NewsBlast

TENNESSEE – May 2014 TNPEC-0694-14-B

The following entry applies to all Tennessee Amerigroup Community Care Providers.

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.

Why is this update necessary?

Hosting our provider manual online is an environmentally friendly way for us to offer you easy access to the most current information about our programs.

What has been updated for this version?

We updated the Pharmacy section to show Magellan Health Services as the new TennCare pharmacy benefits manager. We've also added information about the Population Health Program and new requirements for the Consent for Sterilization forms.

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.

(TNPEC-0603-13)

Reminder: Guidance for Drug Screening CPT Codes

Summary: One of the many ways we support the quality health care you give our members is providing you with information on coding and reimbursement standards and best practices. Our Coding Validation Initiative department identified Current Procedural Terminology (CPT) codes 80100, 80101, G0430 and G0431 — drug screen, qualitative — as codes that are easily misused.

What this means to you: Adopting the nationally recognized standards below for appropriate use will result in more timely and efficient reimbursement of claims.

How should these codes be used?

Code	Description	Comments
80100*	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure	This CPT code remains unchanged and is used to report all multiple drug class assays employing chromatographic methods. (i.e., the unique combination of stationary and mobile phase) * There are no Clinical Laboratory Improvements Amendments (CLIA)-waived, chromatographic, qualitative drug procedures; thus 80100QW is not a payable code.
80101 or 80101QW	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class	These CPT codes will no longer be covered by Amerigroup contracts that use the CMS fee schedule(s). The effective date of this change was April 1, 2010.
G0430 or G0430QW	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	These Healthcare Common Procedure Coding System (HCPCS) codes must be used when reporting qualitative, nonchromatographic, multiple drug class assays. The code is reported only once per procedure. Urine cups, test cards, test strips or other point-of-care devices that provide results for more than one class of drug will be paid for one unit no matter how many drug classes are determined.
G0431 or G0431QW	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class	These HCPCS codes must be used when reporting qualitative single drug or drug class assay. This includes individual drug or drug class assays performed using CLIA moderate- or high-complexity instruments as well as point-of-care devices that produce results for only one drug or class of drugs.

How can I get more information?

You can find a listing of drug screening tests approved for use for the above codes online at www.cms.gov/CLIA/downloads/waivetbl.pdf.

For more information about this initiative, please contact the Coding Validation Team by phone at 1-800-374-3631 or 1-866-696-2675, by fax at 1-888-235-9315 or by email to cvihold@amerigroup.com.

We encourage you to visit providers.amerigroup.com/TN, often, to check out the improvements we are making and the latest information about Amerigroup Community Care and the managed care industry.

(TNPEC-0704-14)

Change to Claim Requirements: Date of Death and Occurrence Code

Summary of change: **Effective June 15, 2014,** Amerigroup Community Care will no longer process claims without occurrence code 55 when reporting patient discharge status code 20, 40, 41 or 42. This is a CMS-1450 (UB-04) form billing requirement for all providers.

✦ **What this means to you: Please pass this information to your billing staff.** Beginning June 15, 2014, all claims submitted without correct occurrence code 55 when reporting patient discharge status code 20, 40, 41 or 42 will be rejected for reason code 159 – Date of death.

What is the impact of this requirement?
If your claim is rejected for reason code 159 – Date of death on or after **June 15, 2014,** you will need to submit a corrected claim with the required occurrence code 55.

Action Required:

Do:	Submit claims with required occurrence code 55 for patient discharge status code 20, 40, 41 or 42.
Do not:	Submit claims with occurrence codes other than 55 for patient discharge status code 20, 40, 41 or 42.

Additional information:
If submitting via Electronic Data Interchange (EDI), contact your clearinghouse for appropriate loops for the above details or call the Amerigroup EDI team at 1-800-590-5745.

(TNPEC-0725-14)

Statement Date or Service Date Not Prior to Subscriber Date of Birth. Claims Received Date Not Prior to Service Date or Statement To Date.

Summary of change: Effective June 15, 2014, Amerigroup Community Care will no longer process for payment, claims submitted with service date or statement dates prior to the subscriber date of birth. Amerigroup Community Care will no longer process for payment, claims submitted with claims received date prior to service date or statement TO date of the claim.

✦ **What this means to you:** Beginning June 15, 2014, claims submitted with service date prior to the subscriber date of birth or claims submitted with received date prior to service date will be rejected for "187 - The Service Date submitted is prior to the Patient/ Subscriber Birth Date or after the Claim Received Date." Claims submitted with statement dates prior to the subscriber date of birth or claims submitted with received date prior to statement TO date will be rejected for Or "188 -The Statement To or From Date submitted is prior to the Patient/ Subscriber Birth Date or after the Claim Received Date."

