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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Quality overview: Special needs plan model of care

Commitment to our D-SNP members' health and their satisfaction with the care and services they receive is the basis for the Amerigroup quality improvement program. Annually, the plan prepares a quality program description that outlines clinical quality and service initiatives. We strive to support the patient-physician relationship through our Model of Care (MOC) program, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives.

Disease modifying anti-rheumatic drugs help prevent long-term disability

The American College of Rheumatology recommends that persons with rheumatoid arthritis (RA) are prescribed a disease modifying anti-rheumatic drug (DMARD) to prevent long-term disability and damage. To help ensure your Medicare Advantage RA patients have these important prescriptions, we will review medical and pharmacy claims looking for members who have an RA diagnosis and do not appear to have a claim for a DMARD. Providers who have members with a diagnosis of RA and not on a DMARD may receive a monthly fax reminder. Please be sure to use correct diagnosis codes for RA and be careful not to use a RA code for ruling out RA, osteoarthritis and joint pain.

Encourage Medicare Advantage members to control high blood pressure

According to the Centers for Disease Control and Prevention (CDC), almost one in three American adults has high blood pressure but only about half have their blood pressure under control. Amerigroup joins you in encouraging our Medicare Advantage members to know and control their blood pressure to lower their risk of heart attack, heart disease, stroke and kidney disease.

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Medical policies update

Summary: On August 6, 2015, the Amerigroup Community Care Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing. The medical policies were made publicly available on the Amerigroup provider website on the effective date listed below. Visit medicalpolicies.amerigroup.com/search to search for specific policies. Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Medical policy effective date	Medical policy number	Medical policy	Medical policy (new/revised)
10/06/15	DRUG.00077	Secukinumab (Cosentyx™)	New
08/10/15	DRUG.00078	Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors	New
10/06/15	SURG.00141	Doppler-Guided Transanal Hemorrhoidal Dearterialization	New
08/10/15	DRUG.00046	Ipilimumab (Yervoy™)	Revised
08/10/15	DRUG.00075	Nivolumab (Opdivo®)	Revised
08/10/15	GENE.00010	Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	Revised
08/10/15	GENE.00026	Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy	Revised
10/06/15	MED.00064	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	Revised
08/10/15	SURG.00055	Cervical Total Disc Arthroplasty	Revised
08/10/15	SURG.00098	Mechanical Embolectomy for Treatment of Acute Stroke	Revised

Clinical Utilization Management Guidelines update

The Clinical Utilization Management (UM) Guidelines on this list represent the Clinical UM Guidelines adopted by the Medical Operations Committee for the Amerigroup* Government Business Division effective February 23, 2015.
The full list of Medical Policies and Clinical Utilization Management Guidelines are publicly available on the Amerigroup Medical Policy and Clinical UM Guideline subsidiary website – their purpose is to help you provide quality care by reducing inappropriate use of medical resources.

