Provider Newsblast

Amerigroup Community Care
providers.amerigroup.com/TN
Medicaid providers: 1-800-454-3730
Medicare providers: 1-866-805-4589

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Attention providers: Revalidate your registration

Just a reminder: In order to continue to be eligible to participate in the Tennessee TennCare/Medicaid program under your current NPI and Tennessee TennCare/Medicaid ID, you must revalidate your registration information.

How can I revalidate my registration information?

You must revalidate your registration information by visiting www.tn.gov/tenncare and selecting Providers, Provider Registration and then Individual (Provider Person) or All Other Provider Registration Information. You will be prompted to choose one Medicaid ID during the revalidation process. Failure to complete this revalidation process will result in termination of your Tennessee TennCare/Medicaid provider number and your agreement with Amerigroup Community Care.

If you have already followed the process through TennCare, there is nothing else you need to do in revalidating your registration.

What if I need assistance?

If you have questions regarding this provider revalidation effort, please contact the TennCare Provider Services Call Center at 1-800-852-2683 between the hours of 8 a.m. and 3:30 p.m. Central time Monday through Friday.

In this issue

Provider Self-Service tools make it easy to do business with our organization

The Provider Self-Service (PSS) web portal offers 24/7 access to update basic provider demographic information like practice address information, practice roster, or termination of a provider in the practice by simply attaching supporting documentation.

Other available tools on the secure PSS site include, but are not limited to:

- Access to PCP member panels
- Patient 360 tool to quickly retrieve detailed records about your patients
- Member eligibility and benefits
- The ability to submit and check status of:
    - Authorizations
    - Claims

You must be a registered user to access the secure PSS tool at providers.amerigroup.com with your Availity username and password. If you do not have a login, go to www.availity.com, select the Register Now option and follow the Availity registration process instructions. Once you have your Availity username and password and have logged in, you may take an online tutorial under Provider Education to guide you through the process to make provider updates.

Important changes regarding long-term services and support (LTSS) home and community based services (HCBS) billing requirements

As a TennCare CHOICES Long-Term Services and Supports (CHOICES) [LTC] provider all LTSS HCBS service claims will be required to be submitted with a patient discharge status code of 01.

Effective [December 1, 2015], when submitting claims for HCBS services, providers will be required to submit claims with 01 as the patient discharge status code. This includes previously submitted claims, which may need a corrected claim submission.

If claims are submitted with any other status code, Amerigroup will deny LTSS (electronic visit verification [EVV] and non-EVV) claims as a billing error. EVV providers will not be required to update any claim information as HealthStar will manage this billing requirement on your behalf.

Effective [March 01, 2016], All LTSS HCBS service claims submitted without 01 as the patient discharge status will be rejected. Choices providers will be required to resubmit all rejected claims with the proper patient discharge state code per LTSS billing requirements.

What is the impact of this change?
Submitting LTSS HCBS service claims with any other patient discharge status code, other than 01, will result in a denial for billing error. Amerigroup will reject LTSS HCBS service claims billed with any other status code as of [March 01, 2016].
Examples:

- **Do:** All LTSS HCBS service claims should be submitted with a patient status code of 01. Description of 01 patient discharge status code- discharge to home or self care (routine discharge).
- **Do not:** Do not submit LTSS HCBS service claims with patient discharge of status code of 30- still a patient or any other status codes. LTSS HCBS service claims may not be billed with a patient discharge status code other than 01.

Home health services missed shift notification requirement

Reminder: Effective April 1, 2013, Amerigroup Community Care required all contracted home health providers to call us if your office is unable to staff a scheduled home health aide or nursing shift. This update is to provide updated accurate methods of submitting notification of missed home health service shifts to Amerigroup.

Home health services offices, including CHOICES providers, are required to contact Amerigroup [no less than 30 minutes prior to] the scheduled arrival time if unable to staff a home health aide or nursing shift. Failure to appropriately staff shifts may lead to Amerigroup imposing sanctions.

How should I report a missed shift during Amerigroup business hours (8 a.m. to 5 p.m. Central time)?
You may call, fax or email your missed shift notification to Amerigroup.