What is the impact of this requirement?
Claims submitted with service date or statement dates prior to the subscriber date of birth or claims received date prior to service date or statement TO date of the claim on or after **June 15, 2014,** you will need to submit a corrected claim with the correct service dates or statement dates.

Example:

Do:	Submit claim for service dates of 1/26/2014 to 1/28/2014 with subscriber date of birth 1/26/2014.
Do not:	Submit claim for service dates of 1/25/2014 to 1/28/2014 with subscriber date of birth 1/26/2014.
Do:	Submit claim for statement dates of 1/26/2014 to 2/1/2014 and claims received date 2/3/2014.
Do Not:	Submit claim for statement dates of 1/26/2014 to 2/1/2014 and claims received date 1/28/2014.

Additional Information:

UB-04 (CMS 1450) claim form details

- Statement coverage period (form number 6)
- Birthdate (form number 10)
- Service date (form number 45)
- Creation date (form number 42-23)

CMS 1500 claim form details

- Patient date of birth form number 3)
- Dates of service (form number 24a)

If submitting via Electronic Data Interchange (EDI), contact your clearinghouse for appropriate loops for the above details or call Amerigroup EDI at 1-800-590-5745.

(TNPEC-0736-14)

Updated CMS 1500 Form

Background: In June 2013, the National Uniform Claim Committee (NUCC) announced the approval of an updated CMS 1500 Claim Form (version 02/12) that accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

✦ **What this means to you:** Effective April 1, 2014, submit a paper CMS 1500 Claim Form using only the revised CMS 1500 Claim Form (version 02/12). After April 1, 2014, claims received on the 08/05 version will be rejected.

Why is this change necessary?

On January 6, 2014, Amerigroup* started accepting the updated CMS 1500 Claim Form version 02/12 to support ICD-10 changes. Please follow the guidelines set forth by the NUCC for completing the new claim form, or your claim will be rejected.

Will a grace period for submitting the old form be allowed?

The grace period ends March 31, 2014. NUCC allows the submission of either CMS 1500 Claim Form version 08/05 or 02/12 from January 6, 2014, through March 31, 2014.

What if I need help?

For more information about the revised CMS 1500 Claim Form, please visit http://www.nucc.org/, which provides helpful resources like a list of changes between the 08/05 and 02/12 claim versions and the CMS 1500 Instruction Manual.

(WEB-PEC-0127-14)

Provider Manual Excerpt: Expedited Appeals

An expedited appeal process is available for adverse actions related to time-sensitive care. Care qualifies as time sensitive if the member's treating physician determines that if the member does not receive the care within 31 days:

- The member will be at risk of serious health problems or death
- The delay will cause serious problems with the member's heart, lungs or other parts of his or her body
- The member will need to go to the hospital

For internal purposes, Amerigroup has five calendar days to respond to the TennCare Bureau.

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as typically manages the medical condition, procedure or treatment under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient's representative.

The Amerigroup time frame in which the reconsideration of an expedited appeal must be completed is based on the medical or dental immediacy of the condition, procedure or treatment, but may not exceed five calendar days from the date the reconsideration request is received from TSU. However, Amerigroup may request a 14 day extension if additional time is required to obtain a member's medical/dental records.

Care is not time sensitive and an appeal is not expedited if the member's treating physician certifies in writing that the matter is not time sensitive.

Initial notice of the decision may be delivered orally if followed by written notice within five calendar days from the date of the reconsideration request.

If Amerigroup upholds its original adverse action through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for precertification of the service (if applicable) and review of the initial notice of adverse action to the member.

(from TN-PM-0010-14B)

The following entry applies to all Ambulance Services providers.

Air and Ground Ambulance Pickup and Drop-off Locations

Summary of change: Effective June 15, 2014, Amerigroup Community Care will no longer process payment claims for air or ground service transportation that are submitted without a complete ambulance pickup and drop-off location. This is a HIPAA 5010 billing requirement for all providers.

✦ **What this means to you: Beginning June 15, 2014, all** claims submitted for any air or ground ambulance service must contain a pickup and drop off location or they will be rejected for "Ambulance pickup/drop location missing" (Status Code GXN or GXO).

What is the impact of this requirement?
If your claim is rejected for "Ambulance pickup/drop location missing" on or after June 15, 2014, you will need to submit a corrected claim with the required ambulance pickup and drop-off location.

Action Required:

Do:	Submit claim with all required pickup and drop-off location.
Do not:	Submit claim with an invalid or missing pickup and drop-off location.

