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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TN-NL-0014-16-B

Vascular embolization or occlusion services to require prior authorization

Summary: Effective September 1, 2016, vascular embolization or occlusion services will require prior authorization (PA).

What this means to you: Vascular embolization or occlusion services requests must be reviewed by Amerigroup Community Care for PA for dates of service on and after September 1, 2016. To request PA, use one of the following methods:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627

Where can I find more detailed information?
For a list of Amerigroup reimbursement policies and more information on PA requirements, please visit our website at https://providers.amerigroup.com/TN and under Provider Resources & Documents, select **Quick Tools**.

- For reimbursement policies, select **Reimbursement Policies**.
- For authorization requirements, select **Precertification Lookup Tool.**

In this issue

Clinical cumulative morphine equivalent dosing point of sale edits effective January 1, 2017

Beginning January 1, 2017, Amerigroup will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale.

This MEq dosing edit will identify members taking a cumulative dose that exceeds the set daily dose. This is a patient safety edit intended to reduce risks from high-dose opioid use. There is a higher risk for overdose when exceeding the set MEq dosing limit. The claim(s) will be rejected at the point of sale and will require a prior authorization (PA) review if the cumulative dosing is over the set daily limit. Certain members may be excluded from the edit, such as members with cancer. The edit supports the CMS guidance mandating that Medicare plans implement a cumulative dosing edit.

Amerigroup anticipates that this edit will impact a fairly high number of claims.

Updated clinical practice guidelines now available online

Summary of change: Updated clinical practice guidelines (CPGs) are now available on the Amerigroup Community Care self-service website, https://providers.amerigroup.com/TN. These evidence-based guidelines were reviewed and approved by our Enterprise Clinical Quality Committee and Preventive Health Guidelines Work Group, a group of specialists and external practitioners. The guidelines include direct links to the source documents for reference.

What this means to you: No action is necessary – this notice is for your information only.

Why is this change necessary?
This is an annual update and notification to providers per National Committee for Quality Assurance (NCQA) guidelines.

What is the impact of this change?
No action is needed; this update is informational only. The guidelines on the following page can be downloaded from our provider website at https://providers.amerigroup.com/TN. Under *Provider Resources & Documents*, select *Clinical Practice Guidelines*. For a printed copy, please call Provider Services at 1-800-454-3730.

Clinical practice guidelines		
Asthma **Autism** **Behavioral health** • Attention deficit hyperactivity disorder • Behavioral health screening, assessment and treatment • Bipolar disorder in children and adolescents • Bipolar disorder in adults • Major depression • Management of substance use disorders in adults • Schizophrenia	**Coronary artery disease** **Coronary artery disease for women** **Chronic obstructive pulmonary disease** **Diabetes** • Diabetes mellitus **HPV** **Hyperlipidemia** **Hypertension** • Hypertension in adults • Hypertension in children and adolescents **Kidney** • Chronic kidney disease	**Maternal health** • Family planning • High-risk obstetrical • Routine antepartum care • Smoking cessation during pregnancy • Postpartum depression (PPD) and postpartum psychosis (PPP) **Obesity** • Obesity in adults • Obesity in children and adolescents **Sickle Cell Anemia** **Preventive health** • Adult preventive health • Child preventive health • Immunizations for adolescents, adults and children

Claims correspondence versus provider payment dispute

Use the charts below to determine if your claims issue should be resolved through the claims correspondence or payment dispute system. If you have questions or need assistance determining the appropriate process to follow, contact our Provider Services team at 1-800-454-3730.

Claims correspondences Requests from Amerigroup Community Care for additional information needed to resolve your claims issue.	
Type of correspondence	**What you need to do**
Rejected claims	If your claim was submitted electronically, but was never paid or was rejected, call the Electronic Data Interchange Hotline at 1-800-590-5745 for help resolving submission or setup issues or problems with electronic claims rejections.
Requests for supporting documentation (Example: sterilization, hysterectomy or abortion consent forms, itemized bills, invoices and explanations of payment EOPs)	Send supporting documentation, including claims correspondence cover sheet and copies of EOPs with claims in question circled, to: Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records Must be submitted within 90 business days of EOP request.	Send supporting documentation, including claims correspondence cover sheet and copies of EOPs with claims in question circled, to: Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599
Corrected claims due to errors or changes on the original submission	For UB04 billing electronically, submit a corrected claim with the correct bill type. For CMS-1500 billing, submit a corrected claim, including claims correspondence cover sheet that clearly identifies the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Send UB04 paper claims and all CMS-1500 paper claims to: Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599
Coordination of benefits (COB)/ Third-party liability (TPL) information	Submit a claims correspondence cover sheet, a copy of your EOP and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency room payment reviews Must be submitted within 90 business days of EOP request.	Submit a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Additional medical records needed	If records were previously sent to Amerigroup, and you know they were received and are on file, call the National Call Center at 1-800-454-3730 and choose the **claims** prompt.

