NewsBlast

TENNESSEE – October/November 2014 TNPEC-0893-14

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

Appropriate Treatment for Children with Upper Respiratory Infections

The HEDIS measure
This Healthcare Effectiveness Data and Information Set (HEDIS) measure is scored according to the percentage of children 3 months to 18 years old who were given a diagnosis of Upper Respiratory Infection (URI) and were not dispensed an antibiotic prescription.

Ways to improve your HEDIS scores
Educating patients on the difference between bacterial and viral infections is a key point in the success of this measure.

- Be equipped to teach patients about the real cause of their illness and explain how using antibiotics when they're not needed can be harmful and cause antibiotic resistance.
- Don't let your patients pressure you into writing antibiotic prescriptions for URIs.
- Educate patients that yellow or green mucus is not an indication of a bacterial infection. It is normal for mucus to be thick or change color during a viral cold.

Best Practices

- Post educational materials in your waiting room and treatment areas for patients.
- Focus your discussion on things patients can do to treat the symptoms of URI and the common cold like:
    - Getting extra rest
    - Drinking plenty of fluids
    - Treating the symptoms with over-the-counter medications

Using a cool mist vaporizer/nasal spray for congestion

- Using ice chips or throat spray/lozenges for sore throats

Proper Coding
The National Committee for Quality Assurance (NCQA) recognizes the following codes to identify URI:

Codes to Identify URI	
Description	**ICD-9-CM Diagnosis**
Acute Nasopharyngitis (Common Cold)	460
URI	465

How we can help
Amerigroup Community Care provides Clinical Practice Guidelines (CPGs) to our providers to help improve health care quality and reduce unnecessary variation in care for our members. You can find the CPGs on our website at providers.amerigroup.com/TN.

What if a parent/caregiver insists on an antibiotic?

- Refer to the illness as a common cold. Parents and caregivers tend to associate the label with a less-frequent need for antibiotics.
- Write a prescription for symptom relief such as an over-the-counter cough medicine.

Other available resources
You can find print and online tools on the Centers for Disease Control and Prevention website as part of the *Get Smart: Know When Antibiotics Work* campaign.

- Go to www.cdc.gov/getsmart for these helpful materials and more:
    - Prescription Pad for Viral Infection (4"x6" handout)
    - Get Smart: Know When Antibiotics Work (podcast)
    - Cold or Flu. Antibiotics Don't Work for You (brochure)

You can also contact your local Amerigroup Provider Relations representative for more information or check out our website at providers.amerigroup.com.

*HEDIS is a registered trademark of the NCQA

from TNPEC-0496-12

Diabetic Retinal Exams

Diabetic retinal exams are a ***covered medical benefit*** for TennCare members who are diagnosed with diabetes. Your TennCare managed care organizations (MCOs) support you in ensuring that members receive this service from a qualified ophthalmologist or optometrist. Members often confuse the diabetic retinal exam with a refraction exam. As a result, some members may fail to see a provider for a diabetic retinal exam because they think it is not a covered benefit.

Diabetes is the leading cause of new cases of blindness among adults ages 20-74. Recommending a retinal exam for diabetic patients can lead to early detection and treatment of diabetic retinopathy and can help prevent vision loss. The American Diabetes Association recommends an annual retinal exam for patients with diabetes.

We encourage you to order an annual retinal exam for your diabetic patients. These members trust you as their health care provider to direct them in their health care needs. We appreciate your efforts in helping us improve the health outcomes of our members.

You may contact your members' MCO for specific information regarding available providers or other information.

Amerigroup Community Care

- 615-316-2400, ext. 22889

UnitedHealthcare

- 1-800-690-1606

BlueCare provider service line

- 1-800-468-9736

TennCare Select provider service line

- 1-800-276-1978

TNPEC-0790-14

REMINDER: Policy on Disclosure of Ownership and Tennessee Medicaid Number Documentation

Summary: We want to remind you that pursuant to the terms of Section 2.12.9.60 of our Contractor Risk Agreement (CRA) with the state of Tennessee and the Code of Federal Regulations (CFR) 42 CFR 455 (B), all providers are required to submit disclosure of ownership information and proof of a Tennessee Medicaid number.

