Provider Update

April 2015 News Bulletin

Claims Tip of the Month

Enhance your payments with Amerigroup Washington, Inc.! Where medically indicated, Amerigroup will pay for sick care the same day as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits. Be sure to include modifier 25 in your billing.

Medicare Claim Rejections

We apologize for a now-corrected system error that caused Medicare claims to deny as "Subscriber and subscriber ID not found" when the member was in fact, eligible. This affected some claims submitted between January 1 and March 23. Providers may contact our Amerivantage Call Center at 1-866-805-4589 if their claims have not already been corrected.

Members Changing Primary Care Providers

The fastest way to make primary care provider (PCP) assignment changes for members is by calling the Amerigroup National Call Center (NCC) at 1-800-600-4441:

- Call made by member – all the member needs to know is the full name or NPI of the provider they want to change to.
- Call made by provider – the change can be done in the provider's office, but the member needs to be present during the call. The NCC will ask to speak to the member to verify the change.

Calling the NCC will ensure the member is moved to the correct provider/location. We will make the change effective within 24-72 hours of the call. All family members will be moved as may be requested and the member/provider will receive confirmation the change has been completed. Please remember that PCPs do not need to be the member's assigned PCP in order to be paid for services rendered.

Preferred Laboratories – Updated

All laboratory tests must be submitted to LabCorp, PACLAB, PAML, Quest Diagnostics or TriCities Laboratory, the preferred lab vendors for our members, or to other network laboratories.

Precertification is required for all laboratory services furnished by non-network providers, except hospital laboratory services occurring in events of emergency medical conditions.

For more information or to receive a specimen drop box, testing solutions and services, or to set up an account, contact any of the following labs:

- LabCorp: 1-800-345-4363
- PACLAB/PAML/TriCities Lab: 1-800-541-7891 or
- Quest Diagnostics: 1-866-MY-QUEST (1-866-697-8378)

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Occupational, Physical and Speech Therapy Update — Administrative Denials

Effective March 9, 2015, Amerigroup began issuing administrative denials for initial occupational, physical and speech therapy visits that exceed the member's benefit limit. Visits up to the limit are approved if the member has not already exhausted their benefit. When visits beyond the benefit are medically necessary, submit the request on our Exception to Rule form (found on our site) **after** the full benefit has been exhausted.

The Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Visit our website to view the Amerigroup HEDIS® Guide, a full reference document featuring many of the HEDIS measures and the charting elements required for each one. Choose the Quality Management link under Provider Resources & Documents.

Amerigroup in the Community

More than 100 families, staff and volunteers from Roxhill Elementary School came together to celebrate each other at the Third Annual Roxhill Elementary Community Dinner on March 13 in Seattle. Families enjoyed dancing, taking part in a drawing and eating dinner.

Primary care and behavioral health providers: Working together to treat the whole person

Why PCPs and BH providers should work together

- **Physical and behavioral health go hand in hand.** Comorbid conditions can complicate treatment of and recovery from both physical and behavioral health issues. A member is more likely to stick to a medical treatment plan if his or her behavioral health needs are properly met, and vice versa.
- **Collaboration leads to well-informed treatment decisions.** Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes and avoiding adverse interaction.
- **Sharing relevant case information in a timely, useful and confidential manner is an Amerigroup requirement.** We abide by standards set by the National Committee for Quality Assurance (NCQA) requiring health plans to ensure coordination of care between PCPs and BH providers.

When PCPs and BH providers should exchange health information

- When a member first accesses a physical or behavioral health service
- When a change in the member's health or treatment plan requires a change to the other provider's treatment plan (e.g., when a member who has been taking lithium becomes pregnant)

- When a member discontinues care
- When a member is admitted to or discharged from the hospital
- When a member is admitted and a consultation is warranted
- Once a quarter if not otherwise required
- When a member has a physical exam and/or laboratory or radiological tests

In the 2014 survey of Amerigroup participating providers, 49 percent of primary care providers said they get timely and useful information from behavioral health specialists. Only 29 percent of behavioral health specialists said they get timely and useful information from PCPs and 19 percent from other specialists.

