NewsBlast

TENNESSEE – APRIL 2015 TNPEC-1014-15-C

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

# Medical record documentation audit changes primary care providers

**Summary**: Amerigroup Quality Management (QM) staff will conduct onsite medical record documentation audits to assess compliance with medical record standards, Clinical Practice Guidelines (CPGs) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards. Records kept in accordance with these standards facilitate effective medical care and continuity of care among practitioners.

✦ **What this means to you**: We may contact your office to schedule an appointment for an audit in the coming weeks. Please take the time to review your medical records documentation to ensure compliance.

**Changes to standards**

We added the following requirement to pass the medical record documentation audit:

- Any provider receiving a score more than one standard deviation from the statewide average (TN State EPSDT MR Review Annual Report) on ***any individual component*** will be required to have office-wide EPSDT training completed within 60 days of receiving audit results. Training will include review of guidelines as recommended by the American Association of Pediatrics.
- Last reported state average scores are as follows:

| Mandated | 2013 state average |
|---|---|
| History | 90.40% |
| Immunizations | 70.80% |
| Physical | 94.90% |
| Lab | 84.30% |
| Health education | 97.30% |
| Vision | 90.90% |
| Hearing | 88.70% |

**By what standard will my office be assessed in this audit?**

The standards developed for medical record documentation reflect a set of commonly accepted standards, CPGs and EPSDT visits. The standards include demographic information, health history, details of ongoing clinical issues, CPGs and preventive health care. Only records within a one-year period from the date of audit will be reviewed. Ten charts with a minimum of eight are assessed for compliance.

**How do you determine who is selected for the audit?**

Primary care providers with 500 or more assigned members and high-volume obstetrics-gynecology providers with 500 or more encounters will be audited against the standards. If your office meets these criteria, the QM department will contact your office to schedule an appointment for the audit within the next two weeks.

**How can I make sure my office is compliant?**
To help you prepare for this important quality assurance activity, the standards are attached. You can also find these standards detailed in Section 17 of your Amerigroup provider manual.

**What if I need assistance?**
If you have questions about the audit, call the Quality Management department at 615-316-2400, ext. 22409. If you received this communication in error or have questions on another topic, contact your local Provider Relations representative or call our Provider Services team at 1-800-454-3730.

## Medical record documentation standards

| | Core standard |
|---|---|
| 1. | Provider has policy and procedures in place to ensure confidentiality to the extent provided by TCA-33-3-101 and HIPAA regulations, security as defined by HIPAA, and member accessibility to the extent provided by TCA 63-2-101/63-2-102/33-3-104 et seq of medical records. |
| 2. | Patient demographic data is present in chart and name or ID number is on each document. |
| 3. | Medication allergies and adverse reactions are prominently noted/displayed in the record. If the member does not have allergies, this should also be noted. |
| 4. | Advanced directives such as a living will for members 18 years and over has been discussed and documented with a date by a PCP. |
| 5. | A current medication list is present in the patient record. (For best practice: dosage, date medication was initiated and dates of refills are present). |
| 6. | A current problem list that includes significant illnesses, medical conditions and psychological conditions is present. |
| 7. | Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses. For children birth through age 20, developmental or behavioral assessment is included. Interval histories should be present as appropriate.<br>**If member will be assessed under the EPSDT guideline, an NA score is applied here and scored appropriately in the EPSDT section of tool.* |
| 8. | A history of immunizations is present in the medical record for adults and up-to-date or offered for children birth to age 20. If parents refused vaccines, a signed waiver by parents and reason are documented.<br>**If member will be assessed under the EPSDT guideline, an NA score is applied here and scored appropriately in the EPSDT section tool.* |
| 9. | Documentation for each visit supports presenting complaints, clinical findings, evaluation, treatment plan and follow-up recommendations. The treatment plan is appropriate to findings and the patient is not at risk for diagnostic or therapeutic problems. All entries are signed and dated (may be a handwritten signature, unique electronic identifier or initials). |
| 10. | Is there evidence in the chart to indicate that PCPs are making referrals to other levels of care? |
| 11. | Provider has in place a policy or procedure for follow up of missed appointments. |
| 12. | If member has a behavioral health diagnosis and a referral to a behavioral health (BH) provider was completed, documentation from the BH provider is present if member approved coordination of care between PCP and BH provider. |
| | **13. Obesity standard** |
| 13a. | Body Mass Index (BMI) calculated within past two years for adults. BMI calculated and plotted for percentile for children age 3 and older with each visit (for adults with obesity diagnosis, BMI is calculated periodically). |
| 13b. | Documentation of counseling for nutrition or referral for nutrition education within the past year. |
| 13c. | Documentation of counseling for physical activity or referral for physical activity within the past year. |