✦ **What this means to you:** Amerigroup denies all claims received without a complete and accurate disclosure form and/or proof of Medicaid ID, CRA Section 2.13.1.5. Claims are denied with exception code G72, No Medicaid ID/Disclosure Form.

What is the impact of this requirement?

Effective January 1, 2012, all providers will need to submit the required complete and accurate disclosure form and/or proof of Medicaid ID within 120 days from the date of service in order for the denied claim(s) to be reprocessed for payment. If the disclosure and/or Medicaid ID are not received within 120 days of the date of service, the claim will be reprocessed and denied for timely filing. In the future, Amerigroup may reject claims if a provider has no record of disclosure of ownership and or Medicaid ID on file.

Failing to submit the required disclosure of ownership form may result in the termination of your participation in the Amerigroup network.

How can I find more information?

You can find information on disclosure of ownership on the Bureau of TennCare website by visiting www.tn.gov/tenncare/pol-policies.html.

TNPEC-0315-11

Availity Multi-Payer Web Portal – Coming Soon!

Background: Physicians, hospitals and other health care providers will soon be able to check their patients' health coverage by going to the Availity Web Portal, a multi-payer portal that gives providers access to multiple payers' information with a single, secure sign-on.

✦ **What this means to you:** The Availity Web Portal will roll out in a phased approach throughout 2014. Look for future communications on registration and training opportunities.

Availity Web Portal Frequently Asked Questions

What is the Availity Web Portal?

The Availity Web Portal is an online multi-payer portal that gives physicians, hospitals and other health care professionals access to multiple payer information with a single, secure sign-on.

What services are available through the Availity Web Portal?

The Availity Web Portal offers the following transactions for Amerigroup providers:

- Eligibility and Benefits Inquiries
- Claim Status Inquiries
- Claim Submissions
- A direct link to the Amerigroup provider self-service website for all other functionality including panel listings, precertification requests and appeals. You can access the link located under the My Payer Portal in the left hand navigation bar on the Availity website.

Why is Amerigroup partnering with Availity?

Availity's Web Portal offers a variety of additional online solutions to help reduce administrative costs by eliminating paperwork and phone calls. This new service simplifies the health care benefit and claim process so you can spend more time on patient care and less time on paperwork.

What are the technical requirements to access the Availity Web Portal?

To access the Availity Web Portal, you must have:

- A computer with Internet access; high speed is recommended for best results
- Microsoft Internet Explorer 8.0 or higher
- A 1024 x 768 or greater pixel display for best results

Is the Availity Web Portal HIPAA compliant?

Yes; the Availity Web Portal is HIPAA compliant.

How does the Availity Web Portal protect the privacy and security of health information?

Information is protected by registration and can only be accessed by designated Availity Web Portal users. Availity does not store health information; it only exchanges the information in strict compliance with privacy laws and regulations as necessary to complete the range of transactions performed by providers.

Is there a charge to use the Availity Web Portal?
No. The standard transactions previously completed on the Amerigroup provider self-service website (e.g., eligibility and benefits, claim status inquiries, claim submissions) are available at no charge to physicians, hospitals and other health care professionals on the Availity Web Portal. There are no set-up fees, monthly fees or per-claim fees for these transaction types.

If I'm already registered for the Amerigroup provider self-service website, do I also need to register for the Availity Web Portal?
Yes, the Availity Web Portal requires providers to register and obtain a user ID and password. Every provider in your practice should have their own individual User ID and password for Availity**.** Once logged into the Availity Web Portal, you have the ability to directly access multiple payer organizations, eliminating the need to visit multiple sites and remember multiple passwords.

Are the tools to check eligibility and benefits, claim status inquiries, and claim submissions on the Amerigroup provider self-service website going away?
Yes. Access to eligibility and benefits, claim status inquiries and claim submissions will soon be available only at Availity.com. To avoid any disruption to accessing information electronically, you will need to be fully transitioned to the Availity Web Portal as the services listed will no longer be available on the Amerigroup provider self-service website. The Amerigroup provider self-service website will continue to offer you the tools you are familiar with but not listed above (e.g., panel listings, precertification requests, appeals, etc.).

If your office is not registered to use the Availity Web Portal, please register at Availity.com today so you and your staff can have immediate access to the online tools. Click on the Get Started button under Register Now for the Availity Web Portal, and then complete the online registration wizard.

