Provider Update

July-August 2015 News Bulletin

Claims tip of the month
Requirements for documentation of proof of timely filing

Amerigroup Washington, Inc. will reconsider reimbursement of a claim that is denied for failure to meet timely filing requirements when a provider can provide proof of a date of claim receipt compliant with applicable timely filing requirements or demonstrates good cause exists.

Good cause may be established by the following:

- If the claim includes an explanation for the delay (or other evidence that establishes the reason), Amerigroup will determine good cause based primarily on that statement or evidence.
- If evidence leads to doubt about the validity of the statement, Amerigroup will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claims filing delay was due to:

- Administrative error – incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary or CMS) to the physician or supplier
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan with the state
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the service provider’s control that demonstrate the physician or supplier could not reasonably be expected to have been aware of the need to file timely
- Destruction or other damage of the physician or supplier’s records unless such destruction or other damage was caused by the physician or supplier’s negligence or intentional misconduct.

August New Provider Orientation webinar

Online via WebEx August 27, 2015
12 - 1:30 p.m. Pacific time
RSVP by Wednesday, August 26, 2015

Join us for an online network provider orientation. We greatly apologize for the technical errors we experienced. 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 emailing wa1provrelations@amerigroup.com.

Updated Medicaid Provider Manual now available

We've made some important changes to our Provider Manual. Download the latest version from our provider self-service website at providers.amerigroup.com/WA. Please destroy old hard copies and electronic versions of the Provider Manual; replace them with the updated version. We encourage you to reference the Provider Manual on our website to ensure you have the most up-to-date information at all times.

We update our Provider Manual to remain in compliance with regulatory requirements, our state contract and standards necessary for NCQA accreditation. We also revise the manual for changes to Amerigroup Washington, Inc. information and procedures.

Below are key changes to the manual you need to review:

- Updated AT&T Relay Services phone number
- Updated vision vendor to eyeQuest
- Updated Pharmacy benefits manager to Express Scripts
- Updated Sections 2.5 and 2.8 – Access and Availability standards for PCPs and Specialists
- Updated Section 2.6 – Specialist providers serving as PCPs for members with special needs
- Added Section 3.1 – Core Provider Agreement Required
- Updated Section 3.1 – Fraud, Waste and Abuse
- Added Section 4.1 – Availity
- Updated Section 4.3 – Identification cards
- Added Section 4.9 – Member self referrals
- Updated Section 5.7 – Enrollment section updated for mother's and eligible newborns
- Updated Section 6.2 – Services covered by HCA
- Updated Section 6.3 – Services covered by Amerigroup, services grid
- Updated Section 7.2 – Coverage guidelines grid
- Updated Section 10.9 – Coordination of Benefits and Third-party Liability

- Updated Section 10.10 – Medical Coding and Corrected Claims section added

Please look for another update to this manual in September 2015.

While we encourage use of the electronic copy in order to reduce use of paper and ensure you reference only the most up-to-date information, you may order a hard copy of the Provider Manual at no charge by calling our Provider Services team at 1-800-454-3730.

The Healthcare Effectiveness Data and Information Set (HEDIS®) tips & best practices

In this month's Healthcare Effectiveness Data and Information Set (HEDIS®) training, we are offering an educational webinar focusing on Well Child 0-15 months, Well Child 3-6 years, Adolescent Well Care, Weight Assessment/ Counseling for Nutrition and Physical Activity, as well as immunization HEDIS measures. This session will provide updated NCQA documentation guidelines and coding, as well as helpful tips and best practices to improve performance. Please join the session for more tips and best practices related to these HEDIS measures. Practices can apply this information to all lines of business with payers. We will also explain any member or provider incentives provided by Amerigroup for services related to the measures. All participating providers are welcome to attend at no cost.

Well Child 0-15 months

- If you use electronic health records (EHRs), consider creating a flag to track patients due or past due for a visit.
- If you do not use EHRs, consider creating a manual tracking method. Sick visits may be a missed opportunity for your patient to get a wellness exam.

Well Child 3-6 years

- Schedule the next visit at the end of the appointment.

Adolescent Well Care

- Complete a well-care visit at the same time as sports physical.
- Consider extending your office hours into the evening, early morning or weekend to accommodate working parents and kids involved in after-school activities.

