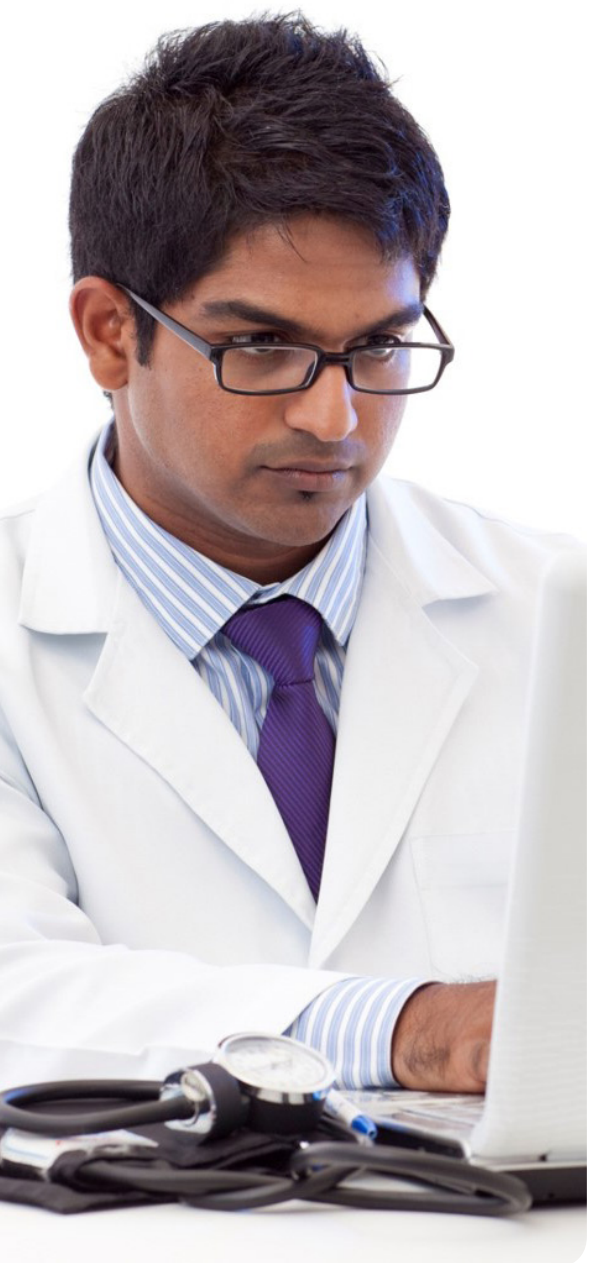
Provider News Bulletin

Amerigroup RealSolutions® in healthcare

Amerigroup Washington, Inc.
https://providers.amerigroup.com/WA
Medicaid providers: 1-800-454-3730
Medicare providers: 1-866-805-4589

March 2017



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2017 Amerigroup Washington, Inc. Risk Adjustment Coding Review process begins

The 2017 Risk Adjustment Coding Review project began January 1, 2017. The coding review is conducted annually and involves the retrieval of medical records from providers. The coding review ensures the Washington State Department of Social and Health Services has an accurate picture of the health status of each member. The coding review process also allows Amerigroup to develop programs that improve quality of care and access for members.

The corporate Risk Adjustment Analytics team manages the coding review project in collaboration with the Amerigroup Provider Relations department. Altegra Health is the contracted records retrieval and coding vendor.

Altegra Health offers multiple convenient methods for providers to submit the requested medical records. Providers may submit requested medical records via the following methods:

- Altegra Health has the capabilities to access electronic medical record/electronic health record systems remotely or onsite at the medical facility. The records can then be transferred electronically to the secure website, or downloaded on an encrypted thumb drive or computer. Paper copies can also be printed.
- Onsite field technicians can visit the provider office/medical facility to scan or upload charts.
- Providers can upload medical records electronically through the secure provider upload website.
- The vendor, Dropbox, Inc., can explain the submission process to the provider during a call.
- Providers can fax Altegra Health directly at 1-866-700-9896.
- Providers can request the FedEx account number to send the medical records directly to Altegra.

WA-NL-0055-17

Availity support training for providers now available

New onboarding courses are available on the Availity Learning Center. These courses will support providers/users in their training as they begin to use the Availity Web Portal.

