# Provider Update

## June 2015 News Bulletin

### Claims tip of the month

**Patient history vs history (of)**

Providers may document a condition as history (of) to show that the patient has had the diagnosis for a long period of time. The term history (of) from a coding perspective indicates that the patient had the condition in the past and that the condition no longer exists.

- History of CHF: Incorrect
  - Instead document status as **compensated** CHF
- History of COPD: Incorrect
  - Instead document status as **stable** COPD

Use V-codes to report historical status if pertinent to the current visit. For example, with a history of CVA:

- V12.54 – Use when no residual effects from the stroke remain.
- 438.x – Use when documentation supports remaining deficits, hemiplegia, dysphagia, etc.

### June New Provider Orientation webinar

**Online via WebEx June 25, 2015**
12 - 1:30 p.m. Pacific time
RSVP by Wednesday, June 24, 2015
Join us for an online network provider orientation. If you tried to join us in May and could not, please try again or arrange an in-person orientation just for your practice. 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.

### July HEDIS training webinar

Each month, we will host a webinar for participating providers to learn how to appropriately chart and bill for HEDIS® services. One of our HEDIS team members will lead the training, along with a Provider Relations representative. This is information practices can apply to all lines of business with payers. The measures on which we train change each month. 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. Send an email with your registration request to wa1provrelations@amerigroup.com Please note "HEDIS Training" in the email subject line.

**Online via WebEx July 14, 2015**
11 a.m. - 12 p.m. Pacific time
RSVP by Monday, July 13th
Measures to be discussed:

- Breast Cancer Screening
- Chlamydia Screening
- Cervical cancer screenings
- Comprehensive Diabetes Care

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

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

## Amerigroup in the community

On May 13th and 14th, Amerigroup sponsored the 25th Annual Conference on Ending Homelessness at the Greater Tacoma Convention and Trade Center. LaMont Green, senior policy analyst for the City of Tacoma served as a speaker at the conference and has been one of many individuals who have been homeless. Green and two other speakers directed a workshop on "Homeless at School: Growing Resources and Relationships for Homeless Youth and Families."

## Univita termination

Effective September 1, 2015, Amerigroup will begin directly managing all home health, home hospice and durable medical equipment services. We will no longer use Univita as a vendor to manage these services. If you provide these services and would like to contract with Amerigroup for them, please email your request along with your W-9 to wa1provrelations@amerigroup.com. We look forward to working with these providers directly. Stay tuned for additional information about how our authorization processes will work; we will continue to provide updates throughout the summer in our news bulletins.

# Provider Update

## Core Provider Agreement Required – Update

As a reminder, 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. If you would like to be a non-billing provider who does not accept Medicaid fee-for-service members, apply at http://www.hca.wa.gov/medicaid/providerenroll/Pages/nonbilling.aspx.

Please confirm on Provider One that your current NPI(s) are registered there. Medicaid managed care plans will coordinate efforts to advise providers when their information submitted on claims does not match what HCA reports. If you have questions, please call Provider Services at 1-800-454-3730.

## 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.

## Hypertensive diseases:
## Navigating the ups and downs of documentation and coding

Blood pressure is the force of blood against the walls of the arteries. Abnormally high pressure or hypertension damages blood vessels causing them to become scarred, hardened and brittle. The damaged vessels are no longer able to adequately supply blood to the organs and tissues of the body. Hypertenstion can lead to strokes, organ failure, or heart attacks when not properly controlled.

**Treating hypertension**

Hypertension is a chronic condition that requires lifelong treatment for most people. Treatment is aimed at controlling blood pressure and treating underlying or secondary conditions. The American Heart Association recommends blood pressure levels below 120/80 and screenings starting at 20 years of age. Hypertension is typically treated with medications, exercise/diet, managing stress and not smoking.

**Documentation and coding**

The medical record documentation for patients with hypertension should include each of the following:

- Type of hypertension – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- Complications – body system such as heart or kidney that are affected by hypertension
- Specific conditions – details on the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)

- Assessment/treatment – all measures aimed at controlling the hypertension or treating symptoms of complication(s)

Diagnosis code assignment is based on provider documentation and the medical record must support the codes submitted on the claim.