Weight Assessment/ Counseling for Nutrition and Physical Activity

- Consider incorporating appropriate nutritional and weight management questioning and counseling into your routine clinical practice.
- Measure height and weight at least annually; for 16- and 17-year-olds only, you may either calculate BMI percentile or document the values alone.

Send an email with your registration request to wa1provrelations@amerigroup.com
Please note "HEDIS Training" in the email subject line.

Online via WebEx August 18, 2015
11 a.m. - 12 p.m. Pacific time
RSVP by Monday, August 17th

Measures to be discussed:

- Well Child 0-15 months
- Well Child 3-6 years
- Adolescent Well Care
- Weight Assessment/ Counseling for Nutrition and Physical Activity

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. See this tool and others under Provider Resources and Documents/Quality Management.

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

State immunization information system

Did you know immunizations can be entered into the Washington State immunization information system by individual entry or utilizing a mass HL7 data format?

This information is shared with Amerigroup on a quarterly basis and reduces the need to request records for immunizations. It also provides many helpful tools to aid in forecasting and tracking immunization status' for your patients.

Go to https://fortress.wa.gov/doh/cpir/iweb then select Help Desk E-Mail to request access.

Amerigroup in the community

On June 6, 2015, Amerigroup sponsored the Marysville Health Communities Challenge Day to help families get started on living healthy this summer. The sun was out and folks actively learned about the opportunities that the community has to offer including the health plan's value-added benefits. Activities included local health and fitness agencies, planting seeds, fitness demos, healthy food vendors and more.

Who can refer Amerigroup members

Amerigroup wants to ensure our members have access to timely health care. Remember, Amerigroup does not require you to be the primary care provider (PCP) listed on the patient's card to treat the member and be paid for providing services. Any

participating PCP my treat any Amerigroup members without calling to change the member's PCP. Additionally, Amerigroup does not restrict the providers who may refer members to specialists and ancillary providers for covered services. Contracted specialists and PCPs may all refer or request authorizations for services.

Univita termination

Effective July 29, 2015, Amerigroup began directly managing all home health, home hospice and durable medical equipment services. We no longer use Univita as a vendor to manage these services. We are not accepting new durable medical equipment vendors, but are accepting new Home Health/Home Infusion providers. Please send your prescriptions for services directly to the vendor/provider and they will coordinate with Amerigroup to have the services authorized and delivered to members.

Back pain management – New utilization management vendor

We have deferred the implementation of a new vendor Orthonet, LLC. Stay tuned for more information.

Musculoskeletal services prepayment review New vendor – Orthonet

We have deferred the implementation of a new vendor Orthonet, LLC. Stay tuned for more information.

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.

Pharmacy management information

Need up-to-date pharmacy information? Log in to our website at providers.amerigroup.com/WA to access our formulary, prior authorization form, processes and the Preferred Drug List. Have questions about the formulary or need a paper copy? Call our Pharmacy department at 1-800-454-3730. Pharmacy technicians are available Monday through Friday from 5 a.m. to 5 p.m. Pacific time and Saturdays from 7 a.m. to 11 a.m. Pacific time.

Provider Update

Medical policies and Clinical Utilization Management Guidelines update

On May 7, 2015, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Amerigroup Medical Policies and Clinical Utilization Management (UM) guidelines, developed or revised to support clinical coding edits. The medical policies and Clinical UM Guidelines are publicly available on Amerigroup provider websites. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.

Several medical policies and Clinical UM guidelines have been updated. Review the following tables for new policies and revisions to clinical coding edits. Please share this notice with other members of your practice and office staff.

Medical policy effective date	Medical policy number	Medical policy	Medical policy (new/revised)
05/11/15	DRUG.00075	Nivolumab (Opdivo®)	New
07/07/15	DRUG.00076	Blinatumomab (Blincyto™)	New
07/07/15	LAB.00031	Advanced Lipoprotein Testing in Cardiac Disease Risk Assessment and Management	New
07/07/15	MED.00118	Continuous Monitoring of Intraocular Pressure	New
07/07/15	SURG.0140	Peripheral Nerve Blocks for Treatment of Neuropathic Pain	New
05/11/15	DRUG.00028	Intravitreal and Periocular Injection Treatment for Retinal Vascular Conditions	Revised
05/11/15	DRUG.00038	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	Revised
05/11/15	DRUG.00047	Brentuximab Vedotin (Adcetris®)	Revised
05/11/15	DRUG.00048	Eribulin mesylate (Halaven®)	Revised
07/07/15	DRUG.00052	Pertuzumab (Perjeta®)	Revised
05/11/15	DRUG.00055	Denosumab (Prolia®, Xgeva™)	Revised