Please note: highlighted sections indicate a revision

Guideline Number	Clinical UM Guidelines Name/Title
CG-ANC-04	Ambulance Services: Air and Water
CG-ANC-05	Ambulance Services: Ground; Emergent
CG-ANC-06	Ambulance Services: Ground; Non-Emergent
CG-BEH-01	Assessment for Autism Spectrum Disorders and Rett Syndrome
CG-BEH-02	Applied Behavioral Analysis for Autism Spectrum Disorder
CG-BEH-03	Psychiatric Disorder Treatment
CG-BEH-04	Substance-Related and Addictive Disorder Treatment
CG-BEH-05	Eating and Feeding Disorder Treatment
CG-BEH-07	Psychological Testing
CG-BEH-09	Assertive Community Treatment (ACT)
CG_BEH-10	Basic Skills Training/Social Skills Training
CG-BEH-11	Mental Health Support Services
CG-BEH-12	Psychosocial Rehabilitation Services
CG-BEH-13	Targeted Case Management (TCM)
CG-DME-01	External (Portable) Continuous Insulin Infusion Pump
CG-DME-03	Neuromuscular Stimulation in the Treatment of Muscle Atrophy
CG-DME-05	Cervical Traction Devices for Home Use
CG-DME-07	Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
CG-DME-08	Infant Home Apnea Monitors
CG-DME-09	Continuous Local Delivery of Analgesia to Operative Sites using an Elastomeric Infusion Pump During the Post-Operative Period
CG-DME-10	Durable Medical Equipment
CG-DME-12	Home Phototherapy Devices for Neonatal Hyperbilirubinemia
CG-DME-13	Lower Limb Prosthesis
CG-DME-15	Hospital Beds and Accessories
CG-DME-16	Pressure Reducing Support Systems Groups 1,2&3
CG-DME-18	Home Oxygen Therapy
CG-DME-19	Therapeutic Shoes, Inserts or Modifications for Individuals with Diabetes
CG-DME-20	Orthopedic Footwear
CG-DME-21	External Infusion Pumps for the Administration of Drugs in the Home or Residential Care Settings
CG-DME-22	Ankle-Foot & Knee-Ankle-Foot-Orthotics (Braces)
CG-DME-23	Lifting Devices for Use in the Home
CG-DME-24	Wheeled Mobility Devices: Manual Wheelchairs–Standard, Heavy Duty, Lightweight
CG-DME-25	Seat Lift Mechanisms
CG-DME-31	Wheeled Mobility Devices: Wheelchairs–Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
CG-DME-33	Wheeled Mobility Devices: Manual Wheelchairs-Ultra Lightweight

CG-DME-34	Wheeled Mobility Devices: Wheelchair Accessories
CG-DME-35	Breastfeeding Pumps
CG DME-36	Pediatric Gait Trainers
	The following CG DRUG Utilization Management Guidelines do not apply to the state of Kansas and are informational only for Kansas
CG-DRUG-01	Off-Label Drug and Approved Orphan Drug Use
CG-DRUG-03	Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
CG-DRUG-04	Use of Low Molecular Weight Heparin Therapy, Fondaparinux (Arixtra®), and Direct Thrombin Inhibitors in the Outpatient Setting
CG-DRUG-05	Recombinant Erythropoietin Products
CG-DRUG-07	Hepatitis C Pegylated Interferon Antiviral Therapy
CG-DRUG-08	Enzyme Replacement Therapy for Gaucher Disease
CG-DRUG-09	Immune Globulin (Ig) Therapy
CG-DRUG-11	Infertility Drugs
CG-DRUG-13	Hepatitis B Interferon Antiviral Therapy
CG-DRUG-15	Gonadotropin Releasing Hormone (GnRH) Analogs
CG-DRUG-16	White Blood Cell Growth Factors
CG-DRUG-19	Progesterone Therapy as a Technique to Prevent Preterm Delivery in High-Risk Women
CG-DRUG-20	Enfuviritide (Fuzeon)
CG-DRUG-21	Naltrexone (Vivitrol®) Injections for the Treatment of Alcohol and Opioid Dependence
CG-DRUG-24	Repository Corticotropin Injection (H.P. Acthar® Gel)
CG-DRUG-27	Clostridial Collagenase Histolyticum Injection
CG-DRUG-28	Alglucosidase alfa (Lumizyme®, Myozyme®)
CG-DRUG-29	Hyaluronan Injections in the Knee
CG-DRUG-30	Oprelvekin (Neumega)
CG-DRUG-33	Palonosetron (Aloxi®)
CG-DRUG-34	Docetaxel (Taxotere®)
CG-DRUG-38	Pemetrexed Disodium (Alimta®)
CG-DRUG-40	Bortezomib (Velcade®)
CG-DRUG-41	Zoledronic acid
CG-DRUG-42	Asparagine Specific Enzymes (Asparaginase)
CG-DRUG-43	Natalizumab (Tysabri®)
CG-DRUG-44	Pegloticase (Krystexxa®)
CG-DRUG-45	Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)
CG-DRUG-46	Fosaprepitant (Emend®)
CG-LAB-09	Drug Testing or Screening in the Context of Substance Abuse and Chronic Pain
CG-MED-08	Home Enteral Nutrition
CG-MED-21	Anesthesia Services and Moderate ("Conscious") Sedation