| | |
|---|---|
| **14. Diabetes standard** | |
| 14a. | Annual history and physical exam completed with depression screening. |
| 14b. | Annual comprehensive dilated eye exam for adults and children 10 years and older. |
| 14c. | Annual foot exam, visual with each visit. |
| 14d. | Annual microalbumin/creatinine ratio <30mg/g and children 10 years and older. |
| 14e. | Annual lipid profile with LDL <100mg and children 2 years and older. |
| 14f. | Annual influenza vaccine. |
| 14g. | Pneumococcal vaccination for all members older than 2 years. |
| 14h. | Documented HgbA1c twice yearly if meeting treatment goals and quarterly if not, members of all ages. |
| 14i. | Advise to quit smoking. |
| 14j. | Education and therapy at clinician's discretion for physical activity, nutrition, self-monitored blood glucose, weight loss, psychosocial counseling and preconception/pregnancy counseling. |
| 14k. | Blood pressure treatment to attain/maintain a blood pressure lower than 130/80. |
| **15. EPSDT standard** | |
| 15a. | Nutrition assessment. |
| 15b. | Past medical history is present and includes serious accidents, operations, substance abuse, family history and illnesses (for children birth through age 20, developmental/behavioral assessment is included. Interval histories should be present as appropriate). ***Mandated state component.*** |
| 15c | A history of immunizations is present in the medical record for adults and up-to-date or offered for children birth to age 20 (if parents refused vaccines, a signed waiver by parents and reason are documented). ***Mandated state component.*** |
| 15d. | Cholesterol risk assessment. |
| 15e. | Lead risk assessment. |
| 15f. | Comprehensive unclothed physical completed. ***Mandated state component.*** |
| 15g. | Appropriate laboratory tests were performed or ordered for age. ***Mandated state component.*** |
| 15h. | Health education was given as appropriate for age. ***Mandated state component.*** |
| 15i. | Vision screening was performed (or referral provided) as appropriate for age. ***Mandated state component.*** |
| 15j. | Hearing screening was performed (or referral provided) as appropriate for age. ***Mandated state component.*** |
| 15k. | If screenings were not completed in a single visit, is there documentation in the chart that a return visit is scheduled? |
| 15l. | Is there documentation of any concerns or questions from the member or member's parent or guardian after the screening process? |
| 15m. | Is there documentation in the chart to indicate the EPSDT services have been refused or declined by a parent, guardian or member? Document reason declined in concerns. |
| 15n. | Is there evidence in the chart to indicate PCPs are making referrals to other levels of care? |
| **16. Major depression (acute and chronic) guidelines** | |
| 16a. | Documentation to support diagnosis of major depression is present in the clinical record. |
| 16b. | DSM-IV/ICD-9 diagnosis is documented. |
| 16c. | Medication prescribed and dosage of antidepressant medications follows recommendations as outlined in CPG. |
| 16d. | **Acute phase:** After initiation of medication for a new diagnosis of major depression, three follow-up contacts occurred during the first 12 weeks of treatment, one of which must have been with the prescribing practitioner. |
| 16e. | **Continuation phase:** After treatment for acute phase, documentation is present that member is maintaining medications for at least six months following remission of symptoms. |
| 16f. | **Maintenance phase:** After treatment for continuation phase, documentation of assessment for recurrence of depression symptoms, presence of comorbid conditions, suicidal thoughts and psychotic features is present. |
| 16g. | Evidence is present in medical record of coordination of care with member's PCP and referring practitioner if referring practitioner is other than PCP. |
| 16h. | If a hospitalization occurred prior to or during the course of treatment, documentation is present of a follow-up visit within seven days of discharge and within 30 days of discharge. |