05/11/15	DRUG.00059	Romiplostim (Nplate®)	Revised
05/11/15	DRUG.00066	Antihemophilic Factors and Clotting Factors	Revised
05/11/15	DRUG.00067	Ramucirumab (Cyramza®)	Revised
05/11/15	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
07/07/15	GENE.00023	Gene Expression Profiling of Melanomas	Revised
07/07/15	RAD.00002	Positron Emission Tomography (PET) and PET/CT Fusion	Revised
07/07/15	RAD.00014	Brachytherapy for Oncologic Indications	Revised
05/11/15	SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
05/11/15	SURG.00033	Implantable Cardioverter-Defibrillator (ICD)	Revised
05/11/15	SURG.00098	Mechanical Embolectomy for Treatment of Acute Stroke	Revised
05/11/15	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	Revised

On May 7, 2015, the MPTAC approved the following Clinical UM Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. The Clinical UM Guidelines on this list represent the Clinical UM Guidelines adopted by the Medical Operations Committee for the Government Business Division on May 18, 2015.

The clinical guidelines are publicly available on the Amerigroup Medical Policies and Clinical UM Guidelines subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.
Note: Existing precertification requirements have not changed.

Provider Update

Effective date	Clinical UM guideline number	Clinical UM guideline title	Revised or new (new/revised)
07/07/15	CG-DRUG-45	Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)	New
07/07/15	CG-DRUG-46	Fosaprepitant (Emend®)	New
06/15/15	CG-SURG-47	Surgical Interventions for Scoliosis and Spinal Deformity	New
05/11/15	CG-BEH-05	Eating and Feeding Disorder Treatment	Revised
07/07/15	CG-DRUG-09	Immune Globulin (Ig) Therapy	Revised
05/11/15	CG-DRUG-15	Gonadotropin Releasing Hormone (GnRH) Analogs	Revised
05/11/15	CG-DRUG-16	White Blood Cell Growth Factors	Revised
07/07/15	CG-MED-46	Ambulatory and Inpatient Video Electroencephalography	Revised
07/07/15	CG-MED-47	Fundus Photography	Revised
07/07/15	CG-REHAB-08	Private Duty Nursing in the Home Setting	Revised
07/07/15	CG-SURG-01	Colonoscopy	Revised
07/07/15	CG-SURG-17	Trigger Point Injections	Revised
05/11/15	CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting	Revised

Provider Update

The following guideline was adopted through the Medical Operations Committee:

04/11/15	CG-DME-20	Orthopedic Footwear	Adopted

The following medical policies and Clinical UM guidelines have been archived on the date listed below:

05/11/15	DRUG.00065	Recombinant Coagulation Factor IX, Fc Fusion Protein (Alprolix™)	Archived
05/11/15	DRUG.00069	Recombinant Antihemophilic Factor, Fc Fusion Protein (Eloctate™)	Archived
05/15/15	RAD.00058	Real-Time Intra-Fraction Target Tracking during Radiation Therapy	Archived
07/07/15	CG-MED-43	Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT)	Archived

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

Now Available: Send claims medical attachments through Availity

Amerigroup partners with Availity to offer providers the ability to check patients' eligibility and claims status, as well as submit claims and access multiple payer information with a single, secure Availity Web Portal login.

The Medical Attachments feature is now available to providers. You can now use your billing National Provider Identifier (NPI) number to register and submit attachments, with or without a claim, through the Availity Web Portal. This service enables you to submit attachments (e.g., medical records, itemized bills, etc.) prior to claims submissions, with claims submission or as requested by Amerigroup.

To access this new feature, Primary Access Administrators (PAAs) should register today by logging in at www.availity.com. Click on the Amerigroup medical attachments registration link under your PAA dashboard, and you can then assign access to appropriate office staff.

