Provider Update

February 2016 News Bulletin

Claims tip of the month

Optimize your claims payment for Apple Health members! Precertification is not required for sports physicals, and they are eligible for reimbursement by Amerigroup Washington, Inc. once every 12 months as a value-added benefit.

To bill for the physical, use CPT code 99212 with DX Z02.5. Providers may also bill Amerigroup for both a well visit and a sports physical on the same day by including modifier 25.

Amerigroup in the community

Our parent foundation awarded the Boys & Girls Clubs of America a $10 million grant to support the after-school Triple Play program in the state of Washington and 25 other states over a five-year period. In Washington, about $250,000 will go to local clubs Triple Play program. Improving youth health aligns with our company's mission of goals and supporting the Triple Play program is a key partnership. Since Triple Play launched in 2005, over 10.9 million kids have connected through this program. The program's goals are to increase daily physical activity and consumption of fruits and vegetables. Club kids on average surpass these goals annually.

New member support program – Vital Decisions, LLC for end-of-life support

Effective February 1, 2016, Amerigroup will start offering a new support program to members facing advanced stages of illness (approx. 6-9 months from death). Vital Decisions, LLC provides telephonic health care counseling service for members. The program consists of a series of telephone counseling sessions with an individual counselor to educate and coach members to become more active participants in health care and end-of-life decision making. This helps members identify, communicate and incorporate their personal preferences and priorities into current and future decisions about their care. Counselors will provide information regarding advance directives and identify resources for other documents members may wish to complete in preparation for their death.

Patient quality of life and associated care preferences are not routinely met during the advanced illness experience. Only 37 percent of patients/families report having end-of-life conversations with their physicians in the months prior to death. While 86 percent of patients indicate a preference to die at home, only 24 percent of individuals pass away at home. We are pleased to be able to provide this service to our members and support providers as they care for members at difficult times in their lives. Amerigroup will identify potential participants through medical and pharmacy claims. If providers wish to refer members to this optional program, they may contact our case managers at 1-800-454-3730.

New vendor available for home sleep studies, Novasom™

Beginning April 1, 2016, members suspected of having noncomplicated obstructive sleep apnea will have the ability to test at home using the AccuSom™ wireless Home Sleep Testing (HST) device. Amerigroup requires preauthorization for home sleep studies as well as verification of clinical appropriateness for a lab setting. For those members completing HST and found to have obstructive sleep apnea, many members may be treated directly with auto-titrating positive airway pressure (APAP) therapy and not require CPAP titration.

Sleep studies are performed in the patient's home and self-administered, which may be more comfortable and reflective of typical sleep behaviors. NovaSom™ provides telephonic clinical support. All data is wirelessly transmitted from the AccuSom™ sleep testing device to the NovaSom™ secure portal during the test process. Data is reviewed by sleep technicians to assure quality, and daily clinical telephonic support is provided to coach the patient throughout the testing process. Once the study is complete, a board-certified sleep physician interprets the study and provides a report with treatment recommendations. The goal is to provide reports within 48 hours of study completion to the ordering practitioner. Please note that you will continue to submit your requests for preauthorization via phone at 1-800-454-3730 or fax to 1-800-964-3627.

MAT (Medication Assisted Treatment) Training
What it is, what it isn't and why it is important?

While the numbers of overdose deaths from prescription opioids may be decreasing in Washington, the numbers attributed to heroin use are increasing. Substance use disorders (SUD) are treatable and in the case of opioids, overdose deaths can be prevented. This training will review the role medications play in the management of substance use disorders with a particular focus on the treatment of opioid use disorder and the integration of Medication Assisted Treatment in traditional SUD treatment programs.

The Health Care Authority (HCA) is providing this no-cost training by Charissa Fotinos, M.D., Deputy Chief Medical Officer, Washington State Health Care Authority. Participants can get 2.75 CEUs for this training. Registration is on a first-come, first-served basis. To register, click on this link: https://www.surveymonkey.com/r/BYZZTRD

Dates:

Spokane	Spokane Public Library, Room 1A	March 4, 1 p.m. – 4 p.m.
Port Angeles	Olympic Medical Ctr, Linkletter Auditorium	February 18, 1 p.m. – 4 p.m.
Seattle	Chinook Building, Rooms 121-123	March 7, 9 a.m. – noon
Selah	Selah Civic Center, Main Hall	February 24, 1 p.m. – 4 p.m.
Longview	Cowlitz PUD Auditorium	April 14, 1 p.m. – 4 p.m.

For more information, contact Harvey Funai at 206-272-2140 at the Department of Social and Health Services.