| 17. ADHD guidelines | |
|---|---|
| 17a. | Documentation to support diagnosis of ADHD should be present in record. |
| 17b. | Medication prescribed and dosage for ADHD follows recommendations outlined in the CPG. |
| 17c. | If tricyclic antidepressants are used, a baseline electrocardiogram (ECG) prior to use is present, with a follow-up ECG after each significant dosage change. If a higher level tricyclic medication is documented, blood levels are present in the medical record. |
| **17. ADHD guidelines** | |
| 17d. | **Initiation phase:** Documentation is present for patients who receive an initial prescription for ADHD medication of at least one follow-up visit with a prescriber within 30 days of initiation of medication and at least two additional visits between four weeks and nine months of the initiation of the medication. |
| 17e. | **Continuation and maintenance phase:** After treatment for initiation phase, documentation is present of at least two follow-up visits between 30 days and ten months (300 days) of the initiation of the medication. |
| 17f. | Follow-up visits include assessment for:<br>• Behavioral assessment (school/peer/family)<br>• Height<br>• Weight<br>• Abnormal movement, signs and symptoms<br>• Follow-up testing with Conners' scales or equivalent scales to track treatment response<br>• School informal plan or Section 504 Plan every two years |

**TNPEC-1002-15**

# Improving your experience: Availity eligibility and benefits (E&B) updates

**Summary**: Availity is launching new eligibility and benefits features for their Web Portal during the 2nd quarter of 2015.These enhancements will make finding eligibility and benefits easier and faster for you. View the chart below for more information on what's coming:

| | |
|---|---|
| New Request page | The new Request page design makes it faster for you to submit member inquiries. Now, you can submit multiple inquiries without having to wait for individual results to show before starting another request. |
| Patient history list | The results list summarizes your most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only the information relevant to that member is displayed. |
| Menu by benefit type | Located under the Coverage and Benefits tab, this interactive list includes key coverage elements and only shows information returned from the payer. |
| Organization-wide view of E&B transactions | You can now see transactions by other users within your organization (shared history) – resulting in less duplication of work already completed by your peers. |
| Organization dropdown menu | Users responsible for more than one organization can switch organizations while staying on the same page, providing a convenient, streamlined workflow. |
| Payer section | In this section, value-added services were consolidated so you can access these services (e.g., a patient care summary) from the same page. |

To learn more about these time-saving features, go to www.availity.com and take a quick tour, view the recorded webinar or join Availity for a live webinar.

**PEC-ALL-1518-15**

# ICD-10 coded prior authorizations

**Summary:** The transition from ICD-9 to ICD 10 goes into effect on October 1, 2015. Amerigroup will begin accepting ICD-10 coded authorizations beginning June 1, 2015. These will only be for those authorization requests where the dates of service are October 1, 2015 or later. Authorization requests for dates of service prior to October 1, 2015 will continue to be coded using ICD-9.

## Getting Ready to Transition to ICD-10

To help ensure you are ready, here are some additional things to remember:

- Make sure your practice management system and/or billing system is ICD-10 ready. Talk with your vendor about the support and services you might need to be compliant for ICD-10.
- There is no need to memorize all of the new ICD-10 diagnosis codes. If you are not an inpatient facility, you only need to be concerned with the most common medical conditions your practice sees today and understand how ICD-10 impacts them.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record.
- If your practice treats a wide range of medical conditions use the 80/20 rule to determine which ICD-10 diagnosis codes are most pertinent. This would include family practice, pediatric medicine, or internal medicine.