If you are already using the Availity Web Portal, no additional registration is needed. Amerigroup will appear as one of the options in your dropdown. If you experience any difficulties, contact Availity Client Services at 1-800-Availity (1-800-282-4548).

What is a Primary Access Administrator (PAA)?
Each provider group registering for the Availity Web Portal will designate a Primary Access Administrator (PAA). The PAA will perform the account administration functions, such as registering new users, assigning business functions to users, revoking user access if needed and controlling the group's information within the Availity Web Portal.

What is the difference between Electronic Data Interchange (EDI), the Availity Web Portal and the Amerigroup provider self-service website?

- **EDI** allows providers to submit claims and retrieve remittance advices and claim file acknowledgements from their computer via modem and phone lines directly to and from the insurance carrier or clearinghouse.
- **Availity's web portal** offers both a multi-payer portal and an EDI clearinghouse. The Availity Web Portal optimizes the flow of information between health care stakeholders (including professional and facility providers, health plans, pharmacies and others) through a secure web-based exchange. We encourage you to continue submitting claims through your third party vendor or clearinghouse.
- **The Amerigroup provider self-service website** is a secure site offering a wide range of online tools and resources to perform daily tasks. Through the provider self-service website, providers access online services to make inquiries for referrals and precertifications/prior authorizations, view claim edit rules on ClearClaimConnection, download commonly used forms, reference materials and provider manuals and view policy and procedure information.

Are there training opportunities available?
Yes, free training webinars are available for providers. For a list of upcoming webinars, visit rsvpbook.com/Amerigroup. Once you are registered for the Availity Web Portal, you will have access to free live and on-demand webinars, online demonstrations, tip sheets and more.

Who should I call if I have questions about the Availity Web Portal?
Contact Availity Client Services at **1-800-Availity (1-800-282-4548)** or email questions to support@availity.com. Availity Web Portal Client Services is available Monday through Friday,
5 a.m. to 4 p.m. Pacific Time (excluding holidays).

PEC-ALL-1127-14

Precertification Code Additions for Cervical Fusion

Summary: New precertification requirements for cervical fusion will go into effect December 1, 2014.

✦ **What this means to you:** The following codes will be added to precertification requirements effective December 1, 2014.

New codes required to be preauthorized:

Please note that you will continue to submit your request for preauthorization through 1-800-454-3730 for phone requests or 1-800-964-3627 for faxed requests.

Code	Description
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

PEC-ALL-1325-14

Medical Policies update

On July 15, 2014, the WellPoint Medical Policy and Technology Assessment Committee (MPTAC) approved and adopted the following Medical Policies applicable to Amerigroup Community Care. These Medical Policies were developed or revised to support clinical coding edits.

Medical Policy	Medical Policy	Medical Policy new/revised
RAD.00031	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy	Revised

Medical Policy	Medical Policy	Medical Policy new/revised
RAD.00011	Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors	Revised
RAD.00033	Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors	Revised
SURG.00017	Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)	Revised

On August 14, 2014, the MPTAC approved and adopted the following Medical Policies applicable to Amerigroup. These Medical Policies were developed or revised to support clinical coding edits.

Medical Policy Effective Date	Medical Policy Number	Medical Policy	Medical Policy new/revised
October 1, 2014	DRUG.00064	Levodopa/Carbidopa Intestinal Infusion	New
October 1, 2014	DRUG.00065	Recombinant Coagulation Factor IX, Fc Fusion Protein (rFIXFc)	New
October 1, 2014	GENE.00039	Genetic Testing for Frontotemporal Dementia (FTD)	New
October 1, 2014	GENE.00042	Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome	New
October 1, 2014	OR-PR.00005	Upper Extremity Myoelectric Orthoses	New
October 1, 2014	DME.00011	Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices	Revised
October 1, 2014	DRUG.00024	Omalizumab (Xolair®)	Revised
October 1, 2014	DRUG.00043	Tocilizumab (Actemra®)	Revised
October 1, 2014	DRUG.00057	Canakinumab (Ilaris®)	Revised
October 1, 2014	DRUG.00058	Pharmacotherapy for Hereditary Angioedema (HAE)	Revised
October 1, 2014	GENE.00010	Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	Revised
October 1, 2014	GENE.00021	Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies	Revised
October 1, 2014	MED.00064	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)	Revised
October 1, 2014	MED.00112	Autonomic Testing	Revised
October 1, 2014	SURG.00007	Vagus Nerve Stimulation	Revised
October 1, 2014	SURG.00020	Bone-Anchored and Bone Conduction Hearing Aids	Revised
October 1, 2014	SURG.00055	Cervical Artificial Intervertebral Discs	Revised
October 1, 2014	SURG.00122	Venous Angioplasty with or without Stent Placement	Revised
October 1, 2014	DME.00037	Cooling Devices and Combined Cooling/Heating Devices	Revised
October 1, 2014	LAB.00011	Analysis of Proteomic Patterns	Revised