Payment appeals Requests from a provider, not acting as an authorized representative on behalf of the member, to change an adverse determination made by the organization related to **payment**, including the following situations: • Care or service rendered that is specifically excluded from the member's benefit package and not covered under any circumstances • Care or service rendered where the provider did not abide by appropriate contractual requirements related to the timely filing of the appeal, appropriate notification of care/service or timely submission of appropriate clinical information • Submission of a corrected claim for a service that has already been processed to pay or deny the payment	
Type of dispute	**What you need to do (providers can choose to do one or both options)**
Timely filing	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
No authorization	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Not paid according to contract	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Other health insurance	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Claim code-editing denial	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Duplicate claim	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Provider data issue denial	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Retro-eligibility issue	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Experimental/ investigational procedure denial	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Claims data entry error	• Complete the Provider Payment Dispute and Correspondence -Submission Form online at https://providers.amerigroup.com/TN under the Forms drop down menu • Call our National Call Center at 1-800-454-3730 and choose claims when prompted
Second-level appeal	• Use the online Provider Payment Dispute and Correspondence -Submission Form with additional supporting documentation to be considered, attached

UPDATE: Effective November 1, 2016, ClaimsCheck® upgrade to ClaimsXten™

Amerigroup Community Care appreciates your participation in our network. Amerigroup uses ClaimCheck 10.2, a comprehensive nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. The purpose of this update is to notify you that we are upgrading ClaimCheck 10.2 to ClaimsXten, McKesson's next generation code auditing

system. As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, AMA/CPT, Specialty Society guidelines and Amerigroup policy. The upgrade will become effective November 1, 2016.

What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that in combination with claims processing systems:

- Reinforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed
- Determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Processes those services according to industry standards

Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes

How will the upgrade to ClaimsXten affect you?

Providers will continue to see similar edits as under ClaimCheck 10.2. ClaimsXten has enhanced audit logic and the ability to analyze claims submission history. Outpatient services will be analyzed for such issues as:

- Rebundled or unbundled services
- Diagnosis to procedure mismatch
- Incidental procedures
- Incorrect use of CPT codes
- Mutually exclusive services
- Upcoded services
- Multi-channel services
- Fragmented billing of pre- and postoperative care

Other procedures and categories that are reviewed include:

- Cosmetic procedures
- Procedures being billed with inappropriate modifiers
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Obsolete or unlisted procedures

What types of edits appear on my explanation of payment (EOP) when an edit is applied by ClaimsXten to a service I submitted?

The following list, which is not all inclusive, contains edits that may appear on your EOP when rule is triggered in ClaimsXten:

Rule	Provider type	Description
Inappropriate age	Professional/ facility	Procedure code is either inappropriate for the member's age or an age-specific CPT code does not match the member's age.
Deleted code	Professional/ facility	Procedure code has been deleted from CPT.
Invalid diagnosis code	Professional/ facility	Procedure submitted with an invalid diagnosis code.
Inappropriate gender	Professional/ facility	Procedure code is either inappropriate for the member's gender or a gender-specific CPT code does not match the member's gender.

Invalid modifier-procedure	Professional/ facility	Modifier used is invalid with the submitted procedure code.
Multiple radiology reduction	Facility	Reduction applied to multiple contiguous radiology procedures using the same modality on the same date of service (DOS).
Assistant surgeon	Professional	Assistant surgeon not eligible for procedure.
Base code quantity	Professional	Base code with units >1, where add-on code would be appropriate.
Bundled services	Professional	Services incidental to the primary procedure.
Multiple surgery reduction	Professional	Reduction applies to multiple procedures on the same DOS. Procedure with highest reimbursement paid as primary.
Global surgical edits	Professional	Pre-op visit, post-op visit, procedure or other service considered part of the global surgical period.
Maximum units	Professional	Medically unlikely number of units on the same DOS.
Global component	Professional/ facility	Audits across multiple providers to ensure that professional and technical components are not reimbursed more than once for the same member, procedure and date of service.
Anesthesia not eligible	Professional	Audits claim lines containing nonanesthesia services submitted by an anesthesiologist as described by the American Society of Anesthesiologists.
Outpatient consultations	Professional	Audits for claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same provider with at least one matching diagnosis within a six-month period.
Inpatient consultations	Professional	Audits for claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a five-day period.
New patient code for established patient	Professional	Audits for claim lines containing a new patient E&M code when another claim line containing any E&M code was billed within a three-year period.
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount.