Tips and tools for screening and follow-up care

When screening for substance abuse and depression, please use standard screening tools or these brief screening questions. If your patient's answer to any of these questions is yes, refer the patient for a complete behavioral health evaluation. Contact us if you need help making this referral. Screenings should be completed annually.

In the last year, did you ever drink or use drugs more than you meant to?

Yes ☐ **No** ☐

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

Yes ☐ **No** ☐

Over the past two weeks, have you felt down, depressed or hopeless?

Yes ☐ **No** ☐

Over the past two weeks, have you felt little interest or pleasure in doing things?

Yes ☐ **No** ☐

Access consultation through Partnership Access Line

The Washington Health Care Authority provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL).

Minimize the need for required medication reviews and get assistance in meeting the needs of children with mental health diagnoses by consulting with child psychiatrists and social workers. For assistance, call the PAL toll-free number at 1-866-599-7257. Please note, Amerigroup is not required to provide payment to prescribers for voluntarily accessing the PAL.
To learn more about PAL, visit http://palforkids.org.

Provider Update

Credentialing and Recredentialing:

If you are a first-time applicant or adding a new provider to your practice, please send all credentialing materials to us via email at wa1provrelations@amerigroup.com or fax them to us at 1-855-270-9583. We are currently taking 90-120 days to process new clean applications. We have implemented new processes and resources to speed up the process and look forward to reporting reduced turnaround times soon.

If you have received a recredentialing request from our vendor, Medversant, please be sure to respond promptly to ensure your credentialing does not expire. Respond to them directly using the contact information provided in their communications. If you have any difficulties with the recredentialing, please let your Provider Relations representative know.

If you want Amerigroup and Medversant to contact one person at your practice for all credentialing business and we are not currently doing this, please email the request to us at wa1provrelations@amerigroup.com. Feel free to copy your Provider Relations representative on the email message. In the email, be sure to include the following: provider group name, tax identification number, contact information (name, phone number, fax number, email address, mailing address) and a list of providers with their NPI numbers.

New Corrected Claim Requirement for CMS1500

As of June 15, 2015, when submitting a correction for a previously billed claim on a CMS 1500 form, providers must include all services on the new submission. If any previously submitted charges or services are not billed on the corrected claim form, they will be removed in the adjustment. Any reduction in payment amount would result in a negative account balance and/or a refund request.

In order to ensure that all claims accurately reflect the services performed, providers will no longer be permitted to submit individual lines for correction on a CMS 1500 form. Adjustments to the previously processed claim will reflect exactly what is shown on the new corrected claim submission. The updated process for CMS 1500 corrected claims will mirror the current process for institutional replacement claims submitted on CMS 1450 claim forms.

By making this change, we will be able to remove possible discrepancies between the intention of the correction and the way the claim is actually adjusted in our systems. The process for submitting facility replacement claims billed on a CMS 1450 form is not affected by this change.

Standard timely filing guidelines apply to all corrected and replacement claims.

Provider Update

Behavioral Health Providers – New State Requirement for Authorizations

Per House Bill 2536, passed during the 2012 Legislative session, HCA is asked to collect information on which Evidence/Research Based Practices (E/RBPs) are being provided to clients under the age of 21 years old covered under Apple Health (formerly Medicaid). With the focus on prevention and intervention services in mental health for children, there is significant support for the use of E/RBPs.