Provider Update

The Healthcare Effectiveness Data and Information Set quick quiz of the month

We are starting a new monthly education program with a few questions you can use to check your knowledge about Healthcare Effectiveness Data and Information Set (HEDIS®) charting and data collection. We hope this is a fun way to help office staff refresh their knowledge.

1. In January through May of each year, HEDIS representatives from health plans collect data from patient charts for care that occurred:
    a. The current (same) year
    b. The prior year
2. For the 3- to 6 year-old well-child measure, there needs to be documentation of at least how many well-child visits during each calendar year?
    a. 1
    b. 2
    c. 6
3. For a visit to qualify as a well-child visit, the reason for visit cannot be for an acute illness.
    a. True
    b. False

Answers: 1 (b), 2 (a), 3 (False, providers must code for both the acute illness and well-child)

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*

Prenatal ultrasound policy change

Amerigroup covers CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816 and 76817 for outpatient prenatal ultrasounds for our pregnant Medicaid members. This policy communication is limited to these specific CPT codes and does not apply to ultrasounds performed by maternal fetal medicine specialists, in hospital settings or by radiology providers. Please refer to clinical guideline entitled “Maternal Ultrasound in the Outpatient Setting,” (CG-Med-42), on the Amerigroup provider website, for detailed medical necessity criteria for maternal ultrasound.

In alignment with the Washington State Health Care Authority, Provider Guide dated January 1, 2016, effective April 1, 2016, Amerigroup will cover two routine prenatal ultrasounds for dating and fetal anatomic survey per pregnancy (76801, 76805). Additional ultrasounds for CPT codes 76811, 76812, 76815, 76816 and 76817 for suspected maternal/fetal abnormality or follow-up require an appropriate diagnosis indicating medical necessity. Without appropriate diagnosis codes supportive of medical necessity, ultrasounds for procedural codes 76811, 76812, 76815, 76816 and 76817 will not be reimbursed. Prior authorization is not required for prenatal ultrasounds.

Our policies are based on medical necessity, consideration of nationally accepted medical practice standards, review of medical literature and government approvals. We referred to the American College of Obstetricians and Gynecologists (ACOG) practice bulletin, Ultrasonography in Pregnancy (number 101, February 2009) to create this policy. According to this bulletin, ultrasonography in pregnancy should be performed only when there is a valid medical indication. Specifically, the ACOG practice bulletin states, “The use of either two-dimensional or three-dimensional ultrasonography only to view

the fetus, obtain a picture of the fetus, or determine the fetal sex without a medical indication is inappropriate and contrary to responsible medical practice."

For a list of the prenatal ultrasound procedure codes with their corresponding medically necessary diagnosis codes, please call our national Provider Relations team at 1-800-454-3730 or contact your local Provider Services representative.

Hip and knee procedures new authorization requirements

Effective May 1, 2016, knee arthroscopy will require prior authorization through Amerigroup. Additionally, effective June 1, 2016, knee and hip arthroplasty will require prior authorization. Please refer to the provider self-service tool at providers.amerigroup.com/WA for specific detailed authorization requirements.

Highline Medical Services Organization

We are pleased to announce that Highline Medical Services Organization (HMSO) and Amerigroup Washington, Inc. have entered into a contract to extend access for Amerigroup members to the physicians and hospitals in the HMSO delivery system. This is a fully delegated risk arrangement that we are confident will be successful for both organizations.

Over the past year we have learned that our organizations are like-minded, driven by the mission to provide Medicaid-eligible individuals and families with high-quality, proactive patient care with a distinct focus on prevention. By working together, we will greatly strengthen the ability to improve the delivery of care for the Medicaid-eligible community in King County.

On February 1, 2016, the administrative procedures for Amerigroup members assigned to primary care providers with HMSO will change to the HMSO utilization management services as well as claims payment process. Providers should follow the established HMSO administrative protocols for these members.

We are incredibly excited about the opportunity to collaborate with HMSO to meet the needs of these patients in our community. If you have questions, please contact the individuals below:

Bonnie Jennings
Marketing and Provider Relations Manager
Bonnie.J@hmsoinc.org
206-724-0869

Stacy Smith
Provider Network Relations Manager
Stacy.Smith@amerigroup.com
206-695-7081, ext. 54252

HEDIS® medical record reviews

The HEDIS® medical record data abstraction process is fast approaching. We request your assistance this year in completing the process in the most efficient manner.

