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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Updated TennCare Episodes of Care

Continuing success with Episodes of Care includes the rollout of Wave 3 and Wave 4 with preview reports posting to Availity June 2016.

Wave 3:
Esophagogastroduodenoscopy
Gastrointestinal hemorrhage
Respiratory infection
Pneumonia
Outpatient urinary tract infection
Inpatient urinary tract infection

Wave 4:
Attention deficit hyperactivity disorder
Acute exacerbation congestive heart failure
Coronary artery bypass grafting
Cardiac valve repair/replacement
Bariatric surgery

Revisions and updates for June 2016:

- Episodes of Care Reports will contain detailed quality metrics tied to each valid episode on reports, making it easier to see where improvements can be made.
- Services in the pre-trigger window with a maternal-fetal medicine (MFM) specialty in the claim will be excluded from valid perinatal episodes.
- The first full calendar year for 2015 will be presented in June 2016 performance reports for Wave 1 episodes which include perinatal, acute asthma exacerbation and total joint replacement.

Updated Patient Centered Medical Home (PCMH) launch timeline

The PCMH program timeline has been updated. The first wave of primary care practices is scheduled to launch January 1, 2017. Applications for voluntary participation in Wave 1 of PCMH will be available on the TennCare website at https://www.tn.gov/hcfa on June 1, 2016. The selected Wave 1 practices will be announced August 1, 2016.

We're here to support you in the TennCare HealthCare Improvement Initiative. For any questions, please call 615-316-2400, ext. 28601 or email agpepisode.reporting@amerigroup.com.

If you need language assistance services in a language other than English, please call us at 1-800-454-3730.
Necesita ayuda con el idioma gratuita? Llame 1-800-454-3730.

You can also dial 711 for telecommunications relay service (TRS) assistance.
If you require materials in alternate formats, please call us at 1-800-454-3730 to make such a request (e.g., provider manual, forms and newsletters in languages other than English or Spanish, braille, large font, etc.).

Medical injectable access via ProCare Pharmacy Direct (CVS Specialty subsidiary)

Effective immediately, providers can order medical injectables through ProCare Pharmacy. Medical injectables are defined as those drugs not usually self-administered by the patient. While a majority of our prescribers buy and bill these medical injectables directly to Amerigroup Community Care, a few prescribers have had difficulty obtaining these drugs for our members. To ensure the members you serve have access to needed treatment, follow the process below to order medical injectables through ProCare Pharmacy.

Medical injectable ordering process:

- Prescribers should continue to purchase medical injectables and bill directly to Amerigroup if this is their current process
- For those prescribers who are having difficulty obtaining these medications, the following steps should be followed in order to obtain medication for your patients:
    - If necessary, obtain the required prior authorization (PA). You can access our precertification lookup tool, medical policies and PA form at https://providers.amerigroup.com/TN
    - Fill the PA form out completely
    - **Once approval is granted, fax a complete order AND a copy of the PA approval to ProCare Pharmacy at 1-888-604-0385** or call 1-800-238-7828 (Monday- Friday, 8 a.m. to 8 p.m. Eastern time or Saturday, 9 a.m. to 1 p.m. Eastern time)
    - ProCare Pharmacy will verify benefits and authorization approval, then ship the requested drug to the prescriber's office with the patient's name affixed to the container
    - ProCare Pharmacy will bill Amerigroup directly for the medication

In order to ensure prompt and accurate delivery of these medications from ProCare Pharmacy, all information must be supplied at the time the order is placed. Any deficiencies, such as incomplete member information or PA approvals, will delay order processing.

Should you have further questions, you may either contact our Provider Relations department at 1-800-454-3730 or ProCare Pharmacy at 1-800-238-7828.

Theophylline drug safety

Theophylline use has declined significantly from when it was considered the primary treatment for airway disease, since inhaled long-acting β2-agonists and inhaled corticosteroids (ICS) have become the preferred treatment.

There are several reasons why theophylline is no longer the preferred treatment:

- Its efficacy is related to blood concentrations which may fluctuate due to several diseases and drug interactions.
- Its adverse effects are related to plasma concentrations and often include nausea, vomiting and headaches.
- At higher concentrations, which are commonly required for treatment, patients may display cardiac arrhythmias and seizures due to the adenosine A1 receptor antagonist.

Today, theophylline is recommended for use only as an alternative treatment, not preferred, for mild persistent asthma or as adjunctive therapy with ICS in patients 5 years of age. Theophylline is not recommended for use in chronic obstructive pulmonary disease, unless other bronchodilators are not available.

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:

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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.

Bureau of TennCare Pharmacy Program Notice

This notice is being sent to notify you of changes for the TennCare pharmacy program. We encourage you to read this notice thoroughly and contact Magellan's Pharmacy Support Center (1-866-434-5520) should you have additional questions.

