Provider Newsletter

https://providers.amerigroup.com/tx

Amerigroup RealSolutions® in healthcare

2016
Quarter 3

Table of Contents

Vascular embolization or occlusion services to require prior authorization

Effective September 1, 2016, vascular embolization or occlusion services will require prior authorization (PA).

Vascular embolization or occlusion services requests must be reviewed by Amerigroup* for PA for dates of service on and after September 1, 2016. To request PA, use one of the following methods:

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627

For a list of Amerigroup reimbursement policies and more information on PA requirements, please visit our website at https://providers.amerigroup.com/TX and under Provider Resources & Documents, select Quick Tools.

- For reimbursement policies, select Reimbursement Policies.
- For authorization requirements, select Precertification Lookup Tool.

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

Clinical cumulative morphine equivalent dosing point of sale edits effective January 1, 2017

Beginning January 1, 2017, Amerigroup will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale.

This MEq dosing edit will identify members taking a cumulative dose that exceeds the set daily dose. This is a patient safety edit intended to reduce risks from high-dose opioid use. There is a higher risk for overdose when exceeding the set MEq dosing limit. The claim(s) will be rejected at the point of sale and will require a prior authorization (PA) review if the cumulative dosing is over the set daily limit. Certain members may be excluded from the edit, such as members with cancer. The edit supports the CMS guidance mandating that Medicare plans implement a cumulative dosing edit.

Amerigroup anticipates that this edit will impact a fairly high number of claims.

Effective November 1, 2016 ClaimsCheck® upgrade to ClaimsXten™

Amerigroup appreciates your participation in our network. Amerigroup uses ClaimCheck 10.2, a comprehensive nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. The purpose of this update is to notify you that we are upgrading ClaimCheck 10.2 to ClaimsXten, McKesson's next generation code auditing system. As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, AMA/CPT, Specialty Society guidelines and Amerigroup policy. The upgrade will become effective November 1, 2016.

In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc.

What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that in combination with claims processing systems:

- einforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed
- Determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Processes those services according to industry standards

Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes

How will the upgrade to ClaimsXten affect you?

Providers will continue to see similar edits as under ClaimCheck 10.2. ClaimsXten has enhanced audit logic and the ability to analyze claims submission history. Outpatient services will be analyzed for such issues as:

- Rebundled or unbundled services
- Multi-channel services
- Mutually exclusive services
- Incidental procedures
- Incorrect use of CPT codes
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/gender mismatch procedures
- Investigational or experimental procedures
- Procedures being billed with inappropriate modifiers

What type of edits appear on my explanation of payment (EOP) when an edit is applied by ClaimsXten to a service I submitted?

The following list, which is not all inclusive, contains edits that may appear on your EOP when a rule is triggered in ClaimsXten:

Rule	Provider type	Description
Inappropriate age	Professional/facility	Procedure code is either inappropriate for the member's age or an age-specific CPT code does not match the member's age.
Deleted code	Professional/facility	Procedure code has been deleted from CPT.
Invalid diagnosis code	Professional/facility	Procedure submitted with an invalid diagnosis code.
Inappropriate gender	Professional/facility	Procedure code is either inappropriate for the member's gender or a gender-specific CPT code does not match the member's gender.

Rule	Provider type	Description
Invalid modifier-procedure	Professional/facility	Modifier used is invalid with the submitted procedure code.
Multiple radiology reduction	Facility	Reduction applied to multiple contiguous radiology procedures using the same modality on the same date of service (DOS).
Assistant surgeon	Professional	Assistant surgeon not eligible for procedure.
Base code quantity	Professional	Base code with units >1, where add-on code would be appropriate.
Bundled services	Professional	Services incidental to the primary procedure.
Multiple surgery reduction	Professional	Reduction applies to multiple procedures on the same DOS. Procedure with highest reimbursement paid as primary.
Global surgical edits	Professional	Pre-op visit, post-op visit, procedure or other service considered part of the global surgical period.
Maximum units	Professional	Medically unlikely number of units on the same DOS.
Global component	Professional/facility	Audits across multiple providers to ensure that professional and technical components are not reimbursed more than once for the same member, procedure and date of service.
Anesthesia not eligible	Professional	Audits claim lines containing nonanesthesia services submitted by an anesthesiologist as described by the American Society of Anesthesiologists.
Outpatient consultations	Professional	Audits for claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same provider with at least one matching diagnosis within a six-month period.
Inpatient consultations	Professional	Audits for claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a five-day period.
New patient code for established patient	Professional	Audits for claim lines containing a new patient E&M code when another claim line containing any E&M code was billed within a three-year period.
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount.

