

# Provider Newsletter



# Amerigroup

An Anthem Company

<https://providers.amerigroup.com/TX>

June 2019

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## 2019 Utilization Management Affirmative Statement concerning utilization management decisions

All associates who make utilization management (UM) decisions are required to adhere to the following principles:

- UM decision making is based only on care appropriateness, and service and existence coverage.
- We do not reward practitioners or other individuals for issuing coverage or care denials. 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 benefit denials.
- We do not offer financial incentives to decision makers for UM determinations that encourage decisions resulting in underutilization or create barriers to care and service.



TX-NL-0192-19

## Members' Rights and Responsibilities Statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment participating practitioners and members in our system, Amerigroup has adopted a *Members' Rights and Responsibilities Statement*, which is located within the provider manual.

If you need a physical copy of the statement, call Provider Services at 1-800-454-3730.

TX-NL-0194-19

## Updated Clinical Practice Guidelines and Preventive Health Guidelines

Updated *Clinical Practice Guidelines* and *Preventive Health Guidelines* are now available on the Amerigroup [provider self-service website](#). Our quality improvement committee reviewed and approved these evidence-based guidelines. The guidelines include direct links to the source documents for reference.

### Clinical Practice Guidelines

Updates for the *Clinical Practice Guidelines* include added topics on the following conditions:

- Oppositional defiant disorder
- Post-traumatic stress disorder
- Suicide risk
- Fall risk/prevention
- Rheumatoid arthritis
- Opioid use in the older adult population

### Preventive Health Guidelines

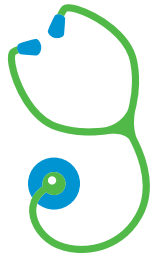
The *Preventive Health Guidelines* were updated to clarify recommendations by the American Academy of Pediatrics and the United States Preventive Services Task Force.



TXPEC-2940-19

## Important information about utilization management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Our medical policies are available on our [provider website](#).



You can request a free copy of our UM criteria from Provider Services at 1-800-454-3730. Providers can discuss a UM denial decision with a physician reviewer by calling us toll-free at the number listed below. Providers can access UM criteria [online](#).

We are staffed with clinical professionals who coordinate our members' care and are available 24 hours a day, 7 days a week to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

For questions, call our Clinical team at 1-800-454-3730 Monday-Friday from 8 a.m.-5 p.m. Central time.

For any physician peer-to-peer discussions regarding a request that is being reviewed by our medical directors: Call 1-817-861-7768 and set up a time for our medical director to call you to discuss the case.

### Submit precertification requests via the following:

#### UM fax numbers:

- Durable medical equipment, pain management injections, nonemergent ambulance services and home health nursing (private duty nursing, skilled nursing visits and home health aid) — excludes long-term support services (LTSS): 1-866-249-1271
- Therapy requests (speech, occupational and physical therapy): 1-844-756-4608
- Inpatient/outpatient surgeries, back and spine procedures, and other general requests: 1-800-964-3627
- Inpatient behavioral health: 1-877-434-7578
- Outpatient behavioral health: 1-866-877-5229
- STAR Kids LTSS/personal attendant services: 1-844-756-4604

#### STAR+PLUS LTSS/personal attendant services fax numbers by service area:

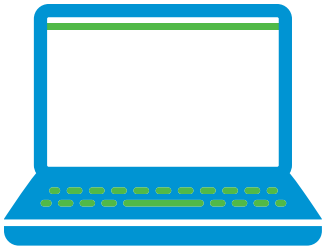
- Austin: 1-877-744-2334
- El Paso: 1-888-822-5790
- Houston/Beaumont: 1-888-220-6828
- Lubbock: 1-888-822-5761
- San Antonio: 1-877-820-9014
- Tarrant/West RSA: 1-888-562-5160

#### Phone:

- Urgent requests: 1-800-454-3730
- [AIM Specialty Health](#)® (cardiology, genetic testing, radiation oncology, radiology [high-tech], sleep studies): 1-800-714-0040
- Access2Care (nonemergent transportation, other than ambulance): 1-855-295-1636

Online: [Availity Portal](#)

TX-NL-0194-19



## Texas Health Steps webinar schedule

### Do you have questions regarding Texas Health Steps?

Please join one of our online provider trainings hosted by Amerigroup. Online sessions will include an overview of the Texas Health Steps program, billing guidelines and related programs such as Case Management for Children and Pregnant Women and the Medicaid Transportation Program.

