Provider Update

March 2016 News Bulletin

Claims tip of the month

Claims Submission – Required Information for Professional Providers
(Policy 06-029, originally effective 06/16/2006)
Professional providers of health care services are required, unless otherwise stipulated in their contract, to submit an original Centers for Medicare and Medicaid Services (CMS)-1500 Health Insurance Claim Form to us for payment of health care services.

Providers must submit a properly completed CMS-1500 for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Amerigroup will deny payment without being liable for interest or penalties. The CMS-1500 claim form must include specific information outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

For additional information, refer to the Claims Submission – Required Information for Professional Providers reimbursement policy at providers.amerigroup.com.

Amerigroup in the community

Amerigroup Foundation was proud to recently support three projects in San Juan County:

- **Lopez Island Family Resource Center** received a $3,000 donation to support their program, Lopez Fresh, which is the organization's fresh food bank that serves about 200 families in need each year. The nutrition needs of Lopez families have increased as food prices and other costs of living have gone up.
- **San Juan Island Family Resource Center** received $3,000 to help support their rural outreach prenatal program. The program, which provides assistance for expectant mothers living in rural communities, is in need of financial assistance with ferry tickets and/or hotel fees related to prenatal appointments on the mainland. The program also provides case management and "new baby" bags containing prenatal and newborn health information for first-time expectant mothers.
- **Orcas Family Connection** received $2,000, which will also help increase travel for expecting mothers in Orcas Island who need to travel off the island for prenatal care appointments. These funds will also be used to create care packages to those expecting mothers who may not have easy access to proper nutrition.

My Advocate – No-cost community resource assistance for members

We're helping our members find and obtain support to meet their basic needs. Many state and local agencies exist that offer people assistance with such services as utilities assistance, home repair, Medicare copayment and prescription assistance, caregiver assistance and more. Finding and applying for assistance programs, though, can be a very complicated. My Advocate is a no-cost service for members. Please encourage members to visit the website at myadvocatehelps.com to start the easy process of obtaining help and guidance to resources in their own communities.

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Prenatal ultrasound policy change reminder

Amerigroup Washington, Inc. 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 30, 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.

Cervical cancer screening coverage for women less than 21 years of age

Cervical cancer screening is considered **medically necessary** for women under 21 years of age who are chronically immunosuppressed (for example, organ transplant recipients or seropositive for the human immunodeficiency virus [HIV]). Cervical cancer screening for women less than 21 years of age is considered **not medically necessary** for all other indications not listed above.

Effective with service dates on or after **June 7, 2016**, cervical cancer screening procedures and testing will not be reimbursed as a covered benefit for average risk women younger than age 21. Please access CG-Med-53 on the Amerigroup provider website at medicalpolicies.amerigroup.com to review the guideline.

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The American Cancer Society, the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all recommend against the use of cervical cancer screening in women younger than age 21. The American College of Obstetricians and Gynecologists recommend that cervical cancer screening should begin at age 21, and women younger than 21 should not be screened, regardless of the age of sexual initiation or the presence of other behavior-related risk factors. The United States Preventive Services Task Force (USPSTF) currently recommends against cervical cancer screening for women younger than age 21, giving it a D rating. This means that there is moderate or high certainty that the service has no net benefit or the harms outweigh the benefits.

Zika virus – An update from Washington Department of Health

Zika virus is circulating in many areas of the world. Know how to appropriately manage potentially exposed patients.

Actions requested for obstetric and women's health care providers:

- Be aware that Zika virus is circulating in many parts of the world. Washington State does not have the mosquito that carries this virus. However, there is potential for cases due to travel to impacted areas. For an up-to-date list of areas with active Zika transmission, see: http://www.cdc.gov/zika/geo/index.html
- Visit the Washington State Department of Health Zika webpage: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/ZikaVirus
- Be familiar with CDC Zika health care professional resources: http://www.cdc.gov/zika/hc-providers/index.html
- Be familiar with CDC information for pregnant women: http://www.cdc.gov/zika/pregnancy/index.html
- Obtain travel history from all pregnant women. Remind pregnant women that CDC advises pregnant women to avoid travel to areas with active Zika transmission, and advises women considering becoming pregnant to consult with their health care provider regarding travel.
- Be familiar with current CDC interim guidelines for health care providers caring for pregnant women and women of reproductive age with possible Zika virus exposure. Recommend printing this and keeping it handy. Check frequently for updated versions: http://www.cdc.gov/mmwr/volumes/65/wr/mm6505e2er.htm?s_cid=mm6505e2er.htm_w
- If you provide pediatric care, be familiar with current interim guidelines for evaluation of infants exposed to congenital Zika: http://www.cdc.gov/mmwr/volumes/65/wr/mm6503e3.htm
- Be aware of CDC recommendations that men who travel to an area with Zika transmission avoid sexual contact with pregnant partners, or correctly and consistently use condoms: http://www.cdc.gov/mmwr/volumes/65/wr/mm6505e1.htm

Enhanced Availity eligibility and benefits inquiry

Beginning in Q2 2016, users will have the added benefit to query for multiple members at one time through the Availity eligibility and benefits inquiry.

What this means to you

You can check up to 50 members' eligibility and benefits during one system transaction. You no longer have to request eligibility information one member at a time, and you can download the results of all your eligibility and benefits inquiries across multiple payers.

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My organization is not using Availity. What do I need to do?
To initiate the registration process, have your primary controlling authority (PCA), a person who is authorized to sign on behalf of your organization, register. Go to availity.com, select Get Started under the Register Now button and complete the online registration wizard.

After your PCA completes registration for the organization, your designated primary access administrator (PAA) will receive an email from Availity with a temporary password and next steps. Once logged in, the PAA can add users, providers and additional enrollments, if applicable. Please make sure every user has their own login and password. Logins and passwords should not be shared.

How can I get additional training on Availity?
Once you complete registration, you can view the current training resources by selecting Help, then Get Trained, at the top of any page in the Availity Web Portal to view Availity workshops and webinars that are available.

What if I need assistance?
For questions or additional registration assistance, contact Availity Client Services at 1 800-282-4548, Monday through Friday from 5 a.m. to 4 p.m. Pacific time.

If you have questions about the tools and resources available on the Amerigroup Washington, Inc. or Availity websites, please visit providers.amerigroup.com. If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Reimbursement policy updates

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website at providers.amerigroup.com and click on Quick Tools.

- **Locum Tenens**
  (Policy 06-063, originally effective 08/23/2006)
  Amerigroup allows reimbursement of locum tenens physicians in accordance with the Centers for Medicare and Medicaid Services (CMS) guidelines. Amerigroup will reimburse the member's regular physician or medical group for all covered services provided by a locum tenens physician during the absence of the regular physician in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis.

  Please note that, Amerigroup requires the regular physician or medical group to identify the locum tenens physician by entering their Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

  For market-specific information, refer to the Locum Tenens reimbursement policy at providers.amerigroup.com.

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- **Claims Submission – Required Information for Facilities**
  (Policy 06-030, originally effective 06/16/2006)
  Institutional Providers (Facilities) are required, unless otherwise stipulated in their contract, to submit the original Centers for Medicare and Medicaid Services UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill to us for payment of health care services. Providers must submit a properly completed UB-04/CMS-1450 for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and Amerigroup can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form must include specific information, which follows CMS guidelines and is outlined in the reimbursement policy. Amerigroup cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

  For additional information, refer to the Claims Submission – Required Information for Facilities reimbursement policy at providers.amerigroup.com.
- **Documentation Standards for Episodes of Care**
  (Policy 11-004, originally effective 12/07/2011)
  Amerigroup requires that documentation for all episodes of care must meet the following criteria:
  - Documentation must be legible to someone other than the writer.
  - Documentation must be complete, dated and timed.
  - Documentation must reflect all aspects of care.
  - Information identifying the member must be included on each page in the medical record.
  - Each entry in the medical record must be dated and include author identification, which may be a handwritten signature, unique electronic identifier, or initials.

For a complete list of minimum documentation requirements, refer to the Documentation Standards of Episodes of Care reimbursement policy at providers.amerigroup.com.

Your continued feedback is critical to our success. If you have questions, please call your local Provider Relations representative. Medicaid providers can call Provider Services at 1-800-454-3730.

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.