As an Amerigroup provider, you can now send up to 10 unsolicited attachments through the web portal. You may submit up to 10 attachments for each claim, with a maximum file size of

10MB per attachment. This service includes attachments for secondary claims, or even attachments that are not related to a claim at all. Availity rejects any individual files larger than 10MB and requests that you split larger files into smaller files. Files can be submitted as TIFFs (.tif), JPEGs (.jpg), and PDFs (.pdf). This new feature allows your team to submit supporting medical documentation for claims without prompting by Amerigroup. Unsolicited attachments streamline the claims process and can improve your revenue cycle by capturing required documentation needed to adjudicate a claim up front. Plus, the Web Portal captures, transmits, stores, and retrieves your medical attachments, providing an electronic history that's easily accessible, now or in the future.

To access additional training about this new Availity feature:

1. Log in to the Availity Web Portal at www.availity.com. To do this:
   - Go to www.availity.com.
   - Click the **Web Portal Users Login** link in the upper right corner.
   - On the Availity portal login page, enter your Availity user ID and password.
   - Click **Log in**.
2. At the top of any Availity portal page, click **Help** | **Get Trained**. *(Make sure you do not have a pop-up blocker turned on or the next page may not open.)*
3. In the new window a list of available topics will open. Locate and click **Medical Attachments**.
4. Under the **Recordings** section, click **View Recording** (next to Amerigroup Medical Attachments).

Availity: New eligibility and benefits functionality and features

The Availity Web Portal launched new eligibility and benefits functionality and features on June 27, 2015. These changes will make finding eligibility and benefits easier and faster for you. Here's a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes user's most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).

Feature	Description
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list displays all service types and benefits returned from the health plan.
Patient snap shot	The summary of patient information is easily found at the top of the page.
Clearer display of details	Users have a clearer and more complete view of specific benefit and financial information.
Advanced printing	By selecting which sections to print, users save paper and can customize prints to target necessary information.
Real-time feedback	Feedback buttons on each returned eligibility allows users to provide instant feedback of missing or inaccurate information.

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

Quality overview: Special needs plan Model of Care

Commitment to our dual eligible-special needs plan members' health and their satisfaction with the care and services they receive is the basis for the Amerigroup quality improvement program. Annually, the plan prepares a quality program description that outlines clinical quality and service initiatives. We strive to support the patient-physician relationship through our Model of Care program, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives.

Provider requirements and Medicare notices

The Centers for Medicare & Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the Important Message from Medicare About Your Rights (IM) notice to every Medicare beneficiary within two calendar days of

the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than two calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, Amerigroup periodically conducts IM and NOMNC audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

Our audit findings show providers would benefit from focusing in on the following elements required by CMS:

NOMNC notices:

- Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
- Include the beneficiaries health care identification number or medical record number on page one
- Include the specific type of services ending on page one
- Include the health plan's contact information on page two
- Have the beneficiary or authorized representative sign and date page two at least two days prior to the end of services
- Retain a copy of the signed notice, both page one and page two.

IM notices:

- Deliver notice to managed Medicare beneficiaries the way you do to traditional Medicare beneficiaries
- Include the physician's name on page one
- Have the beneficiary or authorized representative sign and date page one within two calendar days of the date of an inpatient hospital admission
- Call the authorized representative to deliver the IM when the beneficiary is unable to sign
- Deliver the IM, or copy of the IM again, no sooner than two calendar days before discharge
- Retain a copy of the signed notice, both page one and page two

To download the standardized IM/NOMNC notices required by CMS, along with accompanying instructions, go to CMS website at cms.hhs.gov/bni or refer to the specific links below:

- NOMNC notice: cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
- IM notice: cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Important update: Quality improvement organizations (QIO) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see qioprogram.org to locate your QIO.

For more information on compliance with the Notice of Medicare Non-Coverage or the Important Message from Medicare, contact Mary Heapes, RN, BSN in the Federal Clinical Compliance Department at 212-476-2908.

Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 years of age and older. Once a woman has had a fracture, she has a four times greater risk of another fracture, reports the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

Amerigroup asks that providers encourage women 67 to 85 who have had a fracture or may be a risk for a fracture to have a bone mineral density screening or be placed on osteoporosis medication if appropriate.

Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the Journal of Rheumatology.

