NewsBlast

TENNESSEE – SEPTEMBER 2014 TNPEC-0833-14

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

Medical Policies Update

On May 15, 2014, the WellPoint Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies applicable to Amerigroup health plans. These medical policies were developed or revised to support clinical coding edits.

The medical policies were made publicly available on the Amerigroup Medical Policy and clinical utilization management (UM) guideline subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies. **Existing precertification requirements have not changed.**

Medical Policy Effective Date	Medical Policy Number	Medical Policy	Medical Policy (New/Revised)
July 1, 2014	SURG.00139	Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery with Radiofrequency Spectroscopy or Optical Coherence Tomography	New
July 15, 2014	DRUG.00062	Obinutuzumab (Gazyva®)	New
July 15, 2014	DRUG.00063	Ofatumumab (Arzerra™)	New
July 15, 2014	GENE.00036	Genetic Testing for Hereditary Pancreatitis	New
July 15, 2014	GENE.00037	Genetic Testing for Macular Degeneration	New
July 15, 2014	GENE.00038	Genetic Testing for Statin-Induced Myopathy	New
July 15, 2014	GENE.00040	Genetic Testing for CHARGE Syndrome	New
July 15, 2014	GENE.00041	Short Tandem Repeat Analysis for Specimen Provenance Testing	New
July 15, 2014	DME.00009	Vacuum Assisted Wound Therapy in the Outpatient Setting	Revised
May 19, 2014	SURG.00026	Deep Brain, Cortical and Cerebellar Stimulation	Revised

Please share this information with other members of your practice and office staff. If you have questions about this communication or need assistance with any other items, contact your local Provider Relations representative or call our Provider Services team.

PEC-ALL-1274-14

Sleep Management Program – Additional Codes

Summary: In April of 2014, Amerigroup announced a new Sleep Disorder Management Program would become available April 1, 2014 (PEC-ALL-1146-14). Preauthorization for all sleep studies was still required at that time and list of codes was provided. In addition to the codes that were previously communicated the codes listed below will now require preauthorization.

✦ **What this means to you:** The following codes will be added to the Sleep Management Program effective November 1, 2014. These codes are in addition to the codes that were previously communicated in a notification sent out during the April-May 2014 time frame.

Key points you need to know:

- Additional codes* that will require precertification are: G0398, G0399, G0400, E0470, E0471, E0485, E0486, E0601 and E1399.
- This is in addition to the codes that already require precertification for sleep study management, which includes codes 95782, 95783, 95800, 95801, 95806, 95807, 95808, 95810 and 95811.

Please note that you will continue to submit your request for precertification through 1-800-454-3730 for phone requests or 1-800-964-3627 for faxed requests.

PEC-ALL-1242-14

Durable Medical Equipment, Prosthetics, Orthotics and Supplies Coding Requirements

Background: Over the past several years, durable medical equipment (DME) Regional Contractors (RCs) have shifted toward using modifier requirements when submitting DME claims, largely replacing other requirements, such as diagnostic criteria or the billing of other drugs or equipment to drive payment. The modifier requirements are outlined in local coverage determinations (LCDs). Keep in mind that when DME RCs issue an LCD, all four DME RCs issue identical LCDs, essentially representing a national policy.

Effective November 1, 2014, all Medicare and Medicaid claims submitted to Amerigroup on or after November 1, 2014, with Healthcare Common Procedure Coding System (HCPCS) codes for services considered durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) will be required to follow Centers for Medicare and Medicaid Services (CMS) requirements for proper coding, including HCPCS modifier usage.

Providers of DMEPOS services should be familiar with CMS requirements and begin adhering to the requirements for DME coding and correct use of modifiers as soon as possible.

What are DME and DME modifiers?

Per CMS, to be considered DME, an item is:

- Able to withstand repeated use
- Primarily and customarily used to serve a medical purpose
- Generally not useful to a person in the absence of illness or injury
- Appropriate for use in the home

All requirements of the definition must be met before an item can be considered DME.

A DME modifier is a two-character alpha or numeric code added to the end of an HCPCS code to clarify the services billed. DME modifiers add more information to the code, including:

- The anatomical site
- The functional status of the patient
- Equipment rental or purchase modifiers
- Attestation that the patient meets certain criteria
- Attestation that certain documentation is on file

Summary of modifiers required

The following includes a summary of the most frequently used DME modifiers that may be required by CMS and examples of when the modifiers are required:

Anatomic modifiers

CMS provides coverage for orthotics to support a weak or deformed body part or to restrict motion in a diseased or injured part of the body. A brace is a rigid or semirigid device used for this purpose.

For those orthotics or prosthetics that may be billed bilaterally, CMS requires the use of the right side of body (RT) or left side of body (LT) modifier to define which side is being supported (orthotic) or replaced (prosthetic). Orthotics or prosthetics should not be billed with modifier 50 (bilateral procedure). HCPCS codes defined as "pair" should not be billed with an RT or LT modifier.