**All sessions will be held from noon-1 p.m., Central time.**

**Call line: 1-866-308-0254 ■ Participant code: 1662080765#**

#### Wednesday, June 12, 2019

- Online webinar: <https://tinyurl.com/y3uqyzpq>
- Event password: June12

#### Wednesday, June 26, 2019

- Online webinar: <https://tinyurl.com/y5lu4ead>
- Event password: June26

#### Wednesday, July 17, 2019

- Online webinar: <https://tinyurl.com/y2y3yl8t>
- Event password: July17

#### Wednesday, July 31, 2019

- Online webinar: <https://tinyurl.com/y454acr3>
- Event password: July31

#### Wednesday, August 14, 2019

- Online webinar: <https://tinyurl.com/yyg85wcn>
- Event password: August14

#### Wednesday, August 28, 2019

- Online webinar: <https://tinyurl.com/y5e88fno>
- Event password: August28

#### Wednesday, September 11, 2019

- Online webinar: <https://tinyurl.com/y3ypfkyw>
- Event password: September11

#### Wednesday, September 25, 2019

- Online webinar: <https://tinyurl.com/yylmm4vs>
- Event password: September25

#### Wednesday, October 16, 2019

- Online webinar: <https://tinyurl.com/y64l5xn6>
- Event password: October16

#### Wednesday, October 30, 2019

- Online webinar: <https://tinyurl.com/y5d839o3>
- Event password: October30

#### Wednesday, November 13, 2019

- Online webinar: <https://tinyurl.com/yxpdmwt8>
- Event password: November13

#### Wednesday, November 27, 2019

- Online webinar: <https://tinyurl.com/y3aawy45>
- Event password: November27

#### Wednesday, December 18, 2019

- Online webinar: <https://tinyurl.com/y6ot54aj>
- Event password: December18

TXPEC-2954-19

## Provider Orientation training schedule

### Would you like more information on how to check eligibility, authorizations or claims status?

Join one of the online provider trainings hosted by Amerigroup.

**All sessions will be held from noon-1 p.m., Central time.**

**Call line: 1-866-308-0254 ■ Participant code: 1662080765#**

#### Wednesday, June 19, 2019

- Online webinar: <https://bit.ly/2S1egY8>
- Event password: June19

#### Wednesday, July 24, 2019

- Online webinar: <https://bit.ly/2GGURKn>
- Event password: July24

#### Wednesday, August 21, 2019

- Online webinar: <https://bit.ly/2US0x7S>
- Event password: August21

#### Wednesday, September 18, 2019

- Online webinar: <https://bit.ly/2N8WH80>
- Event password: September18

#### Wednesday, October 23, 2019

- Online webinar: <https://bit.ly/2WXzWZ4>
- Event password: October23

#### Wednesday, November 20, 2019

- Online webinar: <https://bit.ly/2X1PICf>
- Event password: November20

#### Wednesday, December 18, 2019

- Online webinar: <https://bit.ly/2GGbnKA>
- Event password: December18

TXPEC-2944-19

## Update: evaluation and management with Modifier 25

Amerigroup identified that providers often bill a duplicate evaluation and management (E&M) service on the same day as a procedure even when the same provider (or a provider with the same specialty within the same group TIN) recently billed a service or procedure which included an E&M service for the same or similar diagnosis. The use of Modifier 25 to support separate payment of this duplicate service is not consistent with correct coding or Amerigroup reimbursement policy on use of Modifier 25.



Beginning with claims processed on or after July 1, 2019, Amerigroup may enforce the denial of E&M services with a Modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record in accordance with Amerigroup policy.

If you believe a claim should be reprocessed because there are medical records for related visits that demonstrate an unrelated, significant and separately identifiable E&M service, please submit those medical records for consideration.

TX-NL-0188-19

## Why do patients stop taking their prescribed medications, and what can you do to help them?

### You want what's best for your patients' health.

When a patient doesn't follow your prescribed treatment plan, it can be a challenge. Approximately 50 percent of patients with chronic illness stop taking their medications within one year of being prescribed.<sup>1</sup> What can be done differently?



The missed opportunity may be that you're only seeing the tip of the iceberg, that is, the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline — the giant, often invisible, patient self-talk that may not get discussed aloud — can create a misalignment between patient and provider.

We've created an online learning experience to teach the skills and techniques that can help you navigate these uncharted patient waters. After completing the learning experience you'll know how to see the barriers, use each appointment as an opportunity to build trust and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence — and you'll earn continuing medical education credit along the way.