In order to minimize the time required by your staff, Amerigroup has contracted with Health Data Vision, Inc. (HDVI), a national HEDIS medical record collection and abstraction organization, to retrieve the necessary records. If you have records required for Amerigroup's HEDIS analysis, an HDVI Provider

Relations staff will contact your office to determine with you a method of retrieval, i.e., mail, fax, electronic transmission or onsite collection. You will be contacted by HDVI between February and May. To assist you in your preparation for the HDVI chart abstractions, HDVI will send a list of patients whose medical records are being requested. You can return all requested documentation to HDVI or HDVI may offer to collect the medical records at your site, depending on the number of records being requested.

Contractual agreements between Amerigroup and its participating providers contain an explicit provision that requires providers to provide member information when requested for quality review purposes at no cost to the health plan or its contracted agencies.

New collection agency: Lamont, Hanley & Associates, Inc.

Amerigroup has partnered with third-party collection agency, Lamont, Hanley & Associates, Inc. (LHA), to assist in the recovery of overpayment refunds. LHA is a New Hampshire-based, nationwide debt collection agency with a long history of providing excellent collection services for Anthem, parent company of Amerigroup. LHA was chosen due to its philosophy of having a "customer service approach to collections," a value we identify with and one that is critical in ensuring a successful partnership, understanding the sensitivity of releasing a collection agency in our provider networks.

Formulary update

Effective December 1, 2015, we made our quarterly formulary update. All providers were sent the update at the end of December. You can also find these changes at providers.amerigroup.com in the News and Announcements section. Our full formulary is available under the Pharmacy tab located on this site. Please review these changes and work with your Amerigroup patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

We recognize the unique aspects of patients' cases. If for medical reasons your Amerigroup patient cannot be converted to a formulary alternative, call our Pharmacy department at 1-800-454-3730 and follow the voice prompts for pharmacy prior authorization.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Updated value-added benefit reminder – acupuncture

We recognize that members and providers find value in alternative therapies to traditional western medicine. In recognition of this, effective January 1, 2016, Amerigroup will pay for three visits per calendar year per member for acupuncture. Use the following CPT codes: 97810, 97811, 97813, 97814; no authorization is required. We are not amending provider contracts to include these services, but if you provide acupuncture in your practice, do be sure to notify us so we may credential you. Send your information to wa1provrelations@amerigroup.com.

Provider Update

Emergency contraception clarification

We recently recognized providers and members may not have understood the requirements for obtaining over-the-counter emergency contraception medications. Amerigroup requires neither a prescription nor plan authorization for members to receive these medications. We will pay for these medications. If we see an individual member who appears to be utilizing this form of contraception with high frequency, we may reach out to provide them case management assistance but will not make any requirements of them to change their behavior.

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 palforkids.org.

Access to utilization management staff

We are staffed with clinical professionals who coordinate member care and are available 24 hours a day, 7 days a week to accept precertification requests. You can submit precertification requests by:

- Calling us at 1-800-454-3730
- Faxing requests to 1-800-964-3627
- Logging in to providers.amerigroup.com/WA and using the Precertification Lookup Tool

Do you have questions about utilization decisions or the utilization management process in general? Call our clinical team Monday through Friday from 8 a.m. to 5 p.m. Pacific time at 1-800-454-3730.

To request a copy of the specific criteria/guidelines used for the decision, please call Provider Services or write to:

Medical Management
Amerigroup Washington, Inc.
705 Union Station, Suite 110
705 Fifth Ave. South
Seattle, WA 98104

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.

Provider Update

Member rights and responsibilities

We want to keep you informed of our members' defined rights and responsibilities. These can be found in your provider manual and on our website at providers.amerigroup.com/WA. If you'd like us to mail you a copy, call Provider Services at 1-800-454-3730.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4441.

Prior authorization required for H.P. Acthar Gel, Prialt and Retisert

Amerigroup Washington, Inc. is adding the following drugs to the 2016 Medicaid list of injectable or infusible drugs requiring prior authorization (PA). As of June 1, 2016, providers must call for PA of the drugs listed below:

- H.P. Acthar Gel (Repository Corticotropin Injection) for the treatment of infantile spasms and corticosteroid-responsive conditions where there is clear documentation of why all other well-established routes for corticosteroid therapy cannot be used.
  - Amerigroup Clinical Utilization Management Guideline CG-DRUG-24: (J0800=Injection, corticotropin, up to 40 units)
- Prialt (Ziconotide Intrathecal Infusion) for the management of severe chronic pain when intrathecal therapy is warranted and when intolerant or refractory to other treatment
  - Amerigroup Medical Policy Drug 00027: J2278=Injection, ziconotide, 1 microgram)
- Retisert (Fluocinolone acetonide intravitreal implant) for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.
  - Amerigroup Medical Policy DRUG.00032: (J7311=Fluocinolone acetonide, intravitreal implant)

Intensity modulated radiation therapy (IMRT) codes require PA

Effective June 1, 2016, two intensity modulated radiation therapy (IMRT) codes that did not require PA will now require PA. IMRT requests must be reviewed by Amerigroup for PA for dates for service on or after June 1, 2016.