**Essential (primary) hypertension 401**

Code assignement is based on the type of hypertension documented (benign, malignant or unspecified). Statements such as high blood pressure, hypertension and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign code 796.2 elevated blood pressure reading without diagnosis of hypertension.Terms such as controlled and uncontrolled indicate the status of the condition and do not have a bearing on code assignment for hypertension.

**Hypertensive heart disease 402**

Assign category 402 hypertensive heart disease when a cardiac condition is stated (due to hypertension) or implied (hypertensive).The physician must document cause and effect between the two conditions. Category 402 is futher specified based on the presence of heart failure. Use additional codes from (428.0 - 428.43) to specifiy type of heart failure if known.

**Hypertensive chronic kidney disease 403**

ICD-9 coding guidelines assume a cause and effect relationship when both hypertension and chronic kidney disease are documented. Assign codes from category 403 hypertensive chronic kidney disease along with additional codes for the stage of CKD from category 585 chronic kidney disease.

**Hypertensive heart and chronic kidney disease 404**

When documentation supports heart and kidney complications with hypertension, the rules of cause and effect are as follows:

- Assumed cause and effect for hypertension and chronic kidney disease.
- Requires documented cause and effect for hypertension and heart disease.

Instructional notes state to use additional codes from 428.0 to 428.43 to specifiy the type of heart failure (if known) and the stage of CKD from category 585 chronic kidney disease. ICD-10 equivalent code category: I1 hypertensive heart and chronic kidney disease.

**Secondary hypertension 405**

Hypertension caused by underlying conditions such as adrenal gland disorders, kidney disease and drugs is called secondary hypertension. Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

# Provider Update

**AHA Coding Clinic advice**

When the provider establishes a linkage or relationship between two conditions, they should be coded as such. The entire record for the date of service should be reviewed to determine whether a relationship between the two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean that they are related. A different cause may be documented by the provider. If it is not clear whether or not two conditions are related, coders should query the provider (AHA Coding Clinic Q3, 2012.

**Hypertensive Diseases in ICD-10**

An important change for hypertension is that ICD-10 does not require documentation of the type of hypertension for correct code assignment. Providers will need to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

| ICD10 | Description |
|---|---|
| **I10** | Essential (primary) Hypertension |
| **I11** | Hypertensive Heart Disease (with or without heart failure).<br>Use an additional code from I50 to specify type of heart failure (if present). |
| **I12** | Hypertensive Chronic Kidney Disease<br>Use an additional code from N18 to identify stage of chronic kidney disease. |
| **I13** | Hypertensive Heart and Chronic Kidney Disease<br>Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease. |
| **I15** | Secondary Hypertension<br>Requires two codes, one for underlying cause and on from category I15 to identify secondary hypertension. Sequencing is based on circumstances of visit and documentation. |

## 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. Some examples of member rights are the rights to:

- Take part in decisions about their health care and their children's health care, including having candid discussions of appropriate or medically necessary treatment options, regardless of cost or coverage
- Get medical care without long delays
- Refuse treatments and be told of the possible results of refusing treatments, including whether refusals may result in disenrollment from Apple Health.

- Expect their records and their children's records and conversations with providers be kept confidential
- Get second opinions from other providers in their health plans when they disagree with the initial provider's recommended treatment plans

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

## New genetic testing rates effective August 1, 2015

Beginning August 1, 2015, Amerigroup will use updated National Reference Lab Fee Schedule rates for certain genetic testing codes for all markets and products.

Per your existing contract, Amerigroup is required to furnish written notice on any Amerigroup initiated changes to the National Reference Laboratory Fee Schedule.

**Which codes and rates will be updated?**

For dates of services on or after August 1, 2015, the rates for the below referenced CPT codes will be updated as outlined. Each provider will be paid the contracted percentage of these rates for medically necessary and covered laboratory tests (for example, if you are contracted at 39 percent, you would be paid $180.00 for 81220).

| CPT code | New rate |
|---|---|
| 81201 | $638.41 |
| 81203 | $248.03 |
| 81220 | $461.54 |
| 81221 | $64.10 |
| 81222 | $123.08 |
| 81223 | $625.64 |
| 81224 | $46.15 |
| 81229 | $2,546.00 |

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 the toll-free phone numbers listed below:

- Medicaid providers call 1-800-454-3730
- Medicare providers call 1-866-805-4589

# Provider Update

## 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, 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.

## 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.

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