### Take the next step.

Go to [MyDiversePatients.com](https://MyDiversePatients.com) > *The Medication Adherence Iceberg: How to navigate what you can't see to enhance your skills*. The course is approximately one hour and accessible by smart phone, tablet or desktop at no cost.

1 Centers for Disease Control and Prevention. (2017, Feb 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from <https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm>.

TX-NL-0184-19

## Sepsis diagnosis coding and billing reminder

To help ensure compliance with the coding and billing of sepsis, Amerigroup reviews clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for sepsis applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent sepsis-3 clinical criteria published in the [\*Journal of the American Medical Association, February 2016\*](#). At discharge, clinicians and facilities should apply the sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of sepsis. The claim may be subject to an adjustment in reimbursement when sepsis is not supported based on the sepsis-3 definition and criteria.

TX-NL-0195-19

## Sports physicals and annual checkups

Sports physicals are an Amerigroup value-added service for STAR, STAR Kids and CHIP members from ages 6-18 when performed by the primary care provider on record. If the member is due for a Texas Health Steps checkup or CHIP well-child checkup, the provider should complete both the sports physical and all the components required for the annual checkup.



Providers may bill and receive reimbursement for both services. However, a sports physical is not a reason for an exception-to-periodicity checkup. To bill for a sports physical, use CPT code 99212 and diagnosis code Z02.5. No additional modifier is needed.

TX-NL-0191-19



## Intervention for blood sugar control in pregnant women with diabetes

In an effort to help your patients maintain healthy blood sugar levels throughout pregnancy, reduce the probability that babies will be born weighing greater than 4,500 grams and, thereby, reduce the potential for cesarean section, Amerigroup offers the Diabetes in Pregnancy program to support you and your patients. Eligible Amerigroup members in need of additional support may be enrolled in case management and referred to a registered dietitian/nutritionist or certified diabetes educator.

The program includes providing meal planning assistance, physical activity interventions, weight gain interventions and monitoring blood sugar patterns. Pregnant members with diabetes are identified as early as possible and are targeted for outreach to engage in case management.

### Diabetes in pregnancy

The common types of diabetes seen during pregnancy are type 1, type 2 and gestational diabetes, which is defined as diabetes first diagnosed in the second or third trimester of pregnancy that is clearly neither pre-existing type 1 or type 2 diabetes. According to the Centers for Disease Control and Prevention, pre-existing diabetes occurs in 1-2 percent of all pregnancies and gestational diabetes in 6-9 percent of pregnancies.<sup>1</sup>

While pregnancy complicated with diabetes is a low percentage of all pregnancies, the risk of cesarean sections is much higher in this population than for women with uncomplicated pregnancies. Sixty-four percent of women with pre-existing diabetes and 46 percent of women with gestational diabetes will have a cesarean section compared to 32 percent of women who do not have diabetes during pregnancy.<sup>2</sup>



Whether diagnosed with type 1, type 2 diabetes or gestational diabetes, blood sugar control is essential for the health and well-being of mother and infant. All types of diabetes put the baby at risk for macrosomia, making a cesarean section delivery more likely.<sup>3</sup> Research indicates that early lifestyle interventions, such as meal planning and physical activity, can help women reach healthy blood sugar targets more quickly and help them stay in target longer, thus reducing the risk of macrosomia in the infant.<sup>4</sup>

According to the American College of Obstetricians and Gynecologists (ACOG), cesarean sections should be limited to babies of at least 4,500 grams in mothers with diabetes.<sup>5</sup>

### For more information

If you have a patient who would benefit from speaking with an Amerigroup registered dietitian/nutritionist, certified diabetes educator or an obstetric case manager, please call Provider Services at 1-800-454-3730 and ask for a case management referral for the member. If you would like more information on the Diabetes in Pregnancy program, please contact Provider Services at the number above.

1 Retrieved from: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/diabetes-during-pregnancy.htm>.

2 Agency for Healthcare Research and Quality Statistical Brief #102. Retrieved from: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb102.jsp>.

3 *The New England Journal of Medicine*, May 8, 2008 vol. 358 no. 19. *Hyperglycemia and Adverse Pregnancy Outcomes*, The HAPO Study Cooperative Research Group. Retrieved from: <https://www.nejm.org/doi/full/10.1056/NEJMoa0707943>.

4 *Effect of diet and physical activity based interventions in pregnancy on gestational weight gain and pregnancy outcomes: meta-analysis of individual participant data from randomized trials*. *BMJ* 2017;358:j3119 DOI: 10.1136/bmj.j3119 (Published 19 July 2017).