If you have questions regarding ClaimsXten edits that you receive on your explanation of payment, please call the Provider Services at 1-800-454-3730 and select the appropriate prompt.

Authorizations and medical necessity reminder

Requests for authorization for coverage of medical services are reviewed for medical necessity. Amerigroup Community Care utilizes federal and state regulations, Anthem Medical Policies, vendor guidelines approved by the organization, McKesson InterQual ®, and specialty society guidelines or results of clinical studies published in peer-reviewed literature to determine medical necessity as specified for each request (i.e., inpatient requests are reviewed against McKesson InterQual ®).

According to TennCare Rules Chapter 1200-13-16, in order for a medical item or service to be medically necessary, it must satisfy each of the following criteria:

1. It must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee;
2. It must be required in order to diagnose or treat an enrollee's medical condition;
3. It must be safe and effective;
4. It must not be experimental or investigational; and
5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

Additionally, a cost-effective alternative service is a service that is not covered but is approved by TennCare and provided solely at our discretion. TennCare enrollees are not entitled to receive these services. Cost-effective, alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in our judgment, are cost-effective or (2) preventive in nature and offered to avoid the development of conditions that, in our judgment, would require more costly treatment in the future. Cost-effective, alternative services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. (TennCare policy BEN08-001.)

Please note that Medicaid members **must not** be billed for rendered services that are within scope of TennCare benefits, even if your claim is denied.

What does this mean to you?
The following examples are provided in order to illustrate how this applies to specific authorization requests.

Example 1: A physician orders home health services, specifically a home health aide, for 35 hours, seven days a week, for nine weeks to assist with activities of daily living due to functional limitations. Upon further review of the clinical documentation submitted to support medical necessity and an assessment of functional need completed by an Amerigroup clinician, the Amerigroup Medical Director determines the member only needs two hours a day, five days a week to adequately meet his/her needs. Authorization for coverage of the original order is denied but an alternate level of care is approved as the least costly alternative for treatment that is adequate for the enrollee's medical and/or functional condition(s).

Example 2: A physician orders skilled nursing facility admission for a member to receive physical and occupational therapy after the member has been diagnosed with a severe cerebral vascular accident with subsequent one-sided paralysis. Upon further review of the clinical documentation submitted, the Amerigroup Medical Director determines that the nursing facility level of care is appropriate as a cost-effective alternative in order to stabilize the member's condition and support long-term services and completion of a preadmission evaluation (PAE) and the member's eventual return to the community.

Example 3: A physician orders skilled nursing facility admission in order for a member to receive physical therapy after the member has had a total knee replacement. Upon further review of the clinical documentation submitted, the

Amerigroup Medical Director determines that the nursing facility level of care is not appropriate as a cost-effective alternative. This is because home health services are a covered benefit, and will be the least costly alternative course of treatment that is adequate for the enrollee's medical condition.

Example 4: A physician orders inpatient admission for a member who is discharged home within two days. Submitted clinical documentation meets criteria for observation level of care. The Medical Director determines the acute inpatient level of care would not be considered the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition, as the needs could have been met with an observation level of care. The request for coverage of inpatient admission is denied as not medically necessary.

Update: Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. This communication provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, precancerous cervical lesions, cervical cancer or those who are immunocompromised.

Additional coverage information

As previously communicated, routine screening Pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective November 1, 2016, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine pap testing for women 66 and older, with prior negative screening results, will be denied.

Screening method and intervals

The U.S. Preventive Services Task Force[1], the American College of Obstetricians and Gynecologists[2], the American Cancer Society[3], the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical pap alone every three years
Women aged 30-65 years	Human Papillomavirus (HPV) and cervical pap co-testing every five years or cervical pap alone every three years
Women older than 65 years	No screening is necessary after adequate negative prior screening results and are not otherwise at high risk for cervical cancer
Women who underwent total hysterectomy (with no residual cervix) and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia CIN grade 2 or 3) or cervical cancer	No screening is necessary

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.

1. United States Preventive Services Task Force. Cervical Cancer. March 2012.
2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:el-20.
3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.

Provider cultural and linguistic services and capabilities

Thank you for all you do to optimize care for all the patients in your practice! Understanding the cultural and linguistic capabilities of your practice is important and we want to make Amerigroup Community Care members aware of the cultural and linguistic support available from your practice.

Please help us promote your cultural and linguistic services and capabilities by taking this brief, five-minute survey about your practice.

Link to survey:
https://www.surveymonkey.com/r/QC9SLPG

Tennessee population data on language:
Like you, we aim to effectively serve the needs of diverse patients. It's important for all of us to be aware of the cultural and linguistic needs of our communities. For this reason, we are sharing recent data about the languages currently spoken by eligible members in Tennessee. (Source: American Community Survey, 2013 American Community Survey 5-Year Estimates, Table B16001.)