To navigate to and take advantage of this training, please:

1. Log in to the Availity Web Portal.
2. Select **Help | Get Trained**. The Availity Learning Center for Web Portal Products portal will display in a new browser window.
3. In the *Catalog*, search by keyword: onboarding.
4. Select **Enroll in Course** for one or both options.
    - Onboarding Program: For Availity Users — get up and going quickly
    - Onboarding Program: For Availity Administrators — a great place to start your administrative journey

Once enrolled, go to the *Dashboard* tab to launch and complete the course(s), and to download a completion certificate.

WA-NL-0054-17

Amerigroup Washington, Inc. offers HEDIS®* coding training

Amerigroup is launching a quarterly training series to assist providers, office managers, coders and staff in mastering HEDIS documentation for maximum quality ratings. During this series, Amerigroup will provide a deeper dive into Washington state priority measures as well as measures required by the National Committee for Quality Assurance. These sessions are designed to help providers gain compliance via claims and minimize the need for chart reviews.

The seminars are conveniently timed for office lunch hour closures. All are welcome as the information offered may be helpful to both office staff and providers. Each of the trainings in this two-part series will award 1.0 continuing education unit. Additionally, reference desktop materials will be shared at the end of each session for all who attend.

Our first seminar is scheduled for Wednesday, March 29, 2017, from noon-1 p.m. PDT. The measures discussed during this session will include the state priority (Value-Based Purchasing) measures. The state priority measures are new in 2017 and address the following conditions:

1. Managing High Blood Pressure
2. Diabetes Care
3. Immunizations for Children
4. Well-Child Visits (also known as Early, Periodic Screening, Diagnosis and Treatment [EPSDT] Visits)
5. Asthma Medication
6. Antidepressant Medication

All can register for the 2017 Amerigroup (WA) HEDIS Quality Measures - Session One at https://antheminc.adobeconnect.com/e7u5qzaobur/event/registration.html.

If you are unable to attend the first session, there will be additional opportunities each quarter for you to participate.

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

WA-NL-0053-17

Pediatric HEDIS general helpful tips

- Document all discussions in the medical record.
- Discuss importance of ideal weight, nutrition and exercise with all patients.
- Use the state immunization registry and transcribe into the registry the hepatitis B vaccine given at birth in the hospital.
- If you use electronic medical records, consider creating a flag to track patients due or past due for preventive services.
- If you do not use electronic medical records, consider creating a manual tracking method for preventive services such as immunizations and annual well-child exams.
- Make the most of the time in your office. Sick visits may be the opportunity for your patient to get annual health checks on time.
- Encourage your staff to use tools within the office to promote teaching on immunizations, asthma care, healthy living habits and importance of return visits.
- Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about health screenings.
- Consider extending your office hours into the evening, early morning or weekends to accommodate working parents.
- Contact patients to remind them of upcoming appointments and necessary screenings.
- Schedule the next visit at the end of the appointment.
- To increase patient satisfaction while waiting for service, consider offering free Wi-Fi.

WA-NL-0052-17

Additional information on ClaimCheck® upgrade to ClaimsXten™

Amerigroup Washington, Inc. previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-800-454-3730.

ClaimCheck and ClaimsXten are registered trademarks of McKesson Technologies Inc. and McKesson Health Solutions LLC, respectively.

WA-NL-0048-17

Genetic testing services to require prior authorization

Effective May 1, 2017, genetic testing services for epidermal growth factor receptor (EGFR) testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing require prior authorization (PA).

What is the impact of this change?

For dates of service on or after May 1, 2017, PA is required for EGFR testing, prothrombin G20210A (factor II) mutation testing, methylenetetrahydrofolate reductase mutation testing and cell-free fetal DNA-based prenatal testing covered by Amerigroup Washington, Inc. for Washington Apple Health members. Federal and state law as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following codes:

- 81235
- 81291
- 81420
- 81507
- 0009M

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/WA > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

WA-NL-0041-16

Appointment availability and after-hours access requirements

To ensure members receive care in a timely manner, PCPs, specialty providers and behavioral health providers must maintain the following appointment availability and after-hours access standards.

Appointment availability requirements

Appointment type	Appointment standard
Emergency	Immediately
Urgent care	Within 48 hours
Nonurgent sick care	Within 10 calendar days
Routine or preventive care	Within 30 calendar days
Prenatal care	Within 14 calendar days (PCPs and OB/GYN providers)
Newborn care	Within 14 calendar days (PCPs and pediatricians)
Transitional health care follow-up appointment by a PCP…	… shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program
Transitional health care follow-up appointment by a home care nurse or home care registered counselor…	… shall be available within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program

After-hours access requirements

You are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as:
  - An on-call physician
  - A nurse practitioner with physician backup
- If after-hours calls are initially answered with a recorded message before directing to a live party, this message must include instructions for a member to dial 911, go to the emergency room, or stay on the line if there is an emergency situation and a need to speak to someone immediately.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow the referral precertification guidelines. This is a requirement for covering physicians.