Amerigroup will require PA for the following IMRT codes beginning June 1, 2016:

- 77385: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 : Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

ICD-10 and coding for diabetes

Below is some helpful information regarding ICD-10 and how to properly bill for diabetes.

Diabetic complications in ICD-10

A benefit of ICD-10 codes is that providers can now report more clinical details concerning diabetic complications than they could in ICD-9. The increased specificity is possible because ICD-10 contains expanded combination codes for diabetic complications. A combination code describes two or more

conditions within a single code. The ICD-10 code categories E08-E13 contain the combination codes for diabetic complications. The codes include type of diabetes mellitus, body system affected and complications affecting that body system. Combination codes may require additional diagnosis codes to fully describe all associated conditions. Reporting all documented conditions to the highest level of specificity on the claim form helps to promote quality and continuity of patient care. To ensure coding specificity for diabetic complications in ICD-10, medical record documentation should include:

- Type of diabetes (i.e., Type 1, Type 2, secondary)
- Complications and body systems affected (i.e., diabetic neuropathy)
- Control status (document how well diabetes is controlled over time)
- Long term use of insulin (report additional code Z79.4 on the claim)

Some examples of ICD-10-CM type 2 diabetes combination codes include:

Complication type	**Correct code category**
Kidney and renal	E11.2- Type 2 diabetes with kidney complications
Ophthalmic (eye/retinal)	E11.3- Type 2 diabetes with ophthalmic complications
Neurologic (nervous system)	E11.4- Type 2 diabetes with neurological complications
Circulatory (arteries)	E11.5- Type 2 diabetes with circulatory complications
Other specified (arthropathy, skin, ulcerations, oral, hypoglycemia and hyperglycemia)	E11.6- Type 2 diabetes with other specified complications

Note: Not an all-inclusive list. For a complete list consult the current ICD-10-CM coding manual.

Accurately reporting uncontrolled diabetes

Previously, diabetes mellitus codes were classified as controlled or uncontrolled. In ICD-10-CM diabetes described as not being controlled is classified as hyperglycemia which is considered a complication. When documentation contains terms such as *inadequately controlled, out of control* and *poorly controlled,* the index leads to diabetes with hyperglycemia (see example below). Assign as many codes that are needed to accurately describe the patient's diabetic condition(s).

Provider Update

Documentation	Correct code(s)
Male patient is seen and evaluated for diabetes mellitus type 2 poorly controlled.	E11.65 Type 2 diabetes mellitus with hyperglycemia
Female patient is seen and evaluated for shooting pain and numbness in toes and feet. The provider diagnosis type 1 diabetic neuropathy inadequately controlled.	E10.40 Type 1 diabetes mellitus with diabetic neuropathy E10.65 Type 1 diabetes mellitus with hyperglycemia

Documenting to support accurate coding
Since diagnosis coding is based on provider documentation, it is critical that providers include all known details about coexisting and chronic conditions (i.e., diabetes) in the medical record for each patient encounter. Details such as the provider's assessment/evaluation of the condition, medications prescribed, recommendations, referrals and even patient noncompliance help support accurate coding. Documenting support for all current medical conditions improves quality of care and ensures coding guidelines are followed.

ICD-10 Coding Guidelines, Section IV Diagnostic coding and Reporting Guidelines for Outpatient Services

- .I C*hronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions.*
- .J *Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management*.

Documenting cause and effect for diabetic complications
When diabetic complications are present, it is important that medical record documentation support the cause and effect relationship between diabetes and the other conditions with linking verbiage. Examples of linking verbiage include:

- Diabetic
- Due to diabetes
- Secondary to diabetes
- Caused by diabetes

If documentation does not properly link the condition(s), a diabetes combination code should not be assigned. Each condition must be coded separately when documentation does not establish a causal link (see example below).

Documentation	Correct code
Female patient evaluated for type 1 diabetes and stage 1 chronic kidney disease (Cause and effect not documented).	E10.9 Type 1 diabetes mellitus *without complications* N18.1 Chronic kidney disease, stage 1
A male patient is seen and evaluated for diabetic chronic kidney disease-stage 3, he takes insulin on a daily basis.	E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease N18.3 Chronic kidney disease, stage 3 (moderate) Z79.4 Long-term (current) use of insulin

For complete instructions and guidelines, please refer to the current ICD-10-CM coding manual.