If you have questions regarding ClaimsXten edits that you receive on your explanation of payment, please call Provider Services at 1-800-454-3730. Thank you for your support.

Nondiscrimination and accessibility requirements update

On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (Final Rule) to improve health equity under the Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, gender, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

How does the Final Rule apply to managed care organizations?

Amerigroup complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities. Amerigroup provides free tools and services to people with disabilities to communicate effectively with us. Amerigroup also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages).

We notified your Amerigroup patients these services can be obtained by calling the Member Services phone number on their member ID card.

Who can I talk to if Amerigroup isn't following these guidelines?

If you or your patient believe that Amerigroup has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:

- Mail: 823 Congress Ave., Suite 400, Austin, TX 78701
- Phone: 1-800-600-4441 (TTY: 711), and ask for a member advocate
- Email: dl-txmemberadvocates@anthem.com

If you or your patient need help filing a grievance, the member advocate is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html. For additional details about Section 1557 and the Final Rule, visit:

- The DHHS OCR information page: www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
- Frequently asked questions published by the DHHS: www.hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf

Synagis (palivizumab)

Respiratory syncytial virus (RSV) season begins as early as October and runs through March. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. The American Academy of Pediatrics (AAP) recommends a maximum of five (15 mg/kg) monthly doses of palivizumab during the RSV season for high-risk infants who were born before 29 weeks, 0 days gestation, have chronic lung disease (CLD) of prematurity or have hemodynamically significant heart disease. Updated indications for prophylaxis can be found in the July 2014 AAP Policy Statement and on our provider website at https://providers.amerigroup.com/TX .

The Synagis prior authorization form can be found on provider website at https://providers.amerigroup.com/TX > Provider Resources & Documents > Pharmacy > Pharmacy Prior Authorization Forms. Only one request is needed for each patient throughout the RSV season. In a case where higher dosage is necessary due to weight gain, documentation of the patient's new weight must be provided.

In most cases, Express Scripts, Inc. is the preferred provider for Synagis requests. Please check with your local Provider Services representative or call our Provider Services team at 1-800-454-3730 for specific details on how to obtain Synagis. You can also find additional drug information at https://providers.amerigroup.com/TX.

Access to case management

In addition to disease management programs, Amerigroup* offers a complex case management program for high-risk members. Using claims and utilization data, we can identify diseases for which members are most at risk and to which they are most susceptible.

Our case managers use evidence-based guidelines to coordinate care with members and their families with physicians and other health care providers. They work with everyone involved in members' care to help implement a case management plan based on members' individual needs. We provide education and support to our members and their families to help our members improve their health and quality of life. If you have a high-risk member you would like to refer to this program, please call us at 1-800-454-3730.

Vascular embolization or occlusion services to require prior authorization

Effective November 1, 2016, certain vascular embolization or occlusion services will require prior authorization (PA) for Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). This applies to the following procedure codes:

- 37243: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for tumors, organ ischemia or infarction
- 37244: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for arterial/venous hemorrhage or lymphatic extravasation

Noncompliance with the new requirements may result in denied claims.

Federal law, state law, 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.

Not all PA requirements are listed here. For more information, go to https://providers.amerigroup.com and select Quick Tools from the upper right hand corner, and then the Precertification Look-Up Tool. You may also call Provider Services at 1-855-878-1785.

Clinical cumulative morphine equivalent dosing point of sale edit effective January 1, 2017

Beginning January 1, 2017, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale.

This MEq dosing edit will identify members taking a cumulative dose that exceeds the daily dose that has been set. This is a patient safety edit intended to reduce the risk from high-dose opioid use. There is a higher risk for overdose when exceeding the set MEq dosing limit. The claim(s) will reject at the point of sale and require a prior authorization review if the cumulative dosing is over the set daily limit. Certain members may be excluded from the edit, such as members with cancer. The edit supports the CMS guidance mandating that Medicare plans implement a cumulative dosing edit.