JULY 1, 2014 – Implementation Date

Our mission is to capture the use of E/RBPs in children's mental health, including prevention and intervention services when provided to a child covered by Apple Health's Fee-For-Service program or contracted Managed Care Plan. Information to be collected and reported on includes:

- Number of children receiving E/RBP services
- Number and percentage of encounters using these services
- Relative availability of these services

Unfortunately, there are currently no CPT or HCPCS codes describing the service being rendered to this level of specificity to support capturing the required data. Therefore, in order to accomplish the legislative mandate, each of the targeted E/RBPs is assigned a specific EPA number to identify the specific modality used during the visit. These EPA numbers are to be used when submitting the claim:

Programs/Coding for Mental Health Professionals	EPA number
Triple P (Level 2)	870001318
Triple P (Level 3)	870001319
PCIT	870001330
CBT+ for Behaviors, Anxiety and Depression	870001331
TF-CBT	870001332
Bonding and Attachment via the Theraplay model (Promising Practice)	870001333
CBT	870001334
Strengthening Families Program	870001335

The use of these particular EPA numbers will have no bearing on authorization, but will be used solely for the capture of information. This information is necessary to comply with the mandates of HB 2536 and is very important as we push forward to assure children are receiving quality evidence based mental health services.

It is important to add the EPA code in the Procedure/CPT Code field on the Amerigroup Precertification Request Form. For billing questions, refer to Health Care Authority's Provider Guide at http://www.hca.wa.gov/medicaid/billing/Pages/bi.aspx.

ICD-10 Coded Prior Authorizations

The transition from ICD-9 to ICD 10 goes into effect on October 1, 2015. Amerigroup Washington, Inc. 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.

Core Provider Agreement Required

The Washington State Health Care Authority (HCA) now requires that all providers who serve Medicaid enrollees through a managed care organization also hold a Washington State Medicaid Core Provider Agreement (CPA) with the HCA. If you do not currently have an agreement, you must apply with HCA online at http://www.hca.wa.gov/medicaid/providerenroll/Pages/index.aspx.

Providers are not required to accept Medicaid fee-for-service members but must have an active CPA. This allows the HCA to ensure specific communications reach all Medicaid providers and that all providers specifically adhere to state and federal requirements which are also a part of providers' agreements with managed care plans. Instructions on how to become a nonbilling provider are given at the link below at HCA's website. As explained on the website, if a provider who already has a Core Provider Agreement (CPA) submits a nonbilling application, the CPA is replaced by the agreement given in the nonbilling application http://www.hca.wa.gov/medicaid/providerenroll/Pages/nonbilling.aspx.

If you have questions, please call HCA at 1-800-562-3022, ext. 16137. You may also contact Provider Services at 1-800-454-3730.

Join the Medical Advisory or Credentialing Committees

Amerigroup Washington, Inc. invites you to participate on its Medical Advisory and/or Credentialing committees. Participants provide valuable feedback and input to our Medicaid Managed Care partnership. Participants make a difference regarding how Amerigroup provides services to its Medicaid enrollees.

Participants should be licensed in the field of pediatrics or OB-GYN (M.D., D.O., P.A. and ARNP) and have a willingness to share ideas with us. The commitment includes a one-hour monthly meeting, which is held by telephone. Amerigroup offers a $200 stipend for participants.

We hope you will join one or both of these valuable committees and collaborate with us about continuing to provide quality care to Medicaid recipients in Washington. For additional information, contact Lani Spencer, Vice President of Health Care Management Services at 206-674-4470 or toll free at 1-855-323-4688.

April New Provider Orientation Webinar

Join us for our April new provider orientation online via WebEx Thursday, April 23, 2015, from 12 p.m. to 1:30 p.m. Pacific time. Join us for an online network provider orientation. Talk with Amerigroup representatives and get answers to questions you may have. We'll review information like:

- Online tools
- Claims, coding and billing procedures
- Medical management
- Reference materials and support services

Your support staff is invited, too. Attendance is required for all providers joining our network. RSVP to the Provider Relations department by calling 206-674-4479.

Affirmative Statement about Incentives

As a corporation and as individuals involved in Utilization Management (UM) decisions, we are governed by the following statements:

UM decision-making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Distinct Procedural Service coding update

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers to define subsets of the -59 modifier used to define a Distinct Procedural Service.