CG-MED-22	Neuropsychological Testing
CG-MED-23	Home Health
CG-MED-24	Electromyography and Nerve Conduction Studies
CG-MED-28	Iontophoresis for Medical Indications
CG-MED-32	Ancillary Services for Pregnancy Complications
CG-MED-38	Inpatient admission for Radiation Therapy for Cervical or Thyroid Cancer
CG-MED-42	Maternity Ultrasound in the Outpatient Setting
CG-MED-44	Holter Monitors
CG-MED-45	Transrectal Ultrasonography
CG-MED-46	Ambulatory and Inpatient Video Electroencephalography
CG-MED-47	Fundus Photography
CG-MED-48	Scrotal Ultrasound
CG-MED-49	Auditory Brainstem Responses (ABRs) and Evoked Otoacoustic Emissions (OAEs) for Hearing Disorders
CG-MED-50	Visual, Somatosensory and Motor Evoked Potentials
CG-OR-PR-04	Cranial Remodeling Bands and Helmets (Cranial Orthotics)
CG-OR-PR-05	Myoelectric Upper Extremity Prosthesis Devices
CG-REHAB-03	Pulmonary Rehabilitation
CG-REHAB-04	Physical Therapy
CG-REHAB-05	Occupational Therapy
CG-REHAB-06	Speech-Language Pathology Services
CG-REHAB-08	Private Duty Nursing in the Home Setting
CG-SURG-03	Blepharoplasty, Blepharoptosis Repair and Brow Lift
CG-SURG-05	Maze Procedure
CG-SURG-08	Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
CG-SURG-09	Temporomandibular Disorders
CG-SURG-12	Penile Prosthesis Implantation
CG-SURG-18	Septoplasty
CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS)
CG-SURG-25	Injection Treatment for Morton's Neuroma
CG-SURG-27	Gender Reassignment Surgery
CG-SURG-30	Tonsillectomy with or without Adenoidectomy for Children
CG-SURG-31	Treatment of Keloids and Scar Revision
CG-SURG-32	Pain Management: Cervical, Thoracic & Lumbar Facet Injections
CG-SURG-33	Lumbar Fusion and Lumbar Total Disc Arthroplasty (TDA)
CG-SURG-36	Adenoidectomy
CG-SURG-38	Lumbar Laminectomy, Hemi-laminectomy, Laminectomy and/or Discectomy

CG-SURG-39	Pain Management: Epidural Steroid Injections
CG-SURG-40	Cataract Removal Surgery for Adults
CG-SURG-41	Surgical Strabismus Correction
CG-SURG-42	Cervical Fusion
CG-SURG-43	Knee Arthroscopy
CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting
CG-SURG-46	Myringotomy and Tympanostomy Tube Insertion
CG-SURG-45	Bone Graft Substitutes
CG-SURG-47	Surgical Interventions for Scoliosis and Spinal Deformity
CG-TRANS-02	Kidney Transplantation

Summary: On August 6, 2015 the Amerigroup MPTAC approved the following Clinical Utilization Management (UM) Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations Committee for the Government Business Division on August 18, 2015.

On August 6, 2015, the clinical guidelines were made publicly available on the Amerigroup Medical Policies and Clinical UM Guidelines subsidiary website. Visit medicalpolicies.amerigroup.com/search to search for specific policies. Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Effective date	Clinical UM guideline number	Clinical UM guideline title	Revised or new
10/06/15	CG-DRUG-47	Level of Care: Specialty Pharmaceuticals	New
10/06/15	CG-MED-51	Three-Dimensional (3-D) Rendering of Imaging Studies	New
10/06/15	CG-MED-52	Allergy Immunotherapy (Subcutaneous)	New
09/25/15	CG-SURG-48	Elective Percutaneous Coronary Interventions (PCI)	New
09/25/15	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	New
10/06/15	CG-SURG-50	Assistant Surgeons	New
10/06/15	CG-SURG-51	Outpatient Cystourethroscopy	New
10/06/15	CG-BEH-02	Adaptive Behavioral Treatment for Autism Spectrum Disorder	Revised
08/10/15	CG-DME-36	Pediatric Gait Trainers	Revised
08/10/15	CG-SURG-07	Vertical Expandable Prosthetic Titanium Rib (VEPTR)	Revised
08/10/15	CG-SURG-12	Penile Prosthesis Implantation	Revised
10/06/15	CG-SURG-27	Gender Reassignment Surgery	Revised