Amerigroup STAR+PLUS MMP anticipates that this edit will impact a fairly high number of claims. If you have questions, please call Provider Services at 1-855-878-1785.

Members with rheumatoid arthritis may be missing important medications

According to the American College of Rheumatology, disease-modifying antirheumatic drugs (DMARDs) can help prevent long-term disability and damage to persons with rheumatoid arthritis. If you see a STAR+PLUS MMP (Medicare-Medicaid Plan) member who has been diagnosed with rheumatoid arthritis and that member has not received or filled a prescription for DMARDs, you will now receive a fax reminder.

The fax will include the member's contact information and a request to ensure the member has this important medication. A registered nurse also may follow up with the physician or the member to assist with appointments or prescriptions, as needed.

If you have questions about the new rheumatoid arthritis reminder program, please call Provider Services at 1-855-878-1785.

Help improve your members' medication adherence with 90-day prescriptions

Ninety-day prescriptions help improve members' medication adherence by reducing their need to travel to the pharmacy. Therefore, to help improve medication adherence among STAR+PLUS MMP members, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will be communicating with providers who are prescribing a 30-day supply of oral diabetic medications, renin-angiotensin system (RAS) antagonists and statins to encourage the use of 90-day prescriptions.

When medically appropriate, Amerigroup STAR+PLUS MMP requests that you convert your patient's prescription to a 90-day supply to improve adherence and outcomes without compromising quality of care. We will not transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply of medication at the same pharmacy where they previously obtained the 30-day prescription supply and pay the same copay for an extended 90-day supply as they would for a 30-day supply.

Care transition and discharge record reminder

Transition in care is the most critical component in ensuring our members make a smooth and safe transition from the hospital to the place they call home. It is crucial that the receiving primary care provider or facility have the member's discharge record within 24 hours of the member's discharge. Having this record available at the first post-discharge physician visit improves the continuity of care, and can help decrease the chance of a hospital readmission.

Please do your part.

Ensure the member's discharge record is sent to the receiving primary care provider or facility within 24 hours of the member's discharge.

Benefits in sending the discharge records:

- Decrease in hospital readmissions
- Accurate medication management
- Improved care coordination
- Reduction in preventable errors

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 1-855-878-1785.

Prior authorization requirements for new injectable/infusible drugs: Darzalex (daratumumab) and Empliciti (elotuzumab)

On November 1, 2016, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) prior authorization (PA) requirements will change for two new Part B injectable/infusible drugs covered by the plan – Darzalex (daratumumab) and Empliciti (elotuzumab). Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification 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:

- Darzalex (daratumumab): for the treatment of multiple myeloma in patients who have received at least [three] prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent (C9476 or J9999)
- Empliciti (elotuzumab): for treatment of multiple myeloma in combination with lenalidomide and dexamethasone following treatment with one to three prior therapies (C9477 or J9999)

Please note both of these drugs are currently billed under the Not Otherwise Classified (NOC) J code (J999). Since this code includes all drugs NOC, the plan's denial will be for the drug and not the HCPCS.

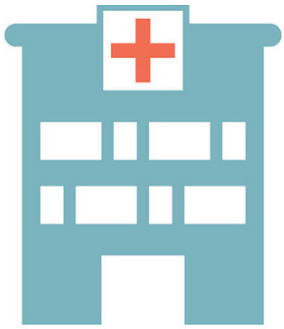
This update to the 2016 PA requirement applies to all the Medicare-Medicaid plans.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool www.Availity.com at https://providers.amerigroup.com > Login. Contracted and noncontracted providers may call Provider Services at 1-855-878-1785 if they are not able to access Availity.

Hospital observation service limits

A STAR+PLUS MMP member's time in observation (and hospital billing) begins with the member's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. The billed units of service should equal the number of hours the patient receives observation services.

Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.



Beginning January 2017, the number of units reported with HCPCS code G0378 (hospital observation service, per hour) must equal or exceed eight hours, but are limited to 72 hours. Observation services billed outside of these parameters will be denied. This pertains to both contracted and noncontracted providers.