5 ACOG *Obstetrics Care Consensus No.1*, March 2014 (reaffirmed 2016), *Safe Prevention of Primary Cesarean Delivery*. Retrieved from: <https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery>.

## Complex Case Management program

Managing an illness can be a daunting task for our members. It is not always easy to understand test results or know how to obtain essential resources for treatment or who to contact with questions and concerns.

Amerigroup is available to offer assistance in these difficult moments with our Complex Care Management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals who support members, families, primary care physicians and caregivers. The Complex Care Management process utilizes the experience and expertise of the Care Coordination team to educate and empower our members by increasing self-management skills. The Complex Care Management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.



Members or caregivers can refer themselves or family members by calling the Member Services number located on their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can call us at 1-800-454-3730 or fax us at 1-866-249-1185. Case Management business hours are Monday-Friday from 8 a.m.-5 p.m. Central time.

TX-NL-0194-19

## Coding Spotlight: Hypertension

### A providers' guide for coding

#### ICD-10-CM hypertension coding highlights:

- Hypertensive crisis can involve hypertensive urgency or emergency.
- Hypertension can occur with heart disease, chronic kidney disease (CKD) or both.
- ICD-10-CM classifies hypertension by type as essential or primary (categories I10-I13) and secondary (category I15).<sup>1</sup>
- Categories I10-I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), CKD (I12), or heart and CKD combined (I13).<sup>1</sup>

For more information, including ICD-10-CM coding and HEDIS® Quality Measures for hypertension:



**Read more online.**

#### Resource

1 "ICD-10-CM Expert for Physicians. The complete official code set," Optum360, LLC (2019).

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

TX-NL-0202-19





## 2019 Utilization Management Affirmative Statement concerning utilization management decisions

View the [article](#) in the Medicaid section.

TX-NL-0192-19

## Provider Orientation training schedule

View the [article](#) in the Medicaid section.

TXPEC-2944-19

## Why do patients stop taking their prescribed medications, and what can you do to help them?

View the [article](#) in the Medicaid section.

TX-NL-0184-19/TXD-NL-0113-19

## Sepsis diagnosis coding and billing reminder

View the [article](#) in the Medicaid section.

TX-NL-0195-19/TXD-NL-0134-19

## Medical records request for risk adjustment

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is working with Optum CiOX Health (CiOX) to request medical records for risk adjustment. Risk adjustment is the process by which CMS reimburses Medicare-Medicaid Plans (MMPs), such as Amerigroup STAR+PLUS MMP, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender), as well as health status.

In 2019, Amerigroup STAR+PLUS MMP will work with Optum, using their copy partner CiOX, to request medical records with dates of service for the target year 2018, through present day, then review and code the record.

Jaime Marcotte, Retrospective Risk Program Lead, is managing this initiative. Should you have any questions regarding this program, please contact Jaime at [Jaime.Marcotte@anthem.com](mailto:Jaime.Marcotte@anthem.com) or 843-666-1970.

TXD-NL-0116-19



**Read more online.**

## Outpatient Rehabilitation Program transitioning to AIM

Effective October 1, 2019, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will transition utilization management of our Outpatient Rehabilitation Program for Medicare Advantage from OrthoNet LLC to AIM Specialty Health® (AIM). AIM is a specialty health benefits company. The Outpatient Rehabilitation Program includes physical, occupational and speech therapy services. Amerigroup STAR+PLUS MMP has an existing relationship with AIM in the administration of other programs.

This transition enables Amerigroup STAR+PLUS MMP to expand and optimize this program, further ensuring that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Amerigroup STAR+PLUS MMP for medical necessity determination. For Medicare Advantage, Amerigroup STAR+PLUS MMP makes coverage determinations based on guidance from CMS including national coverage determinations (NCDs), local coverage determinations (LCDs), other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Amerigroup STAR+PLUS MMP clinical guidelines *CG.REHAB.04*, *CG.REHAB.05* and *CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed [online](#).

Detailed prior authorization requirements are available online by accessing the Precertification Lookup Tool under *Payer Spaces/Amerigroup* at <https://www.availity.com>. Contracted and noncontracted providers may also call Provider Services at 1-855-878-1785 for prior authorization requirements.

### Prior authorization review requirements

For services scheduled to be rendered through September 30, 2019, providers must contact OrthoNet LLC to obtain prior authorizations for outpatient rehabilitation services. Any authorizations OrthoNet LLC issues prior to the transition date of October 1, 2019, will be honored and claims will process accordingly.