- If calling, call the National Contact Center (NCC) at [1-800-454-3730] and choose the precertification -> new precertification -> home health prompts to be transferred directly to the Tennessee utilization management department.
- If faxing, please fax your notification of missed shifts to the same fax number for home health authorizations at [1-866-920-6003].
- If emailing, please email your missed shift notifications to [TN_HH_Missedshifts@anthem.com].

After hours (Monday-Friday from 5 p.m. to 8 a.m.) and on weekends, Friday 5 p.m. to Monday 8 a.m.):
Call the NCC at [1-800-454-3730] and choose the precertification new precertification home health prompts, then [press 1] (regarding a notification of a missed shift), and you will be connected to the Tennessee on-call UM nurse clinician.

What if I need to report a missed shift for a CHOICES member?
Follow your current process for reporting missed shifts for CHOICES members. This update pertains to missed shift for non-CHOICES members.

What information do I need to provide?
When contacting us about missing a scheduled home health aide or nursing shift, provide the following information:

- An explanation of your efforts to staff the shift;
- A plan for staffing future shifts, including the date and time you will resume providing services; and
- A daily report to Amerigroup, which includes the reason for all missed shifts.

What happens if I don't call in?
Please remember, according to the Amerigroup provider manual and your provider contract, we may impose sanctions if a provider:

- Fails to comply with contractual and/or credentialing requirements
- Fails or refuses to respond to a request for information by Amerigroup

Requests for information may include credentialing documentation, medical records and other records demonstrating the medical care provided to members.

We may impose sanctions as appropriate against a provider at our discretion or by specific directive of TennCare.

Prior authorization required for drugs Entyvio and Cyramza

Amerigroup Community Care is adding the following new drugs to the 2015 Medicaid list of injectable or infusible drugs requiring prior authorization (PA).

As of [January 1, 2016], providers must call for PA of:

1. Entyvio (vedolizumab): a monoclonal antibody that is a specific integrin receptor antagonist used for the treatment of moderately to severely active Crohn's disease and ulcerative colitis in adult patients.
   Amerigroup medical policy: DRUG.00068 (C9026 = Injection, vedolizumab, 1 mg)
2. Cyramza (ramucirumab): a monoclonal antibody and human vascular endothelial growth factor receptor 2 antagonist used for treatment of the following:
   a. Metastatic gastric or gastroesophageal junction adenocarcinoma with disease progression during or after treatment with fluoropyrimidine- or platinum-containing chemotherapy, as monotherapy or in combination with paclitaxel
   b. Metastatic non-small cell lung cancer with disease progression on or after platinum-based chemotherapy, in combination with docetaxel
   c. Metastatic colorectal cancer with disease progression on or after therapy with bevacizumab, oxaliplatin and a fluoropyrimidine, in combination with FOLFIRI

Amerigroup medical policy: DRUG.00067 (C9025 = Injection, ramucirumab, 5 mg)

Medicaid Reimbursement Policy Updates

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Community Care benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

Policy updates

Claims Timely Filing: Participating and Nonparticipating
(Policy 06-050, originally effective 08/09/2006)

Amerigroup Community Care follows 120 days for participating providers/facilities and 365 days for nonparticipating providers/facilities for covered services and members. Amerigroup allows providers to submit corrected or replacement claims within 120 calendar days of the last payment notification (explanation of payment).

Corrected claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate. It is also important to know that corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

For additional information, refer to the Claims Timely Filing: Participating and Nonparticipating Reimbursement Policy at providers.amerigroup.com and click on Quick Tools.

Preadmission Services for Inpatient Stays
(Policy 07-017, originally effective 09/28/2007)

Amerigroup allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window). For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three days prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses. For other hospitals and units, applicable preadmission services are included in the inpatient reimbursement within one day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses. For critical access hospitals, outpatient diagnostic services are not subject to either the three-day or one day- payment-window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

Please note, the three-day or one–day- payment window does not apply to outpatient diagnostic services included in the rural health clinic or federally qualified health center all-inclusive rate.

Applicable preadmission services consist of all diagnostic outpatient services (including nonpatient laboratory tests) and clinically related nondiagnostic (e.g., therapeutic) services that are related to the inpatient stay and are included in the inpatient reimbursement. A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately.