08/10/15	CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting	Revised
08/10/15	CG-SURG-46	Myringotomy and Tympanostomy Tube Insertion	Revised
10/06/15	CG-SURG-47	Surgical Interventions for Scoliosis and Spinal Deformity	Revised

Behavioral health: Authorization requirement changes

Summary of change: As part of our goal of being easy to do business with, effective October 1, 2015, Amerigroup Community Care has updated our Precertification Lookup Tool (PLUTO) to more accurately reflect the current behavioral health authorization process for our Medicaid products. As a result of this update and effective October 1, 2015, certain behavioral health services will now require authorization.

Effective October 1, 2015, the codes listed below have been updated in PLUTO to show that authorization is required for the service.

Procedure Code	Service Description
H0008	Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
G0177	Day program for Acute Needs / Day Tx Training and Education
S9480	Intensive outpatient psychiatric services, per diem
H0019	Therapeutic behavioral health services, per diem (therapeutic behavioral group care services)
S5145	Therapeutic Foster Care/child & adolescent

Psychological and Neuropsychological Testing

Historically we have not required authorization for psychological and neuropsychological testing for medical purposes. Effective October 1, 2015, authorization will be required, regardless of the submitted diagnosis, for the testing procedures noted below.

Procedure Code	Service Description
96101	Psychological Testing
96102	Psychological Testing by Technician
96103	Psychological Testing by Computer
96118	Neuropsychological Testing
96119	Neuropsychological Testing by Technician
96120	Neuropsychological Testing by Computer

Correction to Marshall and Wayne Medical Centers notification

We recently notified you through our September edition of the monthly news blast that effective September 1, 2015, Marshall Medical Center and Wayne Medical Center, both owned by Maury Health System, will no longer be participating providers in the Amerigroup Community Care provider network.

We are pleased to notify you that both Marshall and Wayne hospitals will remain in our network and continue to be participating providers.

We apologize for any inconvenience the incorrect notification may have caused, and we appreciate your continued commitment to providing quality care to our members.

CPT Category II payment opportunity (Medicaid/Medicare)

Summary of change: Effective immediately, Amerigroup Community Care will pay providers a $10 administrative fee when reporting select CPT Category II codes on claims.

Why is Amerigroup offering this opportunity?
CPT Category II codes are tracking codes that facilitate data collection for performance measurement. Reporting CPT Category II codes eases the administrative burden of chart review during HEDIS® measurement. The use of these codes also enables us to monitor performance for key measures throughout the year.

The CPT Category II code administrative fee is intended to reimburse providers for the additional effort required to document and report key quality measures.

CPT Category II codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that:

- Support nationally established performance measures
- Have an evidence base of contributing to quality patient care

What is the impact of this change?
Effective immediately, Amerigroup will pay a $10 administrative fee for select (enclosed) CPT Category II codes. Providers reporting the select CPT Category II codes noted will be eligible for a $10 payment for each category per eligible member.

Body Mass Index Readings (BMI)
Category II Code:
3008F - BMI assessed/documented
CPT Codes ***Category II Codes must be billed with one of the following outpatient visit codes:***
99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456

Cholesterol Screening
Category II Codes
3048F - Most recent LDL-C less than 100 mg/dl 3049F - Most recent LDL-C 100 - 129 mg/dl 3050F - Most recent LDL-C greater than 130 mg/dl
CPT Codes *Category II Codes must be billed with one of the following 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
Category II Codes
3044F - Most recent HbA1c level less than 7.0%
3045F - Most recent HbA1c level 7.0 - 9.0%
3046F - Most recent HbA1c level greater than - 9.0%
3048F - Most recent LDL-C less than 100 mg/dl
3049F - Most recent LDL-C 100 - 129 mg/dl
3050F - Most recent LDL-C greater than 130 mg/dl
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 prior year*)
**Only use if there is no eye exam in the current year*
CPT Codes *Category II Codes must be billed with one of the following 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
Category II Codes
0500F - Initial prenatal care visit (report at first prenatal encounter with healthcare professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period - LMP) 0501F - Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period - LMP (Note: If reporting 0501F prenatal flow sheet, it is not necessary to report 0500F initial prenatal care visit) 0502F - Subsequent prenatal care visit (excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care [e.g., an upper respiratory infection; patients seen for consultation only, not for continuing 0503F - Postpartum visit (To be completed between 21-56 days after delivery)