For services that are scheduled on or after October 1, 2019, providers must contact AIM to obtain prior authorization. Beginning September 15, 2019, providers will be able to contact AIM for prior authorization on services to take place on or after October 1, 2019. Providers are strongly encouraged to verify that they have obtained prior authorization before scheduling and performing services.

### How to place a review request

You may place a request online via the AIM **ProviderPortal**<sub>SM</sub>. This service is available 24 hours a day, 7 days a week to process requests in real-time using clinical criteria. Go to [www.providerportal.com](http://www.providerportal.com) to register. You can also call AIM at 1-800-714-0040, Monday-Friday 7 a.m.-7 p.m. Central time.

### For more information

For resources to help your practice get started with the Outpatient Rehabilitation Program, go to [www.aimproviders.com/rehabilitation](http://www.aimproviders.com/rehabilitation). Our provider website helps you learn more and provides access to useful information and tools such as order entry checklists, clinical guidelines and FAQ.

TXD-NL-0139-19

## Home health billing guidelines for contracted providers

This information is intended for providers who **do not** submit their claims to MyNexus.



Below are some billing guidelines we recommend home health providers use when billing a Request for Anticipated Payment (RAP) and final claim to Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan). This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract.

- Amerigroup STAR+PLUS MMP should receive the final bill within 120 days after the start date of the episode or 60 days after the paid date of the RAP claim — whichever is greater. If the final bill is not received within this time frame, the RAP payment will be canceled/recouped — This is a [Medicare billing requirement](#).
- Bill the full Medicare allowed amount for the episode as the billed charges. Do not bill only the expected additional payment on the final claim as the billed charges. When this happens, the Lesser of Logic term in your contract affects the final payment made for the services. If the billed charges are less than the final allowed, the payment will be reduced to only pay up to the billed charges. The billed charges on the final claim should be for at least the full Medicare allowed amount for the services rendered. This will allow the claim to process correctly according to Medicare guidelines.
  - Example: RAP claim paid \$500. The final claim is submitted with billed charges in the amount of \$1,000. The Medicare allowed amount is \$1,500. Since the billed charges on the final claim are only \$1,000, Amerigroup STAR+PLUS MMP would only pay an additional \$500 for the final allowed according to the Lesser of Logic term in the contract. If the provider would have billed charges in the amount of at least \$1,500, then an additional payment of \$1,000 would have been paid.

TXD-NL-0133-19

## Partial hospitalization services

Medicare-Medicaid plans under Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) follow original Medicare guidelines and billing requirements for partial hospitalization services. CMS regulations (42 CFR 410.43(c) (1)) state that partial hospitalization programs (PHPs) are intended for members who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. All partial hospitalization services require prior authorization.



**Read more online.**

TXD-NL-0117-19

## Submitting corrected claims

Effective June 1, 2019, Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) will be treating corrected claims as replacement claims. When you submit a corrected claim, it is important that you clearly identify that the claim is a correction rather than an original claim. Refer to the instructions below for information on submitting *CMS-1500* and *UB-04* claims.

### Electronic *CMS-1500* claims

Enter Claim Frequency Type code (billing code) 7 for a replacement/correction. Enter 8 to void a prior claim in the 2300 loop of CLM\*05 03. Enter the original claim number in the 2300 loop of the REF\*F8\*.

### Paper *CMS-1500* claims

Amerigroup STAR+PLUS MMP will accept:

- *Corrected claim* written on the face of the *CMS-1500* claim.
- The *Provider Adjustment Request Form* clearly identifying the information being corrected.
- Entry in box 22 of the claim:
  - Use resubmission code 7 to notify us of a corrected or replacement claim.
  - Insert an 8 to let us know you are voiding a previously submitted claim.
  - Enter the original claim number in the Original Ref. No. field. If that information is not available, enter the original document control number.



### Electronic or paper *UB-04* claims

- Amerigroup STAR+PLUS MMP will continue to accept the *Provider Adjustment Request Form* clearly identifying the information being corrected.
- When submitting a corrected claim, ensure the type of bill is xx7 (correction/replacement) or xx8 (void) when the correction is made within the initial claim one year timely filing limitation.

When you need to correct a claim and it is beyond the timely filing limit, you should resubmit a reopening request (type of bill XXQ) to correct the error. Reopenings are typically used to correct claims with clerical errors, including minor errors and omissions, and are conducted at the discretion of the plan. Therefore, it is not appealable, and the original initial determination stands as a binding decision. Appeal rights are retained on the original initial determination.