Preferred Drug List (PDL) For TennCare Effective July 1, 2016

TennCare is continuing the process of reviewing all covered drug classes. Changes to the PDL may occur as new classes are reviewed and previously reviewed classes are revisited. As a result of these changes, some medications your patients are now taking may be considered non-preferred agents in the future. Please inform your patients who are on these medications that switching to preferred products will decrease delays in receiving their medications. A copy of the new PDL will be posted July 1, 2016, to https://tenncare.magellanhealth.com. We encourage you to share this information with other TennCare providers. The individual changes to the PDL are listed below. For more details on clinical criteria, please visit: https://tenncare.magellanhealth.com

Below is a summary of the PDL changes that will be effective July 1, 2016

Analgesics

Naloxone

- The following agent will be added to the PDL as preferred: NARCAN nasal spray [PA], [QL].
- The following agent will be added to the PDL as non-preferred: Evzio [PA], [QL].

Changes to Prior Authorization Criteria and quantity limits for the PDL effective July 1, 2016:

Effective July 1, 2016, prior authorization criteria for agents in the Short Acting Narcotics PDL class will be changed to include the following:

- Must be prescribed by a provider with a Tennessee Medicaid Provider ID
- Pain agreement required for all PA required agents
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider
- Prior Authorization approval duration: 3 months
- Effective July 20, 2016: Quantity Limits: 7 day limit for all children with ACUTE pain, and for 1st fill for adults with ACUTE pain

Effective July 1, 2016, prior authorization criteria for agents in the Long Acting Narcotics PDL class will be changed to include the following:

- Must be prescribed by a provider with a Tennessee Medicaid Provider ID
- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf.

All prior authorization fax forms will be updated to reflect this new requirement effective 7/1/16. In order to prevent a delay in processing time, please download new PA fax forms at: https://tenncare.magellanhealth.com.

- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider
- Prior Authorization approval duration: 3 months
- Established opioid tolerance will be required before approval of opioids with REMS requirements (See chart below)

Opioids Requiring a Risk Evaluation and Mitigation Strategy (REMS)	
Avinza (morphine sulfate ER capsules)	Kadian(morphine sulfate ER capsules)
Butrans (buprenorphine transdermal system)	MS Contin (morphine sulfate CR tablets)
Dolophine (methadone hydrochloride tablets)	Nucynta ER(tapentadol ER tablets)
Duragesic (fentanyl transdermal system)	Opana ER (oxymorphone HCL ER tablets)
Embeda (morphine sulfate/naltrexone ER capsules)	OxyContin (oxycodone HCL CR tablets)
Exalgo (hydromorphone hydrochloride ER tablets)	Kadian(morphine sulfate ER capsules)

Changes to Prior Authorization Criteria (PA, QL) for the PDL effective July 1, 2016

- acarbose [PA]
- alogliptin [PA]
- alogliptin/metformin [PA]
- alogliptin/pioglitazone [PA]
- BYDUREON pens & vials [PA]
- BYETTA [PA]
- EVZIO [PA]
- FARXIGA [PA]
- GLYSET [PA]
- GLYXAMBI [PA]
- INVOKAMET [PA]
- INVOKANA [PA]
- JANUVIA [PA]
- JANUMET [PA]
- JANUMET XR [PA]
- JARDIANCE [PA]
- JENTADUETO [PA]
- KAZANO [PA]
- KOMBIGLYZE [PA]
- NESINA [PA]
- ONGLYZA [PA]
- OSENI [PA]
- PRECOSE [PA]
- NARCAN nasal spray [PA, QL]
- SYNJARDY [PA]
- TANZEUM [PA]
- TRULICITY [PA]
- TRADJENTA [PA]
- VICTOZA [PA]
- XIGDUO XR [PA]

Effective July 1, 2016, all agents requiring prior authorization must be prescribed by a provider with a Tennessee Medicaid Provider ID. Providers may register at: http://tennessee.gov/tenncare/topic/provider-registration. All prior authorization fax forms will be updated to reflect this new requirement effective 7/1/16. In order to prevent a delay in processing time, please download new PA fax forms at: https://tenncare.magellanhealth.com.