Disease modifying anti-rheumatic drugs help prevent long-term disability

The American College of Rheumatology recommends that persons with rheumatoid arthritis (RA) are prescribed a disease modifying anti-rheumatic drug (DMARD) to prevent long-term disability and damage. To help ensure your Medicare Advantage RA patients have these important prescriptions, we will review medical and pharmacy claims looking for members who have an RA diagnosis and do not appear to have a claim for a DMARD. Providers who have members with a diagnosis of RA and not on a DMARD may receive a monthly fax reminder. Please be sure to use correct diagnosis codes for RA and be careful not to use a RA code for ruling out RA, osteoarthritis and joint pain.

CMS requirement: Annual medication, supplement review for special needs plan members

Medicare requires that PCPs review all prescription and nonprescription drugs, vitamins, herbals and other supplements at least once per year for members in a special needs plan (SNP).

SNP members 66 years of age or older should also have one functional status assessment each year. According to HEDIS guidelines, notations for a complete functional status assessment should include one of the following:

- Notation that activities of daily living (ADL) were assessed – includes bathing,

dressing, eating, transferring (i.e., getting in and out of chairs), using toilet, walking

- Notation that instrumental activities of daily living (IADL) were assessed – includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - Assessment of living skills and resources (ALSAR)
  - Barthel ADL index physical self-maintenance (ADLS) scale
  - Bayer activities of daily living (B-ADL) scale
  - Barthel index
  - Extended activities of daily living (EADL) scale
  - Independent living scale (ILS)
  - Katz index of independence in activities of daily living
  - Kenny self-care evaluation
  - Klein-Bell activities of daily living scale
  - Kohlman evaluation of living skills (KELS)
  - Lawton & Brody's IADL scales
- Notation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Sensory ability (including hearing, vision and speech)
  - Other functional independence (i.e., exercise, ability to perform job)

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

ICD-10-CM: HIV status

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015.

The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient's human immunodeficiency virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used

for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

The table below reflects the crosswalk from ICD-9 to ICD-10.

ICD-9 Code(s)	ICD-10 Code(s)
• **V08** – Asymptomatic human immunodeficiency virus (HIV) infection status • **042** – Human immunodeficiency virus (HIV) • **079.53** – Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site	• **Z21** – Asymptomatic human immunodeficiency virus (HIV) infection status • **B20** – Human immunodeficiency virus (HIV) disease • **B97.35** – Human immunodeficiency virus, type 2 (HIV 2) as the cause of diseases classified elsewhere

To further assist in preparation for ICD-10, please see the following resources:

- Centers for Medicare & Medicaid Services (CMS): Provider Resources
- American Academy of Professional Coders: AAPC ICD-10 Resources
- World Health Organization: WHO ICD-10 Training

Amerigroup, Optum deliver reports to ensure Medicare Advantage members receive regular exams

Amerigroup collaborates with Optum to educate our individual and group-sponsored members on the importance of annual wellness exams and improvement of chronic conditions.

The patient assessment form (PAF)/health care quality patient assessment form (HQPAF) are used to ensure individual and group-sponsored Medicare Advantage members receive a complete and comprehensive assessment at least once a year. The PAF is always sent when an appointment is scheduled with an Amerigroup member. Some providers, depending on volume, will receive a PAF for all members regardless of an appointment being scheduled.

The members without office visit (MWOV) report identifies patients who have not visited a provider in 12 months. Optum will work with a practice to ensure a patient schedules an updated office visit. Should you have any questions about Optum's relationship with Amerigroup, please call 1-317-287-0719. For questions about the

Healthcare Quality Patient Assessment Form program, please call the Optum Provider Support Center at 1-877-751-9207.

Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Amerigroup follows the Centers for Medicare & Medicaid Services' Medicare Part B immunization billing guidelines.

Please use the following forms when filing flu, pneumonia or hepatitis B claims for Amerigroup individual and group-sponsored Medicare Advantage members.

- Professional claims should be filed on the CMS 1500 form with the appropriate current procedural terminology code and/or health care procedural code for the vaccine and administration
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes
  - Revenue codes (except rural health clinics and federally qualified health centers):
    - 0636 – vaccine (and CPT or HCPC)
    - 0771 – administration (and HCPC)
  - Rural health clinics and federally qualified health clinics – 052X revenue code series

Please refer to page three of the Medicare Part B immunization billing http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf for specifics on institutional billing.