PEC-ALL-1330-14

Effective August 18, 2014, the WellPoint Medical Policy and Technology Assessment Committee approved and adopted the following medical policies applicable to Amerigroup Community Care. These medical policies were developed or revised to support clinical coding edits.

Medical policy number	Medical policy	Medical policy (New/Revised)
DRUG.00015	Prevention of Respiratory Syncytial Virus Infections	Revised

These Medical Policies were made publicly available on the Amerigroup Medical Policy and Clinical Utilization Management (UM) Guideline website.

Visit https://medicalpolicies.amerigroup.com/search to find specific policies. **Existing precertification requirements have not changed.**

TNPEC-0796-14

Clinical Utilization Management Guidelines update

On August 14, 2014, MPTAC approved the following Clinical UM Guidelines. These Clinical Guidelines were developed or revised to support clinical coding edits. This list represents the guidelines approved and adopted by the WellPoint Medical Operations Committee on August 12, 2014.

Clinical UM Guidelines are publicly available on the Amerigroup Medical Policies and Clinical UM Guidelines website. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.

Existing precertification requirements have not changed.

Effective Date	Clinical UM Guideline Number	Clinical UM Guideline Title	Guideline New or Revised
August 18, 2014	CG-BEH-09	Assertive Community Treatment (ACT)	New
August 18, 2014	CG-BEH-10	Basic Skills Training/Social Skills Training	New
August 18, 2014	CG-BEH-11	Mental Health Support Services	New
August 18, 2014	CG-BEH-12	Psychosocial Rehabilitation Services	New
August 18, 2014	CG-BEH-13	Targeted Case Management (TCM)	New
August 18, 2014	CG-SURG-43	Knee Arthroscopy	New
October 14, 2014	CG-DME-36	Pediatric Gait Trainers	New
October 14, 2014	CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting	New
August 18, 2014	CG-SURG-38	Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy	Revised
October 14, 2014	CG DRUG-05	Recombinant Erythropoietin Products	Revised
October 14, 2014	CG-DRUG-28	Alglucosidase alfa (Lumizyme®, Myozyme®)	Revised

TNPEC-0825-14

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 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/quicktools/pages/reimbursementpolicies.aspx.

New Policy: Maternity Services

(Policy 14-001, originally effective [2/1/2015])

Amerigroup policy allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same Federal Tax Identification Number (TIN). Reimbursement is based on all aspects of the global obstetric care package (i.e. antepartum, delivery and postpartum). In the event a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Amerigroup will not reimburse for duplicate or otherwise overlapping services during the course of the same pregnancy. In the event that Global, Delivery Only, Delivery/Postpartum, Antepartum only or Postpartum Only services have been paid for the same pregnancy, a claim for Global services may be denied or may cause a previously paid claim for overlapping services to be recouped. To view specific criteria for Global services, go to https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Surgery.

What is included in the Global Package?

The following elements of the global package are not separately reimbursable when any CPT code for global services is billed:

- Initial and subsequent history and physical exams when diagnosis of pregnancy has already been established
- All routine prenatal visits until delivery (typically monthly through 28 weeks, then biweekly until 36 weeks, and weekly until delivery) – usually 13 visits
- Additional visits for a high-risk pregnancy, potential problems, or history of problems that do not actually develop or are not active in the current pregnancy
- Collection of weight, blood pressure and fetal heart tones
- Routine urinalysis
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E&M) services that occur within 24 hours of delivery
- Management of uncomplicated labor (including administration of labor-inducing agents)
- Insertion of cervical dilators when this occurs on the same date of the delivery
- Simple removal of cerclage
- Vaginal (including forceps or vacuum-assisted delivery) or cesarean delivery of single gestation
- Delivery of the placenta
- Repair of first- or second-degree lacerations
- Uncomplicated inpatient visits following delivery
- Routine outpatient E&M services within six weeks of delivery
- Discussion of contraception
- Postpartum care only
- Education on breast feeding, lactation, exercise or nutrition