Languages currently spoken by 5% or 1,000 eligible members in Tennessee (listed in alphabetical order)
Spanish or Spanish Creole

Language support services:
Also, as a reminder, we provide language assistance services for our members with limited English proficiency (LEP) or hearing, speech or visual impairments. Please see the Amerigroup Provider Manual for details and how to access resources. In addition, we have several resources available to you and your practice that can provide guidance on communicating and serving diverse populations effectively.

Cultural Competency Toolkit:
Diverse cultural backgrounds of patients may present frequent challenges in their receipt of quality health care. Health care providers need a practical set of tools that will enable them to become culturally aware and proficient to help provide a positive, rewarding and quality care experience to patients.

Amerigroup offers a *Cultural Competency Toolkit* containing information, tips and resources regarding language, interpreter services, cross-cultural issues and more. Included are:

- Encounter tips for providers and their staff
- Help in identifying literacy problems
- An interview guide for hiring clinical staff
- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- "I Speak" cards to help identify patients' preferred language (the cards can be posted in provider offices and/or given to patients)
- A sample employee language skills self-assessment tool to help you evaluate the language skills of your staff

How to locate the Cultural Competency Toolkit and related resources:

1. Go to https://providers.amerigroup.com/TN.
2. Under *Provider Resources & Documents*, select *Training Programs*.
3. The toolkit and related cultural competency resources will be available under this heading.

Hospital no longer in Amerigroup Community Care Medicaid network

Network hospital:	County:
Vanderbilt University Medical Center (adult hospital)	Davidson

The Vanderbilt University Medical Center (VUMC) adult hospital is no longer a participating provider in the TennCare provider network. **(Note, this change only applies to the adult hospital for our TennCare members and does not affect the participation status of Vanderbilt Children's Hospital, Vanderbilt psychiatric hospital or adult participation for Amerigroup Amerivantage [Medicare Advantage] at the adult hospital.)** We will continue to offer our members a full range of high-quality health care services at other hospitals in our network. We are notifying our members of this development and are assisting them with any necessary transitions.

In general, providers who admit patients to hospitals for inpatient care must use participating hospitals for Amerigroup members. Providers who are employees of VUMC may admit members to VUMC for services authorized by Amerigroup. Other providers are required to admit Amerigroup members to participating hospitals (except in unique circumstances when Amerigroup authorizes services). **If you only have admitting privileges at VUMC and are not a VUMC employee, you may be required to obtain admitting privileges at one or more network hospitals.** The following options are available:

- If you do not have admitting privileges at a network hospital, but you have a covering physician who has privileges at other network hospitals and will admit members for you, you may arrange for hospital care at a participating hospital through the covering physician. Note, surgeons and obstetrics and gynecology (OB-GYN) specialists may not use a covering physician outside their group.

- If you do not have admitting privileges at other network hospitals or a covering physician as described above and do not have immediate plans to obtain privileges at other network hospitals, you may terminate with Amerigroup in accordance with your agreement.
- If you are a radiologist, dermatologist or other specialist who doesn't normally admit members for inpatient services, you do not need admitting privileges and no action is required.

We will continue to work with Vanderbilt University Medical Center for our members who have special needs and/or who are preauthorized for care, as appropriate. Additionally, we will continue to cover medically necessary services that are approved at VUMC for up to 90 calendar days or through the current period of active treatment, whichever is less.

Important information regarding transfers
For nonemergent, adult transfers from a facility to VUMC adult hospital, providers must contact our Case Management department at 1-800-454-3730, ext. 35856 or 35850 before initiating the transfer.
For questions regarding participating providers, please call:

- Provider Services: 1-800-454-3730
- Provider Relations: 1-615-316-2400, ext. 22160

We appreciate your continued commitment to providing quality care to our members.

Tennessee Medicaid Provider Manual Update Now Available Online

Summary: The latest update to your Amerigroup Community Care provider manual is now available online at our provider website at providers.amerigroup.com/TN.

What this means to you: You can find the most current version of our provider manual on our Tennessee home page at providers.amerigroup.com/TN. Please take an opportunity to review the updated manual.

How can I get a hard copy of the manual?
If you would like a hard copy of the updated manual for your practice, please contact Provider Services at one of the toll-free numbers below.

What if I need other assistance?
If you have questions about this communication, received this communication in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at the toll-free phone numbers listed below:

- Medicaid providers, call 1-800-454-3730
- Medicare providers, call 1-866-805-4589

Thank you for your valued participation with us.