ICD-10 documentation and diagnosis coding tips

ICD-10-CM diagnosis codes

- Contain anywhere from 3-7 characters (seventh character extension)
- Character 1 is alpha
- Character 2 is numeric
- Characters 3-7 are alpha or numeric (alpha digits are not case sensitive)
- Decimal appears after the third digit
- The first three characters make up the ICD-10 category
- Characters 4-7 are driven by clinical concepts in documentation

Understanding ICD-10-CM coding

- The current implementation date of ICD-10 is October 1, 2015. Providers and staff should be engaged in ICD-10 coding training now.
- Dates of service or dates of discharge that occur on or after October 1, 2015, must be reported using ICD-10-CM/PCS.

- ICD-10-CM/PCS will not affect physicians', outpatient facilities', and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis in order to allow the most specific code(s) to be assigned.

ICD-10-CM official coding guidelines for outpatient services

The outpatient coding guidelines for ICD-10-CM are completely similar to those found in ICD-9-CM. For guidelines, visit the CDC website at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2015.pdf. Listed below are some of the ICD-10-CM guidelines pertinent to outpatient and office visit encounters.

- **ICD-10-CM Section IV.C, Accurate reporting of ICD-10-CM diagnosis codes.** For accurate reporting of ICD-10 diagnosis codes, the documentation should describe the patient's diagnoses, symptoms, problems, or reasons for the encounter. It is acceptable to report the appropriate unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.
- **ICD-10-CM Section IV.F. 1-2, Level of detail in coding.** Codes with only 3 characters are used as the heading of categories in ICD-10-CM and may be further subdivided (require additional characters). Providers must report ICD-10-CM diagnosis codes to their highest number of characters available. Incomplete and/or invalid diagnoses codes are not acceptable for reporting.
- **ICD-10-CM Section IV.H, Uncertain diagnosis.** Do not code diagnoses documented as probable, suspected, questionable, rule out, working, consistent with or other similar terms that indicate uncertainty. Instead, code the conditions to the highest degree of certainty for the encounter/visit.
- **ICD-10-CM Section IV.I, Chronic diseases.** Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions. Chronic conditions do not go away and typically always impact care provided. They should be assessed and reported at each visit.
- **ICD-10-CM Section IV.J, Code all documented conditions that co-exist.** Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do note code conditions that were previously treated and that no longer exist.

Clinical concepts in documentation

Certain clinical concepts appear in ICD-10 coding which may or may not be present in ICD-9. Providers should become familiar with these concepts and ensure that

documentation includes all known pertinent details for accurate code assignment in ICD-10. Examples of clinical concepts include:

- Cause and effect
- Laterality
- Timing
- Associated conditions
- Remission status
- Severity
- Episode of care
- Trimester of pregnancy
- Agent and/or organism
- Anatomical location
- Comorbidities
- Depth/stage for wounds and ulcer
- Late effects

New coding conventions

ICD-10-CM has some new coding conventions that are not included in the ICD-9-CM code set. A brief explanation of those follows:

- **Seventh character extension** is required for certain categories in ICD-10 and must always appear in the seventh character field.
- The **dummy placeholder X** may be used in the 5th or 6th character field to ensure that a seventh character is added correctly.
  Example: T15.12XS Foreign body in conjunctival sac, left eye, sequel (late effect)

Locating the correct diagnosis code in the ICD-10 code book

- First, locate the documented term in the alphabetic index and then verify the code in the tabular list.
- Use a current ICD-10 code book. Become familiar with the Official ICD-10-CM Coding Guidelines and follow all instructions for the chapter and category related to specific codes including Excludes1and Excludes2 notes.
  - Excludes1 – Not coded here. The codes should never be used at the same time.
  - Excludes2 – Not typically included here, but a patient may have both conditions at the same time.
- Reliance on coding software, EHR systems, and cheat sheets alone can lead to coding errors.

Locating official coding advice

- The *American Hospital Association (AHA) Coding Clinic*™ is the CMS approved resource for clarification of ICD-10-CM. Volumes are published quarterly and contain new and/or updated information on the use of ICD-10-CM as well as clarification of previously published coding advice.