Note: For adjustments and reopenings that result in higher weighted diagnosis-related groups, there is a congressionally mandated time frame of 60 days from the initial claim determination.

TXD-NL-0118-19

# Prior authorization requirements

## DME repair and portable oxygen concentrator

Effective July 1, 2019, prior authorization (PA) requirements will change for for DME repair and portable oxygen concentrators to be covered by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan).

### PA requirements will be added to the following:

- K0739 — Repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes
- E1392 — Portable oxygen concentrator, rental

TXD-NL-0114-19

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services 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.**

### To request PA, you may use one of the following methods:

- **Web:** <https://www.availity.com>
- **Fax:** 1-888-235-8468
- **Phone:** 1-855-878-1785

Not all PA requirements are listed here. PA requirements are available to contracted and noncontracted providers on our provider website (<https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool). Providers may also call us at 1-855-878-1785 for PA requirements.



## 2019 Utilization Management Affirmative Statement concerning utilization management decisions

View the [article](#) in the Medicaid section.

TX-NL-0192-19/AGPCRNL-0016-19

## Why do patients stop taking their prescribed medications, and what can you do to help them?

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TX-NL-0184-19/AGPCRNL-0007-19

## Sepsis diagnosis coding and billing reminder

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TX-NL-0195-19/AGPCRNL-0018-19

## Medical records request for risk adjustment

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Jaime Marcotte, Retrospective Risk Program Lead, is managing this initiative. Should you have any questions regarding this program, please contact Jaime at [Jaime.Marcotte@anthem.com](mailto:Jaime.Marcotte@anthem.com) or 843-666-1970.

AGPCRNL-0010-19



**Read more online.**



## Outpatient Rehabilitation Program transitioning to AIM

Effective October 1, 2019, Amerigroup will transition utilization management of our Outpatient Rehabilitation Program for Medicare Advantage from OrthoNet LLC to AIM Specialty Health® (AIM). AIM is a specialty health benefits company. The Outpatient Rehabilitation Program includes physical, occupational and speech therapy services. Amerigroup has an existing relationship with AIM in the administration of other programs.

This transition enables Amerigroup to expand and optimize this program, further ensuring that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Amerigroup for medical necessity determination. For Medicare Advantage, Amerigroup makes coverage determinations based on guidance from CMS including national coverage determinations (NCDs), local coverage determinations (LCDs), other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Amerigroup clinical guidelines *GC.REHAB.04*, *CG.REHAB.05* and *CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed in [Availity](#) by selecting **Clinical Resources** in the *Education and Reference Center* under *Payer Spaces*.

Detailed prior authorization requirements are available online by accessing the Precertification Lookup Tool under *Payer Spaces* at <https://www.availity.com>. Contracted and noncontracted providers should call Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

### Prior authorization review requirements

For services scheduled to be rendered through September 30, 2019, providers must contact OrthoNet LLC to obtain prior authorizations for outpatient rehabilitation services. Any authorizations OrthoNet LLC makes prior to the transition date of October 1, 2019, will be honored and claims will process accordingly.

For services that are scheduled on or after October 1, 2019, providers must contact AIM to obtain prior authorization. Beginning September 15, 2019, providers will be able to contact AIM for prior authorization on services to take place on or after October 1, 2019. Providers are strongly encouraged to verify that they have obtained prior authorization before scheduling and performing services.

### How to place a review request

You may place a request online via the AIM **ProviderPortal**<sup>SM</sup>. This service is available 24/7 to process requests in real time using clinical criteria. Go to [www.providerportal.com](http://www.providerportal.com) to register. You can also call AIM at 1-800-714-0040, Monday-Friday 7 a.m.-7 p.m. Central time.

### For more information

For resources to help your practice get started with the Outpatient Rehabilitation Program, go to [www.aimproviders.com/rehabilitation](http://www.aimproviders.com/rehabilitation). Our provider website helps you learn more and provides access to useful information and tools such as order entry checklists, clinical guidelines and FAQ.