Functional modifiers (K0-K4)

A lower limb prosthetic is covered when the patient will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate. Functional modifiers were developed to define ability and are to be used with lower limb prosthetics.

Functional modifiers:

- K0 – Lower-level prosthesis functional level 0; does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance quality of life or mobility
- K1 – Lower-level prosthesis functional level 1; has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence; typical of the limited and unlimited household ambulator
- K2 – Lower-level prosthesis functional level 2; has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces; typical of the limited community ambulator.
- K3 – Lower-level prosthesis functional level 3; has the ability or potential for ambulation with variable cadence; typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic use beyond simple locomotion
- K4 – Lower-level prosthesis functional level 4; has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels; typical of the prosthetic demands of the child, active adult or athlete

Capped rental modifiers

Capped rental modifiers identify which rental month the beneficiary is in:

- KH – Month 1
- KI – Months 2-3
- KJ – Months 4-13

Tape (A4450, A4452)

According to CMS policy, tape is billed with one of the following modifiers to indicate its intended use:

- AU – Item furnished in conjunction with a urological, ostomy or tracheostomy supply
- AV – Item furnished in conjunction with a prosthetic or orthotic device
- AW – Item furnished in conjunction with a surgical dressing
- AX – Item furnished in conjunction with dialysis services

Modifier CG (policy criteria applied)
According to CMS policy, spinal orthoses must be billed with modifier CG (policy criteria applied).

Modifier KX (requirements specified in the medical policy have been met)
Many DMEPOS policies require the KX modifier to indicate provider attestation that specific policy criteria are met:

- KX – Coverage criteria in policy are met
  - Shows the item is reasonable and necessary and has been ordered by a licensed practitioner
  - Documentation must be available, if requested by Amerigroup
- Policies state what documentation is required. The policies may include:
  - CMS LCD
  - Amerigroup Medical Policy
  - For a Medicaid patient, that state's Medicaid policy
- If the criteria for modifier KX are not met, then modifiers GA, GY or GZ may be used, depending on the circumstances

Modifier KS (glucose monitor supply for diabetic beneficiary not treated with insulin)
CMS requires certain glucose monitoring equipment and supplies be appended with a modifier to indicate the beneficiary's treatment status:

- KS – Glucose monitor supply for diabetic beneficiary not treated with insulin
- KX – Documentation on file for diabetic beneficiary treated with insulin

Modifiers to designate rental or purchase status
According to CMS policy, certain items can only be rented or purchased:

- RR – Rented item
- NU – New purchased item
- UE – Used purchased item

Modifiers A1-A9
According to CMS policy, all surgical dressings require a modifier indicating the number of wounds on which the surgical dressing is to be used:

- A1-A9: Dressing for one to nine or more wounds
  - Number of wound dressings used, NOT the number of wounds the patient has

Place of service billing
Per CMS, DMEPOS and enteral/parenteral nutrition should be billed with a place of service indicating where the item(s) will be used, NOT the place of service where they are dispensed.

PEC-ALL-1322-14

Upcoming changes to durable medical equipment precertification requirements

Summary of change: Beginning January 1, 2015, Amerigroup precertification requirements will change for certain durable medical equipment (DME) items. Federal and state law, state contracts and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage.

✦ **What this means to you:** Noncompliance with new requirements may result in denied claims. Please share this information with staff and other providers in your practice. ***Not all changes are listed here. Use the instructions below to look up code-specific requirements.***

What is the impact of the change?

Precertification requirements will be added to specific services in the following categories:

- Hospital beds
- Lifts
- Wheelchair/wheelchair accessories
- Custom DME

Reminder: All DME rentals require precertification.

How do I find precertification and code-specific requirements not listed in this bulletin?

For code-specific precertification requirements, use the Precertification Lookup tool under the Quick Tools menu on our provider website at providers.amerigroup.com.

PEC-ALL-1337-14

Ophthalmology Quality of Care

Background: Beginning November 7, 2014, we will use clinical editing to ensure specialized ophthalmology services are only reimbursed when billed by providers with specialty types appropriate to the services performed.

✦ **What this means to you:** No action necessary – for your information only. Please share with other providers in your practice

What is the impact of this change?

Beginning November 7, 2014, we will only reimburse ophthalmology procedure codes 92002-92499 when billed by providers with an ophthalmology or optometry specialty. Additionally, surgical ophthalmology procedure codes 65091-65175 and 65270-68899 will only be reimbursed when billed by providers with an ophthalmology or appropriate surgical specialty.

PEC-ALL-1299-14

My PCP Connection

Remember to only provide services to members on your assigned PCP member listing or the listing of another participating PCP in your group. Our My PCP Connection program helps to centralize a member's treatment information, minimizing the chances of missing or incomplete records.