CPT Codes *Category II Codes must be billed with one of the following Global Billing codes:*
59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care **59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care** **59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps)and postpartum care, after previous cesarean delivery** **59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Controlling Blood Pressure
Category II Codes
4050F: Hypertension plan of care documented as appropriate HTN.
CPT Codes ***Category II Codes must be billed with one of the following G and CPT codes:***
G8675 - Most recent systolic blood pressure >= 140 mm hg **G8676 - Most recent diastolic blood pressure >= 90 mm hg** **G8677 - Most recent systolic blood pressure < 130 mm hg** **G8678 - Most recent systolic blood pressure 130 to 139 mm hg** **G8679 - Most recent diastolic blood pressure < 80 mm hg** **G8680 - Most recent diastolic blood pressure 80 - 89 mm hg** **99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456**

COA Advance Directives
Category II Codes
1157F – Advance care plan in chart **1158F – Advanced car planning discussion** **1125F – Pain Severity quantified; 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**
CPT Codes ***Category II Codes must be billed with one of the following 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-CM: HIV status

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015. The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient's human immunodeficiency virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

The following table reflects the crosswalk from ICD-9 to ICD-10.

ICD-9 Code(s)	ICD-10 Code(s)
• **V08 –** Asymptomatic human immunodeficiency virus (HIV) infection status • **042 –** Human immunodeficiency virus [HIV] • **079.53 –** Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site	• **Z21 –** Asymptomatic human immunodeficiency virus [HIV] infection status • **B20 –** Human immunodeficiency virus [HIV] disease • **B97.35 –** Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere

To further assist in preparation for ICD-10, please see the following resources:
- Centers for Medicare & Medicaid Services (CMS): Provider Resources
- American Academy of Professional Coders: AAPC ICD-10 Resources
- World Health Organization: WHO ICD-10 Training

ICD-10: From compliance to medical policies

Below is an overview of the ICD-10 update and key information you need to know:

Compliance
- The current implementation date of ICD-10 is October 1, 2015, as mandated by HIPAA.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis for correct coding.
- Providers should submit all known conditions on the claim using ICD-10-CM diagnosis codes.

Claims processing

The following information explains the claims processing procedures for claims according to dates of services. Amerigroup Community Care is committed to ensuring providers understand the correct code set to use. The following information applies to claims processing:
- No mixed claims: Consistent with CMS guidelines, mixed claims (claims filed with ICD-9 and ICD-10 codes on the same claim) will not be accepted.
- ICD-10 codes: Claims with ICD-10 codes for dates of service (DOS) or dates of discharge (DOD) prior to October 1, 2015 will not be accepted.
- ICD-9 codes: HIPAA will not allow the use of ICD-9 codes for claims with DOS or DOD on or after October 1, 2015.
- Resubmitting claims: When resubmitting claims, providers should utilize the code set that is valid for the DOS/DOD.

Update to medical policies

Amerigroup has worked diligently to ensure that medical policies and clinical utilization management (UM) guidelines have been updated to include proposed ICD-10 coding. We want to ensure that providers understand where to locate medical policies and UM guidelines. Preparing policies and processes for ICD-10 helps ensure providers operate smoothly after October 1, 2015. The updated medical policies are available on the Amerigroup provider website at providers.amerigroup.com.

For specific questions regarding medical policies, please contact Provider Services at 1-800-454-3730.

Update to prior authorizations process

Amerigroup has updated prior authorization procedures to accommodate the transition to ICD-10-CM. The updates will ensure that providers understand how to submit prior authorizations according to the date that services are scheduled to be performed. The following information details the process for prior authorizations:

- Starting June 1, 2015, we will begin accepting and processing prior authorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015.
- ICD-9 codes must continue to be used to prior authorize services scheduled through September 30, 2015.
- Existing approved prior authorizations coded in ICD-9 whose effective period spans the ICD-10 date of October 1, 2015, do not need to obtain another authorization that is coded in ICD-10.
- Prior authorizations that span the October 1, 2015, compliance date will be valid for claims submitted using ICD-10 codes.
  - Example: If a DME wheelchair rental authorization coded with ICD-9 was approved for the effective period of April 1, 2015 – April 1, 2016, this authorization will still be valid for claims filed using ICD-10 diagnosis codes with beginning dates of service of October 1, 2015, and later.