Currently, the -59 modifier is used when a code for a service, which would usually be bundled, is being considered separate and distinct from another service.

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier). These modifiers, collectively referred to as -X{EPSU} modifiers, are as follows:

- XE Separate Encounter – A service that is distinct because it occurred during a separate encounter
- XP Separate Practitioner – A service that is distinct because it was performed by a different practitioner
- XS Separate Structure – A service that is distinct because it was performed on a separate organ/structure
- XU Unusual Non-Overlapping Service – The use of a service that is distinct because it does not overlap usual components of the main service

Amerigroup now accepts CMS Modifiers for Distinct Procedural Services. We continue to recognize the -59 modifier; however, CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the -59 modifier; it would be incorrect to include both modifiers on the same line. Amerigroup will be accepting the –X{EPSU} modifiers prior to the National Corrective Coding Initiative (NCCI) edits update. We will require the use of selective modifiers in lieu of the general -59 when the –X{EPSU} modifiers provide more clarity for the service/procedure performed.

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. The following list displays the ranges for adult BMI in relation to the corresponding clinical diagnosis per Centers for Disease Control (CDC):

BMI	**Less than 18.5**	**Underweight**
BMI	**18.5-24.9**	**Healthy weight**
BMI	**25.0 -29.9**	**Overweight**
BMI	**30.0-39.9**	**Obese**
BMI	**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 below shows pediatric BMI in relation to the corresponding clinical diagnosis:

BMI	**Less than 5th**	**Underweight**
BMI	**5th-less than 85th**	**Healthy weight**
BMI	**85th -less than 95th**	**Overweight**
BMI	**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

Medical Policies update

On February 5, 2015, the Medical Policy and Technology Assessment Committee (MPTAC) approved and adopted the following medical policies applicable to Amerigroup Washington, Inc. health plans. These medical policies were developed or revised to support clinical coding edits.

These medical policies were made publicly available on the Amerigroup Medical Policy and Clinical UM Guideline website.

Visit https://medicalpolicies.amerigroup.com/search to find specific policies. **Existing precertification requirements have not changed.**

Medical policy effective date	Medical policy number	Medical policy	Medical policy
April 7, 2015	DRUG.00072	Alpha-1 proteinase inhibitor therapy	NEW
April 7, 2015	DRUG.00073	Rilonacept (Arcalyst®)	NEW
April 7, 2015	DRUG.00074	Alemtuzumab (Lemtrada™)	NEW
April 7, 2015	GENE.00043	Genetic testing of an individual's genome for inherited diseases	NEW
April 7, 2015	MED.00115	Outpatient cardiac hemodynamic monitoring using a wireless sensor for heart failure management	NEW
April 7, 2015	MED.00116	Near-infrared spectroscopy brain screening for hematoma detection	NEW
February 9, 2015	DRUG.00064	Enteral carbidopa and levodopa intestinal gel suspension	Revised
February 9, 2015	GENE.00036	Genetic testing for hereditary pancreatitis	Revised

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Medical policy effective date	Medical policy number	Medical policy	Medical policy new/revised
February 9, 2015	SURG.00136	Intraocular telescope	Revised
April 7, 2015	ADMIN.00001	Medical policy formation	Revised
April 7, 2015	GENE.00010	Genotype testing for genetic polymorphisms to determine drug-metabolizer status	Revised
April 7, 2015	GENE.00026	Cell-free fetal DNA-based prenatal screening for fetal aneuploidy	Revised
April 7, 2015	DRUG.00024	Omalizumab (Xolair®)	Revised
April 7, 2015	DRUG.00044	Belimumab (Benlysta®)	Revised
April 7, 2015	MED.00100	Diaphragmatic/phrenic nerve stimulation and diaphragm pacing systems	Revised
April 7, 2015	MED.00117	Autologous cell therapy for the treatment of damaged myocardium	Revised
April 7, 2015	SURG.00010	Treatments for urinary incontinence	Revised
April 7, 2015	SURG.00067	Percutaneous vertebroplasty, kyphoplasty and sacroplasty	Revised
April 7, 2015	SURG.00117	Sacral nerve stimulation (SNS) and percutaneous tibial nerve stimulation (PTNS) for urinary and fecal incontinence; urinary retention	Revised
April 7, 2015	SURG.00134	Interspinous process fixation devices	Revised
Pending	GENE.00008	Analysis of fecal DNA for colorectal cancer screening and surveillance	Pending
Pending	SURG.00011	Allogeneic, xenographic, synthetic and composite products for wound healing and soft tissue grafting	Pending