Additionally, we encourage you to offer after-hours office care in the evenings and on Saturdays.

The 2017 Immunize WA Provider Recognition Program is underway

The Health Plan Partnership is sponsoring the 2017 Immunize WA Provider Recognition Program. Clinics are encouraged to nominate themselves for recognition between now and February 17, 2017.

All nominees who have achieved immunization rates of 70 percent or higher qualify for an award. Your clinic will be awarded in April during National Infant Immunization Week in recognition of your commitment to ensuring patients are up-to-date on their immunizations.

New for 2017, we have a bronze series award for the adolescent series 1:1:1 (one dose of Tdap, one dose of meningococcal and one dose of human papillomavirus).

To submit a nomination, clinics will need to run an Immunization Information System (IIS) Coverage Rate Report for their child and/or adolescent patients. Directions can be found at http://www.doh.wa.gov/Portals/1/Documents/Pubs/348-445-ImmunizationFlyerUpdated.pdf.

To complete the online nomination form, please visit https://www.surveymonkey.com/r/82GZC8P.

This partnership developed the Immunize Washington initiative with three goals in mind:

1. Provide consistent messages to clinics on how to improve their immunization practices and why it is important to achieve high immunization coverage rates
2. Establish a program to recognize clinics for achieving immunization rates of 70 percent or higher
   a. Gold Level: 80 percent or higher
   b. Silver Level: 70-79 percent
3. Enhance data sharing between health plans and the Washington State IIS

Help spread the word about the recognition program and encourage clinics to submit nominations before the February 17,2017, deadline.

For more information on this program, our partners and other tools to improve immunization rates, visit our website at www.doh.wa.gov/ImmunizeWA or send your questions via email to immunizewa@doh.wa.gov.

WA-NL-0051-17

Notification process reminder

Effective March 12, 2017, failure to obtain precertification for Washington Apple Health members and failure to notify Amerigroup Washington, Inc. of a member's admission or transfer within established time frames (as outlined below) will result in your claims being administratively denied, and you will not receive payment for the service(s). For participating providers, this is a contractual obligation and has been in effect since the execution of your contract. As a reminder, providers cannot balance bill members for services that are administratively denied. Members who are retroactively enrolled into the plan by the state are deemed out of scope.

If your claim is administratively denied, you may file an appeal in accordance with rules and regulations. As part of the appeal, you must demonstrate that you notified or attempted to notify Amerigroup within the contractually established time frame and that the service(s) are medically necessary.

What is the impact of this change?

Notification requirements:

Amerigroup must be notified of all member admissions or transfers within one business day of admission or transfer. Ideally, notification should occur the day of admission or transfer; however, you have one business day to notify Amerigroup without penalty. A business day is considered Monday-Friday and does not include weekends or weekdays that fall on federal holidays.

Notification for all post-stabilization admissions including transfers should occur within one business day of admission. The following clinical scenarios are excluded:

- Admission to a Neonatal Intensive Care Unit (NICU) level III
- Admission to an Intensive Care Unit (ICU)
- Direct admission to an operating room (OR)/recovery room
- Direct admission to a telemetry floor
- Involuntary behavioral health admission

Note, admission to a general ward is considered in scope for our notification requirements. Failure to notify us within one business day of admission to the general ward or NICU level I or II is considered failure to notify, and administrative denial applies. Once the member has been downgraded to a general ward from the NICU level III, ICU, OR/recovery or telemetry, the requirement for notification within one business day applies.

Notification of OB antepartum/postpartum admissions that do not result in a delivery should occur within one business day.

Precertification requirements:

Precertification is required for the following:

- Nonemergent inpatient transfers between acute facilities
- Elective inpatient admissions
- Rehabilitation facility admissions
- Long-term acute care admissions
- Skilled nursing facility admissions
- Behavioral health levels of care (as outlined in the provider handbook and precertification documents)

Notification process reminder continued

- Out-of-area/out-of-network services
- Outpatient services (as outlined within the Precertification Lookup Tool on the website)
- Outpatient durable medical equipment purchases and rentals (as outlined within the Precertification Lookup Tool on the website)

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why precertification was not obtained or why clinical was not submitted).