Additional information and discussion regarding hospital observation services can be found in the Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, 290.2.2.

Home health billing instructions

All claims from Home Health Agencies (HHAs) must follow CMS billing instructions. These billing instructions pertain to providers contracted to Medicare pricing and noncontracted providers. These billing instructions apply to all individual and group-sponsored Medicare Advantage Plans and Medicare-Medicaid Plans.

0322 – Interim first claim

Statement covers period
Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the request for anticipated payment (RAP) is a request for payment for future services, the ending date may not be known. The RAP contains the same date in both the "from" and "through" date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.).

Admission date
Date the patient was admitted to Home Health Care. On the first RAP in an admission, this date should match the statement covers period field (above) "from" date. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

Service date
For initial episodes, use the 0023 revenue code to report the date of the first covered visit provided during the episode. For subsequent episodes, the HHA should use the 0023 revenue code to report the date of the first visit provided during the episode, regardless of whether the visit was covered or non-covered.

0329 – Final bill

Statement covers period
The beginning and ending dates of the period covered by this claim. The "from" date must match the date submitted on the RAP for the episode. For continuous care episodes, the "through" date must be 59 days after the "from" date.

Admission date
The HHA enters the same date of admission that was submitted on the RAP for the episode.

Service date
For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or noncovered.

Hospital observation service limits

An Amerigroup Amerivantage Medicare Advantage member's time in observation (and hospital billing) begins with the member's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. The billed units of service should equal the number of hours the patient receives observation services.

Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.

Beginning January 2017, the number of units reported with HCPCS code G0378 (hospital observation service, per hour) must equal or exceed eight hours, but are limited to 72 hours. Observation services billed outside of these parameters will be denied. This pertains to both contracted and noncontracted providers.

Additional information and discussion regarding hospital observation services can be found in the Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, 290.2.2.

Reimbursement Policies

New Policy - Medicaid and Amerivantage Reimbursement for Maximum Units Per Day

(Policy 15-003, effective 01/01/2017)

Amerigroup allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

For additional information, refer to the Reimbursement for Maximum Units Per Day policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Reminder - Medicaid and Amerivantage DME Modifiers for New, Rented, and Used Equipment

(Policy 06-053, effective 3/14/16)

Amerigroup allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For additional information, refer to the DME Modifiers for New, Rented and Used Equipment policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Reminder - Medicaid and Amerivantage Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

(Policy 06-049, effective 11/18/2013)

Amerigroup allows reimbursement of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program services. The policy provides a list of EPSDT component services included in the reimbursement of the preventive medicine Evaluation and Management (E&M) visit unless they are appended with Modifier 25 to indicate a significant, separately identifiable E&M service by the same physician on the same date of service. If a provider performs EPSDT services in conjunction with a sick visit, all services are subject to our Preventive Medicine and Sick Visits on Same Day reimbursement policy.

For additional information, refer to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Update - Medicaid
Durable Medical Equipment (Rent to Purchase)
(Policy 06-052, effective 01/01/2017)

Amerigroup allows reimbursement for Durable Medical Equipment (DME) under specific guidelines, unless otherwise noted by provider, state, federal, or CMS contracts and/or requirements.

Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of Rental DME
Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances Affecting Rental Reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days
- If a member changes suppliers during the rental period, a new rental period will not start over

Amerigroup allows reimbursement for oxygen equipment for a maximum of 36 months; however, we will continue to reimburse for oxygen contents.

For additional information, refer to the Durable Medical Equipment (Rent to Purchase) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.

Policy Update - Amerivantage
Durable Medical Equipment (Rent to Purchase)
(Policy 06-052, effective 01/01/2016)

Amerigroup allows reimbursement for Durable Medical Equipment (DME) under specific guidelines, unless otherwise noted by provider, state, federal, or CMS contracts and/or requirements.

Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of Rental DME
Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 13 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances Affecting Rental Reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days
- If a member changes suppliers during the rental period, a new rental period will not start over

Amerigroup allows reimbursement for oxygen equipment for a maximum of 36 months; however, we will continue to reimburse for oxygen contents.

For additional information, refer to the Durable Medical Equipment (Rent to Purchase) policy at https://providers.amerigroup.com > Quick Tools > Reimbursement Policies > Medicaid/Medicare.