Clinical Utilization Management Guidelines update

On February 5, 2015, MPTAC approved the following Clinical Utilization Management (UM) Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. This list represents the guidelines approved and adopted by the Medical Operations Committee on February 23, 2015.

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

Existing precertification requirements have not changed.

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Effective date	Clinical UM guideline number	Clinical UM guideline title	Guideline new/revised
April 7, 2015	CG-DRUG-43	Natalizumab (Tysabri®)	NEW
April 7, 2015	CG-DRUG-44	Pegloticase (Krystexxa®)	NEW
April 7, 2015	CG-SURG-46	Myringotomy and Tympanostomy tube insertion	NEW
February 9, 2015	CG-ANC-04	Ambulance services: air and water	Revised
February 9, 2015	CG-DME-21	External infusion pumps for the administration of drugs in the home or residential care settings	Revised
February 9, 2015	CG-OR-PR-04	Cranial remodeling bands and helmets (cranial orthotics)	Revised
April 7, 2015	CG-BEH-07	Psychological testing	Revised
April 7, 2015	CG-DME-19	Therapeutic shoes, inserts or modifications for individuals with diabetes	Revised
April 7, 2015	CG-DME-24	Wheeled mobility devices: manual wheelchairs–standard, heavy duty, lightweight	Revised
April 7, 2015	CG-DME-31	Wheeled mobility devices: wheelchairs–powered, motorized, with or without power seating systems and	Revised
April 7, 2015	CG-DME-33	Wheeled mobility devices: manual wheelchairs–ultra lightweight	Revised
April 7, 2015	CG-DRUG-07	Hepatitis C pegylated interferon antiviral therapy	Revised
April 7, 2015	CG-DRUG-14	Dihydroergotamine mesylate (DHE) injection for the treatment of migraine or cluster headaches in adults	Revised
April 7, 2015	CG-DRUG-21	Naltrexone (Vivitrol®) injections for the treatment of alcohol and opioid dependence	Revised
April 7, 2015	CG-LAB-09	Drug testing or screening in the context of substance abuse and chronic pain	Revised
April 7, 2015	CG-MED-22	Neuropsychological testing	Revised
April 7, 2015	CG-MED-32	Ancillary services for pregnancy complications	Revised
April 7, 2015	CG-MED-46	Ambulatory and inpatient video Electroencephalography	Revised
April 7, 2015	CG-SURG-33	Lumbar fusion and lumbar artificial intervertebral disc (LAID)	Revised
April 7, 2015	CG-SURG-39	Pain management: epidural steroid injections	Revised
April 7, 2015	CG-SURG-41	Surgical strabismus correction	Revised
April 7, 2015	CG-SURG-44	Coronary angiography and cardiac catheterization in the outpatient setting	Revised

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The following Medical Policies and Clinical UM guidelines have been archived on the date listed below.

Effective date	Clinical UM guideline number	Clinical UM guideline title	Guideline
April 7, 2015	GENE.00013	Diagnostic genetic testing of a potentially affected individual (adult or child)	Archived
April 7, 2015	GENE.00015	Predictive genetic testing for non-malignant diseases	Archived
April 7, 2015	CG-DRUG-32	HCV and HIV-AIDS anti-viral drug treatment regimens	Archived

What if I have questions?

If you have questions about this communication, received this fax in error or need assistance with any other items, call our Provider Services team at 1-800-454-3730.

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