If Amerigroup overturns its administrative decision, then the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

To obtain precertification or to verify member eligibility, benefits or account information, follow instructions outlined on the provider website or in the *Quick Reference Guide*, provider manual, interactive voice response system or Availity Web Portal where applicable.

For additional information and/or detailed precertification requirements, refer to the provider website (https://providers.amerigroup.com/WA > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

WAPEC-1034-16

Claims tip of the month: How to verify if a CPT and/or HCPCS code requires a prior authorization

To verify if/when a CPT and/or HCPCS code will require a prior authorization, always start your research with the Precertification Lookup Tool (PLUTO) at https://agpapps.corp.agp.ads/authprecert/CodeSearch.aspx prior to performing services.

Complete the three drop-down boxes as applicable for your state, product and code.

Drop-down:	Entry:
Market * Select Market	Washington
Line of Business *	Medicaid/SCHIP/ Family Care
CPT / HCPCS Code or Description *	Enter code and/or written description

When using PLUTO, please remember that the tool is to advise if a code requires a prior authorization. This tool does not provide covered versus noncovered CPT and/or HCPCS coding.

Covered versus noncovered codes

To ensure a CPT and/or HCPCS code is covered, please always cross reference code with the appropriate Medicaid provider billing guide and fee schedule at http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides.

Please note that obtaining prior authorization is not a guarantee of payment.

WA-NL-0050-17

Medical Policies and *Clinical Utilization Management Guidelines* update

Medical Policies update

On November 3, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Amerigroup Washington, Inc. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The *Medical Policies* were made publicly available on the Amerigroup provider website on the effective date listed below. Visit https://medicalpolicies.amerigroup.com/search to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
12/28/2016	DME.00040	Automated Insulin Delivery Devices	New
12/28/2016	DRUG.00090	Bezlotoxumab (ZINPLAVA™)	New
11/17/2016	DRUG.00097	Olaratumab (Lartruvo™)	New
12/28/2016	DRUG.00102	Cabazitaxel (Jevtana®)	New
12/28/2016	LAB.00033	Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer	New
11/17/2016	DME.00036	Ultraviolet Light Therapy Delivery Devices for Home Use	Revised
11/17/2016	DRUG.00038	Bevacizumab (Avastin®) for Non Ophthalmologic Indications	Revised
11/17/2016	DRUG.00041	Rituximab (Rituxan®) for Non-Oncologic Indications	Revised
11/17/2016	DRUG.00042	Ustekinumab (Stelara®) (HAE)	Revised
11/17/2016	DRUG.00048	Eribulin mesylate (Halaven®)	Revised
11/17/2016	DRUG.00057	Canakinumab (Ilaris®)	Revised
11/17/2016	DRUG.00068	Vedolizumab (Entyvio®)	Revised
12/28/2016	DRUG.00066	Antihemophilic Factors and Clotting Factors	Revised
11/17/2016	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
11/17/2016	DRUG.00075	Nivolumab (Opdivo®)	Revised
11/17/2016	DRUG.00082	Daratumumab (DARZALEX™)	Revised

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
11/17/2016	DRUG.00085	Ixabepilone (Ixempra®)	Revised
11/17/2016	DRUG.00088	Atezolizumab (Tecentriq™)	Revised
12/28/2016	GENE.00002	Preimplantation Genetic Diagnosis Testing	Revised
11/17/2016	GENE.00019	BRAF Mutation Analysis	Revised
11/17/2016	GENE.00035	Genetic Testing for TP53 Mutations	Revised
11/17/2016	MED.00064	Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	Revised
11/17/2016	MED.00083	Melanoma Vaccines	Revised
11/17/2016	SURG.00055	Cervical Total Disc Arthroplasty	Revised
11/17/2016	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical Utilization Management Guidelines update

On November 3, 2016, the MPTAC approved the following *Clinical Utilization Management (UM) Guidelines* applicable to Amerigroup. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on December 6, 2016.

On November 3, 2016, the clinical guidelines were made publicly available on the Amerigroup *Medical Policies* and *Clinical UM Guidelines* subsidiary website. Visit https://medicalpolicies.amerigroup.com/search to search for specific guidelines.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Please note: For markets with pharmacy services carved out, the applicable listings below would be informational only.