Claims testing

The Amerigroup ICD-10 migrations team is conducting end-to-end testing of claims with providers. The process is designed to help ensure that provider systems can submit. Amerigroup claims successfully. Providers interested in conducting testing with [Amerigroup] should contact their local Provider Services representative. Providers are encouraged to participate in testing to ensure successful claims processing using ICD-10.

Coding updates and resources for providers

Amerigroup is committed to helping providers transition smoothly to the new ICD-10-CM code set. The resources below provide valuable information in terms of assessment, planning and training to help providers at any stage in the ICD-10-CM implementation process.

- Amerigroup provider home page: This site offers the latest news on ICD-10 and links to industry resources. Visit our provider website at providers.amerigroup.com and look for the ICD-10 news link.
- The Amerigroup newsletter: This communication provides documentation and coding information on ICD-10 and Healthcare Effectiveness Data and Info Set (HEDIS®) in addition to important network updates. Find our newsletter online at providers.amerigroup.com.

- Road to 10: CME Online Tool for Small Practices: This online resource built with the help of providers in small practices is intended to help small medical practices jumpstart their ICD-10 transition. It includes specialty references, access to free Medscape education modules and CME credits for physicians and nurses who complete the learning modules. Use this tool at www.roadto10.org/.
- ICD-10 Monitor: This online news and information source was created to help healthcare providers make informed decisions as they transition to ICD-10. The ICD-10 Monitor hosts weekly live broadcasts where relevant ICD-10 topics are discussed with industry experts called Talk Ten Tuesdays. Visit the site at www.icd10monitor.com.

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

ICD-10: Documentation and diagnosis coding tips

ICD-10-CM diagnosis codes

- Contain anywhere from 3-7 characters (seventh character extension)
- Character 1 is alpha
- Character 2 is numeric
- Characters 3-7 are alpha or numeric (alpha digits are not case sensitive
- Decimal appears after the third digit
- The first three characters make up the ICD-10 category
- Characters 4-7 are driven by clinical concepts in documentation

Understanding ICD-10-CM coding

- The current implementation date of ICD-10 is October 1, 2015. Providers and staff should be engaged in ICD-10 coding training now.
- Dates of service or dates of discharge that occur on or after October 1, 2015, must be reported using ICD-10-CM/PCS.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities', and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis in order to allow the most specific code(s) to be assigned.

ICD-10-CM official coding guidelines for outpatient services

The outpatient coding guidelines for ICD-10-CM are completely similar to those found in ICD-9-CM. Listed below are some of the ICD-10-CM guidelines pertinent to outpatient and office visit encounters. Visit the CDC website at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2015.pdf

- **ICD-10-CM Section IV.C, Accurate reporting of ICD-10-CM diagnosis codes.** For accurate reporting of ICD-10 diagnosis codes, the documentation should describe the patient's diagnoses, symptoms, problems, or reasons for the encounter. It is acceptable to report the appropriate unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.

- **ICD-10-CM Section IV.F. 1-2, Level of detail in coding.** Codes with only 3 characters are used as the heading of categories in ICD-10-CM and may be further subdivided (require additional characters). Providers must report ICD-10-CM diagnosis codes to their highest number of characters available. Incomplete and/or invalid diagnoses codes are not acceptable for reporting.
- **ICD-10-CM Section IV.H, Uncertain diagnosis**. Do not code diagnoses documented as probable, suspected, questionable, rule out, working, consistent with or other similar terms that indicate uncertainty. Instead, code the conditions to the highest degree of certainty for the encounter/visit.
- **ICD-10-CM Section IV.I, Chronic diseases.** Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions. Chronic conditions do not go away and typically always impact care provided. They should be assessed and reported at each visit.
- **ICD-10-CM Section IV.J**, **Code all documented conditions that co-exist**. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do note code conditions that were previously treated and that no longer exist.

