be limited to, the following:

> Section 2.15.7.1.4.3 - Requiring that its staff and contract CHOICES HCBS providers immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members. If the allegation is in reference to a CHOICES HCBS worker, the worker shall be immediately released from providing services to any TennCare member until the investigation is complete.

Prior to Amendment 16, the HCBS worker or caregiver referenced in an allegation was removed from a member's home and from all CHOICES members' cases.

TNPEC-0834-14

Proper reporting of covered and non-covered days

Summary of change: As a reminder, Amerigroup Community Care will not process for payment inpatient claims submitted without the proper reporting of covered and non-covered total days billed and corresponding units.

✦ **What this means to you:** Covered days and non-covered days (as applicable) are required data on all inpatient claims. Covered days must balance to the days (units) reported, as referenced in the UB04 guide FL46. This applies to accommodation revenue codes 0100-0219 and 1000-1005 for behavioral health.

What is the impact of this requirement?

Claims submitted without the correct covered and non-covered days not balancing to the statement coverage period for inpatient claims will deny as "Billing Error" (Status Code V51) or "Resubmit With Valid/Correct Service Date" (Status code G90). If your claim is

denied “Billing Error“ or “Resubmit With Valid/Correct Service Date”, you will need to submit a corrected claim with the correct statement dates and total billed day units.

Example:

Do:	Submit claim with statement dates of October 1, 2014, to October 31, 2014, and 31 total day units.
Do not:	Submit claim with statement dates of October 1, 2014, to October 15, 2014, and 10 total day units.

Additional information:

The covered days plus non-covered days must equal the statement to date minus the statement from date (statement covers period). A variance of one day plus or minus is allowed.

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 about this or any other entry in the NewsBlast can be found on our website, providers.amerigroup.com/TN. If you have questions or need assistance, contact your local Provider Relations representative or call Provider Services at the toll-free phone numbers listed below:

- Medicaid 1-800-454-3730
- Medicare 1-866-805-4589
- Long-Term Services and Supports (HCBS) 1-866-840-4991

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