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## Update: 2019 risk adjustment provider trainings

The Amerigroup Medicare Risk Adjustment regulatory compliance team offers two provider training series regarding Medicare risk adjustment guidelines. Information for each training is outlined below:

Medicare Risk Adjustment and Documentation Guidance (General) training	
<b>Series:</b>	Offered the first Wednesday of each month from 1 p.m.-2 p.m. ET
<b>Learning objective:</b>	Provide an overview of Medicare risk adjustment, including the risk adjustment factor and the hierarchical condition category (HCC) model, with guidance on medical record documentation and coding
<b>Credits:</b>	This live activity is offered from December 5, 2018-November 6, 2019. The American Academy of Family Physicians has reviewed this activity, and it is acceptable for up to 1.00 prescribed credit.
For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at the link below: <a href="https://antheminc.adobeconnect.com/admin/show-event-catalog?folder-id=38826374">https://antheminc.adobeconnect.com/admin/show-event-catalog?folder-id=38826374</a> .	
Medicare Risk Adjustment, Documentation and Coding Guidance (Condition Specific) training	
<b>Series:</b>	Offered bimonthly on the fourth Wednesday from noon-1 p.m. ET
<b>Learning objective:</b>	Collaborative learning event with enhanced personal health care to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding HCCs, with guidance on documentation and coding
<b>Credits:</b>	This live activity series is offered from January 23, 2019-November 27, 2019. The American Academy of Family Physicians has reviewed this activity, and it is acceptable for credit.
For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates to register for below:	
<ol style="list-style-type: none"> <li><b>1. Red Flag HCCs, Part 1</b> (Register for recording of live session): Training will cover HCCs most commonly reported in error as identified by CMS: chronic kidney disease (stage 5), ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, and end-stage liver disease. Recording will play upon registration. <a href="https://antheminc.cosocloud.com/e4i5k4h7cf3j/event/registration.html">https://antheminc.cosocloud.com/e4i5k4h7cf3j/event/registration.html</a></li> <li><b>2. Red Flag HCCs, Part 2</b> (March 27, 2019): Training will cover HCCs most commonly reported in error as identified by CMS: atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, and diabetes with ophthalmologic or unspecified manifestation. Recording will play upon registration. <a href="https://antheminc.cosocloud.com/enfndbyedd5g/event/event_info.html">https://antheminc.cosocloud.com/enfndbyedd5g/event/event_info.html</a></li> <li><b>3. Opioids and more: Substance abuse and dependence</b> (May 22, 2019): Register at <a href="https://antheminc.cosocloud.com/ej8ltgkxa1ch/event/registration.html">https://antheminc.cosocloud.com/ej8ltgkxa1ch/event/registration.html</a>.</li> <li><b>4. Acute, chronic and status conditions</b> (July 24, 2019): Register at <a href="https://antheminc.cosocloud.com/e2j034x8nshx/event/registration.html">https://antheminc.cosocloud.com/e2j034x8nshx/event/registration.html</a>.</li> <li><b>5. Diabetes mellitus and other metabolic disorders</b> (September 25, 2019): Register at <a href="https://antheminc.cosocloud.com/e9l4sxzbd2lq/event/registration.html">https://antheminc.cosocloud.com/e9l4sxzbd2lq/event/registration.html</a>.</li> <li><b>6. Behavioral health</b> (November 27, 2019): Register at <a href="https://antheminc.cosocloud.com/eatxsocnqf6h/event/registration.html">https://antheminc.cosocloud.com/eatxsocnqf6h/event/registration.html</a>.</li> </ol>	

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## Home health billing guidelines for contracted providers

This information is intended for providers who **do not** submit their claims to MyNexus.

Below are some billing guidelines we recommend home health providers use when billing a Request for Anticipated Payment (RAP) and final claim to Amerigroup. This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract.



- Amerigroup should receive the final bill within 120 days after the start date of the episode or 60 days after the paid date of the RAP claim — whichever is greater. If the final bill is not received within this time frame, the RAP payment will be canceled/recouped — This is a [Medicare billing requirement](#).
- Bill the full Medicare allowed amount for the episode as the billed charges. Do not bill only the expected additional payment on the final claim as the billed charges. When this happens, the Lesser of Logic term in your contract affects the final payment made for the services. If the billed charges are less than the final allowed, the payment will be reduced to only pay up to the billed charges. The billed charges on the final claim should be for at least the full Medicare allowed amount for the services rendered. This will allow the claim to process correctly according to Medicare guidelines.
  - Example: RAP claim paid \$500. The final claim is submitted with billed charges in the amount of \$1,000. The Medicare allowed amount is \$1,500. Since the billed charges on the final claim are only \$1,000, Amerigroup would only pay an additional \$500 for the final allowed according to the Lesser of Logic term in the contract. If the provider would have billed charges in the amount of at least \$1,500, then an additional payment of \$1,000 would have been paid.