The Centers for Medicaid and Medicare Services (CMS) offers the "Road to ICD-10" – a comprehensive tool where you can explore common codes, primers for clinical documentation, clinical scenarios, and additional resources associated by specialty. Visit www.roadto10.org to find information for:

- Family Practice
- Pediatrics
- OB/GYN
- Cardiology
- Orthopedics
- Internal Medicine
- Other Specialties

Did you know you also have the opportunity to earn continuing medical education (CME) credits while preparing for ICD-10? CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition. The video lectures are specifically for physicians, while the article covers more general topics for all health care providers. CME credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion. The modules are free and can be found at www.cms.gov/Medicare/Coding/ICD10.

**PEC-ALL-1521-15**

# ClaimCheck Version 55 Upgrade Effective July 2015

**Summary**: In 2015, Amerigroup will complete two upgrades to newer versions of ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in Version 55 of the upgrade are effective July 2015. The changes included in Version 56 of the upgrade are effective August 2015.

## Additional Background

Amerigroup uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to industry standards.

**Why is this change necessary?**

ClaimCheck is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes.

Amerigroup uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

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

PEC-ALL-1495-15

# Nondiscrimination training presentation

**Summary**: Recently, the TennCare division of Health Care Finance and Administration added a new Nondiscrimination Compliance Training presentation for entities contracted to provide services to TennCare recipients. View the training at www.tn.gov/tenncare/nondiscriminationComplianceTraining.shtml.

**About the training**

This training provides an understanding of federal and state laws that protect individual recipients of federal financial assistance from unequal or different treatment.

Entities receiving financial assistance shall not do any of the following based upon protected status:

- Deny an individual a service, aid or other benefit
- Provide a benefit that is different or in a different manner
- Subject an individual to segregation or separate treatment
- Restrict an individual in the enjoyment of benefits, privileges, etc.
- Treat an individual differently when determining eligibility
- Select sites or locations of facilities that exclude protected individuals

Treating our members fairly is a critical part of the job we do. Thank you for your attention to this important training objective.

TNPEC-0993-15

# Body mass index and obesity: Tips and tools for tackling a growing issue

**What is obesity?**

For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called body mass index (BMI). BMI is used for most adults since it correlates with an individual's amount of body fat. However, BMI does not directly measure body fat; instead, it gives ranges of weight that show what is generally considered healthy for a given height. This list displays the ranges for adult BMI in relation to the corresponding clinical diagnosis per Centers for Disease Control (CDC).

| Adult BMI | |
|---|---|
| Less than 18.5 | Underweight |
| 18.5-24.9 | Healthy weight |
| 25.0 -29.9 | Overweight |
| 30.0-39.9 | Obese |
| 40.0 or more | Morbidly obese |

A child's weight status is detemined by using an age and sex specific percentile for BMI rather than the BMI categories used for adults since a child's body composition varies as they age and based on gender. BMI for pediatrics ages 2-20 is based on the growth charts published by the CDC. The list to the left shows pediatric BMI in relation to the corresponding clinical diagnosis.

| Child Age- and Sex-specific Percentile | |
|---|---|
| Less than 5th | Underweight |
| 5th-less than 85th | Healthy weight |
| 85th -less than 95th | Overweight |
| At or above 95th | Obesity |

Obesity can have very harmful effects on the body. A 2007 study from the *Journal of Pediatrics* concluded that 70 percent of obese children had at least one cardiovascular risk factor such as high blood pressure or high cholesterol. Many health risks can be caused by obesity including diabetes, breathing issues, joint problems, fatty liver disease, gallstones and gastro-esophageal reflux (GERD, chronic heartburn). Providers should report the BMI on claims for patients with weight issues. While most providers have electronic medical records software that automatically calculates BMI for the patient, the CDC offers BMI calculators for children/teens and adults for those who do not.

**Obesity-related services**

Obesity-related services are those services that help address unhealthy weight. Insurance plans and health programs may cover a range of services to prevent and reduce obesity including BMI screening, education and counseling on nutrition and physical activity, prescription drugs and surgery.