Effective date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
11/17/2016	CG-DRUG-64	FDA-Approved Biosimilar Products	New
12/28/2016	CG-DRUG-54	Agalsidase beta (Fabrazyme®)	New
12/28/2016	CG-DRUG-55	Elosulfase alfa (Vimizim®)	New

Effective date	*Medical Policy* number	*Medical Policy* title	New or revised
12/28/2016	CG-DRUG-56	Galsulfase (Naglazyme®)	New
12/28/2016	CG-DRUG-57	Idurasufase (Elaprase®)	New
12/28/2016	CG-DRUG-58	Laronidase (Aldurazyme®)	New
12/28/2016	CG-DRUG-60	Gonadotropin Releasing Hormone Analogs for the Treatment of Oncologic Indications	New
12/28/2016	CG-DRUG-61	Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications	New
12/28/2016	CG-DRUG-62	Fulvestrant (FASLODEX®)	New
12/28/2016	CG-DRUG-63	Levoleucovorin Calcium (Fusilev®)	New
12/28/2016	CG-SURG-56	Diagnostic Fiberoptic Flexible Laryngoscopy	New
11/17/2016	CG-DRUG-38	Pemetrexed Disodium (Alimta®)	Revised
11/17/2016	CG-SURG-15	Endometrial Ablation	Revised
11/17/2016	CG-SURG-45	Bone Graft Substitutes	Revised
11/17/2016	CG-SURG-58	Radioactive Seed Localization of Nonpalpable Breast Lesions	Revised

WAPEC-1058-16

Launch of the Retrospective Medical Record Review Program

Risk adjustment is the method used by CMS to adjust the capitated payment made to Amerigroup Washington, Inc. based on demographic characteristics and health status (represented by diagnosis data and disease interactions) of each Amerigroup Amerivantage (Medicare Advantage) member. Risk adjustment relies on the timely and accurate collection and submission of member diagnosis data each year. All diagnosis data must be supported by the member's medical record documentation. Federal regulations require Amerigroup to review and validate medical records to avoid underpayments and overpayments.

Program details:

Our retrospective medical record review initiative is a risk adjustment program intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations.

Amerigroup contracts with Verscend Health (formerly Verisk) to conduct outreach to providers as well as collect, review and code medical records with dates of service for the 2017 target year through present day.

What if I need assistance?

The Retrospective Risk Program Lead, Jaime Marcotte, is managing this initiative. For more information on this program, please contact Jaime at 314-925-6094.

FAQ — Retrospective Medical Record Review Program

Q. What is the Retrospective Medical Record Review Program?

A. The program is intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations. We exclusively contract with Verscend Health (formerly Verisk) for this initiative.

Q. What services is Verscend performing on behalf of Amerigroup?

A. Verscend is contracted to retrieve the medical records of targeted members as well as review these records and code them based on ICD-10-CM coding guidelines and requirements. Additionally, Verscend sends a data extract including the coded conditions to us.

Q. Is the retrospective medical record review an audit?

A. This is not a retrospective claims validation audit.

Q. What dates of service are included for the 2017 initiative?

A. The scope for this initiative includes 2016 dates of service through present day.

Q. Are all Amerigroup Amerivantage (Medicare Advantage) members targeted?

A. No, Amerigroup conducts a complex effort synthesizing claims and pharmacy data with enrollment data. Due to the high probability of identifying undocumented data and/or new diagnosis information, persistent members are targeted for this initiative.

Q. What is the provider notification process?

A. Beginning in early May, Verscend will initiate the record retrieval process. The process begins with phone/fax outreach to the provider that is followed by a written request. The written request includes:

- Role of Verscend
- Purpose of the medical record retrieval request
- Action being requested (e.g., submission of the entire medical record)
- Name of the member
- Date(s) of service being requested

Q. When do I need to submit the requested medical records?

A. You should supply the medical records within two weeks of receipt of the request. If the volume is large, Verscend will work with you throughout 2017 to obtain the requested records.

Q. What should I do if I did not actually see the member during the requested date(s) of service?

A. You should return the request to Verscend and include an explanation stating you do not have information relative to the request in the patient's medical record.

Q. How do I submit a medical record? Are there different submission options?

A. Medical records should be returned to Verscend using one of the following methods:

- Mail with prepaid postage
- Electronic medical record (EMR) integration (Verscend requires remote access to the provider's EMR system.)
- Secure file transfer protocol
- Secure Provider Upload Portal (Contact Jaime Marcotte for details regarding this option.)
- On-site scanning (reserved for providers with large record requests)

Q. I received a request for a large number of medical records; can special arrangements be made?

A. Verscend offers on-site scanning services for providers who receive a request for a large number of medical records.

Q. Am I required to comply with the request for medical records?

A. In accordance with the language in the Terms and Conditions of Payment section of your Provider Agreement, you are required to comply with requests from Amerigroup for medical records.