Excerpt from TNPEC-0620-13

Appropriate Medication Management of Asthma Patients

Our Quality Management team may reach out to you regarding asthma patients who had an emergency room visit and multiple urgent care visits. They may have needed this emergency care because they did not fill their asthma medication or only filled a rescue medication several times, thus needing a controller medication.

Here's what you can do:

1. Schedule an appointment to review the member's treatment plans and fill his or her prescriptions.
2. Emphasize the importance of filling prescriptions on time and taking medication correctly.
3. Share the educational materials available from Amerigroup Community Care, the Asthma and Allergy Foundation of America, and the Centers for Disease Control and Prevention to help your patients understand and manage their asthma.
4. Arrange a follow-up appointment before the member leaves the office.
5. Review the member's current medications and consider other medications on our formulary that might help.

Proper coding

The National Committee for Quality Assurance recognizes the following diagnosis codes to document an asthma diagnosis and the use of appropriate medications for patients with asthma.

ICD-9-CM diagnosis codes	
Asthma	493.0, 493.1, 493.8, 493.9
Asthma controller medications	
Antiasthmatic combinations	Dyphylline-guifenesin
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol Mometersone-formoterol
Inhaled corticosteroids	Beclomethasone Budesconide Flunisolide Fluticasone CFC free Momethsone Triamcinolone
Leukotiene modifiers	Montelukast Zafirlukast Zieuton
Mast cell stabilizers	Cromolyn
Methylxanthines	Aminophylline Dyphylline Theophylline

How we can help

We help you coordinate the use of appropriate medications for your asthma patients by:

- Providing Clinical Practice Guidelines (CPGs) to help improve health care quality and reduce unnecessary variation in care for our members; you can find CPGs on our provider self-service website at providers.amerigroup.com/TN
- Reaching out to our members with asthma through the Population Health program
- Letting you know if our members with asthma are frequently using the emergency room and may require intervention
- Working with you to coordinate and plan prevention clinic days to improve health awareness with screenings, activities, materials and resources
- Educating our members on asthma through quarterly newsletters and health education materials like our Ameritips fliers *Asthma*, *Asthma Triggers* and *Tobacco Cessation*; contact your Provider Relations representative for more information and to request copies of Ameritips for your office

We are committed to providing the tools and support you need to provide quality care for our members. Our team is reaching out to our members with asthma to educate them on effective care for their condition and to help them schedule and keep appointments with providers like you.

If you have any questions, please call our Quality Management department at 615-316-2400. Thank you for helping our members and their families lead healthier lives.

TNPEC-0770-14

Clinical Utilization Management Guidelines Update

The clinical utilization management (UM) guidelines on this list represent the guidelines approved and adopted by the WellPoint Medical Operations Committee on the dates listed below.

Clinical UM guidelines are publicly available on our Medical Policies and Clinical UM Guidelines subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with staff and other providers in your practice.

Guideline adopted	Clinical UM Guideline Number	Clinical UM Guideline Title	Revised or Newly Adopted (New/Revised)
May 28, 2014	CG-SURG-42	Cervical Fusion	Newly Adopted
July 30, 2014	CG-DME-09	Continuous Local Delivery of Analgesia to Operative Sites using an Elastomeric Infusion Pump During the Post-Operative Period	Newly Adopted
July 30, 2014	CG-DME-22	Ankle-Foot & Knee-Ankle-Foot-Orthotics (Braces)	Newly Adopted
July 30, 2014	CG-DME-33	Ultralight Wheelchair	Newly Adopted
July 30, 2014	CG-DRUG-30	Oprelvekin (Neumega)	Newly Adopted
July 30, 2014	CG-MED-38	Inpatient admission for Radiation Therapy for Cervical or Thyroid Cancer	Newly Adopted
July 30, 2014	CG-MED-43	Multiple Sleep Latency Testing (MLST) and Maintenance of Wakefulness Testing (MWT)	Newly Adopted
July 30, 2014	CG-MED-38	Inpatient admission for Radiation Therapy for Cervical or Thyroid Cancer	Newly Adopted
July 30, 2014	CG-TRANS-02	Kidney Transplantation	Newly Adopted
August 12, 2014	CG-DME-15	Hospital Beds and Accessories	Newly Adopted
August 12, 2014	CG-DME-16	Pressure Reducing Support Systems Groups 1,2 & 3	Newly Adopted
August 12, 2014	CG-DME-23	Lifting Devices for use in the Home	Newly Adopted
August 12, 2014	CG-DRUG-11	Infertility Drugs	Newly Adopted
August 12, 2014	CG-MED-22	Neuropsychological Testing	Newly Adopted
August 12, 2014	CG-SURG-31	Treatment of Keloids and Scar Revision	Newly Adopted

PEC-ALL-1347-14