New Policy: Inpatient Facility Transfers

(Policy 13-002, effective [2/1/2015])

Amerigroup allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for the same episode of care, in compliance with federal and/or state guidelines and/or regulations regarding facility transfers payment.

In the absence of such guidelines, Amerigroup will use the following criteria:

- The transferring facility will receive a calculated per diem rate based on the length of stay, not to exceed the amount that would have been paid if the patient had been discharged to another setting
- The receiving facility will receive full Diagnosis-Related Group (DRG) payment

This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.

To view specific criteria for Inpatient Facility Transfers, please refer to the policy at https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Reimbursement Administration - General.

Policy Update: Requirements for Documentation of Proof of Timely Filing

(Policy 06-133, originally effective 11/15/2006)

Amerigroup will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements when a provider can provide proof of a date of claim receipt compliant with applicable timely filing requirements or demonstrate "good cause" exists.

Good cause may be established by the following:

- If the claim includes an explanation for the delay (or other evidence that establishes the reason), Amerigroup will determine good cause based primarily on that statement or evidence.
- If the evidence leads to doubt about the validity of the statement, Amerigroup will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claims filing delay was due to:

- Administrative error – incorrect or incomplete information furnished by official sources (e.g. carrier, intermediary or CMS) to the physician or supplier
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence
- Unusual, unavoidable, or other circumstances beyond the service provider's control which demonstrate that the physician or supplier could not reasonably be expected to have been aware of the need to file timely
- Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's negligence or intentional misconduct

To view more information about Requirements for Documentation of Proof of Timely Filing, please refer to the policy at https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx and click on Reimbursement Administration - General.

Policy Update: Modifier 63 - Procedure Performed on Infants less than 4 kg

(Policy 06-015, effective [2/1/2015])

Amerigroup reimburses **120 percent** of the applicable fee schedule (not to exceed the billed charges) or contracted/negotiated rate for the procedure code when the modifier is valid for services performed. Medical records may be requested for review to support the additional payment. The neonate weight should be documented clearly in the report for the service.

When an assistant surgeon is used and/or multiple procedures are performed on neonates or infants less than 4 kg in the same operative session, assistant surgeon and/or multiple procedure rules and fee reductions apply.

✦ Please note that state-specific exemptions apply to Maternity Services and Modifier 63. ✦
For additional information, refer to the reimbursement policies at
https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx.

To view additional information for Maternity Services and Modifier 63, please view the policies at https://providers.amerigroup.com/QuickTools/Pages/ReimbursementPolicies.aspx and click on Coding.

Policy update: Modifier 22 – Increased Procedural Service

(Policy 07-020, originally effective 10/04/07)

Amerigroup allows reimbursement for procedure codes appended with Modifier 22 when the procedure or service provided is greater than what is usually required for the listed procedure code. Prepayment reviews are performed to support the use of Modifier 22. If medical review of the documentation submitted with the claim supports Modifier 22, reimbursement is based on **120 percent*** of the fee schedule or contracted/negotiated rate for the procedure appended with Modifier 22. In addition, if the documentation does not support the use of Modifier 22 or there is no documentation submitted with the claim, reimbursement will not exceed 100 percent of the fee schedule or contracted/negotiated rate of the procedure.

Reminder: Modifier 22 is appropriate to use only with surgery, radiology, pathology, laboratory and medicine procedure codes with a global period of 0, 10 or 90 days.

*For market-specific reimbursement information and/or nonreimbursable services, refer to the Modifier 22 Reimbursement Policy at https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx under Coding.