Q. Do I need HIPAA authorization or a release from the patient in order to supply their medical records?

A. No, the collection of risk adjustment data as well as the request for medical records to validate payment made to Medicare Advantage organizations is considered a health care operation and, as such, does not violate the privacy provisions of HIPAA (CFR 164.502).

Q. Whom can I contact if I have questions?

A. Verscend Retrospective Program Manager, Jaime Marcotte, is managing this initiative. She can be reached by phone at 314-925-6094.

SSO-NL-0009-16

New Policy

Modifier 26 and TC: Professional and Technical Component

(Policy 15-004, effective 07/01/17)

Amerigroup Washington, Inc. allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC when appropriate.

Professional Component (Modifier 26)

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

Technical Component (Modifier TC)

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable X-ray suppliers should bill **only** for the technical component by appending Modifier TC.

Global Procedure

In the absence of Modifier TC and Modifier 26, the physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Amerigroup does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only, or global test only of a selected diagnostic test

Amerigroup reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

For additional information and to view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component Reimbursement Policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0013-16

Policy Update

Modifier Usage

(Policy 06-006, effective 08/01/16)

Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0008-16

Policy Update

Modifier 91: Repeat Clinical Diagnostic Laboratory Test

(Policy 06-020, effective 07/01/17)

Amerigroup Washington, Inc. allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100 percent of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0011-16

Policy Update — Medicaid Reimbursement for Reduced and Discontinued Services

(Policy 10-003, effective 04/27/2015)

Amerigroup Washington, Inc. allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Amerigroup does not allow reduced reimbursement of claims with Modifier 52.

Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Amerigroup only recognizes Modifier 53 for certain colonoscopy procedure and screening codes; for all other procedures, the modifier is informational.

Modifier 73 indicates the physician canceled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

Modifier 74 indicates a procedure was stopped after the administration of anesthesia or after the procedure was started. Reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0006-16 A

Policy Update — Amerivantage Reimbursement for Reduced and Discontinued Services

(Policy 10-003, effective 04/27/2015)

Amerigroup Washington, Inc. allows reimbursement to professional providers and facilities for reduced or discontinued services when appended with the appropriate modifier. Modifiers 52, 53, 73 and 74 can be appended for reduced and discontinued services, if applicable.

Modifier 52 indicates procedures for which services performed are significantly less than usually required. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Do not report Modifier 52 on Evaluation & Management (E&M) and consultation codes.

Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances that threatened the well-being of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 53 is not applicable for facility billing and is not valid when billed with E&M or time-based codes.

Modifier 73 indicates the physician canceled the surgical or diagnostic procedure prior to administration of anesthesia and/or surgical preparation of the patient. Reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 73 is not applicable for professional provider billing.

Modifier 74 indicates a procedure was stopped after the administration of anesthesia or after the procedure was started. Reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. Modifier 74 is not applicable for professional provider billing.

For additional information and/or applicable modifier rules, refer to the Reimbursement for Reduced and Discontinued Services reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0006-16 B

Policy Reminder — Medicaid

Claims Timely Filing

(Policy 06-050, originally effective 07/01/2013)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 180 days for participating and nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0010-16

Policy Update — Amerivantage

Claims Timely Filing

(Policy 06-050, effective 08/01/16)

To be considered for reimbursement, the initial claim must be received and accepted by the following standard:

- 12 months for participating and nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies.

Reimbursement Policy Disclaimer

These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. To view the Reimbursement Policy Disclaimer, please visit https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Policy Disclaimer.

SSO-PEC-0006-16

Policy Reminder — Medicaid
Split-Care Surgical Modifiers
(Policy 11-005, effective 08/01/16)

Reimbursement of **surgical codes** appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/ negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 10 percent
- Modifier 56 (preoperative management only): 10 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

WA-NL-0014-16

Policy Reminder — Amerivantage
Split-Care Surgical Modifiers
(Policy 11-005, effective 08/01/16)

Reimbursement of **surgical codes** appended with "split-care modifiers" is allowed and based on a percentage of the fee schedule or contracted/ negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 20 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

SSO-PEC-0722-16