Claim Requirements:	**Drop-off location requirements:**
Pickup location requirements: • Physical street address. If the pickup is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "exit near mile marker 42 on Interstate 24") • City • State • ZIP code (in 5 or 9 digit format)	• Physical street address • City • State • ZIP code (in 5 or 9 digit format)

If submitting via Electronic Data Interchange (EDI), contact your clearinghouse for appropriate loops for the above details or call Amerigroup EDI at 1-800-590-5745.

(TNPEC-0709-14)

The following entries apply to Home- and Community-Based Services providers

Reminder: Exception Requests for Workers Who Fail Criminal Background Checks

Background: Your agreement with TennCare included a new requirement that became effective January 1, 2014. As a courtesy, we remind you of this requirement and your responsibilities to maintain written policies and procedures to address exception requests for potential workers who fail criminal background checks.

✦ **What this means to you:** Amendment 16 of your TennCare Contractor Risk Agreement (CRA) requires you to maintain these written policies and procedures. When we perform the Home- and Community-Based Services (HCBS) Audit, this is something we will check for.

Why is this change necessary?
Effective January 1, 2014, the CRA requires Amerigroup Community Care to ensure providers have policies and processes in place to address potential exceptions.

Your policy/process must include an individualized assessment.
If a potential worker fails a criminal background check, he or she may request an individualized assessment be conducted by the provider. The individualized assessment:

- Helps to determine whether the potential worker may be excluded from your pool of candidates because of past criminal conduct
- Provides the potential worker with notice he or she was disqualified as a candidate because of criminal conduct
- Provides an opportunity for the potential worker to explain why the exclusion should not be applied to his or her circumstances

(TNPEC-0715-14)

HCBS providers must visually confirm enrollee's presence during visits

Background: Home- and Community-Based Services (HCBS) providers must visually confirm enrollees at the beginning and end of their shifts. This will ensure the enrollee is aware of the worker's presence and the worker is aware of the enrollee's current physical state.

✦ **What this means to you:** Providers must have a written policy and process in place requiring workers to visually confirm an enrollee's presence at the beginning and end of their shifts.

Why is this change necessary?

Not visually confirming an enrollee's presence could result in a critical incident going unreported. You must report critical incidents to us in accordance with applicable requirements. The maximum time frame for reporting an incident is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case, you must submit a follow-up written report within 48 hours.

See more information on critical incidents and critical incident reporting in your CHOICES provider manual supplement.

TNPEC-0737-14

Home- and Community-Based Services Audit Standards

Standard	Policy and Procedure must include:
Section I. Administration Policies and Procedures	
1. Policy assuring the provider will be staffed to operate during normal working hours (37.5–40 hours/week)	• Statement that the provider-staffing model will cover service delivery between 37.5–40 hours/week • Normal working hours • No requirement for weekend hours
2. Policy assuring the provider's ability to staff 24 hours a day, 7 days a week	• Statement that the provider-staffing model will cover service delivery 24/7 • Monitoring plan • Methods to correct any deficiencies
3. Policy detailing the method to monitor services and assure the quality of care provided to clients	• Quality Monitoring policy that includes a minimum of quarterly reporting and analysis of data by a multidisciplinary team

4. Policy detailing a protocol that ensures enrollees and caregivers have the ability to contact the provider agency through the use of voicemail technology, answering machines, mobile telephones, pagers, backup systems and/or interagency agreements	• Detail of protocol to ensure enrollees and caregivers have the ability to contact the provider agency through the use of voicemail technology, answering machines, mobile telephones, pagers, backup systems and/or interagency agreements • Process for communicating this protocol to enrollees and caregivers
5. Policy of placing calls to the response center at least once monthly to ensure the system is working or other appropriate process meeting the same requirement	• Process for testing Personal Emergency Response System (PERS) functioning • Method of evaluating results and ensuring any deficiencies are corrected
Section II. Employee Education Policies and Procedures	
1. Policy and process in place to provide and document initial and annual education of employees who will provide services to CHOICES members that includes, at a minimum, (2.11.8.4.1.2.5)	• Detail of required initial and annual training required for all employees
2. Caring for the elderly and disabled population (2.11.8.4.1.2.5.1)	• Topic regarding how to care for the elderly and disabled population
3. Abuse and neglect prevention, identification and reporting (2.11.8.4.1.2.5..2)	• Topic regarding prevention, identification and how to report abuse and neglect of enrollees
4. Critical incident reporting (2.11.8.4.1.2.5.3)	• Topic regarding identification and how to report critical incidents
5. Documentation of service delivery (2.11.8.4.1.2.5.4)	• Topic regarding appropriate documentation procedures for service delivery
6. Use of Electronic Visit Verification (EVV) System (2.11.8.4.1.2.5.5)	• Topic regarding when, how and the appropriate steps to utilize the EVV system
7. Policy mandating criminal background checks. Each employee shall have a valid criminal background check in Tennessee, which includes a check of the: (2.11.8.4.1.2.4) i) Tennessee Abuse Registry ii) Tennessee Felony Offender Registry iii) National and Tennessee Sexual Offender Registry iv) List of Excluded Individuals/Entities (LEIE)/GSA EPLS	• Detail of required criminal background checks prior to providing services to enrollees. The policy must include all components listed in the standard. This includes all prospective employees who will deliver CHOICES HCBS and document these in the worker's employment record. No person convicted of a felony will be a care provider. No person will be a care provider if an abuse or assault charge exists. No person is an excluded individual.
8. Policy and process in place to address exception requests for workers who fail a criminal background check (2.11.8.4.1.2.4.1)	• Detail stating how exception requests are handled for workers who fail a criminal background check. This includes notification to Amerigroup of exception requests.