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Changes to QL for the PDL effective September 1, 2016

Effective September 1, 2016, a quantity limit of 20 tablets per month will be implemented on all butalbital containing-products, including the following products and all equivalent products:

- butalbital/APAP [QL]
- butalbital/APAP/caffeine [QL]
- butalbital/APAP/caffeine/codeine [QL]
- butalbital/ASA/caffeine [QL]
- butalbital/ASA/caffeine/codeine [QL]

Below is a summary of PDL additions that were made to the PDL effective June 1, 2016

Analgesics

Non-steroidal Anti-inflammatory Drugs

- The following agent was added to the PDL as non-preferred: VIVLODEX [PA, QL]

Central Nervous System

Antihyperkinesis: Stimulants

- The following agent was added to the PDL as non-preferred: DYANAVEL XR [PA, QL]

Dermatologics

Topical Antipsoriatics

- The following agent was added to the PDL as non-preferred: ENSTILAR [PA]

Endocrine and Metabolic Agents

Antirheumatic: Kinase Inhibitors

- The following agent was added to the PDL as non-preferred: XELJANZ XR [PA, QL]

NOTE:

All of the aforementioned changes, whether preferred or non-preferred, may have additional criteria which control their usage. Any agent noted above with a superscripted "PA" requires Prior Authorization. Please refer to the document "Drug Criteria Listing" located at: https://tenncare.magellanhealth.com for additional information.

Guide for TennCare Pharmacies: Override Codes

Override Type	Override NCPDP Field	Code
Emergency 3-Day Supply of Non-PDL Product	Prior Authorization Type Code (D.0 461-EU)	8
Hospice Patient (Exempt from Co-pay)	Patient Residence (D.0 384-4X)	11
Pregnant Patient (Exempt from Co-pay)	Pregnancy Indicator (D.0 335-2C)	2
Titration Dose Override for the following select drugs/drug classes: oral oncology agents, anticonvulsants, warfarin, low molecular weight heparins, theophylline, Selective Serotonin Reuptake Inhibitors (SSRIs), Selective	Submission Clarification Code (D.0 42Ø-DK)	2

Norepinephrine Reuptake Inhibitors (SNRIs), atypical antipsychotics (except clozapine/ Clozaril®), Hizentra®, Vivaglobin® - process second Rx for the same drug within 21 days of initial Rx with an override code to avoid the second Rx counting as another prescription against the limit.		
Titration Dose Override for the following select drugs/drug classes: clozapine/Clozaril®, Suboxone®, Zubsolv® and buprenorphine- will allow up to five prescription fills to process for the same drug within a month of the initial prescription without the subsequent fills counting against the enrollee's monthly RX limit.	Submission Clarification Code (D.0 42Ø-DK)	6

Important Phone Numbers:
TennCare Family Assistance Service Center: 1-866-311-4287
TennCare Fraud and Abuse Hotline: 1-800-433-3982
TennCare Pharmacy Program Fax: 1-888-298-4130
Magellan Pharmacy Support Center: 1-866-434-5520
Magellan Clinical Call Center: 1-866-434-5524
Magellan Call Center Fax: 1-866-434-5523

Helpful TennCare Internet Links:
Magellan: https://tenncare.magellanhealth.com
TennCare website: www.tn.gov/tenncare/

Please visit the Magellan TennCare website regularly to stay up-to-date on changes to the pharmacy program.
For additional information or updated payer specifications, please visit the Magellan website at: https://tenncare.magellanhealth.com then click on pharmacy and choose program information from the drop down menu.
Please forward or copy the information in this notice to all providers who may be affected by these processing changes.

Thank you for your valued participation in the TennCare Program.

Reimbursement Policy Provider Notifications

New Policy

Medical Recalls

(Policy 06-111, effective 10/01/16)

Amerigroup Community Care does not allow reimbursement for repair or replacement of items due to a medical recall. The following are applicable items:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/vaccines

Amerigroup will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Amerigroup will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

For additional information, refer to the Medical Recalls reimbursement policy on the Amerigroup provider website.

New Policy
Multiple Procedure Payment Reduction
(Policy 15-002, effective 10/01/16)
When services are performed on the same date of service during the same patient encounter, and are performed by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- "Always therapy" services
- Cardiovascular procedures
- Ophthalmology procedures

For market-specific information regarding reimbursement for these services and procedures, refer to the MPPR policy at https://providers.amerigroup.com.

Policy Reminder
Facility Take Home DME and Medical Supplies
(Policy 06-081, effective 12/10/15)
Amerigroup does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Amerigroup allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

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Refer to the Facility Take Home DME and Medical Supplies reimbursement policy at https://providers.amerigroup.com.

Policy Reminder

Code and Clinical Editing Guidelines

(Policy 06-005, effective 11/09/2015)

Amerigroup Community Care in Tennessee applies Code and Clinical Editing Guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits.

Amerigroup uses software products that ensure compliance with standard code edits and rules to increase consistency of payment for providers. CCEG consists of the following measures:

- Code editing software, CMS National Correct Coding Initiative (NCCI) edits and Outpatient Code Edits (OCE)
- Code editing software is updated biannually to conform to changes in coding standards.
- National Correct Coding Initiative (NCCI) edits are updated on a quarterly basis according to CMS published updates
- Clinical criteria
- Licensed clinical medical review
- Claims processing platform

Refer to the Code and Clinical Editing Guidelines reimbursement policy for more information at https://providers.amerigroup.com.