- Additional advice on ICD-10-CM can be located on CMS website at http://cms.hhs.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

Documenting specificity for accurate ICD-10 coding

Specificity in documentation allows the most accurate ICD-10 codes to be assigned. Accurate and complete coding shows a true picture of each member's health status. As the October 1, 2015, compliance date draws near, healthcare providers should begin incorporating additional documentation into patient encounters. The table below shows some common chronic conditions and the documentation requirements for accurate ICD-10 code assignment.

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Asthma	• **Severity** – Document asthma severity as either, intermittent, mild persistent, moderate persistent or severe persistent. • **Type** – Exercise induced or cough variant are other types of asthma, documentation should specify type. • **Acute exacerbation** – Documentation should state if the asthma is in acute exacerbation. • **Status asthmaticus** – Defined as an acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators. • **Infection** – A superimposed infection may be present this should clearly be documented by the provider.	J45.20 – J45.998
Hypertension	• **Primary or secondary** – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension, one to identify the underlying etiology and one from category I15 Secondary hypertension. • **Transient** – Temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code R03.0 elevated blood pressure reading without a diagnosis of hypertension. • **Controlled/uncontrolled** – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is I10 Essential (primary) hypertension.	I10 – I15.9

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Hypertension	• **Complications** – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive, caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following coding guidance applies to hypertensive complications: − **I11 Hypertensive heart disease** – Use additional code from category *I50 Heart failure* if present. − **I12 Hypertensive chronic kidney disease** – Use additional code from category *N18 chronic kidney disease* to identify the stage. − **I13 Hypertensive heart and chronic kidney disease** – Requires use of additional code from category *I50 Heart failure* if present and use additional code from category *N18* C*hronic kidney disease* to identify the stage. − **I60 – I69 Hypertensive cerebrovascular disease** – Code also *I10 Essential (primary) hypertension.* − **H35.0 Hypertensive retinopathy** – Code also *I10 Essential (primary) hypertension.*	I10 – I15.9
Diabetes mellitus (DM)	− **Type** – Providers must document the type of diabetes in ICD-10-CM: − **E08 Diabetes mellitus** – Due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc. − **E09 Drug or chemical induced diabetes mellitus** – Code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect if applicable, to identify drug. − **E10 Type 1 diabetes mellitus** – Due to pancreatic islet B cell destruction. Also known as juvenile diabetes. − **E11 Type 2 diabetes mellitus** – Use for diabetes not otherwise specified.	E08 – E13

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Diabetes mellitus (DM)	− **E13 Other specified diabetes mellitus** – Includes that due to genetic defects and secondary diabetes not classified elsewhere. • **Body system affected** – Diabetes may affect multiple body systems. Providers should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented. • **Complications affecting that body system** – Providers must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include: diabetes with neuropathy, diabetic retinopathy, and nephropathy due to diabetes. • **Insulin use** – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term then apply code Z79.4 (long term, current use of insulin).	E08 – E13

ICD-10: From compliance to medical policies

Below is an overview of the ICD-10 update and key information you need to know:

Compliance

- The current implementation date of ICD-10 is October 1, 2015, as mandated by HIPAA.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' and hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis for correct coding.
- Providers should submit all known conditions on the claim using ICD-10-CM diagnosis codes.

Claims processing

The following information explains the claims processing procedures for claims

according to dates of services. Amerigroup is committed to ensuring providers understand the correct code set to use. The following information applies to claims processing:

- No mixed claims: Consistent with CMS guidelines, mixed claims (claims filed with ICD-9 and ICD-10 codes on the same claim) will not be accepted.
- ICD-10 codes: Claims with ICD-10 codes for dates of service (DOS) or dates of discharge (DOD) prior to October 1, 2015 will not be accepted.
- ICD-9 codes: HIPAA will not allow the use of ICD-9 codes for claims with DOS or DOD on or after October 1, 2015.
- Resubmitting claims: When resubmitting claims, providers should utilize the code set that is valid for the DOS/DOD.