New coding conventions

ICD-10-CM has some new coding conventions that are not included in the ICD-9-CM code set. A brief explanation of those follows:

- **Seventh character extension** is required for certain categories in ICD-10 and must always appear in the seventh character field.
- The **dummy placeholder X** may be used in the 5th or 6th character field to ensure that a seventh character is added correctly.

Example: T15.12XS Foreign body in conjunctival sac, left eye, sequel (late effect)

Locating the correct diagnosis code in the ICD-10 code book

- First, locate the documented term in the alphabetic index and then verify the code in the tabular list.
- Use a current ICD-10 code book. Become familiar with the Official ICD-10-CM Coding Guidelines and follow all instructions for the chapter and category related to specific codes including Excludes1and Excludes2 notes.
  - Excludes1 – Not coded here. The codes should never be used at the same time.
  - Excludes2 – Not typically included here, but a patient may have both conditions at the same time.
- Reliance on coding software, EHR systems, and cheat sheets alone can lead to coding errors.

Locating official coding advice

- The *American Hospital Association (AHA) Coding Clinic*™ is the CMS approved resource for clarification of ICD-10-CM. Volumes are published quarterly and contain new and/or updated information on the use of ICD-10-CM as well as clarification of previously published coding advice.
- Additional advice on ICD-10-CM can be located on CMS website at http://cms.hhs.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

Documenting specificity for accurate ICD-10 coding

- Specificity in documentation allows the most accurate ICD-10 codes to be assigned. Accurate and complete coding shows a true picture of each member's health status. As the October 1, 2015, compliance date draws near, health care providers should begin incorporating additional documentation into patient encounters. The table below shows some common chronic conditions and the documentation requirements for accurate ICD-10 code assignment.

<table>
<tr><th>Chronic condition:</th><th>Provider documentation required for correct coding:</th><th>ICD-10 code</th></tr>
<tr><td>Asthma</td><td>

Severity – Document asthma severity as either intermittent, mild persistent, moderate persistent or severe persistent.
Type – Exercise induced or cough variant are other types of asthma; documentation should specify type.
Acute exacerbation – Documentation should state if the asthma is in acute exacerbation.
Status asthmaticus – Defined as an acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators.
Infection – Superimposed infection may be present this should clearly be documented by the provider.
</td><td>J45.20 – J45.998</td></tr>
<tr><td>Hypertension</td><td>

Primary or secondary – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension, one to identify the underlying etiology and one from category I15 Secondary hypertension.
Transient – Temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code R03.0 Elevated blood pressure reading without a diagnosis of hypertension.
Controlled/uncontrolled – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is I10 Essential (primary) hypertension.
Complications – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive, caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following coding guidance applies to hypertensive complications:

I11 Hypertensive heart disease – Use additional code from category I50 Heart failure if present.
I12 Hypertensive chronic kidney disease – Use additional code from category N18 Chronic kidney disease to identify the stage.
I13 Hypertensive heart and chronic kidney disease – requires use of additional code from category I50 Heart failure if present and use additional code from category N18 Chronic kidney disease to identify the stage.
I60 – I69 Hypertensive cerebrovascular disease – Code also I10 Essential (primary) hypertension.
H35.0 Hypertensive retinopathy – Code also I10 Essential (primary) hypertension.

</td><td>I10 – I15.9</td></tr>
</table>

Diabetes mellitus (DM)	**Type** – Providers must document the type of diabetes in ICD-10-CM: • **E08 Diabetes mellitus** – Due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc. • **E09 Drug or chemical-induced diabetes mellitus** – Code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect if applicable, to identify drug. • **E10 Type 1 diabetes mellitus** – Due to pancreatic islet B cell destruction. Also known as juvenile diabetes. • **E11 Type 2 diabetes mellitus** – Use for diabetes not otherwise specified. • **E13 Other specified diabetes mellitus** – Includes that due to genetic defects and secondary diabetes not classified elsewhere. **Body system affected** – Diabetes may affect multiple body systems. Providers should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented. **Complications affecting that body system** – Providers must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include: diabetes with neuropathy, diabetic retinopathy, and nephropathy due to diabetes. **Insulin use** – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term then apply code Z79.4 (long term, current use of insulin).	

Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Amerigroup follows Centers for Medicare & Medicaid Services' Medicare Part B immunization billing guidelines.

Please use the following forms when filing flu, pneumonia or hepatitis B claims for Amerigroup individual and group-sponsored Medicare Advantage members:

- Professional claims should be filed on the CMS 1500 form with the appropriate current procedural terminology code and/or health care procedural code for the vaccine and administration.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes
- Revenue codes (except rural health clinics and federally qualified health centers):
  - 0636 – vaccine (and CPT or HCPC)
  - 0771 – administration (and HCPC)
- Rural health clinics and federally qualified health clinics – 052X revenue code series

Please refer to page three of the Medicare Part B immunization billing http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf for specifics on institutional billing.

CMS requirements: Annual medication, supplement review for special needs plan members

Medicare requires that primary care providers (PCPs) review all prescription and nonprescription drugs, vitamins, herbals and other supplements at least once per year for members in a special needs plan (SNP).
SNP members 66 years of age or older should also have one functional status assessment each year. According to HEDIS® guidelines, notations for a complete functional status assessment should include one of the following:
• Notation that activities of daily living (ADL) were assessed – includes bathing, dressing, eating, transferring (i.e., getting in and out of chairs), using toilet, walking
• Notation that instrumental activities of daily living (IADL) were assessed – includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
• Result of assessment using a standardized functional status assessment tool, not limited to:

- SF-36®
- Assessment of living skills and resources (ALSAR)
- Barthel ADL index physical self-maintenance (ADLS) scale
- Bayer activities of daily living (B-ADL) scale
- Barthel index
- Extended activities of daily living (EADL) scale
- Independent living scale (ILS)
- Katz index of independence in activities of daily living
- Kenny self-care evaluation
- Klein-Bell activities of daily living scale
- Kohlman evaluation of living skills (KELS)
- Lawton & Brody's IADL scales
- Notation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Sensory ability (including hearing, vision and speech)
  - Other functional independence (i.e., exercise, ability to perform job)

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

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

Availity: New eligibility and benefits functionality and features

The Availity web portal launched new eligibility and benefits (E&B) functionality and features on June 27, 2015. These changes will make finding eligibility and benefits easier and faster for you. The following is a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes user's most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list displays all service types and benefits returned from the health plan.
Patient snap shot	The summary of patient information is easily found at the top of the page.
Clearer display of details	Users have a clearer and more complete view of specific benefit and financial information.
Advanced printing	By selecting which sections to print, users save paper and can customize prints to target necessary information.
Real-time feedback	Feedback buttons on each returned eligibility allows users to provide instant feedback of missing or inaccurate information.

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

Provider requirements and Medicare notices

The Centers for Medicare & Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the Important Message from Medicare About Your Rights (IM) notice to every Medicare beneficiary within two calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than two calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, Amerigroup periodically conducts IM and NOMNC audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

Our audit findings show providers would benefit from focusing in on the following elements required by CMS:

- NOMNC notices:
  - Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
  - Include the beneficiaries health care identification number or medical record number on page one
  - Include the specific type of services ending on page one
  - Include the health plan's contact information on page two
  - Have the beneficiary or authorized representative sign and date page 2 at least 2 days prior to the end of services
  - Retain a copy of the signed notice, both page one and page two.
- IM notices:
  - Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
  - Include the physician's name on page one
- Have the beneficiary or authorized representative sign and date page one within two calendar days of the date of an inpatient hospital admission
- Call the authorized representative to deliver the IM when the beneficiary is unable to sign
- Deliver the IM, or copy of the IM again, no sooner than two calendar days before discharge
- Retain a copy of the signed notice, both page one and page two

To download the standardized IM/NOMNC notices required by CMS, along with accompanying instructions, go to CMS website at cms.hhs.gov/bni or refer to the specific links below:

- NOMNC notice: cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
- IM notice: cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Important update: quality improvement organizations (QIO) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see qioprogram.org to locate your QIO.

For more information on compliance with the Notice of Medicare Non-Coverage or the Important Message from Medicare, contact Mary Heapes, RN, BSN in the Federal Clinical Compliance Department at 212-476-2908.