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## Partial hospitalization services



Medicare Advantage plans under Amerigroup follow original Medicare guidelines and billing requirements for partial hospitalization services.

CMS regulations (*42 CFR 410.43(c)(1)*) state that partial hospitalization programs (PHPs) are intended for members who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. All partial hospitalization services require prior authorization.



**Read more online.**

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## Fall prevention tips

Each year, falls result in more than 2.8 million ER visits, 800,000 hospitalizations and 27,000 deaths. Additional information about helping patients enrolled in Amerigroup Amerivantage (Medicare Advantage) prevent falls is available [online](#).



**Read more online.**

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## Submitting corrected claims

Amerigroup will treat corrected claims as replacement claims. When you submit a corrected claim, it is important that you clearly identify that the claim is a correction rather than an original claim. Refer to the instructions below for information on submitting *CMS-1500* and *UB-04* claims.

### Electronic *CMS-1500* claims

Enter Claim Frequency Type code (billing code) 7 for a replacement/correction. Enter 8 to void a prior claim in the 2300 loop of CLM\*05 03. Enter the original claim number in the 2300 loop of the REF\*F8\*.

### Paper *CMS-1500* claims

Amerigroup will accept:

- *Corrected claim* written on the face of the *CMS-1500* claim.
- The *Provider Adjustment Request Form* clearly identifying the information being corrected.
- Entry in box 22 of the claim:
  - Use resubmission code 7 to notify us of a corrected or replacement claim.
  - Insert an 8 to let us know you are voiding a previously submitted claim.
  - Enter the original claim number in the Original Ref. No. field. If that information is not available, enter the original document control number.



### Electronic or paper *UB-04* claims

- Amerigroup will continue to accept the *Provider Adjustment Request Form* clearly identifying the information being corrected.
- When submitting a corrected claim, ensure the type of bill is xx7 (correction/replacement) or xx8 (void) when the correction is made within the initial claim one year timely filing limitation.

When you need to correct a claim and it is beyond the timely filing limit of one calendar year from the through date on claim, you should resubmit a reopening request (type of bill XXQ) to correct the error. Reopenings are typically used to correct claims with clerical errors, including minor errors and omissions, and are conducted at the discretion of the plan. Therefore, it is not appealable, and the original initial determination stands as a binding decision. Appeal rights are retained on the original initial determination. Omissions do not include failure to bill items or services such as late charges.

Note: For adjustments and reopenings that result in higher weighted diagnosis-related groups, there is a congressionally mandated time frame of 60 days from the initial claim determination.

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# Prior authorization requirements

## DME repair and portable oxygen concentrator

Effective July 1, 2019, prior authorization (PA) requirements will change for for DME repair and portable oxygen concentrators to be covered by Amerigroup.

### PA requirements will be added to the following:

- K0739 — Repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes
- E1392 — Portable oxygen concentrator, rental

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Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services 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.**

### To request PA:

- Web: <https://www.availity.com>

Not all PA requirements are listed here. PA requirements are available to contracted providers through the [Availity Portal](#). Providers may also call the Provider Services number on the back of the member's ID card for PA requirements.

# Reimbursement Policy

## Policy Update — Medicaid Professional Anesthesia Services

(Policy 06-019, effective 09/01/2019)

Amerigroup allows reimbursement of anesthesia services rendered by professional providers for covered members. Reimbursement is based upon:

- The reimbursement formula for the allowance and time increments in accordance with state guidelines.
- Proper use of applicable modifiers.

Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time **starts** with the preparation of the member for administration of anesthesia and **stops** when the anesthesia provider is no longer in personal and continuous attendance. The reimbursement formula for anesthesia allowance is based on state guidelines.

Amerigroup considers reimbursement for procedure codes 01960 and 01967 with a flat-fee rate. Effective September 1, 2019, time-based add-on code 01968 must be billed in addition to the flat-fee for anesthesia for cesarean delivery following neuraxial labor anesthesia. Amerigroup will also require that anesthesia providers to submit modifier U1 or U2 in combination with an appropriate pricing modifier when billing for any payable anesthesia procedure codes.

Please refer to the *Professional Anesthesia Services Reimbursement Policy* for additional details at <https://providers.amerigroup.com/TX> > Provider Resources & Documents > Quick Tools > Reimbursement Policies > Medicaid/Medicare > Anesthesia > [Professional Anesthesia Services](#).

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