Update to prior authorizations process

Amerigroup has updated prior authorization procedures to accommodate the transition to ICD-10-CM. The updates will ensure that providers understand how to submit prior authorizations according to the date that services are scheduled to be performed. The following information details the process for prior authorizations:

- Starting June 1, 2015, we will begin accepting and processing prior authorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015.
- ICD-9 codes must continue to be used to prior authorize services scheduled through September 30, 2015.
- Existing approved prior authorizations coded in ICD-9 whose effective period spans the ICD-10 date of October 1, 2015, do not need to obtain another authorization that is coded in ICD-10.
- Prior authorizations that span the October 1, 2015, compliance date will be valid for claims submitted using ICD-10 codes.
- Example: If a DME wheelchair rental authorization coded with ICD-9 was approved for the effective period of April 1, 2015 – April 1, 2016, this authorization will still be valid for claims filed using ICD-10 diagnosis codes with beginning dates of service of October 1, 2015, and later.

Update to medical policies

Amerigroup has worked diligently to ensure that medical policies and clinical utilization management (UM) guidelines have been updated to include proposed ICD-10 coding.

We want to ensure that providers understand where to locate medical policies and UM guidelines. Preparing policies and processes for ICD-10 helps ensure providers operate smoothly after October 1, 2015. The updated medical policies are available on the Amerigroup provider website at providers.amerigroup.com.

For specific questions regarding medical policies, please contact Provider Services at 1-800-454-3730.

Claims testing
The Amerigroup ICD-10 migrations team is conducting end-to-end testing of claims with providers. The process is designed to help ensure that provider systems can submit. Amerigroup claims successfully. Providers interested in conducting testing with Amerigroup should contact their local Provider Services representative by September 1, 2015. Providers are encouraged to participate in testing to ensure successful claims processing using ICD-10. Providers who have not already enrolled in claims testing should be registered by September 1, 2015, in order to be ready for the October 1, 2015, implementation date.

Coding updates and resources for providers
Amerigroup is committed to helping providers transition smoothly to the new ICD-10-CM code set. The resources below provide valuable information in terms of assessment, planning and training to help providers at any stage in the ICD-10-CM implementation process.

- Amerigroup provider home page: This site offers the latest news on ICD-10 and links to industry resources. Visit our provider website at providers.amerigroup.com and look for the ICD-10 news link.
- The Amerigroup newsletter: This communication provides documentation and coding information on ICD-10 and HEDIS in addition to important network updates. Find our newsletter online at providers.amerigroup.com.
- Road to 10: CME Online Tool for Small Practices: This online resource built with the help of providers in small practices is intended to help small medical practices jumpstart their ICD-10 transition. It includes specialty references, access to free Medscape education modules and CME credits for physicians and nurses who complete the learning modules. Use this tool at www.roadto10.org/.
- ICD-10 Monitor: This online news and information source was created to help healthcare providers make informed decisions as they transition to ICD-10. The ICD-10 Monitor hosts weekly live broadcasts where relevant ICD-10 topics are discussed with industry experts called Talk Ten Tuesdays. Visit the site at .icd10monitor.com.

Allergy Treatment: Immunotherapy Reimbursement Policy Update

Allergy Treatment: Immunotherapy
(Policy 06-110, effective 09/20/2015)
Reimbursement is allowed for allergy immunotherapy. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the injection, antigen dosage/preparation when meeting the below criteria.

The injection service component code and the antigen dosage/preparation component

code (per dose) should be billed separately. Additionally:

- Claims submitted with a procedure code representing the complete service (collectively including the injection service, antigen dose and the antigen preparation) will be denied.
- If the antigen is prepared other than in the physician's office, the physician may bill only for the injection services.
- Physicians using treatment boards must bill with the component codes even though they prepare no vials.
- If multiple antigen doses are prepared in the same setting, either:
  - The injection service and the antigen dosage/preparation service indicating the number of dosages for the injection administered during the first visit must be billed
  - The injection service only for remaining injections administered during subsequent visits must be billed.

Note: Amerigroup allows reimbursement of up to 20 doses billed for preparation of single or multiple antigen doses for a 30-day period. **Claims billed for more than 60 doses during a 90-day period will be denied.**

Providers may not bill for Evaluation and Management (E&M) visits for established patients on the same day as allergy injection services unless the E&M visit represents a significant, separately identifiable service and is appended with Modifier 25. Claims submitted for an E&M visit in conjunction with allergy injection services without the Modifier 25 will be denied. Claims submitted for E&M visits for new patients on the same day as allergy injection services may be reviewed for medical necessity.

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