Policy Update: Documentation Standards for Episodes of Care

(Policy 11-004, originally effective 12/07/2011)

Amerigroup requires that upon request for clinical documentation to support claims payment for services, the provided information should identify the member, be legible, and reflect all aspects of care.
To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Admission and discharge dates and instructions
- Preventive services provided or offered, appropriate to member's age and health status
- Evidence of coordination of care between primary and specialty physicians, when applicable
- Patient's identifying information
- Consent forms
- Health history including applicable drug allergies
- Physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician's orders
- Face to face evaluations
- Progress notes referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Working diagnoses consistent with findings and test results
- Treatment plans consistent with diagnoses

To view specifics of this policy, visit https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Reimbursement Administration - General.

Policy Update: Unlisted or Miscellaneous Codes (aka: Dump Codes)

(Policy 06-004, originally effective 03/02/2006)

Amerigroup allows reimbursement for unlisted or miscellaneous codes (a.k.a. dump codes). They should only be used when an established code does not exist to describe the service, procedure or item rendered.

Claims submitted with unlisted or miscellaneous codes must contain the following information and/or documentation for consideration during review:

- Include a written description, office notes, or operative report when describing the procedure or service performed
- Submit an invoice and written description for items and supplies
- Show the corresponding National Drug Code (NDC) number for an unlisted drug code

To view this policy, please visit https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Coding

Policy Update: Claims Submission – Required Information for Professional Providers

(Policy 06-029, originally effective 06/16/2006)

Professional providers of health care services are required to submit an original Centers for Medicare and Medicaid Services (CMS)-1500 health insurance claim form for payment of health care services. In addition to the required information, the CMS-1500 claim form must include the Clinical Laboratory Improvement Act (CLIA) certification number for applicable lab tests.

All claims must be legible. If any field on the claim is illegible the claim will be rejected or denied.

To view specifics of this policy, visit https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Reimbursement Administration - General.

Policy reminders: Split-care Surgical Modifiers

(Policy 11-005, originally effective 03/16/12)

Reimbursement of surgical codes appended with “split-care modifiers,” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code. For your reference, a market specific grid is below.

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member’s care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

Split-care modifier percentages by market

Market	Modifier 54	Modifier 55	Modifier 56
Tennessee	70%	20%	10%

To view specifics of this policy, visit https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Coding.

Other Reminders

Claims Timely Filing

As indicated on our Claims Timely Filing policy, corrected claims must be clearly marked. Failure to mark the claim appropriately may result in the denial of the claim as a duplicate. For example, claims submitted with the Modifier CC will be denied, as it is an inappropriate modifier for provider use. As stipulated by CMS, Modifier CC is not to be utilized when submitting a corrected claim. This modifier is to be used by the contractor (MCO) when the procedure code submitted was changed either for administrative reasons or because an incorrect code was used.

To view specifics of this policy, visit https://providers.amerigroup.com/quicktools/pages/reimbursementpolicies.aspx and click on Reimbursement Administration - General.

Obstetrics – New Condition Codes

Global Use of Condition Codes

Effective October 1, 2013, per the National Uniform Billing Committee Manual, new condition codes that indicate gestation and delivery must be reported on the delivery claim if required by the payer. These codes are listed below for your review:

Report condition code:

- 81 – C-sections or inductions performed at less than 39 weeks gestation for medical necessity
- 82 – C-sections or inductions performed at less than 39 weeks gestation electively
- 83 – C-sections or inductions performed at 39 weeks gestation or greater

Note: A number of state Medicaid fee-for-service plans are reducing payments for elective deliveries at less than 39 weeks gestation. Medically necessary deliveries are reimbursed the full rate. Retrospective reviews may be performed to verify the accuracy of the condition code reported. The implementation of ICD-10-CM may negate the need for these codes and the codes may be retired at that time. **This requirement is in addition to mandated modifier requirements.**

CMS 1500 – Appropriate Reporting for Place of Service

Services reported on a CMS-1500 Form require an accurate Place of Service (POS) consistent with the CPT or HCPCS code description. Providers are required to bill the appropriate POS for that claim to be eligible for reimbursement. In accordance with coding guidelines, physicians should not bill separately for performing administrative or clinical functions that are paid through the facility reimbursement.

For a complete list of reimbursement policies and clinical policy bulletins, visit providers.amerigroup.com and click on Quick Tools. Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative.

PEC-ALL-1039-13, PEC-ALL-1105-14, PEC-ALL-1206-14, PEC-ALL-1327-14