For additional information, refer to the Preadmission Services for Inpatient Stays Reimbursement Policy at providers.amerigroup.com and click on Quick Tools.

Prosthetic and Orthotic Devices
(Policy 06-084, originally effective 09/06/2006)

Reimbursement is allowed for prosthetic and orthotic devices when provided as part of a physician's services or ordered by a physician and used in accepted medical practice. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the prosthetic or orthotic device dispensed. The design, materials, measurements, fabrications, testing, fitting and training in the use of the device are included in the reimbursement of the device and are not separately reimbursable expenses. In instances of theft, a police report is required for consideration of replacements.

For additional information, refer to the Prosthetic and Orthotic Devices Reimbursement Policy at providers.amerigroup.com and click on Quick Tools.

Transportation Services: Ambulance and Nonemergent Transport
(Policy 07-036, originally effective 02/26/2008)

Amerigroup allows reimbursement for transport to and from covered services or other services mandated by contract. Due to the complex nature of transportation services, Amerigroup recommends that providers also review individual state guidelines for coverage requirements. Please note, Amerigroup does not allow reimbursement for mileage when the transport service has been denied or is not covered.

For additional information, refer to the Transportation Services: Ambulance and Nonemergent Transport Reimbursement Policy at providers.amerigroup.com and click on Quick Tools.

Policy reminder

Reimbursement of Sanctioned and Opt-Out Providers
(Policy 10-002, originally effective 10/11/2010)

Reimbursement is not allowed for providers who are excluded, debarred or who opt out from participation in state and federal health care programs. Reimbursement is also not allowed for providers who have rendered services to members enrolled in any Medicare program if such provider has opted out from participation in Medicare. Services that are rendered by a provider who is sanctioned or who has opted out of participation in Medicare may only be reimbursed in urgent or emergent situations. Claims received for services other than emergency services submitted by sanctioned or opt-out providers as provided herein will be denied. Amerigroup screens providers through all applicable state and federal exclusion lists.

Medicare Reimbursement Policy Updates

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Amerivantage (Medicare Advantage) benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Reimbursement Policies, visit our website at providers.amerigroup.com and select Quick Tools.

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(Policy 07-017, originally effective 09/28/2007)

Amerigroup allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window). For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three days prior to and including the day of the member's admission, and, therefore, are not separately reimbursable expenses. For other hospitals and units, applicable preadmission services are included in the inpatient reimbursement within one day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses. For critical access hospitals, outpatient diagnostic services are not subject to either the three-day or one-day payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

Please note, the three-day or one-day payment window does not apply to outpatient diagnostic services included in the rural health clinic or federally qualified health center all-inclusive rate.

Applicable preadmission services consist of all diagnostic outpatient services (including non-patient laboratory tests) and clinically related nondiagnostic services that are related to the inpatient stay and are included in the inpatient reimbursement. A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately.

For additional information and/or nonreimbursable services, refer to the Preadmission Services Reimbursement Policy at providers.amerigroup.com.

Prosthetic and Orthotic Devices
(Policy 06-084, originally effective 09/06/2006)

Reimbursement is allowed for prosthetic and orthotic devices when provided as part of a physician's services or ordered by a physician and used in accepted medical practice. Reimbursement is based on the applicable fee schedule or contracted/ negotiated rate for the prosthetic or orthotic device dispensed. The design, materials, measurements, fabrications, testing, fitting and training in the use of the device are included in the reimbursement of the device and are not separately reimbursable expenses. In instances of theft, a police report is required for consideration of replacements.

For additional information and/or nonreimbursable services, refer to the Prosthetic and Orthotic Devices Reimbursement Policy at providers.amerigroup.com.

Transportation Services: Ambulance and Non-Emergent Transport
(Policy 07-036, originally effective 02/26/2008)

Amerigroup allows reimbursement for transport to and from covered services or other services mandated by contract. Please note, Amerigroup does not allow reimbursement for mileage when the transport service has been denied or is not covered. Amerigroup also does not allow separate reimbursement for additional medical personnel, unusual waiting time and disposable/first aid supplies.

For additional information and/or nonreimbursable services, refer to the Transportation Reimbursement Policy at providers.amerigroup.com.