Health care providers should conduct height, weight and nutrition assessments as part of all well-child visits and adult annual checkups. If primary care providers counsel patients regarding obesity there are procedure codes that can be billed to report the services for reimbursement. Providers should ensure the correct diagnosis and BMI codes are billed that correlate to obesity to support the counseling. For questions about benefit levels and available coverage, contact Provider Services at 1-800-454-3730.

**Documentation and coding**

Obesity codes are located in the Endocrine, Nutritional and Metabolic Diseases chapter of ICD-9-CM. The codes are to be applied when documentation supports a clinical diagnosis from physician documentation.

The ICD-9 codes for reporting weight-related clinical diagnoses include:

**278.00 Obesity unspecified**
**278.01 Morbid obesity**
**278.02 Overweight**

A coding instructional note listed with category 278.0 states to code BMI using codes V85.0-V85.54. Assign both the clinical diagnosis and the BMI on your claim. ICD-9 Coding Guidelines define morbid obesity as BMI greater than 40.

**AHA Coding Clinic advice**

Per American Hospital Association's (AHA) Coding Clinic 2010, Q2, BMI itself may be retrieved from nonphysician documentation such as a dietician, however, the clinical diagnosis must come from physician documentation.

Per AHA Coding Clinic 2011, Q3, individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the BMI code meets the requirement for clinical significance when obesity is documented.

**Obesity and BMI coding in ICD-10**

Document the type (i.e., morbid, obese, overweight) and cause of obesity for ICD-10 (e.g., excess calories, drugs, etc)

| ICD-10 | Description |
|---|---|
| **E66.3** | Overweight |
| **E66.8** | Obesity, other causes |
| **E66.9** | Obesity, unspecified |
| **E66.01** | Morbid obesity, due to excess calories |
| **E66.09** | Other obesity due to excess calories |
| **Z68** | Body mass index |

**TNPEC-0997-15**

**The following notes apply to Medicare Providers.**

# Medicare Advantage national coverage determinations

National coverage determinations (NCDs) are developed by CMS to identify member benefits and for provider guidance. Effective January 1, 2015, claim edits will be enhanced to consistently apply NCD criteria during the adjudication process for Amerigroup Amerivantage (Medicare Advantage).

**SSO-PEC-0527-14**

# Clearinghouse helps ensure timely and accurate claims payment for vaccines covered by Medicare Part D

**Background**: Providers who have administered a shingles or tetanus vaccine to our individual and group sponsored Medicare Advantage plan members with pharmacy benefits may encounter a denial as these claims are covered under Medicare Part D only.

To streamline claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use TransactRX. This clearinghouse for claims submission may be used by physicians, facilities, health clinics and pharmacies.

To use TransactRX, visit www.transactrx.com or call the Customer Service department at 1-866-522-3386. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

For more information on Part D vaccines visit www.cms.gov and follow the steps below:

1. Select Outreach & Education from the top menu bar
2. Under Look up topics, select Medicare
3. Select Medicare Learning Network® (MLN) general information
4. Select the first option from the list, MLN Education Products
5. Under MLN products on the left-hand side, select MLN Publications and type June 2013 in the search box
6. Select the third option, Vaccine Payments Under Medicare Part D

Amerivantage is an HMO plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in Amerivantage depends on contract renewal.

**TNPEC-0991-15**

Do you need free language help? ¿Habla español y necesita ayuda con esta carta? Llámenos gratis al 1-800-600-4441 (TennCare) o al 1-866-840-4991 (CHOICES).

العربية *(Arabic);* Bosanski *(Bosnian);* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese)* call 1-800-600-4441 (TennCare), 1-866-840-4991 (CHOICES) or 1-800-758-1638. For TDD/TTY help call 1-800-855-2880. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to a disability or to report a different treatment claim? Call the Office of Non-Discrimination Compliance for free at 1-855-286-9085 or 1-866-840-4991 (CHOICES). For TTY dial 711 and ask for 1-855-286-9085.