9. Compliance with Amerigroup critical incident reporting and management process (2.11.8.4.1.2.6.1)	• As reported by inquiry with the Quality Management coordinator handling critical incidents and evidenced by a lack of required or additional mandatory training sessions
10. Appropriate use of the EVV system (2.11.8.4.1.2.6.2)	• As reported by inquiry with long-term care staff handling the EVV system and evidenced by a lack of provider payment denials due to timely filing of services
11. Policy ensuring personnel contracting infectious illnesses or diseases do not serve enrollees until they no longer present symptoms of illness	• Statement that employees should not work while infected with an infectious illness • Requirement to have a physician's release prior to resuming services to enrollees • A method for communication to all employees
12. Policy requiring personnel to meet in-person with the patient immediately upon arrival; meeting or speaking with the patient's family member or caretaker instead of the patient does not meet requirements	• Requirement for personnel to meet in-person with the patient immediately upon arrival
Section III. Employee Records	
1. Documentation of employee initial training as outlined in 2.11.8.4.1.2.5.	• All employees must attend individual trainings or a single training, including all required training topics as evidenced by a training roster or log in the employee's file.
2. Documentation of employee annual training as outlined in 2.11.8.4.1.2.5.	• All employees must attend individual trainings or a single training, including all required training topics as evidenced by a training roster or log in the employee's file.
3. Adherence with criminal background checks as outlined in 2.11.8.4.1.2.4.	100 percent of employees selected in a random sample from the employee roster: • Have documentation of all required elements of the criminal background check • Did not provide enrollee services prior to completion of the check • Have no felony or positive sexual abuse record (Those who have a felony or positive sexual abuse record cannot provide services to enrollees.)
Section IV. HIPAA	
1. Policy and process ensuring electronic and paper information containing Personal Health Information (PHI) or Individually Identifiable Health Information (III) is protected and secure per HIPAA regulations.	• Policy detailing the storage of electronic information, assigning of passwords, manual data storage, limited access and use of locked cabinets • A method for communication to employees
2. Policy and process ensuring information is released only per HIPAA regulations.	• Policy detailing the process for releasing PHI or III information that is compliant with HIPAA • A method for communication to employees

The following entry applies to long-term services and supports providers and Electronic Visit Verification (EVV) users.

Frequently Asked Questions about Electronic Visit Verification

Summary: To ensure providers who serve Amerigroup Community Care CHOICES members in home settings and use the Electronic Visit Verification (EVV) system have all available information about best practices and frequently asked questions, this document contains answers to questions we often receive.

We also included some best practices to help ensure our members receive the care they need when they need it and our providers are paid for the care they give our members in accordance with established and authorized plans of care (POCs).

✦ **What this means to you:** Share this information with your staff and keep it on hand as a reference.

Key contact information

Amerigroup Long-Term Services and Supports (LTSS)
Phone: 1-866-840-4991
Fax: 1-888-762-3203
Email: LTCProvReq@amerigroup.com

Contact Amerigroup LTSS for the following types of issues:

- Authorizations are expiring
- Need a copy of the member's POC
- Missing an authorization
- Need a new authorization

Sandata Customer Service
Phone: 1-877-526-0516
Call Sandata Customer Service with the following types of issues:

- Unable/need assistance with entering schedule
- Unable to export claims for billing
- Receiving errors from the EVV system
- Unable to access the EVV system

Authorizations

1. How do I request an authorization?

A. Care Coordinators routinely renew authorizations one month before they expire. If you have an authorization expiring within the next two weeks or are missing an authorization, send us an email at LTCProvReq@Amerigroup.com. Once we get your request, we'll forward it to the care coordinator for review and approval. Don't forget to include the member's name, subscriber ID, service requested, dates of service covered in the request and the member's schedule.

2. I was verbally asked to perform a service. Should I do it without an authorization?

A. No. You should have an authorization for all services you are asked to perform. Amerigroup does not accept verbal authorizations when adjudicating claims. Before you perform any service, be sure you have an authorization in the EVV system for the service you're asked to perform.

3. I don't see my authorization/scheduling information in the EVV. What should I do?

A. It can take up to 24 hours for the authorization to upload into the EVV system. If it's been more than 24 hours since you received your paper fax confirmation stating you have authorization for a service but you have not yet seen it in the EVV system, email us at LTCProvReq@Amerigroup.com. Be sure to include the member's name, ID and authorization reference number!

B. If you have not yet received your paper fax confirmation, it is not yet authorized. Due to the volume of requests our Authorizations team receives, it can take up to two business days to enter the necessary authorization and schedule information into our system. Please allow us two business days to enter your requests.

Schedules in the EVV

1. Do I have to schedule the services I'm supposed to provide in the EVV?
A. Yes.

2. How far out does the EVV enter schedules for my Amerigroup patient?
A. We recommend entering schedules for a period of no more than one month out from the current date. This practice allows schedule changes without you needing to make EVV updates to many months of schedules in the future.

3. Should I schedule from the authorization or the new events screen?
A. It's always best to schedule from the authorization itself. This ensures your schedule is tied to the correct authorization, avoiding potential claims issues.

4. Should I perform my scheduled visit earlier than the date authorized?
A. No. Follow the schedule as it is laid out in the authorizations listed in the EVV. If the authorization has a fixed start time, go at the time listed in the authorization. If the authorization has a scheduling window, the service must be provided during the scheduling window authorized.

5. What do I do if the member asked me to come at a different time?
A. Follow the schedule change process.

6. How do I submit a Schedule Change Request form?
A. Follow the schedule change process.

7. Should I cancel schedules?
A. No.

8. Should I change a scheduled service with an assigned caregiver less than 30 minutes before the scheduled start time?
A. No; not if at all possible. If you do, we will get an alert, and we will call you.

9. Should I try to change either the modifier or the event ID on my authorization or schedule?
A. No. These fields should not be modified. Modification may cause issues with submitting claims and the subsequent reimbursement from those claims.

10. I have an authorization for a member to get multiple same-day services, but none of the authorizations have duplicate visit modifiers. What do I do?
A. Let us know immediately! Be sure to include the member's name, ID and authorization reference number.

Missed Visits

1. When should I enter a missed visit reason code in the EVV?
A. Enter the code immediately, if possible, but not more than three business days after the missed visit.

2. Should I cancel a visit if it will go missed?
A. No; not all missed visits are bad. It's important for us to know when our members aren't getting care as outlined in their POCs (even when the member requested the service not be provided).

3. Do I need to submit a Missed Visit Unit Release Request form if I have a one-time authorization for a schedule change?
A. No. The one-time authorization is used to cover the rescheduled visit; therefore, the units from the originally scheduled visit do not need to be released.

4. My visit rolled to a missed status, but I provided the service. How do I get my units back?
A. Follow the Missed Visit Unit Release Request process.

EVV

1. Do I have to use the member's home phone to call in/out of my shift?
A. Yes.

2. What do I do if the member refuses to allow me to use the phone or does not have a home phone?
A. Let the member's care coordinator and EVV team know by sending an email to LTCProvReq@amerigroup.com. Don't forget to include the member's name, subscriber ID and a description of the issue experienced.

4. What do I do if there are two members receiving services in the same home?
a. The EVV system has a feature that allows the assigned caregiver to enter the member's unique Santrax ID. This ID can be obtained by running the Client Addresses report. Specific instructions regarding the process for the assigned caregiver are available in the Sandata Document Library or by contacting Sandata Customer Service.

3. What if the member's phone number changed and the member has not yet updated the phone number with the State?
A. Tell the member's care coordinator and let the EVV team know by sending an email to LTCProvReq@amerigroup.com. Don't forget to include the member's name, subscriber ID and phone number when sending in your notice of a new phone number.

4. Does my agency need to have someone available after normal business hours for scheduling issues?
A. Yes. We expect our providers to be available when our members receive services.

(TNPEC-0735-14)